Population Health Management (PHM) Advisory Group – Meeting #9

April 26, 2023

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Emma Petievich – 00:00:12	Hello, and welcome. My name is Emma, 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 Pamela Riley, Chief Health Equity Officer and Assistant Deputy Director of the Quality and Population Health Management Program at DHCS.
Slide 2	Pamela Riley – 00:00:44	Hi, good afternoon everyone and welcome to the April CalAIM Population Health Management Advisory Group meeting. Welcoming you on behalf of all of my DHCS colleagues. Before we get into the primary agenda, we did want to take this opportunity to remind everyone that the public health emergency is ending and millions of Medi-Cal me members may soon lose their coverage. And our goal is to minimize that disruption to our members and promote continuity of coverage for our members. So how you can help. As we presume, normal Medi-Cal eligibility operations members will need to know what to expect, and what they need to do to keep their coverage. Most will remain eligible for Medi-Cal or qualify for tax subsidies that allow them to abide affordable covered California coverage, but we really need your help with this effort. So to that end, you can become a DHCS coverage ambassador. DHCS Is engaging community partners to service coverage ambassadors to deliver important messages to Medi-Cal members about maintaining their coverage after the public health emergency ends.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 2-3	Pamela Riley – 00:02:01	And we hope that these coverage ambassadors will be serving as the trusted messengers to really reach out to members in culturally and linguistically appropriate ways and really connect members at the local level to make sure that their coverage can continue. So if you would like more information about becoming an coverage ambassador, please download the outreach toolkit on the DHCS coverage ambassador website, and you can also join the mailing list to receive updates about toolkit information once it becomes available. We do want to just make people aware of the communication strategy. As you know, the end of the public health emergency will really require a very coordinated and phase communication campaign, really to that is going to most effectively reach members with messages that resonate with them, and we will rely heavily on the coverage ambassadors to get those messages out. The campaign is engaging in a two phased approach. Phase one is currently underway.
Slides 3-4	Pamela Riley – 00:03:11	And it's really designed to encourage members to provide updated contact information to the extent possible, so that they can make sure that they have the most appropriate and up-to-date information about keeping their coverage. And phase two is alerting people to watch for renewal packets in the mail. And this is really, again, making sure the most important thing that we launched 60 days prior to the end of the public health emergency, and it's really designed to make sure that people are looking for that yellow envelope in the mail to make sure that they can continue to renew their coverage. So again, we are relying on all of you as partners in this effort, and you can sign up on the DHCS website for additional information. With that, I will turn to our primary agenda. On today's agenda, we are looking forward to a conversation with all of you about the population needs assessment and how we might re-envision that moving forward to more effectively meet the needs of our members.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Pamela Riley – 00:04:17	So we will have a three-part agenda. The first is an overview of re-imagining the population needs assessment overview of the vision and current state for doing that in order to better align health plan, public health and community efforts to really better understand and address the needs of members and communities. Then we will turn to a panel discussion on the value of collaboration within existing population and community needs assessment efforts. And finally, we will conclude with the bulk of the time for discussion hearing from all of you. We will give you an overview of DHCS's proposed approach to re-imagining the population needs assessment and discussing with the Population Health Management Advisory group, and we will conclude with next steps. And with that, I will turn it over to my colleague Yoshi Lang.
Slides 4-5	Yoshi Lang – 00:05:10	Hi, everybody. Good to be with you all today. My name is Yoshi Lang. I'm a practicing family physician out in Contra Costa County and a medical consultant with DHCS and population health management. And so we're going to launch into this discussion about reimagining the population needs assessment. And when I think about this, the way I conceptualize it is that this is about asking managed care plans to stretch a bit beyond a focus on solely their members and try to deepen their understanding of the communities in which their members live. And we really believe that this new PNA will ultimately strengthen our ability. And when I say our ability, I mean all of us here in this virtual room. So the state MCPs, public health hospitals improves our ability to improve the lives of communities in California. So I think this work is critical, and we're glad you're all here for the discussion. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Yoshi Lang – 00:06:21	So the context. I think most people are aware, we launched the PHM program January of this year. It's a cornerstone of CalAIM. And to support the success of the PHM program, we're really emphasizing redesigning the MCP requirements for the population needs assessment. And I wanted to pause here for a second to mention that we know that the NCQA requirements for MCPs are a lot regarding the population assessment, and so we're really aiming to reduce duplication of work and promote alignment there. Also, PNAs have historically been the mechanism that MCPs use to identify the priority health and social needs of their members. And today, we're going to share our vision and a proposed approach to do this redesign and get your feedback. Next slide, please.
Slide 7	Yoshi Lang – 00:07:22	I'm still seeing the same. There we go. Whoop. There's probably a delay. I'll wait just a second to get back to... Yes, there we go. All right. So DHCS's vision is that this new PNA is going to do several things. So one is to promote deeper understanding of member needs, particularly around social drivers of health. We're going to advance upstream interventions that look beyond the four walls of healthcare, right? There's only so much I can do as a family physician and a clinic room with a patient. And we want to deepen relationships between MCPs, public health, and other stakeholders like CBOs. We want to reduce community fatigue. We know that communities get surveyed from various entities about the same topics, and we don't want to do that. We want to strengthen a focus on equity by integrating data from various sources, and then we also want to support public health response to emerging trends. Big one recently was COVID. We want to improve their ability to respond to those trends, especially where MCPs can intervene, so provide coverage, education, and outreach.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 7-8	Yoshi Lang – 00:08:31	That applies also to communicable diseases other than COVID, of course. So to achieve this vision, DHCS is proposing the central requirement that MCPs collaborate with local health departments. Next slide, please. We're going to start talking about requirements. So on the MCP side of requirements, they have to meet DHCS and NCQA requirements to assess the needs of their population. So there's a lot of text here. This is more for your reference, so I'm going to direct your eyeballs to the bold words. On the DHCS side, the requirements have been around for a long time, and that's mostly about meeting state and federal requirements on a couple things which are listed there. Other thing to note throughout these slides is the timeline, because that's another place we're really looking for alignment. And currently, the DHCS requirements say you got to do this every year. On the NCQA side, the other side of this slide, we're noting here, California MCPs are required to obtain this full health plan accreditation and health equity accreditation with NCQA by 2026.
Slides 8-9	Yoshi Lang – 00:09:49	NCQA requires every plan to develop what's called a PHM strategy. And then to inform that strategy, health plans must conduct an annual population assessment. So we can't change what NCQA requires, but we can align what they require with our vision, and that's part of what we're trying to do. Okay, next slide. So now, we're going to shift, I'm talking about requirements on the public health and hospital side. So public health entities and nonprofit hospitals have this long history of assessing community needs and having that informed local action. And these assessments are referred to as community health assessments or CHAs, Community Health Needs Assessments, or CHNAs. And these are accompanied by what's called a community health implementation plan. So that's the action side of what they do. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Yoshi Lang – 00:10:48	And a little more about the requirements for public health and hospitals. Since the requirements do overlap, and the populations overlap, some of the LHDs and nonprofit hospitals already collaborate on their assessments. And wanted to note here, again, just looking at the bold words under public health requirements, they have to do it every five years, but some actually do it every three years so that they can align with their local hospitals assessment and the LHJs, local health jurisdictions, are required to submit a public health plan every three years. And then nonprofit hospital requirements, that's also every three years. So directing your eyes to the right side of the slide, there's a lot of variation in the CHAs, CHNAs, but something they usually have in common is they have this really great robust governance structure. And that can include CBOs, academic institutions. We're going to hear from San Francisco/UCSF today, and other community leaders.
Slides 10-11	Yoshi Lang – 00:12:00	They also get a wide range of community input and use diverse data sources. So this isn't just quantitative data, but there's also quantitative data, like interviews and focus groups. So various data there. And one more slide from me, which I am not going to read through this table, but this is just showing that there's a lot of overlap, I think that's a theme that I've been trying to point out here, between these various sectors. And there's really an opportunity to try to align these sectors more closely. So you can see there's the Medi-Cal MCPs, local health departments and nonprofit hospitals. And what we just outlined here is what's the authority that's sort of requiring this work? What are the timelines, what's the jurisdiction? Just as a visual to help us think about how to align all of this activity that's going on.
Slide 11	Yoshi Lang – 00:13:00	So the last thing I'll say is if we can get healthcare delivery and public health and hospitals to all work together to really try to improve the health of Californians, that would be such a powerful thing. And with that, I will hand it off to my amazing colleague, Carrie Whitaker. Take it away, Carrie.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 11-12	Carrie Whitaker – 00:13:21	Thanks, Yoshi. And hi everybody. This is Carrie Whitaker. I'm a nurse consultant with Quality Population health Management within DHCS. I'm part of Yoshi's team, and working with Dr. Palav Babaria. And I am here with our wonderful guests and panelists. And we wanted to start off by saying that usually in these population health management advisory group meetings, we focus on a member story. But today, we're going to actually center around community stories because we're talking about community and population assessments. And you could think of it, the data generated, leveraged and interpreted through those assessments do tell us a story about communities and populations and how unique they are, depending on where you go and timing and all that. And they say a lot. The data say a lot about challenges, strengths, and priorities. So to illustrate these stories and the value of a more collaborative community level needs assessment, we're joined by a panel of guests who have participated in these, and they have all graciously offered to share their experience for this purpose.
Slide 13	Carrie Whitaker – 00:14:38	Let's see. So we'll go to the next slide, but I'll say that after this panelist session, which I'll help facilitate QQ&A, Dr. Babaria will come on and present our concepts and research around where we want to go and how we were informed by that, and then open it up to panelists and advisory group discussion at that point. And then again, all of our guests who are not panelists or advisory group members, also please use the chat. This is meant for all of us to engage. So thank you all for joining this panel to share your experience working on collaborative population level needs assessments. And as I first go around to introduce each of you to the others on the call, I will also ask how you and your respective organizations intersect with population and community level health assessments, just briefly for context for everyone else. We're all coming from different disciplines and different communities today.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Carrie Whitaker – 00:15:42	Then I'm going to facilitate a more in-depth Q&A session, so that the participants on the call get a better understanding of what more collaborative approaches look like practically, or even if they are also participant in more collaborative approaches at population level assessments, how this collaboration looks like with you and maybe get some good ideas. So thank you for being here and sharing the wonderful work that you're doing for your communities, our communities in California. So I'll start with Peter Shih. Peter Shih serves as San Mateo's County Senior Manager of Delivery System planning, and is also a member of the County Health Executives Association of California, also called CHEAC. And Peter can provide our local public health department program administrative perspective on the panel today. And we're also grateful that CHEAC executive director, Michelle Gibbons, is also here and can chime in to enrich the conversation. So thanks for being here, Michelle. We know we have a public health perspective is not all public health perspectives, so we appreciate that. And Peter, before I introduce the other folks, can you tell us about your involvement in local health jurisdiction needs assessments briefly?
Slide 13	Peter Shih – 00:17:04	Sure. Thanks, Carrie. Happy Wednesday everybody. Actually, all this work that I've been doing started back in 1995. Now, it kind of dates me, but this is when SB697 was approved in 1994 and I was working for Daniel Freeman Hospitals in LA. And then went to South Carolina, got really involved with the public health department there as part of Greenville Hospital system, and then San Diego County with LiveWell San Diego, and then now here in San Mateo. So that's sort of been my experience on both coasts of this country. So pretty excited to be here and talk with the team about this.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Carrie Whitaker – 00:17:51	Awesome. Thank you. All right. And next, representing the San Francisco Health Improvement Partnership, we have our guest, Esperanza Macias and Alex Mitra. And what San Francisco Health Improvement Partnership, or SFHIP, is a cross-sector of collaborative public health and hospital-based anchor institutions that then also work with health equity coalitions and educational faith-based and service provider networks serving the city. And SSFHIP has conducted these community health needs assessments since 1994, so we've got some old schoolers on the call. Thank you. And I'll also add, Esperanza is the director of policy and communications and represents the Instituto Familiar de la Raza, which is a health and wellness community-based organization. And Alex is the director of community health and Volunteer services from Dignity Health Hospital System within San Francisco. And as co-chairs, they work to lift community voices to inform San Francisco's community health needs assessment. So Esperanza and Alex, would each of you please briefly share how you first learned of this collaborative and why your respective organizations decided to join it?
Slide 13	Esperanza Macias – 00:19:11	Thank you, Carrie. I've been a part of SFHIP for about four or five years. SFHIP includes three health equity coalitions representing the African-American, Asian-American, Pacific Islander, and Chicano Latino health equity coalitions. I was the chair of the CLI Health Equity Coalition. And as such I was able to serve on SFHIP as their representative. The CLI was comprised of various Latino serving health related organizations. And so we, kind of as a coalition, wanted to play a role in SFHIP with a broader health landscape of San Francisco. And so I was able to participate in the last two CHNAs for San Francisco.
Slide 13	Carrie Whitaker – 00:20:05	Great, thank you, Esperanza. And how about you Alex? How did you decide?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Alexander Mitra – 00:20:11	Thank you, Esperanza. I came in 2018 and was really marveled at how SFHIP was a way to both conduct the needs assessments jointly with a broad group of stakeholders, but also stay at the table to address the needs that we identify. I think we hear from the community often that we keep assessing them over and over again, but what's the next step? Where are we actually addressing those needs? And how do those needs both exist in our organizations? And how can we address them outside of the organization? So very lucky to have been part of this. Esperanza is a wonderful partner in this. And I think the unique thing about SFHIP is how we are intentionally lifting those community voices because they bring insights that we don't see in our EMRs and various data sources across the state.
Slide 13	Carrie Whitaker – 00:21:02	Oh, thank you. And last but not least, we have Nishtha Patel on. And were you able to join? We were having some technical difficulties.
Slide 13	Nishtha Patel – 00:21:15	Yeah.
Slide 13	Carrie Whitaker – 00:21:15	Yay. I'm so glad. All right, well Nishtha is a special programs manager from Inland Empire Health Plan, also known as IEHP, which is a Medi-Cal managed care plan in California. And NHA supported IEHP's first community health assessment in 2022 as a stakeholder committee member in collaboration with other health and social service delivery system representatives within Riverside and San Bernardino counties. And Nishtha brings the perspective of a managed care plan. So Nishtha, would you please briefly share how you and IEHP became involved in last year's Riverside and San Bernardino CHA?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Nishtha Patel – 00:21:57	Sure. So IEHP actually has a very longstanding relationship with the county entities and community partners, and I think that stems from the fact that our region is particularly challenging when it comes to social determinants of health. So our leadership was interested in coordinating a community health assessment because addressing some of those needs and our community can't really be done without community partnership. While our membership does include a large portion of the residents living in the county, it doesn't include everybody, so it was in everyone's best interest for the region to kind of work together to identify care gaps that we were all interested in so that we could better coordinate initiatives to address them.
Slide 13	Carrie Whitaker – 00:22:48	Thank you. All right. Now that we have some background for the rest of the participants and each of you, we'll ask each of you specific questions to help all of us on the call learn from you and from each other. So the first part of the panel questions is kind of about the nuts and bolts of collaborative groups and processes. And again, we'll start with Peter. As a CHEAC representative from your experience in San Mateo and other counties and states where you've worked, could you tell us generally about what kind of stakeholders are usually involved in local health department community health assessments and what types of data are commonly leveraged or primary sources of data?

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Peter Shih – 00:23:38	Sure. Thank you Carrie. We, in San Mateo, have been super collaborative since the nineties, mid-nineties, right? And we've brought a lot of folks together. And people like the local health plan, obviously. And by the way, San Mateo is a small county where we only have one health plan. And then the schools, the Human Services agency, CBOs, other federally qualified health centers. So we bring a lot of folks to the table. And our data that we collect is pretty comprehensive, obviously the health metrics, income, employment. We even have a question about community attachment, domestic violence data, school readiness, availability of childcare, how many folks are on government assistance, and obviously homelessness. So these are all data points that we take to bring together to get a real good view of what's happening. And like you said earlier, Carrie, every county's a little different, but the local health department is usually a convener.
Shared Screen	Peter Shih – 00:24:55	We bring folks together. And that's what we do, I think really well, getting them to the table. I think that the challenge that I've seen across the state and other parts of the country is we may agree on pulling the things together and what's in front of us, but oftentimes we don't have a joint project. We have organizations who act like sovereign nations and kind of do their own thing. And I think that's the challenge, is that we have to have not just the gathering of conversations about what data we need to gather and what the data tells us, but finish that with working on joint projects together make a tremendous impact across the counties that we are in. So I think I experienced that in San Diego, and I also experienced that here in San Mateo. So it's pretty consistent, and I think some of our other counties also have that challenge, is getting everyone on the same page to do the things that we see from the data.

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Carrie Whitaker – 00:26:06	Yeah, that's a lot of that community fatigue, is what are you going to do with all that data you asked us for? Yes. Thank you. And a similar question for SFHIP. Specifically, what types of stakeholders in San Francisco, different city, county, do you work with maybe consistently or maybe are more highly involved in the processes, if that even applies? And what types of data are you looking for and leveraging to understand San Francisco's needs better?
Shared Screen	Alexander Mitra – 00:26:42	I'll take this one. I'll start off. And Esperanza, please let me know if I miss anything. I will say our local public health department is so crucial in this effort because they have those county and city relationships to be able to pull that data. State level information is three year lagged a lot of the time. And as we were going through COVID, we knew that information is pulling... It's very outdated due to COVID. In addition to the partnership with the county, really our partnerships with the joint health equity groups, the CLI, the API, and the African American Joint Health Equity groups are so crucial to get that qualitative data, that real community voice for us to hear what is going on. Because oftentimes, that kind of bubbles up what the quantitative data is saying. Esperanza, anything to add?
Shared Screen	Esperanza Macias – 00:27:46	I think to that, I might just add, we also include the unified school district, our consortium of community clinics and a few others that are not typically thought of to participate in a CHNA as fully, and throughout the year with SFHIP. That, I think has really enriched our process, but I think it also addresses one of the issues that Peter mentioned that is a familiar challenge to us, is that how do we identify an issue to work on jointly that impacts the schools, as well as hospitals and other primary care facilities and CBOs in a way that feels like all of this time and energy will go to a cohesive collective impact? I think that it continues to be a challenge. At the same time, because of COVID, I think we were able to focus more on qualitative data to further enrich our findings.

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Esperanza Macias – 00:28:51	We learned that the CBOs are also a wonderful source of providing data because they were able to not only point to individual health issues, but they were able to see the patterns within the communities, the vulnerable communities that an individual providing input is enabled to offer, as well as we were able to offer our findings within a context of social determinants of health, and that made it more accessible and relevant to housing and homeless groups, senior groups and others where the issues of access to care, behavioral health, and perhaps how we deliver services became a larger conversation that impacted more people.
Shared Screen	Carrie Whitaker – 00:29:49	Thank you all. Thank you for the work that you do for San Francisco, and for the folks that sometimes maybe feel left out in the conversations. All right. And then Nishtha, could you tell us about your 2022 community health assessment experience and how that aligned maybe with the additional population needs assessment that your managed care plan was also implementing concurrently? And then I have two other little questions on that, so ask me, please, to remind you, but also... And for the community health assessment specifically, again, similarly to what I asked, what were some primary data sets that you leveraged that made a big difference in your findings? And what communities did other stakeholders working on this trial represent?

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Nishtha Patel – 00:30:41	Sure. So for your first question, RCHA and PNA actually had some similar areas of focus, I would say. But the difference was that the CHA kind of... Because it wasn't a requirement, it had a little more flexibility in terms of what we decided to focus on with our community partners. So it was kind of left open for our stakeholder group to kind of decide what their areas of focus would be. They weren't necessarily surprising, because like I said, some of them did overlap with areas of interest in PNA, mental health, maternal and infant health, homelessness. All of these things came up when it came to both assessments. But for the CHA, our primary data sources, so we had both primary and secondary data. We actually utilized a consultant to kind of aggregate all of the data and all of the information for us. So we used both claims data, some census data. And then they had their own data warehouse as well, which we were able to pull from that pulled some regional data in terms of the rate of homelessness in each individual region.
Shared Screen	Nishtha Patel – 00:32:09	We had rates of disease prevalence by region. So we were able to pull all of those things and build one sort of like an interactive website where you can toggle the regions and the Inland Empire to show some of the health outcomes of interest in those regions. And then some partners that we had for the CHA were all of our community hospitals. We had First Five, we had the Departments of Public Health from both counties. We had a couple of CBOs, Kaiser, several members from IEHP. And those are the ones that come to mind. But we actually had to separate our community health assessment into two separate assessments. So one was a community based health assessment. One was a community health needs assessment. The needs assessment was specifically for hospitals. And the reason that we had to do that was because the areas of focus for hospitals were obviously very different than the areas of focus that our stakeholders wanted to focus on overall.

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Nishtha Patel – 00:33:22	And hospitals are interested in specific disease outcomes and metrics that affect their immediate area for the patients that they see in each of their facilities. But for us as a plan for the counties, for our CBOs, we wanted to see something a little more region-wide and not as specific to smaller region.
Shared Screen	Carrie Whitaker – 00:33:45	That makes sense. And that's also really interesting how you, again, were able to have that flexibility to meet the needs. The study did not design needs that were demanded, so you understood your communities. And nothing got kind of drowned out for one subpopulation within the Inland Empire. Also, very cool that you developed a product that was available for the public to review all of the data, I think on that data dashboard that you were referring to. Okay. So that's a good jumping off point to talking about the benefits from your perspective that you've realized from participating in this, or that you've seen your communities that you live in and work in realized, and maybe some of the lessons learned tied to that. So let's start maybe with Esperanza. Could you talk about the advantages of receiving community input and integrating the voices of those specifically who are thought of as historically unheard?

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Esperanza Macias – 00:34:59	Yes. And I will say also that the inclusion of input from community organizations along with that individual level data was really critical. There's a level of translation and a level of trust that it doesn't feel like data fatigue when it comes from people that they receive services from regularly, where there's a preexisting relationship, that even were language... And not even English versus another language, but in the Latino community there can be 20 different ways to suggest that a person has depression or anxiety without ever using those words. And the community liaison experience, I think has been very helpful in that. I think also, as I mentioned earlier, it provided for a macro view of what the broader issues are that impact particularly communities of color that have more specific needs. We can all oftentimes be very shallow in the level of data that we collect on individual communities that also are based on the number of years that they're here, the specific language or dialects that they speak, the particular experiences that are... the type of trauma that they have, whether that comes from their immigration experience from a war experience or other.
Shared Screen	Esperanza Macias – 00:36:42	And the qualitative data a allowed us to go a little bit deeper and understand that so that we knew what type of need we were really uncovering. And so with our current CHNA, I think it was the first time that we were also able to... As a result of those community voices coming from individuals and organizations, we were able to provide targeted recommendations in our CHNA. And I think that this was probably the first time we were actually able to do that, so that hopefully it gives some guidance to our county Department of Public Health to look at that in the years ahead.

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Carrie Whitaker – 00:37:27	Wow. Yeah, that's amazing. You're helping us all ask the right questions and use the right ways of delivery that are preferred by the communities by getting this better level of depth than we could ever do any one organization. That's amazing. And Alex, can you talk about the benefits with working public health? I think maybe last year, or last time maybe, San Francisco Department of Public Health couldn't be involved as much, but it sounds like you've been working with the health department in your experience, right?
Shared Screen	Alexander Mitra – 00:38:08	We have.
Shared Screen	Carrie Whitaker – 00:38:08	Yeah.
Shared Screen	Alexander Mitra – 00:38:09	And they've been a great partner. We know 20% of a patient's health outcomes come from clinical care. That means the other 80% come from social determinants of health. And so how do we pull that information? How do we learn more about it? How do we connect to those services? Really public health is one of those connection tools public. Here in San Francisco, public health has been really helpful with data crunching, again, pulling from data sources, but also having epidemiologists who can take a look at that data and really filter it through a lens with that community voice so we can have a more robust assessment. I also think public health creates an almost neutral convener and allows us to build those relationships. I think, I'm not sharing anything that everybody doesn't know, that maybe manage care plans and hospitals sometimes have more challenging relationships.
Shared Screen	Alexander Mitra – 00:39:11	And I think public health can be that convenor where we just we're talking about an area. And they're able to set it so there's less agendas that are set there. And also operationally, those public health departments do receive state and federal dollars to provide those services. And so I would imagine that MCPs and hospitals want to be at the table to learn about new services that are being offered, what are the new best practices? And so there's multiple reasons why it's really helpful for, at least us as a hospital, and I imagine others to be at the table with public health as that convener.

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VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Carrie Whitaker – 00:39:50	Thanks, Alex. And I'll move on to Nishtha representing IEHP. What are the most salient ways that Inland Empires the region's community health assessment, both deepen IEHP's understanding of population serves and strengthen community partnerships?
Shared Screen	Nishtha Patel – 00:40:14	I think because our membership makes up about 25% of the people living in the region, I think we always had an understanding of where health disparities lived in our region, whether that was in a specific zip code, whether that was health disparities faced by certain demographic groups. So we had an understanding of that, but I think the value in community partnerships is that each CBO, each county office, each hospital, they're all going to see different things based off of where they are and who they interact with. And having access to that sort of information and that data just better guides all of the organizations to kind of prioritize their efforts in reducing health disparities in the region. Because while we can speak to our membership specifically because we have access to claims data, obviously, that doesn't mean that we can speak to the region in the Inland Empire as a whole. And because social determinants of health are so... They're so impactful on community's wellbeing, it's better to get an understanding from all community partners as to what they're seeing in the region, what resources that they have available.
Shared Screen	Nishtha Patel – 00:41:49	And instead of maybe everybody kind of trying to move the needle on their own, it's better to collaborate, share resources. Whatever resource that may be, whether it's funding, whether it's workforce, whatever it is, it's just better and more effective for everybody in the community to work together.
Shared Screen	Carrie Whitaker – 00:42:18	Thank you. And then Peter, what are some ways that you can think of the county CHAs have helped to improve community health and strengthen relationships within the counties you've served, or what are some highlights that you can think of?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Peter Shih – 00:42:35	How much time do I have? Let me keep going. No, I think one of the great things about county CHAs is that as a local health department, we're responsible for all residents, right? We Mandates are not funded, but we continue to do that work. We gather data across all disciplines. We analyze it, and then we share that information with the community with a focus on population health. Really, we care about all of our residents. And so to me, the community's assessments that local health departments compile is really focused on how to lift everyone up. And I think the information that we gather really helped a lot of our response with the pandemic, and as a great example of that. And even in San Diego, all the information that we gathered was trying to lift everyone up. And for me, the CHAs that we do, we have to focus on how do we stand in the gap so that we can all thrive in San Mateo County or any other county.
Shared Screen	Peter Shih – 00:44:08	And our goal with the CHA are to help people be healthier. And so San Mateo and San Diego, the only two that I can speak to that that I've been part of, we brought people to the table. We try to address the issues. We even help try to secure funding as a group of folks coming together to do this. And so I think because the county is a real convener, we maintain strong relationships so that we can get things done. And so we don't compete, we collaborate, and most importantly, we care with compassion. So for me, the local health departments, all of our local health departments approach our CHAs this way. And I think that's the benefit of looking at it from a local health department perspective.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Michelle Gibbons – 00:45:11	Peter, this is Michelle. And Carrie, I just want to add too, that collaboration can't be underscored enough. I think it's really important to note too that when the CHAs and the CHIPs are created, it's not just about, okay, now what is public health going to do? There are responsibilities for other partners. And we talk so much about the social determinants of health. And the reason why we bring some of the other partners to the table is so that they can start to think through their piece of the plan, right? So if we're talking about educational attainment and school readiness and things of that nature, having the schools at the table as we create the plan, and then having schools take part in that plan, and say, "Okay, well here's our slice of the pie that we can start to address." And so it's really important because it's not just tackling it from a medical lens or from a primary care perspective or anything like that.
Shared Screen	Michelle Gibbons – 00:46:02	It's really about let's look systematically, let's do an assessment and build a plan that looks at everything systematically and says, "Okay, here's what we as the health department can do. Here's where the plan can do something. Here's where a hospital can support it. Here's where schools or other dynamics play in." And I think that is the benefit of having the health department be a part of that process and be the convener, because we have those partnerships. We do it in other spaces like active transportation, and there's so many other spaces where public health kind of sits in that gap, and it really lends to good collaboration, but also actionable steps that all partners can contribute to.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Carrie Whitaker – 00:46:40	Thanks, Michelle. And that's a really perfect segue to the last question that I'll oppose to everybody here. So please feel free to stay pinned in this Zoom space. We were going to acknowledge about how of course the logistics and sharing governments creates a lot of challenges, either perceived or experienced. And we do want to save time for Dr. Babaria, who's here now to go through what we're thinking going forward and open it up to... I'm sure lots of people also on the call who are in the advisory group or on the call would like to speak to that. So I'll end the panelist session, putting a pin in the challenges, but actually asking maybe if you all could take turns or think about specifically what roles the managed care plans could play in supplementing, enhancing these community health assessments, not just in their kind of corner of their subject matter expertise, but in other ways, how they can help bring resources or expertise data to the table. And what do you see? How do you see managed care plans working in more collaborative spaces? And I'm happy to...
Shared Screen	Nishtha Patel – 00:48:10	I can go first. Oh, sorry. I think it makes sense for MCPs obviously to be involved in this work, given our breadth of regional coverage and our access to data, but I think it's important to recognize that one of the largest challenges is when we have these... We have several requirements that expect us to pull data for various deliverables, and we're pulling data all the time. And I feel that the risk in having a CHA requirement or a new PNA requirement, if the requirement for submission is too close together, then the issue we're going to have is the MCPs are going to be pulling data and submitting it constantly, but there's no room in between for the plans to actually do any work with their community partners. It's just submission after submission. So I think it's important to recognize that in order for a CHA to be effective, we need to give MCPs the amount of time, one, to build relationships with their community partners because that takes a significant amount of time.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Nishtha Patel – 00:49:31	Give them the leverage and encouragement to probably use consultants because it's a big administrative lift if MCCs are going to be the ones leading the coordination of the entire process, and to spread the requirement out far enough that MCPs and their community partners have time to actually implement change in between, because collecting this sort of information... Publishing a community health assessment is only as valuable as the time that's given to actually do work to implement change in what the assessment has shown.
Shared Screen	Carrie Whitaker – 00:50:08	Thank you, Nishtha. That's a good set up for our next part of our conversation, but we'll give some space. Peter, I see your hands up. And Michelle, you were about to speak as well. And we'll see if after that if Alex and Esperanza have any final thoughts.
Shared Screen	Peter Shih – 00:50:29	Yeah, I just want to kind of tee up what I had shared at the beginning, having joint projects. And to piggyback on what Michelle said, every part of the stakeholder group has a role to play. And so we need to have clear guidance, because clearly it hasn't worked in the last 20 some years, where here's a community benefits requirement for hospitals and we're doing all this work. And San Mateo, for example, has been at this for a bit, and San Diego's got LiveWell, but we still haven't been able to get everyone on the same page about, here's what our needs are, and this is what we're going to tackle. This is your role. And then we all work together to lift that up. And I think that we don't want the state to be so prescriptive that then we don't have the flexibility. But now that we're looking at this in a very systematic way, maybe you could be prescriptive about especially the timelines, the funding streams, and about who's supposed to take on what.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Peter Shih – 00:51:39	And I think that's critical. We have a lot of great thinking, we've got a lot of great intentions, but we would just like to all row in the same direction. So that would be fantastic for us. I know Michelle's representing too, and I'm representing... It just feels like the relationships with the MCPs and the counties are so variable, right? In San Diego, we're like cousins. In San Diego, we had five plans. There's like seven plans now. There's a lot of sort of challenges with that. And some counties don't have a great relationship with the plans, and so there's that variability. And so maybe where the state can be helpful is to have some really clear guidelines to help say, here's what collaboration looks like. This is what partnership looks like, and these are potential outcomes of everyone working together. And it's like modeling the type of future ideal state that we're looking for versus here's our guidance, go and have at it.
Shared Screen	Peter Shih – 00:52:53	I don't think that's been necessarily helpful because we're still struggling through it. And I think it's important for us to have that collaborative clear direction from the state, what everyone's role is going to be, what the outcome looks like. And then that way, we can all row in the same direction.
Shared Screen	Michelle Gibbons – 00:53:16	Yeah. And I just followed behind that and share some key actions. I think the first thing that I hear on the call that I think CHEAC has been trying to articulate is that we don't want plans to have their own separate community health assessment process, because I think that that makes it disparate efforts instead of a collective effort altogether. And so what would be helpful is really incentivizing and supporting the plans to engage in the community health needs assessment and improvement plan process that already exists. And to do that, there's some things that we would love to see the plans do. For example, we would love to see plans help to invest in efforts that draw the community in. I know local health departments oftentimes will do little transportation cards or things like that that will help community members get to the meetings so that they can have their voices heard.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Michelle Gibbons – 00:54:03	So investing in those community opportunities, whether it's like a pizza party or something that can really help to support people to participate, that would be really helpful. The other thing is giving dedicated staff. I think it can't be underscored that this is not an effort that you participate in for a moment, and then you jump out and we just, we've done the plan and you go away. This is an iterative process, so you have to do the assessment, you put together the plan, and then there should be continuous engagement with all the partners. How are we doing? What did we say needed to improve? And where are we in that process? Let's continue to evaluate. Sharing data would be really helpful, making sure that there's that open line of data communication in exchange. And then I'd also just mention around supporting upstream interventions or tackling issues together and finding ways to leverage the work that happens, not just within the managed care providers, but in other parts of the system.
Shared Screen	Michelle Gibbons – 00:54:54	I think public health is maybe a unidentified partner in many cases that can help to address some of these key issues. If we talk about... I've seen community health improvement plans address communicable disease rates that are going higher, and at the top of that list is STDs, for example. Well, local health departments have some pretty proven strategies where we can get the STD rate down, and we know how to engage and we know how to do that from a competent manner. Leverage those expertise and skills. Also, when it comes to infant mortality or disparities in maternal mortality, this is work that health departments have been doing for quite some time. We have data on. We can also share some of the best practices and I know others in the community can too, so really just leveraging what's already being done and supporting processes, and really not just doing it one time, but making it an iterative, ongoing, committed, dedicated partner.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Shared Screen	Carrie Whitaker – 00:55:48	Thank you, Michelle. And that is actually... Dr. Babaria is about to present some of these ideas because we have done some research and stakeholder engage engagement with lots of you, some of you on the call. And we do want to get to that part so that we have all of the context we need to then open it up. I see Phoebe and Amy, you have your hands raised, but for the sake of time, I'd like to ask if Alex and Esperanza have maybe about a minute, any last words, and then we should move along to the PNA re-envision concepts so that we have all of the information we need to continue discussing the challenges and opportunities. Anything to add, Esperanza or Alex?
Shared Screen	Esperanza Macias – 00:56:43	This affects my colleague, Alex, and the hospitals much more than it does the community or organizations. That said, I would just continue to encourage a level of diversity and equity as a serious commitment at who's coming to the table and who's missing, and who are the best messengers to bring them in.
Shared Screen	Alexander Mitra – 00:57:12	Also, I was just about to say that, Esperanza, where trust is at a premium in the healthcare space, and really bringing in community is a very important way to understand, for those underserved communities, how to navigate the system, who to trust, who not to trust, how these interventions get rolled out. So to the extent that you can bring in those communities, I think it has to be part of the plan. But I'll leave time for the more robust discussion that's to follow.
Slide 14	Carrie Whitaker – 00:57:49	Thank you both. Thank you all panelists for being here. And we'll turn this over to Dr. Palav Babaria, our amazing Population Health Management Program deputy director. And Palav will take us through the next part of the meeting with our proposed collaborative approaches to manage care plan population needs assessment. And then afterwards, as promised, we'll have time to discuss. Thank you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:58:14	Thanks, Carrie. I don't know about amazing, but I'm here. So hi everyone. I think I've met many, if not most of you. Palav Babaria, Chief Quality and Medical Officer here at DHCS. Full disclosure, I'm sitting in a little tiny exam room at a community provider office in Riverside County. And I'll just preface, before we get into the slides, to say me and a few members of my team, we've been visiting sites throughout Kern and San Bernardino and Riverside County over the last few days, and I think the providers that we've met with and the plans that we've met with have really just underscored to me personally how critical it is that we start to integrate efforts to serve the Medi-Cal population at the local level. I keep getting the question, CalAIM is really ambitious. There's so much going on that it's really hard. There aren't enough providers, there aren't enough resources, there isn't enough bandwidth.
Slide 14	Palav Babaria – 00:59:03	And I think to lift up some of Michelle's comments earlier, the PNA and community health assessment process is one of those where we know right now we have silos, we have duplicative efforts that are not aligned. And I think one of the ways in which we all collectively move the needle on quality and health equity is by closer integration, collaboration, and really reducing both the silos, but also resource inefficiencies that we all know exist. So I think from the department perspective, we are hoping to walk through what our proposed approach is regarding the population needs assessment moving forward. So this is a concept. This is not final policy guidance, but look forward to the robust discussion. And we'll try to get through slides relatively quickly so we have time for that. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Palav Babaria – 00:59:52	So our proposal is that starting in 2024, instead of having Medi-Cal managed care plans that are contracted with DHCS fulfill their population needs assessment requirement by doing their own PNA and submitting it to the department, that instead, that requirement would be fulfilled by participating meaningfully in the existing CHA and CHIP process that is already led by county local health jurisdictions. So that plan is exactly, to piggyback off the conversation that we were having, would no longer do a separate siloed process. They would participate and contribute to the county-led process. I think two things to lift up. We recognize there are counties, where there are multiple Medi-Cal managed care plans. In those counties, we would expect all Medi-Cal managed care plans to participate with the county sort of leading the effort in a collaborative coordinated fashion. We also recognize that we have Medi-Cal managed care plans who operate in multiple counties, and local health jurisdictions. And in those cases we would expect that the managed care plan participates and supports the CHA and CHIP process in each and every single county in which they have a Medi-Cal contract. We're going to keep going.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 01:01:10	So I think just... Hopefully some of this has already come out in the conversation that we have had, but I think our vision and proposal is that the county local health jurisdiction really serves as the anchor to bring together all the various stakeholders. I think the rationale for that is obviously this is work that is already happening that is usually embedded very tightly with the community and community-based partners. Because it is led through a public health lens, it obviously also often looks at upstream drivers of health, which is a major critical and strategic priority for DHCS, through CalAIM and other initiatives, and really can serve as that anchor to coordinate all of the moving pieces in this process. We have looked at the data. When we get to the sort of next steps, you can see some of those citations where this type of approach has been shown to be successful in other parts of our nation, and really bridging that silo between public health and the healthcare delivery system.
Slide 16	Palav Babaria – 01:02:08	We also recognize that the current existing CHAs and CHIPs that happen with the local health jurisdictions, as you just heard, already have robust governance structures, and really engage the community in meaningful ways that can be leveraged by the managed care plans. We do recognize in current state, that the CHA and CHIP are done on different cycles for local health jurisdictions. So the expectation would be that managed care plans will move in the cycle that the local health jurisdiction is already in. Over time, we could see if there are opportunities to streamline and standardize some of those cycles, but right now, they are off cycle. And I think to one of the earlier comments, we also want to provide local health jurisdictions with support that is needed as they serve as anchors and not just issue this guidance, and then walk away. Peter, I think I is what I heard you say, and really think about how do we ensure that this isn't just guidance on paper, but that we are supporting our plans and counties and working together in this way.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Palav Babaria – 01:03:06	We can go to the next slide. I think Michelle's comments touched a little bit on this, but I think we envision that there are multiple ways in which managed care plans would be expected to and could participate in the local CHA and CHIP process. Obviously, a big piece of this is data that we know all of our Medi-Cal MCPs have a treasure trope of data on the Medi-Cal members that they serve in granular detail that could be de-identified and shared. There's obviously CHA and CHIP steering committees and decision making processes that managed care plans could participate in with other local partners. They could lead one or more CHA and CHIP working groups. They could also support exploring how to meaningfully engage tribal partners in the township process via the MCP tribal liaisons. They could provide staffing support. We heard that ask very clearly from our public health colleagues, to really ease the burden of how resource intensive effective community engagement can be.
Slide 17	Palav Babaria – 01:04:06	But I will underscore, I think we at DHCS absolutely agree with the statement that this is where we need to go. If we are ever going to make a dent in the health inequities in our state and in our program, it will not happen without meaningful sustained community engagement. There's also funding needs to support convenings, to support some of those pizza parties and small gestures of appreciation to members who participate in the CHA and CHIP process. And then they can also collaborate with local health jurisdictions and other participants to develop joint action plans that really address some of those upstream drivers of health that we know affect all the clinical quality and equity outcomes that we see. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 01:04:50	So I do hear in the conversation right before this, that there is concern about how often is this going to happen? And what will the burden look like? And will there be time to be thoughtful? So I do think we DHCS are very interested in sort of really limiting the administrative burden and making this about really meaningful strong partnerships and collaboration. So for the population needs assessment itself, the MCP's PNA requirement would be met through the publication of the local health jurisdiction CHA and CHIP. We would not expect MCPs to submit a separate PNA to the department. We would expect that they published the ships from their local health jurisdictions and explain how they participated in the process on their website, but there would not be sort of separate formatting, packaging and publication that would need to happen to DHCS directly.
Slides 18-19	Palav Babaria – 01:05:42	As you all know, at least for the MCPs, through our population health management policy guidance, there's also a requirement to submit a population health management strategy, and that is also an NCQA requirement. Our goal to reduce administrative burden is that we would ask you all the managed care plans to provide a brief population health management strategy that is informed by the PNA, and then also leverages what is already being done and submitted to NCQA that ties these pieces together, but to not recreate the wheel and have a very long intensive duplicative submission to DHCS. We can go to the next slide. And I think just to flag for people, since this is a proposal that we would expect to launch in 2024, for 2023, we are really trying to streamline and slim down the population health management strategy deliverable.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 01:06:36	And the current proposed approach is that we would ask all managed care plans to create one smart goal that involves collaboration with your local health jurisdictions. Again, not necessarily the CHA/CHIP process because that is going to take a few years to stand up, and local health jurisdictions are in different phases. But to really start establishing these relationships and identifying one common goal, and that is also aligned with DHCS' strategic priorities, as well as a description of how you already have started or will start to participate in the CHA and CHIP process, as well as an attestation that will be relatively brief. And go to the next slide.
Slide 20	Palav Babaria – 01:07:16	So I know I breezed through that, but I do want us to get to the meat of the conversation, which is really to open it up and hear from all of you, what do you think are the benefits of this approach? Do we think that this will help break down silos, improve collaboration, reduce community fatigue? Recognizing that this collaboration will take time and effort, what are some of the challenges that you all foresee coming up if we move forward with this proposed approach? What else are your ideas of how we can address or maybe mitigate some of these challenges? And then beyond the managed care plans, local health jurisdictions and nonprofit hospitals where there are obviously set requirements, what should the role of other entities be in the proposed approach? And I will open it up to ask Carrie or Natassia or others, did I miss anything that I was supposed to have covered in this section?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Carrie Whitaker – 01:08:13	Well, I forgot to say that also, we'll be releasing a concept paper with all of this. We're just going through the final accessibility review process. And we will also invite you all to review discussion questions that'll be found at the end and submit your feedback. So there's this opportunity here. We'll be capturing in the chat, anything that we can't talk about, we run out of time to talk about online. And then we are trying to develop this with you also that it actually works. So we do really want your feedback, and that's another way that you can provide it. And we'll be able to release that paper with the discussion questions and instructions on how to submit widely once we have that published, I think next week.
Slide 20	Palav Babaria – 01:09:11	Great. And I'm going to turn over to Natasha to help facilitate the Q&A portion.
Slide 20	Natassia Rozario – 01:09:17	Wonderful. If folks want to raise their hands to answer any of the questions here, we can begin with that. And then there are some questions in the chat as well so why don't we start with these questions, if folks want to raise their hand? Great. Caroline, you go first?
Slide 20	Caroline Sanders – 01:09:40	Hi. Thank so much for this presentation, and I'm still taking all of this in. I think I had... Just to go back to the initial, I think goal of the PNA, the health education and linguistic needs assessment, as it was formally called, I love the upstream approach. I'm just curious how the community health needs look specifically at the special needs of the populations that are to be served by the PNAs, seniors and persons with disabilities, children with special healthcare needs, members with limited English proficiency. I know you know, talked generally about that, but I think the goal, in our view of the PNA, is to ensure that if there are gaps in the services that a health plan specifically is providing to those communities, that those gaps are filled. And so I'm just curious. I'd love to hear your thoughts on how CHA could ensure that that's still happening at the plan level, and really get to some of our questions around those particular populations. I appreciate all the other benefits that you've mentioned, but just really want to see if we can drill down a little bit on that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 01:11:07	Such a great question. I'm glad you asked him. We probably should have preempted that question. So I think one of the things that went into our thinking was the PNA was obviously conceived of and has been going on long before we had a population health management program as a part of CalAIM, as well as long before all of our health plans were required to be NCQA accredited and meet the NCQA accreditation requirements, specifically for population health management, which went live a few months ago. So when you look at the actual NCQA requirements, for accreditation and the assessment that plans have to do as well, as the population health management strategy, Caroline, almost everything that you just listed out is covered in those requirements. Full disclosure, those requirements are proprietary, so we are not allowed to publicly publish what all of those nitty gritty details are.
Slide 20	Palav Babaria – 01:11:55	We can take back to see if there are publicly available examples of what those assessments, and really the PHMS strategy that plans will be submitted to NCQA look, because most of that is covered in there. So then the thought exercise was we don't want to duplicate efforts or have sort of extra administrative burden. So what is really the role of the PNA that is not already covered in that NCQA requirement? And I think that is really where the upstream understanding the local needs of the community more holistically, above and beyond just the healthcare services and cultural linguistic diversity and unique needs was really critical.
Slide 20	Caroline Sanders – 01:12:38	That's really helpful. I appreciate that. And I know that NCQA is proprietary, but I do think that... And maybe you've done this before, but I do think even just a general sort of crosswalk of, this is what we are expecting of health plans and enforcement mechanisms for X, Y, and Z, and sort of how all these pieces fit together could be really helpful for us in evaluating this better.
Slide 20	Palav Babaria – 01:13:10	That is a really helpful suggestion. Thank you.
Slide 20	Caroline Sanders – 01:13:13	Thanks.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Natassia Rozario – 01:13:15	I think we have Phebe.
Slide 20	Phebe Bell – 01:13:19	Thanks. Yeah. And I recognize this is sort of a sub strand to this broader conversation, so I'll be brief, but I think we have to recognize the work being done in the behavioral health world around these assessments, particularly our three-year planning process for Mental Health Services Act funding. And we just finished our three-year planning process. We're really good at grassroots, focus groups with underrepresented populations, really getting a lot of voices to the table. And then what's happened twice now in our county is then... I literally today got the invite to our public health departments community needs assessment process and community health assessment, and we're going to start all over again trying to reach the exact same populations that we just reached out to. And I think there's obvious problems with that on the community level in terms of... You just asked me about my mental health.
Slide 20	Phebe Bell – 01:14:10	And last time mental health substance use and homelessness came up as the top needs in our public health department's assessment. And so just figuring out how to dovetail those processes. And obviously our process speeds, it informs a specific funding stream and that's needed there, but how do we import that information and not replicate it or duplicate the processes.
Slide 20	Palav Babaria – 01:14:32	I'm writing down behavioral health wants to join the party, Phebe.
Slide 20	Phebe Bell – 01:14:37	I don't want to go to the same party I just threw.
Slide 20	Natassia Rozario – 01:14:45	Any other folks. Thank you Phebe. Peter.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Peter Shih – 01:14:52	You didn't see my hand the first time. I just want to make sure you noted that. You jumped over me, but it's okay. It's all right. No, this is awesome. I'm really glad that you heard our perspective and that you've incorporated it. And I definitely just want to echo what Phebe said earlier, is there's often enough resources within the county to line efforts. It's just that we haven't agreed to do it, like I was saying earlier. And so no one's ever questioned DHS's intentions and what it's trying to achieve.
Slide 20	Peter Shih – 01:15:39	We always falter on execution. And so we just have to be really mindful of that. And I think that when you ask this question of what other entities should be in this, obviously the schools are a big part of how this is going to be successful, I believe. And there's data sharing challenges that we, again, face, and there's the data exchange framework that we're working on. All of that ties into these assessments from my perspective. And so, again, I really appreciate this initial draft. It's really, I think, important for the local health departments to take a lead, to help bring folks together. And I think that's the way that we help everyone, because our responsibility as local departments is everyone, regardless of which zip code you're in, our job is to help the entire population. And so I think this is a great first pass at this, and appreciate DHCS listening to feedback.
Slide 20	Palav Babaria – 01:16:59	Thanks, Peter. And we're going to make sure to keep watching out for your hand moving forward.
Slide 20	Natassia Rozario – 01:17:04	I see Rebecca's hand up.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Rebecca Boyd Anderson – 01:17:09	Hi. Thank you. So Rebecca Boyd Anderson from Partnership Health Plan. I think that my first reaction to this is that it's a tremendous relief. It's like oh, thank you that we don't have to do duplicative work and reproduce the work that we're trying to do for NCQA, but also reproduce the work that other agencies are also incentivized to do. I think one of the challenges that we have is partnership, as you know, is currently in 14 counties. And some of the counties collaborate on various things, and we collaborate with other payers, for example, non-medical payers. And so we were part of a multi-county collaboration on the CHA for a few years ago with a few of the health systems, another payer, and a few county representatives.
Slide 20	Rebecca Boyd Anderson – 01:18:17	I don't know what the mitigation would be on that, but certainly just recognizing that the more counties a health plan is responsible for or the more players that are all playing in the same county, I think it needs to be... We're going to need a little bit of grace and figuring it out and understanding we didn't hit the mark the first few times. And it's not for lack of will, it's just clarifying lanes.
Slide 20	Palav Babaria – 01:18:54	Thanks, Rebecca. And I will just say I think we acknowledge that in counties with a lot of different plans, or in plans that are in multiple counties, it is more complicated. So as you review the concept paper, if you have any specific suggestions or ideas of things that may mitigate that challenge, we would love any feedback.
Slide 20	Natassia Rozario – 01:19:19	Anyone else who... There's some questions in the chat that we can go to, but anyone else who wants to raise their hand and respond to some of the questions here. All right, Palav, let's go to some of these chat questions. So there are some questions here around timing, and folks just want to be sure they heard correctly what we said. But do you want to talk a little bit more about what does it mean to sync with LHD timelines? Some of them are on three year plans, some of them are on five year plans, so there was some questions around that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 01:19:54	Great question. Because the LHD is the anchor institution, we would expect that you participate in that process, whatever that cadence is. If that's three years, three years. If it's five years, five years. It's basically whatever. The LHD in the county is leading the CHA and CHIP process, the MCP would participate, and then obviously publish the new CHA/CHIP on their website at that cadence. The population health management strategy that is submitted to DHCS, that brief deliverable that we talked about, would be submitted annually, and would be updated with other information that you may have just at the plan level. And NCQA is a list of sort of information that you'll be assessing like quality scores, cultural, linguistic needs, et cetera. But then this sort of PNA input would only be updated every three to five years, depending on what cadence the local health jurisdiction is on.
Slide 20	Natassia Rozario – 01:20:45	Great, thank you. There's a specific question about the justice involved individuals and how we envision including data associated with that population here.
Slide 20	Palav Babaria – 01:21:01	So I will see if any of the advisory group members who already do the local health jurisdiction CHA and CHIP process, or any of our managed care plan partners, want to share how they're currently including the justice involved population in their community assessment process. I do think from a data perspective, obviously as we get ready to launch the justice involved program and ECM for that population, there will be more data that all of you at the plan level have about those numbers. And we are also exploring ways at the state level, collecting more robust justice involved data, especially for the jails. There's some data we already have about prisons across the state that we hope will make it easier for all of us to collectively care for this population.
Slide 20	Peter Shih – 01:21:48	I definitely think... Sorry, I was going to just...
Slide 20	Natassia Rozario – 01:21:49	No, go for it.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Peter Shih – 01:21:54	So again, the different jurisdictions, some of the correctional health, like in San Diego... I'm sorry, in San Mateo. I'm getting my counties mixed up. In San Mateo is under health. Some of them are under the sheriff, and some of them have hybrids, right? So I think for those who have maybe health department and correctional health under one jurisdiction or an agency, it's easier to do the community needs assessments with them. So I think it's going to be very variable. But with this approach that's been laid out, I think it makes it a lot easier for us to engage the other maybe outside departments in this assessment, because now I love your anchor analogy to bring all the folks together. Thank you.
Slide 20	Natassia Rozario – 01:22:53	Amie, looks like your hand is up.
Slide 20	Amie Miller – 01:22:55	Just a question. Do you guys have an idea around how to make alignment between methodology with the plans? Because in behavioral health, we've done a lot of community planning, and it can go a lot of different ways. And so I anticipate that what you're wanting is alignment between the 58 counties and the way that they do this and how it feeds up to a statewide strategy. Are you planning on doing? Maybe some TA to help facilitate that?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 01:23:21	So I think... And welcome feedback on this. And so I would say I think globally, through the NCQA submissions and the population health management strategy submissions, those will be sort of templated submissions to DHCS where we will ensure alignment across our managed care plans. I think the purpose of the PNA is less about what you send to DHCS, and more about how are local entities breaking down silos, making maximum use of their existing resources, and really listening and understanding the community so that they can structure their services and programs to meet those community needs. So I don't know that there necessarily needs to be alignment between all 58 counties and all 20 something managed care plans. It's really more about, again, to the anchor institution concept that how do we get all the local entities anchored in a uniform collaborative fashion? The structures of each county are different, and that may look different from county to county. And I think, at least for right now... Don't hold me to this, but I think that is okay.
Slide 20	Amie Miller – 01:24:25	What about uplift. Do you have an appetite for uplifting best practices though? Because when I did community planning, you could invite people to a government conference room, or you can go to underserved, mapped out zip codes and hand out food, and literally shake hands and ask, "How can I be of better service to you?" And that's what I've seen done in our behavioral health planning. Because when you invite the same players to the table, you sometimes don't solve for the correct problem.
Slide 20	Palav Babaria – 01:24:50	Yeah, I 100% agree, and I think welcome feedback from all of you. First phase is we need to figure out our final policy and policy guidance, but I do think we are very interested not just on the PNA process, but all of our initiatives. How do we actually identify best practices, share best practices, and collectively across the state, evolve over time to do this to the best of our ability. And DHCS absolutely intends to be a part of that process. And if folks have ideas on what you would like our role to be, we welcome that feedback.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Natassia Rozario – 01:25:24	And I think in the chat, the process was highlighted as well, which is a process that was put together by CDC and NACCHO, I believe. And it's a best practice that a lot of local health departments use in developing their trials as well. So thank you for putting that in the chat. We have four minutes. So one more question that I'm seeing in the chat is, are there any examples of smart goals that plans are expected to have with LHDs?
Slide 20	Palav Babaria – 01:26:02	When we issue guidance on what the 2023 deliverable looks like, we can definitely include some examples of that.
Slide 20	Natassia Rozario – 01:26:11	Wonderful. And then I think we've gotten through a lot of our questions here. And I think also in the chat, there is a lot of notes about this is a relief, and a lot of folks are excited about moving forward together. So thank you all.
Slides 21-22	Palav Babaria – 01:26:31	Great. And I think we just have two more slides just on next steps so that we don't leave everyone hanging. We can go one more slide. So as Carrie mentioned, we will be issuing publicly and posting a concept paper detailing the proposed approach that we just walked through at a high level with the slides. It has a lot more details, citations, and background. And so we welcome all of you to provide comment. Our advisory group members, you have a copy of that. And then if you follow our DHCS stakeholder announcements, we'll be issuing announcement with a specific date. But Natasha, keep me honest. I think by next week, we're hoping to get that publicly posted on our website, so keep a lookout for it. And we also are hoping, based off of that feedback, we're going to be issuing a new high level APL on the PNA and PHM strategy that will replace the previous APL 19-011.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 22-23	Palav Babaria – 01:27:22	Then in quarter two, we will issue guidance on what the 2023 PHM strategy will look like. That is that abbreviated one that will have the smart goal. And then in quarter three, we will finalize this approach that we... Or sorry, quarter three is 2023. The strategy is deliverables due for MCP, so you'll have a few months to work through that smart goal deliverable. And then more detailed guidance will come out by the end of the year. We can go to the next slide. And our public comment period for the concept paper will be through May 19th, 2023. And then you can email all your feedback to the PHM section at dhcs.ca.gov.
Slide 23	Palav Babaria – 01:28:01	And I just want to give a huge shout out to all of our panelists. We couldn't have a thoughtful conversation like this without you, as well as each and every one of you that has time to meet with our team and really inform our thinking to this point. We are really grateful for the collaborative effort on this. Any other final comments from anyone? We are shockingly one minute ahead of schedule, which never happens in our advisory group meetings. Okay. Well, thank you, and hope everyone has a lovely day.
Slide 23	Natassia Rozario – 01:28:38	Thank you all.