CalAIM PHM December Advisory Group Meeting

December 11, 2023

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Alice Keane – 00:00:10	Hello and welcome. My name is Alice, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A. We also encourage you to submit written questions at any time using the Q&A. The chat panel will also be available for comments and feedback.
Slide 1	Alice Keane – 00:00:33	During today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Palav Babaria, chief quality and medical officer and deputy director of the Quality and Population Health Management Division at DHCS.
Slide 1	Palav Babaria – 00:00:55	Thank you so much, Alice, and, everyone, welcome to our December meeting of the CalAIM Population Health Management Advisory Group. We can go to the next slide.
Slide 2	Palav Babaria – 00:01:07	So as a reminder, I think all of you on this call probably are aware of this already, but our continuous coverage requirement for Medi-Cal enrollment that had been put in place as a part of the COVID-19 public health emergency ended on March 31, 2023 which means as of April, Medi-Cal members are undergoing redeterminations, many of whom for the first time in three years, many of whom have never had to do this before.
Slide 2	Palav Babaria – 00:01:34	Our explicit goal is to make sure that everyone who is eligible for Medi-Cal coverage stays on Medi-Cal coverage, and anyone who is found to be ineligible is covered to another type of health insurance coverage through Covered California and elsewhere. You can click on the links below and get an update on all of the announcements and access toolkits and communications messages that you can use in your communications with Medi-Cal members. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 3	Palav Babaria – 00:02:02	Most importantly, I will guide you all to the new Medi-Cal Continuous Coverage Unwinding Dashboard, which releases really helpful critical data, including at the local level, to see how many members are meeting redetermination requirements, how many are being disenrolled for procedural reasons. When you look at the data, you will see there are many opportunities to better support and inform our members throughout this process to make sure that they are keeping a lookout for their redetermination packets and submitting them in a timely fashion, as well as updating their contact information.
Slide 3	Palav Babaria – 00:02:35	The bottom two websites you'll see are member-facing. So please feel free to get the word out. You can go to the next slide.
Slide 4	Palav Babaria – 00:02:42	So I'm really excited that today for our pop health advisory group meeting, we are going to do a follow-up deep dive on our proposed population needs assessment policy. As a part of the pop health program, which many of you got a preview of several months ago. We have guest speakers from our MCP-local health jurisdiction collaborations that have been happening across the state for CHAs and CHIPs.
Slide 4	Palav Babaria – 00:03:07	We'll then go through a recap of what the 2023 policy was for the population needs assessment that our managed care plans have been working on in partnership with public health. Then do a deep dive on the forthcoming requirements for 2024 to 2027 PNA policies and upcoming guidance and technical assistance.
Slide 4	Palav Babaria – 00:03:26	Then mostly we want feedback from all of you, first and foremost, from our advisory group, but also for our attendees. We have an open chat as always. Your feedback and comments in the chat will really help us strengthen and refine this policy before it is finalized and published later this year. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:03:47	So we are now going to jump into our guest speakers. So I am thrilled to have Dr. Phuong Luu and Barb Personal joining us today for this part of the conversation. I'm going to have both of you introduce yourselves and your role, and then we'll go through a few questions that we have for you.
Slide 6	Barb Alberson – 00:04:07	Okay. I'll go first. I am ... Oh, I will not go first. Go ahead, Dr. Luu.
Slide 6	Phuong Luu – 00:04:13	Hi, good morning. My name is Phuong Luu. I'm the health officer for Yuba County and Sutter County.
Slide 6	Barb Alberson – 00:04:21	And I'm Barb Alberson. I'm interim health director here in San Joaquin County Public Health.
Slide 6	Palav Babaria – 00:04:28	Fantastic. If it's okay, maybe we can take the slides down so that we can spotlight and see our speakers as we're having this conversation. So I'm going to turn it to both of you, and you guys get to pick who wants to go first. We're hoping that you can provide a one to two-minute overview of how your current public health community health assessment and community health needs assessment process is working in your county.
Slide 6	Palav Babaria – 00:04:53	Maybe actually, Barb, let's start with you since you had volunteered to go first earlier. It would be great if you could provide an overview and history of the process, including stakeholders involved and data shared, as well as how different stakeholders have contributed resources.
Slide 6	Barb Alberson – 00:05:09	Okay then. Hi, everybody. In San Joaquin County, we call it CHNA since our nonprofit hospitals have to call it that under their IRS regulations. It's always made common sense to us to work together to co-produce one county-wide CHNA and CHIP.

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Slide 6	Barb Alberson – 00:05:26	Our three managed care plans, which is Health Plan of San Joaquin and Health Net and Kaiser, participate very fully in their development. All three plans contribute to the cost of hiring a process consultant, serve on the core team, which does the day-to-day decision-making, and in facilitating the meetings of our 50-member community steering committee, which is all our community partners throughout the county, all of our nonprofit hospitals and our FQHCs, also our core team members, and with the same level of collaboration.
Slide 6	Barb Alberson – 00:06:02	In terms of data sharing, my public health epidemiology staff do the heavy lifting there. They compile and analyze the quantitative data. We base our work on the Healthy Places Index. In this cycle, my epis pulled indicators, ready for this, for more than 20 different data sources.
Slide 6	Barb Alberson – 00:06:20	Garnering qualitative data is shared by all of us with the support of our consulting firms. For example, outreach residents for a community survey, all the key informant interviews, and the focus groups. Significantly, and I'm sure this is true statewide, what has not been routinely in the mix is follow through. More clarifying language in the guidance would help to provide a clear path to assign resources to help not just plan and do the reports, but implement our CHNA and our CHIP strategies. Our nonprofit hospitals do this routinely using their community benefit dollars.
Slide 6	Palav Babaria – 00:07:01	Thank you.
Slide 6	Phuong Luu – 00:07:02	That is hard ... Just follow up. I can't follow up with that. This is just amazing. So we're not as good as San Joaquin County. In terms of Sutter County and Yuba County, for the first time in many years, we initiated a robust child CHA/CHIP process. So I do want to clarify that even though I serve two counties, they have very distinct processes.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Phuong Luu – 00:07:28	So the CHA/CHIP process for Sutter County completed in June 2023. We had three health priorities of addressing homelessness, reducing the burden of sexually transmitted infection, and building resilient community. Then once we were able to complete the CHIP, we published publicly the dashboard across all three health priorities.
Slide 6	Phuong Luu – 00:07:52	Then based on the population health management guidance issued out by the ACS, we did meet with both incoming Medi-Cal Managed Care, Partnership HealthPlan, and Kaiser Medi-Cal. We called out a specific strategy that they can assist us with in terms of financial support for our project manager to stand up a behavioral health learning collaborative, because one of the key need from our community was called out, is navigation of services, that people really didn't know what insurance even they have, where to go based on in-network providers, any specific telehealth options. So we're very excited and we're waiting to hear back from our MCP partners in regards to that request, financial request.
Slide 6	Phuong Luu – 00:08:39	On the Yuba County side, we're a bit behind Sutter County. So we completed our CHA/CHIP process in September 2023. But as part of the CHIP process, we had also three health priorities, healthcare access, mental health access, and safe neighborhood and built environment. We broke it into three different work groups.
Slide 6	Phuong Luu – 00:09:02	And so, knowing that Partnership HealthPlan was entering very soon, as of 1/1/24, I took it upon myself to email their chief medical officer and their behavioral health administrator and asked for representation at the work groups for both health priorities of healthcare access and mental health access. They provided a lot of great input, and we are in the process of drafting a very similar financial request for Partnership and Kaiser for Yuba County.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Palav Babaria – 00:09:35	Thank you both so much. Clearly there's a spectrum of experience. Barb, as you said, this makes common sense. So we're excited that the rest of the state is finally catching up to what you all in San Joaquin County figured out some time ago.
Slide 6	Palav Babaria – 00:09:48	So you both hinted at this, but, Barb, would love to hear a little bit more about some of the ways in which this combined CHNA process has helped to improve community health and strengthen relationships in San Joaquin County.
Slide 6	Barb Alberson – 00:10:02	I think the one element that I'd like to share with you today is what we call our priority neighborhood profiles. These are the heart of our CHNA and speak to our shared commitment for both health equity and for collective impact. It takes a very deep dive into data that defines just 14 of our disadvantaged census tracts that suffer the greatest burden of disease and injury and also the negative conditions that impact health.
Slide 6	Barb Alberson – 00:10:30	In true terms, we just threw away service areas. We all focused and aligned our resources to be more powerful to help these neighborhoods thrive. For example, we've aligned funding to work on improving unsafe and neglected parks in six of our priority neighborhoods. Also, many of us have used this approach to successfully compete for extramural grants.
Slide 6	Barb Alberson – 00:10:57	For example, public health was successful in garnering a three-year $3 million CDC community health worker grant. We share that with six of our CBOs. The reason I think we got this grant is because we were deploying our CHWs to work in one or more of the priority neighborhoods. They got it and they understood what we were talking about.
Slide 6	Palav Babaria – 00:11:22	Thank you so much. Phuong, would love to hear you talk about the advantages of looking more upstream and taking a more holistic view of health.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Phuong Luu – 00:11:31	Sure. It's because we only see one facet within each of our lenses. For example, let's say Mr. Jetson, he might have syphilis, but also homeless and also on Medi-Cal and has type two diabetes. So from a public health standpoint, we see him through the lens of syphilis management. From a social services standpoint, we will take care of his housing needs. Then his frequent visits to the ED interacts between the MCP and, of course, the hospital care.
Slide 6	Phuong Luu – 00:12:08	But if we take a step back and look all the way upstream of it's like it's actually the same person. It's one Mr. Jetson. So how do we share information in a timely manner so that we deliver whole-person, high-quality care that is timely to this individual? Really, that is the only way that we can move the needle in providing good healthcare to all of Californians.
Slide 6	Phuong Luu – 00:12:36	So the community health assessment and community health improvement plan really is community. It takes a village, like the cliche, but it's not just through the lens of public health patients or healthcare-specific patients or even MCP beneficiary. It's that it's every one of us. So taking a global view is very much necessary to move that needle.
Slide 6	Palav Babaria – 00:12:59	So I think we all know that, at the end of the day, when we get to brass tacks, a lot of it is about resources and having the funding and bandwidth and people to do this work at the local level.
Slide 6	Palav Babaria – 00:13:14	And so, Barb, would love to hear a little bit about how the managed care plans that you've been partnering with have contributed to the community health assessment process that you've been doing and how the modified PNA requirements are trying to get us to this future state. What have you seen as the value of aligning this process locally and what's the value for MCPs who've been partnering with you?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Barb Alberson – 00:13:40	Well, here's my professional opinion. It's terrific value. A special note when we're talking about aligning processes, I do need to share with you that local health departments who are seeking national accreditation are to do their CHNA every five years. Our nonprofit hospitals, by IRS regulation, have to do it every three years.
Slide 6	Barb Alberson – 00:14:02	So all of us together decided we will do it every three years so it's copacetic for our hospitals, because they're one of our major funders. So that's why we do that. But it works out great for us. But every three years, not every five. Since I'm at ... Let' see.
Slide 6	Barb Alberson – 00:14:24	I think the best way to respond to this is to say we try and answer the what's in it for me question. It maximizes resources for sure. It reduces redundancy and absolutely reduces duplication. Then MCPs have their PNAs, non-profit hospitals have their CHNA, health department has a CHA, also even our First 5 commission has to do an annual assessment.
Slide 6	Barb Alberson – 00:14:49	So I can't imagine if we each had to do it separately, especially if we're talking about the fact of trying to avoid getting in each other's way when we're garnering input from the same community stakeholders.
Slide 6	Barb Alberson – 00:15:04	The approach has another nice dividend, though, because it also lends to a better understanding of how we each operate and what our constraints are. For example, I can talk HEDIS measures and my managed care plans can tell you all about the public health, social ecological model, and social justice. So I'm being a bit facetious, but it really does allow us to blend our talents and our expertise in a way that we might not have otherwise.
Slide 6	Palav Babaria – 00:15:36	Thank you so much, Barb, for really sharing how you're bridging that chasm in real time locally between public health and healthcare that exists throughout our entire nation.

VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Palav Babaria – 00:15:48	Phuong, same question for you. Would love to hear what you think the value is for MCPs to participate and also how you've started collaborating already with MCPs for the SMART goals and for 2023.
Slide 6	Phuong Luu – 00:16:01	Yeah. So I want to echo everything that Barbara just said. She has said it so eloquently. How we have approached it in terms of Sutter County, Yuba County, because we're a bit behind San Joaquin County, is that we really emphasized it's not a one and done. So it's not just participate in completion of the CHA or completion of the CHIP, but it's always iterative. So now we're in the implementation phase.
Slide 6	Phuong Luu – 00:16:24	So we really make a point to communicate the what's in it for MCPs to participate with us in the successful implementation of the goals, objective strategies, and actions spelled out within the Sutter County and the Yuba County CHIPs.
Slide 6	Phuong Luu – 00:16:39	Then we're going to do it again. So in a few years, we're going to reassess where we're at, and we need MCPs to be at the table, because, yeah, we need our HEDIS measures, and then but they also need our expertise in terms of a population health expertise. We're very, very proud in terms of local health jurisdiction that we truly are the population health experts.
Slide 6	Palav Babaria – 00:17:05	So final question from me for both of you is what does success look like in 10 years if we really get this local collaboration between MCPs and public health and ideally nonprofit hospitals right?
Slide 6	Barb Alberson – 00:17:22	Well, LOL. As I shared, we've been collaborating on the CHNA and CHIP process for probably 25 years. So for us, it's just growing more of the same. This winter, we're going to start our next three-year cycle. Again, I anticipate that we are going to address root causes with a very strong health equity lens.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Barb Alberson – 00:17:44	That has actually caused a little bit of disconnect with what the population managed care plan has to do. It was a bit of a slog for us to find a SMART objective that worked for us because, as I say, we dive deep on root causes, and your DHCS directors were pretty medical model. So finding the connect up.
Slide 6	Barb Alberson – 00:18:10	What we did was ... I'm pretty pleased about it and I think it'll be a process that continues. It's not going to be a one-off. But that is that we focused on mental health. But the managed care plans will be doing the depression screenings, maternal and adolescent depression screenings, and of course follow through with mental health services when it's a clinical issue.
Slide 6	Barb Alberson – 00:18:35	But we all know that depression and anxiety and chronic stress have to do a lot with life issues. For example, the car won't start, you have a kid who's truant, there's no daycare. In all of those cases, the managed care plans will do a warm handoff to public health and we will convene our community partners to help address those community needs. We see that going forward getting stronger and better and more concerted as we go through it.
Slide 6	Barb Alberson – 00:19:06	So we just hope that your targets at DHCS will give us a little bit more wiggle room going forward in terms of what meaningful participation actually is.
Slide 6	Palav Babaria – 00:19:20	Thank you so much, Barb. I will just acknowledge on behalf of the department that we recognize the way we measure quality using largely HEDIS and core set measures is very medically driven, often far too downstream. And so, we too are eager to learn through this process to see how we all can evolve together to really think about that holistic, upstream, whole-person-based approach.
Slide 6	Barb Alberson – 00:19:43	Beautifully said. Thank you.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Phuong Luu – 00:19:44	In 10 years, I just want to be where San Joaquin County is already at. But to take a step back, I think this is very much an opportunity to align priorities and reduce redundancy. There's so much need, and if we're disparate in our focus or we're doing duplicate work, then it actually makes us less efficient.
Slide 6	Phuong Luu – 00:20:11	So the alignment of the PNA, the CHA/CHIP, the CHNA, and even potentially other health assessment is going to ultimately be helpful for our community, which we all serve. It's the same patients, the same beneficiaries, the same clients, however terminologies you use, whether related to healthcare, public health, or social services. So when we align, we can do much better for our community.
Slide 6	Barb Alberson – 00:20:40	Palav, can I just say one more thing? Of course, Barb always has to say one more thing. I'd like to see the guidance reframed just a bit. As Dr. Luu has said, and I've shared, we're not starting from scratch in many communities. So I would like it to say to initiate or to strengthen ties, because there are quite a few counties that have been working hard on developing and strengthening ties with their managed care plans. This is a wonderful step forward, but it's not always starting from scratch.
Slide 6	Palav Babaria – 00:21:18	We really appreciate that edit. I'm certainly taking away how avant-garde San Joaquin County has been for the last 25 years. So, Barb, we're going to be asking for your phone number, and I'm sure I'm not the only one who wants it.
Slide 6	Palav Babaria – 00:21:29	I'm going to lift up one question from the chat, and then I'll open it up to our advisory group if any of you have questions for our panelists before we move on to the next section.
Slide 6	Palav Babaria – 00:21:37	So Diane Dooley in the chat is asking, "Will your public health departments be participating in the statewide data exchange framework? Why or why not are you participating?"

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Phuong Luu – 00:21:51	So Sutter County and Yuba County as of yet have not participated. We are not a required signatory. However, we are looking into it. I think there's quite a bit of unknowns. Even for the required signatories, the data exchange will just start beginning of next year. So we will see how things go, but we are keeping close monitoring of it.
Slide 6	Barb Alberson – 00:22:21	I'm being facetious, but, seriously, it's a little bit of a watch and learn.
Slide 6	Palav Babaria – 00:22:29	Great. Advisory group members, feel free to just take yourselves off of mute or raise your hand if you can't unmute for some reason, if you have any comments or questions.
Slide 6	Mike Odeh – 00:22:46	Hi, this is Mike Odeh with Children Now. Appreciate the conversation and was curious, Barb, I think you had mentioned warm handoffs. As those relationships get strengthened and there's more folks referring and warm handoffs happening, what challenges do you foresee in that being successful and effective for families?
Slide 6	Barb Alberson – 00:23:12	One of the things that's useful for us ... So we have a Connected Communities Network. I don't know if all of you are familiar with that. But we have a closed referral system. About 80 to 90 of our community partners of all public and private partners are part of that. So we have a referral network that is in place that we all use. So it won't be quite as complicated-sounding as it might seem at first blush.
Slide 6	Palav Babaria – 00:23:53	Rob, go ahead.
Slide 6	Rob Oldham – 00:23:55	Yeah. Hey, Rob Oldham from Placer County. Just wanted to say mainly thanks so much for the presentations, Barb and Dr. Luu, and thanks to ... I think we've been talking about better aligning the CHA and CHNA processes for many years. So kudos to the DHCS team, and actually a lot of people on this call, not just from DHCS, in finally moving the needle a little bit on better alignment.

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Slide 6	Rob Oldham – 00:24:20	I know, yeah, IRS and the Public Health Accreditation Board, I know they had some incentive for each of our entities to do our respective assessments, but I think this will really ... Some of the efforts under CalAIM will help make these much more closely aligned.
Slide 6	Rob Oldham – 00:24:38	I guess my question is thoughts about how we can evaluate this. I appreciate having flexibility with, I believe, 61 different health jurisdictions, and lots of different hospital systems and a lot of different health plans across the state having some flexibility in how we do this. But thoughts about how we can evaluate the integration of the respective assessment processes to see how this is going and maybe evaluate and look back a few years down the road. Thanks.
Slide 6	Palav Babaria – 00:25:10	Great questions. I don't know that we're going to answer all of them today, but that's a perfect segue. Actually, Caroline, let's take your question, and then I'll tee up our next section.
Slide 6	Caroline Sanders – 00:25:19	Well, thanks, Palav. Just really appreciate also the presentations today. Thank you both so much. I was excited, Barb, to hear about the funding that you got for community health workers in your area.
Slide 6	Caroline Sanders – 00:25:37	I guess two questions. One for Phuong is to what extent are you looking at leveraging community health workers and local allied professionals in the community health needs assessments that you're pulling together?
Slide 6	Caroline Sanders – 00:25:59	Then just maybe a broader question about the way that both of your counties are doing the community health needs assessments. What does the governance structure look like for those? How are you working with CBOs and community leaders to decide on the interventions and where to apply for funding for various interventions that you land on? Thanks.
Slide 6	Barb Alberson – 00:26:27	Well, let me flip it.
Slide 6	Phuong Luu – 00:26:32	Go ahead, Barb.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Barb Alberson – 00:26:32	Your second question, or the first one. Sorry, Dr. Luu. Do you want to go? No? But the governance structure is very clean. There is a co-lead. It's the public health department and one of our healthcare systems.
Slide 6	Barb Alberson – 00:26:48	So right now, there's actually three. There's Kaiser, Dignity Health, and Public Health are the co-leads. Then we have a core team made up of the funders, and there's 12 different funders right now, everything from our County Office of Education and our First 5 commission, to all of our non-profit hospitals, our FQHCs, and our Medicaid managed care plans. That's the core team that does the day-to-day decision-making.
Slide 6	Barb Alberson – 00:27:14	During the development of the project, we meet every other week. We have a standing call. Sometimes it's only 10 minutes. But we direct what the consultants will do. They take their directives from us.
Slide 6	Barb Alberson – 00:27:29	Then we have the steering committee, which is, like I said, is 50-plus members. They only meet a couple of times because they agree to and understand that we can do the day-to-day stuff. But when we need to prioritize, when we need to develop our ranking, that's where we go to them. Then when we develop our strategies, they develop the strategies.
Slide 6	Barb Alberson – 00:27:53	So it's co-leads, core team, steering committee, but we take our direction, to tell you the truth, from our ... Is community-led. So what the community tells us they want in our focus groups and on our surveys is a lot of times what we decide to make as our priorities.
Slide 6	Barb Alberson – 00:28:16	Then on CHWs, that's a whole another conversation, and you can't answer that in five minutes. But we have many, many different sources of funding for CHWs, and trying to network them all and ensure that it works with CalAIM, as well as with the other sources of ... Is a work in progress. But we're pretty excited about it. But it's definitely a work in progress.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Phuong Luu – 00:28:45	So we have a very similar process to San Joaquin County. So initially with the community health assessment, we did a very large community survey. For instance, on the Yuba County side, we had 996 just general survey. Then we did key informant interviews and a focus group. Then we gather all that rich quantitative, qualitative data and brought it back to the entire community.
Slide 6	Phuong Luu – 00:29:09	So invited more than 90 key stakeholders to come, presented the data, and we presented our list of recommended priorities. Then they voted. Then we say, "Power of three update. Since we only have three to five years, please let us know what you as the community think should be the three health priorities." That's what rose, healthcare access, mental health access, and safe neighborhood and built environment.
Slide 6	Phuong Luu – 00:29:35	Then afterwards, we broke each of those health priorities into specific work groups, and each of the stakeholders were able to volunteer for one or maybe even all three work groups. They, within those work groups, decided on the goals, the objectives, the strategy, the actions. Some of them would raise their hand as lead entity.
Slide 6	Phuong Luu – 00:29:56	So we heavily emphasized that this is community-led, community-driven. This is not a public health plan, it's not a hospital plan, it's a Yuba County plan. So we are the convener, the facilitator of the process within Yuba County Public Health or Sutter County Public Health, but it really very much requires the entire community. I'll happy to put in the chat the public-facing dashboard for each of our health priorities, just so you can see what I verbally went through.

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Slide 6	Palav Babaria – 00:30:29	Thank you so much, Phuong. I'll just add an editorial comment that the community-led process that you both described is so critical to the vision that DHCS also has for health equity and how we get there, and really thinking about how we power share and lift up community voices to drive both the county's interest but also the Medi-Cal policy forward is of great interest to us.
Slide 6	Palav Babaria – 00:30:51	There's lots of comments and lots of questions. I do want to move us onto the next section. But, Michelle, let's take you as a final comment, and then I promise there'll be more time for dialogue.
Slide 6	Michelle Gibbons – 00:31:01	Yeah, thank you, Palav. I do just, as I see some of the comments in the chat, want to round up the understanding of what this is. Local health departments have been doing CHA/CHIP processes without promise for funding. This has been really around planning for their communities.
Slide 6	Michelle Gibbons – 00:31:15	I think with the great benefit that ... The hope and the goal is that managed care plans will help partner with us in moving the needle forward and in those strategies of the CHIP. But this has not been a process where as a jurisdiction does this, all of a sudden there's 10 new funding streams to invest in all of these new different things. And so, they've been doing it with the very limited resources they have, and the hope is that this will move the needle forward.
Slide 6	Michelle Gibbons – 00:31:41	It also is not ... At least on the health department side, it's not incumbent or our ability to approve or authorize what types of ECM and community supports that are then invested in. It can help inform that if a plan so chooses, but it's not where the health departments now have resources to invest in these things.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Michelle Gibbons – 00:32:00	So I just want to make sure that we're keeping that conversation at the forefront that this has been a tool for local health departments to figure out what are the strategies and they've been doing what they can to move the needle in those strategies forward. But I'm starting to sense in some of the questions about is this a funding source for CHWs or for ECM investments and things like that, and that is not necessarily what this piece is. I just want to level set that.
Slide 6	Palav Babaria – 00:32:25	Really great flag. Thank you so much. Okay, so we're going to put up the slides and go through the next two policy sections. Then we'll definitely have some time for Q&A and the robust dialogue that we're hoping to happen. So we can go to the next slide.
Slide 8	Palav Babaria – 00:32:40	So to recap what happened or is happening in 2023, so as you all are tracking, in January of 2023, the Population Health Management Program went live. In May, we released a concept paper about what this potential could look like, where managed care plans really join and partner with existing public health, community health assessment processes. You all got a presentation of that and provided really helpful comment and feedback.
Slide 8	Palav Babaria – 00:33:07	Then in August, we updated our policy guide and APL language to really lay out what plans should be working on for 2023. We required plans to submit a planning worksheet to us in October, which was really how they were coordinating with their local health jurisdiction, meeting and discussing areas to align, largely around DHCS's Bold Goals Initiative, which you heard our panelists talk about briefly. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Palav Babaria – 00:33:40	Then in 2023, our plans were required to submit a strategy deliverable, which again was really about are you meeting with your local health jurisdiction? As Barb is mentioning, in some areas, this is a robust partnership that has been present for many years and folks are working on strengthening it. In other areas, this is really a first-time effort.
Slide 9	Palav Babaria – 00:34:00	Then we also know with the new plans that are entering and exiting Medi-Cal as of January 1, 2024, there's also new partnerships and collaboratives that need to be set up to accommodate that change.
Slide 9	Palav Babaria – 00:34:11	And so, as a part of that, plans are required to submit what they're working on with their local health jurisdiction. Then also to meet NCQA requirements, plans have to have a membership assessment and the population health management strategy that they submit to NCQA. And so, plans that are already accredited have sent that strategy into NCQA, and then plans that are not are sending their strategy to us. We can keep going.
Slide 10	Palav Babaria – 00:34:41	So now this is the new stuff which we are previewing you all for the first time. I just want to acknowledge this is not just a DHCS effort. There has really been tremendous partnership and collaboration across the state. So huge shout out to our state partners HCAI and CDPH, as well as to CCLHO and CHIAC who really provided invaluable feedback, expertise, and partnership to hopefully bring this vision to reality. So we wanted to cover what the proposed requirements are for managed care plans for 2024 to 2027. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide	Palav Babaria – 00:35:16	So some of this got so complicated that we needed to put it on a timeline. And so, the ultimate vision, I think, as Rob was alluding to, some of this can be really complicated. We have 61 local health jurisdictions across the state. We have plans where in some plans, they're covering 20, 30 counties across the state. We have other counties that have up to five managed care plans that they have to work with.
Slide 11	Palav Babaria – 00:35:40	And so, one of the pieces of feedback we heard loud and clear from almost all the stakeholder comments we got on our concept paper was that there needs to be some sort of strategic alignment to get everyone across the state onto the same cycle and rowing in the same direction at the same time for this to really work, and to allow both managed care plans and local health jurisdictions to really go all in on this partnership.
Slide 11	Palav Babaria – 00:36:05	And so, the current policy is predicated on that between 2024 and 2027, if a local health jurisdiction is conducting a community health assessment, the plan will participate in that preplanned existing community health assessment process. This also allows all local health jurisdictions to be on a glide path with the vision that starting in 2028, the entire state is on a three-year cycle for community health assessments and CHIP submissions, and that we stay on that three-year cycle forever more and really allow everyone to coalesce.
Slide 11	Palav Babaria – 00:36:42	So the goal for this would be that the first statewide community health assessment that would be done in every single county and local health jurisdiction would happen over the course of 2028, with the community health assessment portion of the process being done by the end of 2028. Then everyone would have about six months to turn that around into the deliverable.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Palav Babaria – 00:37:04	So for local health jurisdictions, that six-month writing process results in the CHIP. For managed care plans, that six-month writing process would result in a population health management strategy deliverable to the department. Then this timeline loosely, though not perfectly, aligns with nonprofit hospitals as well, although, as mentioned earlier, their timeline is dictated by the IRS and when their tax filings are. As we have learned, some of those vary from hospital to hospital as well. We can keep going.
Slide 11	Palav Babaria – 00:37:38	Actually, can we go back one slide? I just wanted to lift up a comment in the chat. "Is CDPH also mandating this timeline?" So I think our CDPH colleagues are on the call. I don't know if you want to take that question, and then talk about the timeline from your perspective.
Slide 11	Palav Babaria – 00:38:11	Trudy, I don't know if you're having a hard time taking yourself off of mute. We can help unmute you if you want. Okay, we will come back to our public health colleagues as we can work out their tech issues. Alice, maybe you can connect with Trudy offline to see if she's having issues unmuting herself. We can go to the next slide.
Slide 12	Palav Babaria – 00:38:48	So now we're going to do a deeper dive into what these requirements actually mean. So as I alluded to, the prime plan must participate on the CHA/CHIP process for every LHJ in their service area. And so, the prime MCP is the managed care plan that has a contract directly with DHCS. When we say every LHJ in their service area, this includes not just all counties they serve, but also those cities that have their own LHJ. So if they're operating in that service area, they're expected to participate in the community health assessment process.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:39:24	Yes, for MCPs, that span multiple counties or cities. That means they will be participating in multiple CHAs and CHIPs across the state. Although, again, once we get to 2028 and there's a more consistent timeline, we hope that there will be opportunities for partnership and scaling and organizing that effort.
Slide 12	Palav Babaria – 00:39:43	For any prime MCPs that are covered by a subcontractor, they are included in the PNA process. So the prime managed care plan will be figuring out how their subcontractors contribute resources, participate in the process, but there will not be a separate deliverable. The deliverables come from the prime managed care plan that holds the contract with DHCS.
Slide 12	Palav Babaria – 00:40:06	Then we definitely heard also in public comment and from our local public health colleagues loud and clear that when there are multiple managed care plans in the same service area, it is really critical that there isn't siloed conversations happening. So if there are multiple MCPs in the same service area, for example, five plans in a certain county, the managed care plans must collaborate with each other, as well as with the local health jurisdiction, so that there is a unified planning process. There will not be siloed planning processes with each MCP.
Slide 12	Palav Babaria – 00:40:39	Then managed care plans in that scenario must also coordinate what types of investments they provide, so that that is shared and communicated with the LHJs, again to make the most of this collaborative opportunity and not duplicate resources or efforts. We can go to the next slide.
Slide 13	Palav Babaria – 00:41:00	So in-kind staffing and funding. So we are strongly encouraging all managed care plans who are prime managed care plan to allocate resources to this process for all of the service areas in which they operate.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:41:15	Starting in January of 2024, they'll be strongly encouraged to work with the local health jurisdictions to figure out what that support looks like, whether that is funding or in-kind staffing. Then starting in January 1, 2025 is when we would strongly encourage managed care plans to effectuate that funding.
Slide 13	Palav Babaria – 00:41:34	So 2024 is really a planning year, and then 2025 is when we would expect that investment to be made. Then plans will also be required to report directly to DHCS at least annually how they're contributing these resources. That will be part of the deliverable for the population health management strategy deliverable.
Slide 13	Palav Babaria – 00:41:54	Then you'll see here these are the types of funding that in the comment letters and stakeholdering that we have done that have been needs that have been identified. So things like administrative support, project management, data infrastructure, community engagement, all of these have costs. As Michelle Gibbons pointed out earlier, there isn't new funding streams that come along to really effectuate all of these processes for the most part.
Slide 13	Palav Babaria – 00:42:22	Then in-kind staffing may also help support or augment some of this actual funding to meet all of these needs. We can go to the next slide.
Slide 14	Palav Babaria – 00:42:34	The other big piece that came through in all of the public comment letters is really data sharing. And so, I think there is general acknowledgement, and we heard from our panelists concrete ways in which this is already happening on the ground. But managed care plans and local health jurisdictions each have really incredible valuable data, most of which is from different perspectives.
Slide 14	Palav Babaria – 00:42:54	And so, there's definitely data that local health jurisdictions have that is informative to MCPs. Then really rich data that MCPs have about Medi-Cal members that they serve that can really help inform the local community health assessment.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:43:08	And so, between 2024 and 2027, MCPs are expected to begin data sharing with local health jurisdictions in ways that support the CHA and CHIP process. I will also point everyone to the boilerplate memorandums of understanding that are also rolling out with the new 2024 Medi-Cal Managed Care contracts, also have provisions for data sharing. Then the population needs assessment is explicitly also identified in there.
Slide 14	Palav Babaria – 00:43:33	So this is not an entirely new requirement. This is really building upon some of the foundation that we've been laying with the new contracts.
Slide 14	Palav Babaria – 00:43:43	In 2024, we will expect every managed care plan for each of the local health jurisdictions in which they are operating to identify priority areas where they will start sharing data. Then starting in 2025 at the latest, the actual data that has been agreed to must be flowing from the managed care plan to the local health jurisdiction.
Slide 14	Palav Babaria – 00:44:06	Then since MCPs are required signatories of the data exchange framework, we'll expect them to be following the provisions of the data exchange framework when sharing data with other LHJs that are also signatories. As you heard, LHJs are not required to be signatories. And so, for ones that are not yet signatories, that will not be a requirement.
Slide 14	Palav Babaria – 00:44:28	It looks like we have figured out the technical issues. I'm going to turn it over to Trudy. If we can go back to the timeline slide to just talk a little bit about the public health expectations on this.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Trudy Raymundo – 00:44:39	Hi, good morning. Apologies, Palav. I was having some technical issues, so had to log off and log back in. But to the question about local health departments, so the intent is that, as you can see here, during 2024 through 2027, that will be a planning and ramp-up period, because we know that many of the local health departments are either having completed their CHA, in the process of completing their CHA, or even going through an update of their current CHA.
Slide 11	Trudy Raymundo – 00:45:09	So we want to make sure to provide for a ramp-up period, with the intent that starting in 2028, the LHJs will shift to that three-year cycle to line with the MCPs, as you see here. We are working really closely to with HCAI on ... Because we know many of you are also working with your not-for-profit hospitals on their CHNAs. So we are also working really closely to see how that happens as well.
Slide 11	Trudy Raymundo – 00:45:38	But, again, we want to make sure that there was enough of a planning period between '24 and '27, with the intent that LHJs then align starting in 2028.
Slide 11	Palav Babaria – 00:45:47	Then while we have you today, I'm going to turn one more question to you. Laura Salcedo is asking, "Will the new three-year cycle requirement be approved by FAB?" We know that, as you heard from our San Joaquin County colleagues, they've been on a three-year cycle for some time. So there are ways of meeting it. But, Trudy, I don't know if you want to talk about that more explicitly.
Slide 11	Trudy Raymundo – 00:46:10	Absolutely. So within the 2022 reaccreditation standards, it does say that CHA collaboratives can choose a cycle that is less than the five years, and they do use three years as an example. Even dynamic CHAs are also acceptable to FAB, where folks use like an update to a website and things like that and constantly updating the data.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Trudy Raymundo – 00:46:39	It's more about the process for FAB. So as long as the data is updated every five years and it's dated by five years, absolutely acceptable to FAB that LHJs move to a more frequent cadence.
Slide 14	Palav Babaria – 00:46:58	Perfect. Let's get back to the data slide. Great. I also saw some questions in the chat about demographic data that will allow us to stratify this information. So, yes, that can be a part of the data that is exchanged, depending on the local needs and what their focus areas are. We can keep going.
Slide 15	Palav Babaria – 00:47:29	So I think that we recognize that in some areas, these partnerships, as mentioned, are really nascent. In other areas, they're much more robust. And so, really starting in January 2024, as is already captured somewhat in the MOU, but building upon that, managed care plans will be expected to attend key CHA and CHIP meetings as requested by their local health jurisdiction partners. Also serve on a CHA or CHIP governance structure, including subcommittees, as requested by their local health jurisdiction partners. Then also really engage their community advisory committees as a part of this process.
Slide 15	Palav Babaria – 00:48:08	And so, for those of you who are not aware with the new Medi-Cal Managed Care plan contracts, effective January 2024, every single Medi-Cal Managed Care plan is required to have a community advisory committee that, again, is really designed to strengthen that community voice and engagement within the process of dictating Medi-Cal policy and provision of services.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Palav Babaria – 00:48:30	And so, MCPs will be required to report on their involvement in and findings from this joint CHA/CHIP process to their community advisory committees. They will be asking their community advisory committees about input and advice on how to use these findings to influence managed care plan strategies, work streams related to a whole host of services, inclusive of Bold Goals, wellness and prevention, and health equity. Then, over time, also work with LHJs to really use the community advisory committee as a resource for stakeholder participation in the CHA and CHIP process as well.
Slide 15	Palav Babaria – 00:49:05	Then plans will also be required to publish the common local health jurisdiction version of their CHA and CHIP on their websites for all service areas in which they operate, as well as the brief summary of what their goals are.
Slide 15	Palav Babaria – 00:49:20	Then I also saw, I just wanted to lift up, there was a question about the Bold Goals and are they limiting if we want to get to a true community voice? So I would just say, Hannah, I think in talking to our public health partners and looking at a number of CHAs and CHIPs, most of the conditions that the Bold Goals cover really are around maternal/child health and mental health. I would say most of those conditions are present in almost every single CHA and CHIP that I've seen.
Slide 15	Palav Babaria – 00:49:47	That was also a slight interim strategy for 2023. So I think as we get to the statewide aligned approach by 2028, a lot of that is likely going to change as we get into a more uniform process across the state. Katherine, I see your hand's up, if you want to make a comment on this slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Katherine Barresi – 00:50:09	Sure, yes. Just a quick question with regards to the community advisory committees and the intersection of the MOU quarterly meetings that we will be having with the local health departments, in addition to the CHA/CHIP planning meetings, do you guys really see this community advisory committee as separate, distinct from those MOU planning discussions or those quarterly required meetings, or are they one and the same?
Slide 15	Palav Babaria – 00:50:33	I think we'll probably need to take that question back and dig into it a little bit more, because that policy straddles a few different teams at DHCS. But thank you for raising that.
Slide 15	Katherine Barresi – 00:50:40	Okay. Yeah, thanks.
Slide 15	Palav Babaria – 00:50:41	Then I also see a question about Kaiser. And so, yes, the new Kaiser direct contract sets the same expectations for Kaiser. As every single other Medi-Cal Managed Care plan, it is a common managed care contract. So the 32 counties in which Kaiser is operating will also follow the same format. Okay, we can go to the next slide.
Slide 16	Palav Babaria – 00:51:07	So this just gets a little bit more into the detail about how we want to start digging into understanding and ensuring that managed care plans are really building these relationships in during this critical planning period and phase up period between 2024 and 2027. And so, managed care plans will be working with their local health jurisdictions to complete this worksheet by August 1st of 2024. The managed care plan will not be submitting this to DHCS, but we may be reviewing it if we have concerns or questions and want to do a deeper dive.

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 00:51:41	And so, the worksheet is really again to start figuring out where are their pain points, where are things working, where are things not working, and to really guide technical assistance. So a lot of this policy that we've reviewed today is about the community health assessment process. We know that that's not the end of this process. The community health assessment really just identifies community needs, and then those needs are turned into an action plan.
Slide 16	Palav Babaria – 00:52:06	And so, there still is a lot of work across our state departments, with our managed care plan partners, with our local health jurisdictions to figure out how are these entities working together, not just for this part of the process but then for the implementation pieces that will be coming down the road.
Slide 16	Palav Babaria – 00:52:23	We fully intend to think through technical assistance that we can provide at the state level to managed care plans and LHJs both for the assessment process that we're talking about, but also for the implementation process thereafter.
Slide 16	Palav Babaria – 00:52:37	Then, again, to reduce the burden on LHJs, if there are multiple MCPs working with a single local health jurisdiction, we expect a single worksheet to be submitted as a demonstration of that partnership and commitment. We will not be getting five worksheets for the five plans in that county. We can go to the next slide.
Slide 17	Palav Babaria – 00:52:58	Then so that worksheet is due in August of next year. In October, plans will be required to submit their annual population health management strategy deliverable to DHCS. We have not released the template for that deliverable yet, but again there will be one population health management strategy deliverable per local health jurisdiction in their service area. So if you're in 32 service areas, there will be 32 deliverables. Then if there are other MCPs working in that area, MCPs will need to collaborate to submit a single shared population health management strategy deliverable.

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VISUAL	SPEAKER – TIME	AUDIO
Slide	Palav Babaria – 00:53:38	We've listed here some of the things that we will be expecting, but again a template will be made available in the spring with more specific requirements. But mostly we'll be checking in on how the collaboration is going with local health jurisdictions, what progress has been made to the SMART goals that were identified this year, really a description of how community needs are being centered in this process, and then any updates to the NCQA pop health strategy and any other relevant updates.
Slide 17	Palav Babaria – 00:54:06	Then someone had also asked about evaluation. So obviously I think the long-term goal would be to really understand how these local partnerships drive improved outcomes for the community, including health outcomes, but also others. In the short term, we are going to be really laser-focused on how is the relationship and trust and partnership going.
Slide 17	Palav Babaria – 00:54:25	And so, in addition to having managed care plans submit these deliverables to DHCS, we will also be conducting a survey directly with local health jurisdictions to get all of your feedback on this process and what the partnership has been like from your managed care plan partners, so we can really make sure that this new process is working for everyone. We can go to the next slide.
Slide 18	Palav Babaria – 00:54:49	So upcoming things that are coming down the pike. We will be updating the policy guide with a lot of these requirements that we just previewed today by the end of the year, so that managed care plans know what the expectations are. Then next year, statewide technical assistance and clarifying guidance will be provided to really set managed care plans and local health jurisdictions up for success for the CHA/CHIP process as we're in the glide path years between 2024 and 2027. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 00:55:23	So maybe we can take down the slide so we can see everyone. Then I'm going to ask our Manatt colleagues to maybe field questions and send them our way. My public health and CCLHO and CHIAC and HCAI colleagues, please feel free to join in as well as you've been a critical part of developing this policy.
Slide 19	Natassia Rozario – 00:55:58	I was on double mute. Can you hear me? Yes. Okay. Thanks. Okay. Thank you. We're getting some great questions. And so, one of the questions that ... Some of the questions are around what's going to be public? Are the worksheets going to be public? Are the strategy deliverables going to be public? The work sheets, again, are an internal collaboration tool. But, Palav, do you want to speak to any consideration of whether these documents will be made public?
Slide 19	Palav Babaria – 00:56:31	Yes. I think the worksheet won't be collected by DHCS. So I can't comment on that one and not sure that that would make sense to be made public. The joint community health assessment, which is ... And the CHIP, which are the products of this joint collaborative, are already public and posted by our local health jurisdictions. Plans will also be required to post that same document on their website.
Slide 19	Palav Babaria – 00:56:52	Then we can definitely take the feedback about the population health management strategy and whether or not that is required to be posted publicly, as we're still working on the guidance and we'll be releasing more detailed guidance on that front next spring. So thank you for that suggestion.
Slide 19	Natassia Rozario – 00:57:08	Great. Then just questions about the information that we've provided today and the guidance provided, including details on how MCPs and LHJs should engage with CHCs. And so, when will we be releasing guidance related to all of that?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 00:57:28	Yeah. So, as always, the materials in our advisory group today are pre-decisional, so they will be posted publicly, but they're not final policy. We will be incorporating based off of today's conversation and final feedback from stakeholders these details, Kim, to your question, in the revised population health management policy guide, which should ... We're hoping to finalize the guide this calendar year, so in 2023, in the upcoming weeks. How quickly we can get it remediated and posted to our website may bleed into the first few weeks of January, but it should be out pretty soon within the next month.
Slide 19	Natassia Rozario – 00:58:05	Great. This is a question ... And perhaps it's for Phuong and Barb. But there was a question about how community leaders, providers are actively involved in seeking funding for community change. I'm not sure if you want to talk about your perspective around that. It's particularly related to the CHIP process and how they've been involved there. But yes.
Slide 19	Phuong Luu – 00:58:39	We're still in the very nascent stages there. I do want to lift up what Michelle Gibbons highlighted, that most of the time we have tried to implement the strategies and action called out within the CHIP with no funding. And so, we're really, really excited to align with our nonprofit hospital partners and our MCPs so that we can have now new sources of funding.
Slide 19	Phuong Luu – 00:59:07	But I think it's also now clarity of, say, a new grant would come up and then we're like, "Okay. Yes, this makes sense for Yuba County," or, "This makes sense for Sutter County. Let's collectively apply for this because our community tells us this is a priority." Like Barb said about her community health worker grant, that was awesome, $3 million in CDC, it just really provides clarity of why and where we need to focus.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Barb Alberson – 00:59:37	Yeah, I can't state strongly enough that we take it out of our hide. It's more about people giving their time rather than funding available. We do go after grants, and we've been lucky enough to get a Robert Wood Johnson grant here called BUILD Health and an ACT grant from PHI. So we cobble it together. You just have to have that work now for payoff later.
Slide 19	Barb Alberson – 01:00:04	What we do have, which is a wonderful dividend, is that our nonprofit hospitals give us priority in their community benefits grant funding. So Kaiser and CommonSpirit now, Dignity Health, and Sutter Tracy, they've all used their funding, and Adventist Health as well, to help guide some of the work we do.
Slide 19	Barb Alberson – 01:00:31	But we're not talking gigantic dollars. Even a large ... St. Joseph's Hospital has like $340,000 in their community benefits fund for everything. So it's nickel and diming. It's mostly passion and compassion and doing the work, labor of love kind of stuff. More money would be very nice.
Slide 19	Natassia Rozario – 01:00:54	So here's another question for you both. I know, Barb, you've mentioned some work particularly that you've done in your county in this area. But so, Phuong, you mentioned that the built environment has emerged in the CHA. And so, what strategies in the CHIP are addressing this issue and how can they be funded?
Slide 19	Natassia Rozario – 01:01:18	So, Phuong, I'm not sure if you have a response there. I know, Barb, you definitely have something to say here based on some conversations that we've had with you in the past. But open it up to both of you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Phuong Luu – 01:01:30	Sure. So Yuba County, one of its health priorities is a safe neighborhood and built environment. It was very critical for us to think broadly about stakeholders. So we actually invited to the table Community Development and Services Agency, which has public works under it. So we have some strategies around banning tobacco smoking, including vaping and smokeless tobacco, in all parks within Yuba County jurisdiction.
Slide 19	Phuong Luu – 01:02:02	We also are fortunate to have the Blue Zone. So they're spearheading a lot of efforts about bikeability and walkability promotion. They have these walking MOAs that they've started within one of our local cities, and they're expanding to an additional couple of cities within Yuba County.
Slide 19	Phuong Luu – 01:02:23	But most of the time it's also finding out what our public works colleagues, our CBOs colleagues, even our offices of education colleagues are already doing surrounding safe neighborhood and built environment and aligning all those efforts. So yeah.
Slide 19	Barb Alberson – 01:02:41	Well, I don't mean to gloat, but our public works directors and our park directors and our council of governments directors are all part of our steering committee. So it's really a wonderful dividend for us.
Slide 19	Barb Alberson – 01:02:55	But in terms of what we're doing in our CHIP, because we want to focus on parks, we have what we call ... Getting in the back door, it's called Safe Routes to Parks. So absolutely working on the built environment with lighting and safe pathways for bikes and walkers to get to the parks.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Barb Alberson – 01:03:14	But urban greening. So for the park piece, it works well, but our partners then do use the priority neighborhoods when they go after Caltrans grants to do work on walkability. Our council of governments, our COG, did a planning grant just in terms of what infrastructure was needed, and some of our neighborhoods are really ... Infrastructure is not very good at all, and got funding because they focused as a priority neighborhood issue.
Slide 19	Natassia Rozario – 01:03:47	Thanks, Barb. Another question for you both. Could there be a requirement that community committees serve in co-leadership rather than advisory roles in the CHA and CHIP as they have in San Joaquin, Sutter, and Yuba Counties?
Slide 19	Michelle Gibbons – 01:04:11	Palav, this is Michelle Gibbons. I'm happy to take that one with CHIAC.
Slide 19	Natassia Rozario – 01:04:15	Great. Thank you, Michelle.
Slide 19	Michelle Gibbons – 01:04:16	Sure. I think the important thing to note is that there is a wide amount or a large amount of community engagement that goes into the CHA/CHIP processes. I'd also mention, though, that there's a wide amount of accountability as well. These are public things that they're putting forward about what the community is saying, the needs are, the improvement plan to address those needs.
Slide 19	Michelle Gibbons – 01:04:38	And so, jurisdictions, on a routine basis, are evaluating where are we in that endeavor and really just trying to figure out, are resources being invested that help to support that? As we look at funds that come down, as limited and constrained as they are, are they looking at that community health improvement plan to help identify how those funds are moving forward?
Slide 19	Michelle Gibbons – 01:05:01	I think some of them have chair leads, things like that that happen in that community health assessment and improvement plan process. But I will say that it really is a jurisdiction by jurisdiction space.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Michelle Gibbons – 01:05:16	I would also just say that as we're expanding into partnering with different entities that may not have been our traditional partners before, I think there's going to be a whole host of new roles that continue to be explored and new partnerships.
Slide 19	Michelle Gibbons – 01:05:29	But I do just want to iterate, I have seen in our research on this a tremendous amount of community engagement from a wide array of community partners as well. So it's not that we are just looking at one area that a specific partner may be really interested in. There's a lot of community engagement. There is individual representatives, not just organizations. There's a lot of outreach that goes out to get people into these community forums, whether they're town halls and folks trying to support stipends or trying to draw folks. Child care has been something that folks are providing. So there is a wide array of partnership that is happening in different structures in which that'll continue to happen.
Slide 19	Natassia Rozario – 01:06:14	Thanks, Michelle. So, Palav, going back to you, there are a couple of questions here. In terms of data, are race, ethnicity, and language part of the data to be exchanged, or would they come from a DHCS data bank?
Slide 19	Palav Babaria – 01:06:33	So I think our plans and local health jurisdictions have different sources of demographic data. So I think we absolutely encourage everyone to be looking at health disparities locally. I think that would be one of the conversations that plans and local health jurisdictions would have about what is the best source of getting stratified data to understand some of those disparities.
Slide 19	Natassia Rozario – 01:06:55	Thank you.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Barb Alberson – 01:06:58	Excuse me. That's why I brought up the Healthy Places Index. If you're not familiar with that, that is the go-to Bible, so to speak, for health disparities. It's an amazing, amazing tour de force, layers and layers and layers on demographics of all kinds. Many, many health departments use that because it was during COVID. You had to say where your HealthCore trial was that was having the most difficulty. So we're all pretty familiar with it on the public health side, but it's the Healthy Places Index.
Slide 19	Natassia Rozario – 01:07:32	Great, thank you. There are a couple of questions here about gaps identified in the CHAs and what to do in the CHIP, and where the plans come in in terms of really supporting the CHIPs. Palav, do you want to speak at all to those questions?
Slide 19	Palav Babaria – 01:07:53	Yeah. So I think, as I alluded to, obviously doing the assessment is step one. The point of the assessment is to then come up with a plan to actually invest, and then address those community needs over time.
Slide 19	Palav Babaria – 01:08:05	The current policy guide requirements that we are issuing are really on that step one of how is this assessment done? I think there are still policy development work we have to do for that step two and what is the role of the plans in actually implementing both the CHIP, but also the population health management strategy pieces that will be delivered to the department.
Slide 19	Palav Babaria – 01:08:24	And so, we're still figuring that out in the public comment and conversations we've had. We do obviously see there is a connection possibly between this effort and the community reinvestment requirements in the new 2024 Medi-Cal Managed Care contracts, which will require all Medi-Cal Managed Care plans that make a profit to reinvest a certain percentage of that profit back into the community. We are still working on policy guidance for that. So we're exploring what opportunities there are as well.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 01:08:53	Then I did see, I'll just answer the question while we're on it, Natasha Deepa's question about whether you can submit one population health management strategy, all lines of business. And so, plans are required to submit to NCQA what your existing population health management strategy is per NCQA requirements. If you are currently submitting one to NCQA for all lines of business, this policy does not change that.
Slide 19	Palav Babaria – 01:09:18	We will be having a state-specific additional requirement for the population health management strategy. That is the guidance that will come out next spring, which will be Medi-Cal-specific. We are doing our best to not have it be duplicative with the NCQA submissions, but additive to those.
Slide 19	Natassia Rozario – 01:09:36	Great. There's a question here specific to Ventura County. And so, Trudy, I'm not sure if you can be on to help with this question, and Michelle as well. But, "For Ventura County, we already have a collaborative CHNA and CHIP. The next CHNA would be published in June 2025, and then subsequently in June 2028. Since the CHNAs will be due by December 2028, does the current timeline work for this? The CHIP is usually published four to six months later." Sounds like it's on track. But, Trudy and Michelle, just wanted to turn to you to make sure that's right.
Slide 19	Trudy Raymundo – 01:10:17	Yeah, I think it is. I mean the whole intent is to align all of the processes to that every three years. Our understanding is that for the majority of local health departments, the CHA process will normally take a year. And so, that's why we included that December date. But if it happens sooner, I mean I think that's great, and then you move into your CHIP process.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Trudy Raymundo – 01:10:38	But really the intent is to align that three-year process. So if it happens sooner, that's great. But the idea being that that CHA then really help ... The CHA informs the PHM strategy for the MCPs, and then they work collaboratively together around the CHIP process as well.
Slide 19	Natassia Rozario – 01:10:59	Thanks so much, Trudy. A question again for our public health colleagues. But in general for the CHAs and CHIPs, there's a question here about the engagement of tribal organizations in these discussions. As Michelle mentioned, that these CHAs and CHIPs have deep stakeholder engagement in the community with a wide array. So do you want to speak to that? Barb and Phuong, if you want to speak to that as well, but just on the tribal piece.
Slide 19	Trudy Raymundo – 01:11:32	Yeah, I'm actually ... I see Latesa is on the line. She's probably much more experienced on the requirements for FAB currently around tribal engagement.
Slide 19	Natassia Rozario – 01:11:45	Thank you.
Slide 19	Latesa Slone – 01:11:46	Thank you, Trudy. So one important thing to take into consideration is that each local health jurisdiction is in different places. So accreditation requirements oftentimes get enhanced every several years. So there was a 2016 version, which we're currently working off of for our state health assessment and state health improvement plan. But when we reaccredit and create our next iteration of the CHA/CHIP, we'll be pursuant to the 2022 version.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Latesa Slone – 01:12:17	So that's one distinction to make clear. Then secondary to that, there's also a distinction around there's initial accreditation requirements, and then there's reaccreditation requirements. So often if a local health jurisdiction is just pursuing accreditation, their requirements around a CHA and a CHIP will be different because they're mostly just supposed to be able to show that they have that collaborative partnership. They have a process in place.
Slide 19	Latesa Slone – 01:12:47	But when you're up for reaccreditation, they actually enhance some of those requirements, because they really want to see how you're enhancing your CHA and CHIP to better understand the needs of the population to address some of the emerging threats to public health, particularly ... Like I had noted in the chat that for reaccreditation, they put an added emphasis around environmental resiliency.
Slide 19	Latesa Slone – 01:13:12	So for 2016 version, they actually used to specifically and explicitly call out that state, local, and tribal iterations of a CHA and CHIP should show how they align with one another. So we as a state would have to show how we were aligning to local community health assessments and improvement plans within our jurisdiction, as well as the tribes. Then vice versa, locals would have to show how they're aligning to the state and the tribes.
Slide 19	Latesa Slone – 01:13:43	They have since in the 2022 version pulled that explicit requirement out. However, it is still insinuated in a sense, and you are likely to be asked ... when the site visitors review your materials and such, you are likely to be asked, "Do you have tribal populations within your jurisdiction? How do you partner with them to advance these efforts?"
Slide 19	Latesa Slone – 01:14:06	So it's definitely something that you should always consider, but just recognizing that the explicit requirement has been pulled out of the latest iteration of requirements.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Natassia Rozario – 01:14:21	Thank you so much for that. There's another question. Palav, maybe you want to talk about this. But will there be requirements on other hospitals, for example, for-profit hospitals, to participate in these collaborative efforts?
Slide 19	Palav Babaria – 01:14:41	Yeah, I'll take that one, and then the related question around other lines of business. So currently there is no state or federal requirement over any hospital that is not a nonprofit hospital to participate in a community assessment process, and DHCS does not have direct regulatory authority over those entities.
Slide 19	Palav Babaria – 01:15:01	So I think we'll defer to our public health colleagues. I imagine local health jurisdictions are reaching out to their hospital partners and encouraging participation, but there is no requirements.
Slide 19	Palav Babaria – 01:15:11	Then also to be clear, for nonprofit hospitals, they have a federal requirement tied to, again, their IRS filings and their nonprofit tax exempt status to perform a community assessment, the community health needs assessment, and then have a community benefit reinvestment program. There is no requirement of them to participate in this joint MCP-local health jurisdiction process.
Slide 19	Palav Babaria – 01:15:35	So clearly some local communities in our state. The nonprofit hospital has been a strong partner and joined the table, but they are not required to do so. Then similarly on the managed care plan side, we hope that these robust relationships will result in our local health jurisdictions and managed care plans finding and taking advantage of all the creative ways in which they can partner to achieve mutual goals. But DHCS's policy will be limited to the Medi-Cal members because that is where our authority is.
Slide 19	Natassia Rozario – 01:16:08	Great. I think we've got-
Slide 19	Barb Alberson – 01:16:09	And-

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Natassia Rozario – 01:16:09	Go ahead.
Slide 19	Barb Alberson – 01:16:11	I'm sorry. In San Joaquin County, we have seven hospitals. Six of them are nonprofits, one of them is for-profit. We have six nonprofit hospitals who participate fully, and we do not have very good participation with our for-profit hospital.
Slide 19	Natassia Rozario – 01:16:33	Great. I think we've come upon most of the questions here. So should we open it up to our PHM advisory group? Does anybody want to come up, unmute, and ask any further questions? Are there areas that require further clarification or elaboration?
Slide 19	Katherine Barresi – 01:16:58	This is Katherine. Just one quick question. I think I might've gotten it in the slides. In terms of the draft language for the proposal, what's the turnaround time it's going to be released? I know you've got to get something out by the end of this year, the first week of January.
Slide 19	Palav Babaria – 01:17:17	So I would say I think at this point we're really trying to put pens down as quickly as possible. So if you have any feedback, I would say please get it to us within the next week if possible.
Slide 19	Katherine Barresi – 01:17:26	Absolutely. Thank you.
Slide 19	Natassia Rozario – 01:17:34	Any other questions here?
Slide 19	Caroline Sanders – 01:17:40	Sorry, just a follow up to Katherine's question. To clarify, this would be feedback just on the slides that we've seen today.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 01:17:51	Correct. Then as all of you have probably noticed, our population health management policy guide is a little bit of a living document because there are so many pieces that are evolving. And so, as mentioned, there is going to be further guidance coming out next year. So any feedback that, for whatever reason, we cannot accommodate this go-around, there will be an opportunity to deepen and further this policy as we continue conversations with all of our partners.
Slide 19	Natassia Rozario – 01:18:21	Just to clarify as well, at the end of this year, we'll be issuing a pre-release version of the guidance to MCPs, and then the full guidance will go up on the website at the beginning of next year, if that's helpful. Any other questions?
Slide 19	Natassia Rozario – 01:18:50	There's actually one that came through the chat, Palav, and I think you already answered this. But it relates to NCQ accreditation. And so, how does the PNA the NCQ-accredited MCPs have to submit for NCQ requirements fit into this reimagined PNA process? I think you've already addressed it, saying we're trying to align these processes as closely as possible. But not sure if you want to elaborate a bit more on that.
Slide 19	Palav Babaria – 01:19:12	Yeah, and I will say we're trying to clean up our nomenclature. The DHCS have had a long-standing population needs assessment requirement, which is pretty robust and is now being morphed into this new PNA.
Slide 19	Palav Babaria – 01:19:24	The language and the standards that NCQA has, they use the term assessment, and it's part of their population health management standards. That process is, I would say, globally more data-driven and not necessarily as robust and deep as what our old state-specific process was or this new process that is being implemented.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 01:19:45	And so, we are working with NCQA to really help develop a crosswalk to make these different distinct requirements that we imagine are mutually synergistic, but not the same, very clear. So more to come on that and we hope to get that out to plans and partners in the new year sometime. Any final comments from any of our advisory group?
Slide 19	Palav Babaria – 01:20:16	Okay. If not, we can give everyone a few minutes back. I just want to really sincerely thank both Barb and Phuong for just sharing your lived experience in this space. Really a huge shout out to CCLHO, CHIAC, CDPH, and HCAI for just being wonderful partners to hopefully get us as a state to a future place where there's a lot of local synergy and alignment. So thank you everyone, and we look forward to seeing all of you in the new year.
Slide 19	Phuong Luu – 01:20:54	Thank you.