Population Health Management (PHM) Advisory Group – Meeting #11

October, 2023

Transcript

Contents

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Ethan Keller – 00:00:15	Hello and welcome. My name is Ethan 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 and A. We encourage you to submit written questions at any time using the Q and A. The chat panel will also be available for comments and feedback during today's event. Live post captioning will be available in English and Spanish. You can find the link in the chat field.
Slide 1	Ethan Keller – 00:00:39	With that, I'd like to introduce Palav Babaria, Chief Quality and Medical Officer, and Deputy Director of Quality and Population Health Management Division at DHCS.
Slide 1	Palav Babaria – 00:00:51	Hi everyone. Thank you so much for joining for our population Health Management advisory group meeting. We have some exciting updates teed up for today. You can go to the next slide.
Slide 2	Palav Babaria – 00:01:03	So we'll go through a round of introductions and then are going to be spending the bulk of our time today sharing the really tremendous development of the Risk Stratification, Segmentation and Tiering approach that our RSST work group informed by our scientific advisory committee, which comprises of many of you who are on this call today have been working on so that we can really move towards our statewide risk stratification, segmentation, and tiering approach. We also will be issuing some guidance shortly on refining and clarifying our PHM transitional care services policy, half of which went live in January of this year, and the rest of the policy, which will be going live January 1st, 2024. So we'll reserve some time for discussion and feedback there as well. And then we'll go to next steps. Go to the next slide.
Slide 3	Palav Babaria – 00:01:53	So I'm going to turn it over to Dr. David Tian, who is one of our population health management DHCS medical consultants. And Maya Petersen who's a professor at UC, Berkeley to walk us through our Risk Stratification, Segmentation and Tiering work. So David and Maya, feel free to take it away. Thanks

VISUAL	SPEAKER – TIME	AUDIO
Slide 3	David Tian – 00:02:11	Palav, and good afternoon everybody. So David Tian. As Palav said, I'm medical consultant in pop health and am proud to be our DHCS project lead here on the Risk Stratification, Segmentation and Tiering work stream. So we can go on to the next slide.
Slide 4	David Tian – 00:02:28	And so I just wanted to take a step back and think about the scope of today's presentation. What we're really hoping to do is provide more detailed context of the Risk Stratification, Segmentation and Tiering algorithm that's being developed, and also go over how this work is connected to the population health management program overall as well as the population health management service. And I know that these are all hot topics that have been brought to various advisor groups before.
Slide 4	David Tian – 00:02:57	We also would like to provide you an overview of the algorithm's contextual design and actually get some feedback from you as well, really at a higher level, thinking about how the algorithm is structured, how risk tiers are determined, as well as our approach to identifying predictor variables and adverse events or outcome measures that are both the inputs and outputs of the algorithm itself. And so we'll dive into each of these topics more granularly.
Slide 4	David Tian – 00:03:24	However, I will start off by giving a higher level overview of Risk Stratification, Segmentation and Tiering in the work that's happened since, believe it or not, last year in October, 2022 when we presented this topic to the advisor group previously. Next slide please.
Slide 5	David Tian – 00:03:45	And so today's agenda is basically as follows. And so after my overview Dr. Maya Petersen will be going over algorithm contextual design, and then we'll also be talking about the predictor variables. And then finally, adverse events and outcome measures. And so we can go ahead and go to the next slide. Great. So starting with the overview, next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 7	David Tian – 00:04:11	And so first I'd like to start off by thinking about the context of Risk Stratification, Segmentation and Tiering. If we can go back one slide. Population health management as a program that launched in January of this year is quite broad. And so I think that zooming out, we know that population health really addresses members' needs often outside of individual care episodes or direct healthcare interactions that we're used to thinking about like clinic visits, admissions and so forth. And so broadly speaking, population health management is about gathering member information from screening and claims and counter information. And then after that, using that information to understand their needs and their risks.
Slide 7	David Tian – 00:04:58	And so we're focusing on that aspect today, and that's highlighted in this orange, yellow color. And so far as there's risk stratification, segmentation, determination of a risk tier, and then thinking about what should happen next in terms of an assessment. This should in turn lead to providing services and supports. And so we're all very used to thinking about basic population health management, which spans prevention as well as general care management approaches and services that should be available to all members. And then also more targeted care management services that should be available to a smaller subset of members. And then finally, transitional care services, which we're going to talk a lot about later today. And then finally, the population health needs assessment and population health management strategy, which I know that a lot of folks, especially from the plans are working on. And DHCS is an active work stream thinking about how to align efforts in public health, healthcare delivery systems, as well as managed care plans in regard to identifying the needs of populations in the communities that we serve.
Slide 7	David Tian – 00:06:08	However, I do want to make sure that we don't lose sight of the place of risk ratification within this environment of population health management. Next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 8	David Tian – 00:06:20	And so just some definitions. This has been presented before, but currently DHCS requires Medi-Cal managed care plans to implement a Risk Stratification, Segmentation and Tiering methodology that meets NCQA requirements. And all of our managed care plans have submitted information for DHCS review on their strategies here. But in terms of definitions just to level set or be on the same page with everyone, risk stratification, segmentation means the process of differentiating all members, all Medi-Cal members in our case, into separate risk groups and or meaningful subsets. And basically at the end of this process, risk stratification and segmentation categorizes all members according to their care and risk needs at all levels and intensities. Risk tiering on the other hand, means the assigning of members to risk tiers that are standardized at the state level. And we'll go over this in greater detail later. For our state process here, it would be high risk, medium slash rising risk or low risk. You could go back to the previous slide please. With the goal of determining the appropriate level of care management or other specific services. And so I think that overall, if we could progress one slide, I think we're having some lag issues here.
Slide 8	David Tian – 00:07:45	Forward, two slides please. Forward again. Keep on going forward. Back one slide. Great. Basically we'll be talking about the outputs of the algorithm later today as well. But this presentation really focuses on the process of risk stratification, segmentation, and tiering that happens after the population health management service is available. And we'll talk about the design principles. And so just say that one more time. I think that what we're talking about today in terms of design is for a future state once the pop health service is available. Next slide please. Okay. Back one slide.

VISUAL	SPEAKER – TIME	AUDIO
Slide 9	David Tian – 00:09:12	This slide really distinguishes between the population health management program and the population health management service. This was actually presented one year ago at this meeting, but overall, the pop health program is that entire ecosystem of considerations that I presented first in that diagram that includes systems to provide care for the whole person. And this launch in January of this year and has a very broad scope. The POP health management service is a technological service that supports DHCS's population health management vision by bringing data in from many sources and integrating that together, performing pop health functions and allowing hopefully in the future data sharing between parties as well. However, the pop health service includes programs and infrastructure that extend beyond our risk stratification, segmentation, and also beyond managed care programs. And the launch day is to be determined. We are hoping to bring additional and more specific information about the launch day of the service. I saw that question in the chat in the near future, but we are working on it diligently and hoping to actually have a timeline for folks publicly available soon. Next slide please.
Slide 10	David Tian – 00:10:34	So the underpinning principles of risk stratification were shared previously, but I think that this is the underpinning information that will hopefully inform what Maya will present later in the presentation. So Risk Stratification, Segmentation and Tiering is part of the population health management program, and it is going to be built and deployed within the population health management service. And the goal is to identify members at higher risk and standardize how Medi-Cal members are identified for assessment of needs and connection to services. And in this purpose statement, I think that the word choice is really deliberate in so far as it's standardized for all Medi-Cal members and the output is a risk tier and especially to identify folks at higher risk. And those people and members identified as being at higher risk are required to have an assessment of needs and any related connection to services based on that assessment.

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	David Tian – 00:11:34	The objective here is to create a statewide transparent and standardized risk scoring mechanism in risk tiers that might benefit from services. And some other underpinning principles here that are important to lift up compared to the current state now, this future state creates a statewide minimum standard for risk stratification. It also is designed to be transparent in so far as a lot of risk stratification methodologies focus only on utilization and may also have elements of their scoring and outputs and inputs that might be proprietary and not readily available to the public. And so there's a strong dedication, and you'll hear more about this, more towards transparency, especially to avoid potential pitfalls like algorithmic bias. And finally, it's a standardized risk scoring mechanism, meaning that we will be using this methodology across all Medi-Cal members as fall. Next slide please. In terms of more detailed design principles, some of these were known previously and some of them are new. One important consideration that I'd like for you to hold onto as you hear more detailed information today, is that these risk tiers must be based not only on medical risk, which is pretty common, or behavioral health risk, which has increasingly been incorporated, but also social risk, and importantly, must also consider under utilization. I'll spend an extra second here and say that we are aware of and actively designing to address the phenomenon in which people who do not seek services are often not known to healthcare systems and their needs as well as the risks might not be identified because they're not seeking care. They may not feel welcome to seek care, they might not be able to access care in some way, but that doesn't mean that they don't have those needs and face those risks. And that is an important driver of bias currently. And so we are trying to address that head on.
Slide 11	David Tian – 00:13:29	Secondly, the algorithm and this RSST process is designed to reduce bias and promote equity. And equity goals might be addressed either within the algorithm itself or separately from risk estimation insofar. As the algorithm focuses on risk. But we're taking a broad look at equity considerations.

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	David Tian – 00:13:48	Third, this must be a transparent and informed process by stakeholders including today's conversation. So we really welcome folks' feedback here and continued feedback from various groups. And that will be shown in a next slide. Already mentioned the next point, and the next one there. But I will just emphasize that the output of the algorithm is a risk tier and low medium rising or high risk. And finally, we understand that this will be an iterative process that requires continuous improvement based on seeing how this process plays out and also making any adjustments and refinements based on our information that we gather in the launch of this exciting program. Next slide, please.
Slide 12	David Tian – 00:14:41	And so in terms of the people working on the Risk Stratification, Segmentation and Tiering project, there are two groups, and I think that many of you are actually on our scientific advisory council members because we put out an invitation for involvement about a year ago. So thank you for everyone who's involved. You'll see that our work group members, starting on the left side, are a group of experts in their field, and led by Dr. Maya Petersen, who is the next presenter. And these are experts in various disciplines including algorithmic design, causal inference economics, algorithmic bias, health services, research and so forth, as well as health policy, thinking about the incentives and the outputs and changes in response to risk ratification. Secondly, we have our scientific advisory council members. And so the RSST work group members actually look at specifically how to design the elements of the algorithm. And Maya will be going over that today. We bring that information to our scientific advisory council members that you see are representative of a broader set of stakeholders that include people more directly involved in healthcare delivery, in terms of healthcare systems, as well as managed care plans to make sure that our approaches are aligned and would be most relevant and hopefully successful and the environment of real world implementation.

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	David Tian – 00:16:09	And finally, I think that we have additional stakeholder engagement opportunities such as this one as well. So I think that we will pause here now for questions. We have about four minutes for a subset of questions and happy also to take further questions later. And so let's see.
Slide 12	Amy Salerno – 00:16:45	David, I think there's a comment in the chat about representation of tribal health in these groups. And wondering if you could comment on plans, on engaging broader stakeholders potentially outside of these groups.
Slide 12	David Tian – 00:17:06	Thanks so much. That is an excellent lift up and point. I think that in our considerations of health equity, we certainly really welcome this type of feedback. In terms of stakeholders we are not considering, and we'll definitely take that back to our work group and think about how we can specifically consider the need of native indigenous people in California as well as tribal health providers. I think that DHCS is engaged in work to gather information from tribes as well as tribal health providers in other work streams. And certainly we can leverage those relationships and those interactions to inform this project as well. But I think that Dr. Anna Zink, who's leading our work on algorithmic bias, I think will especially appreciate this lift up.
Slide 12	David Tian – 00:18:06	Any other questions or comments about the big picture in terms of risk stratification, the before state and the after state? Because I think the next set of slides are going to dive deeper. So if there are any broader contextual questions and so forth, really welcome those now. We can also talk about them later as well.
Slide 13	Amy Salerno – 00:18:24	I don't see any more questions, so let's go forward with Maya.
Slide 13	David Tian – 00:18:50	Great. Thanks Amy. And so at this point I'd like to introduce Dr. Maya Petersen, who is the lead of our work group for Risk Stratification, Segmentation and Tiering. As Palav mentioned, Dr. Maya Petersen is a professor at Berkeley and a real thought leader in the areas of causal inference as well as algorithmic design. And Maya, please take us through more of the algorithms, context and design considerations.

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Dr. Maya Petersen – 00:19:16	Thank you so much, David and Palav. And I just want to start by saying it's been a real honor to serve on this working group. And I think what we're presenting here is, as David said, the current design thinking and overall approach, we are still taking feedback and certainly welcome yours. And this is the result really of an effort by the full working group members listed and extensive feedback from a wide range of stakeholders. Thanks so much. So next slide please.
Slide 14	Dr. Maya Petersen – 00:19:53	Right, so first of all, what is this algorithm doing? How are we operationalizing really those key objectives and design principles that David laid out? So what it will do is on the left you can see the Medi-Cal population for each member of the medical population at a given time period. What we are really tasked with developing is an algorithm that will take in information about this population and then provide, at the end of the day, an output that puts each member into one of these three risk tiers, as David said. So there's low risk, medium rising risk and high risk.
Slide 14	Dr. Maya Petersen – 00:20:38	And then for those members who are classified as high risk, MCPs will be required to conduct an assessment per PHM policy. So maybe the first thing to say is what do we mean by risk? So in the context of this algorithm we're discussing, risk is going to be the likelihood that a negative health event or an outcome happens to an individual really in the coming year. And we'll spend a little time getting more specific about what types of negative health events and outcomes we're going to be considering, as well as how we put those together to generate this single output of which of these three risk tiers each member falls into. Next slide please.
Slide 15	Dr. Maya Petersen – 00:21:25	So how will this work? So fundamentally, the algorithm is going to use each individual's observed past data and take that in and then give as output, again, this risk tier to identify members who are at risk of a bad outcome and who may benefit from additional services to ensure they get a needs assessment.

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Dr. Maya Petersen – 00:21:50	So we can see on the far left of this slide an example Medi-Cal member. So the algorithm will then take in a large set of data on this member. So these are just examples shown here, and they can include things like demographics, claims data, past utilization data, duration of membership or transitions, et cetera. And I'll go into a little detail coming up the general structure, we're thinking about what categories and which types of data are going to be brought in to generate these predictions.
Slide 15	Dr. Maya Petersen – 00:22:25	Based on these predictions. What we're doing is we're developing, we're using machine learning to develop an algorithm. So for a given member, you would put in their values of this wide range of data, and then what it will give out is really a predicted risk. And then we're going to be turning that again into a risk tier as shown on the previous slide. So specifically, what sorts of risk are we going to be predicting? We're going to be predicting risk in really three domains, risk of adverse health events, social risk and risk of under utilization in the next 12 months. And so we'll go into a little bit more detail about-
Slide 16	Dr. Maya Petersen – 00:23:03	In the next 12 months. And so we'll go into a little bit more detail about each of those. Next slide please. Importantly, when developing this approach to risk score generation and risk tiering, we are going to do this for three distinct populations. So specifically, this is really recognizing that the types of outcomes that constitute adverse events are going to be different for different populations. And in some cases, the types of information that we want to use to predict those adverse events may also be different. So with that as rationale, we're going to be developing really three versions of this risk scoring and risk tiering algorithm to apply to these three different populations. One is adults, one is the pediatric population, and one is the birthing population, including in the birthing population, infants from zero to three months. Next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Dr. Maya Petersen – 00:24:11	So what is our approach then to really operationalizing these core design principles that David raised? Realizing that when we predict a member's risk, we want to be sure to predict not only risk of adverse events as captured by claims data, but also really to capture risk of underutilization. So the fact that person is not utilizing services really may be at high-risk, but not be as easily detected using more traditional outcome measures as well as social risk. So for that reason, we're going to be looking at predicting risk in these three domains. And then in addition, within each of these domains, we also subdivided them further really to make sure we were getting a more comprehensive picture of what sorts of adverse outcomes a member might be at risk of. So we're looking within adverse events, physical health and behavioral health events. Within underutilization, again, physical health and behavioral health. And then within social risk, adverse social events as well as underuse of social services. Next slide please. So how will this work? I'll give an overview of the general approach. So if you look at the bottom right-hand corner, we're going to be taking a range of predictor variables. Again, these are just examples listed here, HEDIS measures, age, prior inpatient admissions, et cetera. And then if we focus just on this subdomain of physical health within the overall risk of adverse events, what we would do then is these predictor variables for a member at a given time point would provide the input to the algorithm and that would then give a risk score or a predicted risk of having any of a number of adverse physical health events in the next 12 months. And I'll give some examples of what those might be in the coming slide. So the predictor variables are put in, the algorithm then predicts risk of at least one of a set of adverse physical health events in the next 12 months.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Dr. Maya Petersen – 00:26:28	And that's really the subdomain risk score. We're going to be doing this for each of these subdomains. So similarly, predicting risk of adverse behavioral health events, predicting risk of physical health underutilization, behavioral health underutilization. And then again, adverse social events and underuse of social services. So this then gives six risk scores. But at the end of the day, what we need out is really this single risk tier. So these scores will then be turned into tiers. Risk tiers at the subdomain level. To classify at this subdomain level is a person at high, medium, high rising or low-risk of, for example, adverse physical health events and then similarly for each of those other subdomains. And then those risk tiers will then be aggregated upward to create the overall risk tier. So if you're at high-risk in any of these subdomains, you then are classified at high-risk in the overall risk tier. And again, being at high-risk in the overall risk tier will then trigger a needs assessment by PHM per PHM policy. Next slide please.
Slide 19	Dr. Maya Petersen – 00:27:51	So the following several slides now are just to illustrate our approach to first identifying predictor variables and then we'll talk about our approach to identifying outcome variables. I'll say a couple of things in framing both of these. One is that as the population health management platform and service becomes available, there is increasingly an ability to really bring in more diverse data types that can either let us do a better job of predicting risk or let us do a better job of defining risk more broadly. And so, what we've done is really try to create a structure for both predictor variables and for the outcome measures we're trying to predict. That first of all takes advantage of the increasingly rich data streams that are available, but also builds in flexibility to continue to bring in new types of data that will be helpful in predicting risk or understanding bad outcomes as new data streams become available.

VISUAL	SPEAKER – TIME	AUDIO
Slides 19-20	Dr. Maya Petersen – 00:29:05	So what we are presenting examples of here really is a draft of the first version of this algorithm. But again, the whole thing, as David said, has really been designed and is intended to improve over time and iterate based on experience, based on new data sources, and based on feedback as well. All right. So with that framing, we'll have a look at our general approach to identifying predictor variables. Next slide please. So what we've done in terms of identifying predictor variables is again, really try to take a structured approach based on overall domains and subdomains to make sure we are really thinking of considering and to the extent the data are available, bringing in as broad a set of predictors as possible. One thing to consider when you look at this list is because we are using a machine learning-based approach to generate the risk scores, we want to cast as wide a net as possible at this stage to bring in types of data, types of predictors that may help us do a better job predicting risk.
Slide 20	Dr. Maya Petersen – 00:30:22	If it turns out that some of these don't, then they will end up being dropped out of the ultimate algorithm. But the goal at this point is to set cast a wide net in terms of the types of variables we're considering. So again, we're using a structured approach to this. We have again split these into several domains, sociodemographic risk factors. And these are really, again, potential risk factors. We're not betting on them being, but we're casting a wide net prior use and prior outcomes as risk factors and then transition events. And then within each of these, again just to make sure that we are keeping as comprehensive a picture as possible and also that we allow really for the flexibility to bring in new predictors as new data becomes available. Thinking of structured subdomains including geography, demographics, and social factors under sociodemographic, physical health, behavioral health, and social health in the prior use and outcomes category. And then transition events in medical and non-medical.

VISUAL	SPEAKER – TIME	AUDIO
Slides 20-21	Dr. Maya Petersen – 00:31:35	And then finally, what you can see at the bottom are just some examples of types of predictors that would fall under each of these subdomains. We'll say that there will be a first draft of the comprehensive set of predictors to be included in the first version of this algorithm that will be sent to the advisory group to provide comments. But what's shown here are really just examples to make this more concrete. Rather than step through each of these examples, I think we can go to the next slide. So that is our structured approach to identifying predictor variables or inputs to the algorithm that we want to then use to predict the risk of one of these adverse either health events, underutilization or social risk events happening in the next 12 months. So with these final slides then, we just want to step through our approach to identifying what are those adverse events or outcome measures that we're trying to predict. Again, with this similar structure of having a comprehensive, thoughtful approach, making sure that we are thinking, again, beyond perhaps traditional utilization-based measures or cost measures and including underutilization and social risk.

VISUAL	SPEAKER – TIME	AUDIO
Slides 21-23	Dr. Maya Petersen – 0:33:15	And again, having an approach that lets us build off what's available now, but also bring in new types of outcomes in the future. Next slide please. So just to remind folks where we are, we are now going to just talk about what exact definitions are we going to use, what exact events are we going to use when we define, for example, physical health adverse events, behavioral health adverse events, et cetera, at each subdomain. All right. So next slide please. So the first thing to remind folks of is that we're going to be doing this entire exercise for three distinct populations. Again, recognizing that the types of predictors may differ and also the important outcomes to consider when we look at adverse events may differ. So all of this will be done for adults, the pediatric, and the birthing populations. So what you can see on this slide, it is a little busy, but really just designed to give an overview of the approach and then some examples of the types of adverse outcomes in each of these categories. So again, for each population and for each subdomain, we're going to be looking at specific types of adverse events captured in the data. So for example, under physical health adverse events, we have for adults all cause inpatient admissions. If you look at underutilization for adults, we have for example that somebody will not... For example, adults not receiving primary care preventive visits that were scheduled. An example under social risk would be housing instability for adults. I'll note that there are a lot of TBDs for the adult... Sorry, for the social risk outcomes and this is really as new data sources become available will be brought in. So I think maybe I will conclude there as examples and open it up to either additional comments by Palav or David or questions. Thanks very much.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 00:35:52	I think just the only editorial comment I would as most of you're probably aware, existing or predictive risk models for the most part are using physical health indicators and utilization to a lesser extent behavioral health indicators where that data is available. So I think one of the really novel but critically important things that we are doing with this approach is really bringing in the underutilization because we recognize that that drives serious, poor long-term health outcomes, as well as health disparities, especially by race and ethnicity in our state. And then also really incorporating social risk, which certainly we've done to some extent with things like the healthy places index, but not to this degree of really integrating non-healthcare data. As Maya alluded to, one of our limitations is at DHCS sort of what data we currently have available to us. But we welcome any and all feedback from all of you as to other data points, especially in the social risk categories or underutilization where it is more novel that we should be exploring and happy to take that feedback back and look at feasibility in terms of when we can get that incorporated.
Slide 23	Amy Salerno – 00:37:12	Great. And I'm going to read off some of the questions in the chat and direct them to you, Maya or David. But if there's advisory group members who would like to ask a question, please raise your hand as well. So a question near the beginning of the presentation about having a separate category for the SPD populations or seniors or persons with disabilities and why that was not as specifically called out population for the three separate populations that are currently there. I don't know, Maya, if you want to take that.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Dr. Maya Petersen – 00:37:54	Sure. Thanks. I think the first thing to say is that this is certainly the initial version of, again, as David emphasized, an algorithm that we hope and expect to iterate on over time. And so in this first version, we're really balancing complexity and granularity with a transparently developed approach that can also be deployed with the data we have. So in the current version, we've really decided to take just these three populations to develop these initial risk tiers. Given that within each of these three populations, there's already the full level of complexity that we ran through. I think for the future, there's a potential to see whether that population is really being served by the algorithm as it's currently designed or whether there's need to pull out that population in a separate tier. But that's also something we're going to have the ability to actually look at using the data.
Slide 23	Dr. Maya Petersen – 00:39:09	And so, a key piece of all of this that I think hasn't been emphasized in this particular presentation is that once we've done the initial stage of algorithm development. Even before it's deployed, we're going to be taking a very close look using the data that we already have looking backwards to say not just how well is this algorithm doing overall in terms of efficiently and effectively identifying persons who really do go on to develop adverse events, but also how well is it doing for key subgroups. And if we see that it's really underperforming for key groups that this design isn't working, there's the opportunity to iterate at that stage two pre-deployment. I don't know if David wants to add anything to that in terms of particular populations though.
Slide 23	David Tian – 00:40:02	No, I think that you covered it well, Maya just we're certainly open to additional populations in the future. And so really welcome that feedback.
Slide 23	Amy Salerno – 00:40:11	Right. I am seeing a few questions that I think I just want to make sure we're addressing sooner rather than later. There's a couple of questions about why choosing specific outcomes over others within this outcome table and specifically like prenatal care versus doula services or those sort of questions. And so Maya, I don't know if you wanted to talk to how these are examples and there's more comprehensive setter.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Dr. Maya Petersen – 00:40:43	Exactly. So I think... Let me try to clarify this table again. So for each population, we essentially have a version of this table. So adults, pediatric, and birthing. And then in each of the boxes of this table, there's actually a long list of outcomes. So this is really for each of these, it's just one has been pulled out as an example. So for example, in the birthing population, we're absolutely looking at prenatal and postnatal services. And underutilization of those services would absolutely be included as... Or failure to receive the services as indicated would absolutely be included as an example of an underutilization outcome. So this is really just an illustrative table that shows the general structure. And again, the full draft of the adverse event outcome measures for each population, as well as of the predictor variables will be circulated to the advisory group for further input coming up soon. I haven't maybe seen all of the questions. So if that doesn't answer it, please flag it for me.
Slide 23	Amy Salerno – 00:41:58	Great. I think that will help for several of the questions. So just to clarify, for example, WIC versus CalFresh. Both of those are being planned to be used. And healthy places index or some other marker or similar to that we'll plan to be used in geographic. And I think just as a clarifying item, while the PHM advisory group will have a chance to comment on the draft versions, eventually all of that will be transparent for everyone publicly. Right, David?
Slide 23	David Tian – 00:42:48	Correct. Yeah, I think that what we wanted to do is keep the conversation a bit... The focus today really to address the broader considerations to make sure that we started there and got feedback there. But certainly, the specific outcome measures and predictors that we've shown today are not meant to be exclusive and chosen relative to one another. And we are specifically tracking your comments here. And so we'll definitely take all of this back and thinking about these data sources, making sure that we have flagged them for either active consideration now if the data are available or future consideration if the data aren't available.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Dr. Maya Petersen – 00:43:24	Great. And maybe just to run through a couple specific ones. Underutilization, yes. In the pediatrics is absolutely not receiving a lot of child visits is part of the pediatric underutilization outcome. And then importantly, for all of the predictor variables, we use prior versions of the outcomes to predict future risk as well, so yes.
Slide 23	David Tian – 00:43:51	Yes, Caroline-
Slide 23	Dr. Maya Petersen – 00:43:51	And then similarly for doula care and prenatal, absolutely prenatal. A doula just was an example that was pulled out there, but prenatal and postnatal are absolutely part of those definitions.
Slide 23	Amy Salerno – 00:44:05	Great. And Caroline, I see your hand is raised.
Slide 23	Caroline Sanders – 00:44:09	Yes, thanks. I just had a question. It sounds like you're looking at using the HPI or area-based social indices to look at geographic regions. However, we know that smaller racially, ethnically diverse populations, LGBTQ are not always... They don't always fall within those census categories. And so this is related to my broader question is how do we ensure that we're adequately balancing that with those types of predictors that may not capture these smaller populations with accurate demographic data. And do you feel like DHCS, and managed care plans have accurate and complete demographic data to really ensure that we are accurately mitigating risk for vulnerable populations?
Slide 23	Dr. Maya Petersen – 00:45:13	Thanks. I think I'll let David... Yeah, exactly. That's for you.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	David Tian – 00:45:15	Yeah, I can take that one. Thanks. Yeah. And so I think broadly speaking, DHCS definitely recognizes the need to have more complete and more accurate demographic information. And on our population health management website, there is a link to the member contact and demographic information initiative that really walks through our thinking around how we might improve gathering this information going forward. I think based on our existing work and conversations with managed care plans, we know that the completeness and the additional demographic information available to health plans, it varies across California. But health plans often do have additional sources of demographic information. So I think that that type of consideration in terms-
Slide 23	David Tian – 00:46:03	So I think that that type of consideration, in terms of how to make data for projects such as this one, and other project, as complete as possible is a key consideration. And certainly on this project and other projects, we are taking an active look and consideration of what happens when we lack accurate and complete information and how to directly address and mitigate potential biases, or just oversights, in our various work streams due to some of these data limitations.
Slide 23	Caroline Sanders – 00:46:33	And sorry, just to follow up, would include oversampling for some smaller populations or do you have particular thoughts that you can share?
Slide 23	David Tian – 00:46:46	Yeah, I think that in terms of the specific sampling of data and how we are going to look at data completeness and availability for this project, I think that is more within the purview of my and the work group members. And the caveat here is that we currently are still in the stages of obtaining and looking at that information to perform these types of analysis. However, I think that we do recognize the fact that there are going to be different levels of representation within data sets, what we have and what we don't have, and so I think that I can't be specific with that information in terms of a direct response, but I think that we are definitely tracking that need and are specifically going to be looking at that for this work stream and others.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Dr. Maya Petersen – 00:47:31	I don't have too much to add to that other than to say as part of a certainly pre-deployment evaluation of how this is working, looking not just at data completeness, but how it works for members who don't have complete data, is also a really important consideration that's top of mind. And I think if we really see that we're not doing a good job serving those members who may have those missing data, then that's going to be really a call to either change approach, get more data, or really take some action. So thanks for that.
Slide 23	Amy Salerno – 00:48:12	Peter.
Slide 23	Peter Shih – 00:48:15	Yes, thanks for presenting this model. I just wanted to comment on housing instability in the adult adverse event side. Are we going to be pulling data from the homeless management information system from all the various counties? Because that would be a great source of data to be part of the risk stratification process. Because it seems like that's a topic of great concern for everyone and that's a great data source for figuring out who's had an adverse event.
Slide 23	Peter Shih – 00:49:01	So that, and obviously just piggybacking on the idea that the algorithms will improve over time is hopefully the feedback of what's been learned would go back in the system, and not to talk about machine learning, but that's kind of where opportunities are for us to give the information about the risk stratification and the actions that are taken and what the outcomes are and how that can be fed back. That would really improve the system overall and benefit everyone. And just the idea that many of our folks move from county to county on a regular basis, and so that state database would be super helpful for the MCPs and for those of us who are contracted with the MCPs. Thanks.
Slide 23	Amy Salerno – 00:49:52	Palav.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 00:49:53	Yeah, I can take an initial response. Peter, we 100% agree with you. And so the long-term vision is absolutely getting access to HMIS data and using that across the state. I think I'm correct in saying that right this second. DHCS does not have a data sharing agreement to get HMIS data, but I know conversations are ongoing. So I think some of that is a timing issue that what we do have today is largely Z codes that have been coded as a part of CalAIM and the social drivers of health coding guidance that was released around housing and homelessness. I think we all recognize that is inadequate and so we're looking at how we can better leverage some of those statewide data pieces.
Slide 23	Palav Babaria – 00:50:35	Similarly, you see incarceration on here. Currently, DHCS does have data about those individuals who've been incarcerated in prisons. We are lacking that data often for jails and local facilities. So I think those are all of the sort of questions we are thinking through broadly with the PHM service, not just for the RSST process.
Slide 23	Peter Shih – 00:50:51	That brings a great point. I was going to talk about incarceration, but I figured that that was a bigger hurdle than HMIS. But definitely the jail information systems, if we can get some access to that, that would be huge. And just to give context, in San Mateo, over 50%, like 51% of our inmates are all out of county. So that's something that I think would be super helpful if the state can tap into that for their various counties so that we can make the connection, and then when they're discharged that they can go right back to their county and be connected to services right away. That would be fantastic.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 00:51:34	Yeah, and as I'm sure all of you are tracking, as we prepare for our justice-involved go live, which is going to be in a staggered fashion across the state over the next few years, those are exactly the questions that are occurring because we recognize, especially for incarceration, whether that's at jails or prisons, that there is a lot of cross-county lines and transfers and coordination that needs to happen. So our entire justice-involved initiative is thinking through the data elements of that. And as pre-release services go live, I do think that'll be another data element that we will know who is incarcerated and has been screened for pre-release services, or received them, and how we can incorporate that data as well into the RSST is something we're definitely considering.
Slide 23	Amy Salerno – 00:52:25	Thanks. I think another question around what level of data may be available to the MCPs, for example, the domain or the sub-domain sort of level, so that they can kind of prioritize resources. And Maya, I'll kick that over to you.
Slide 23	Dr. Maya Petersen – 00:52:48	Sure, happy to take that. I mean, I think the short answer is that exactly what output to send, how, and when to the MCPs is very much an area of active discussion and stakeholder input. Obviously we want to share the information that will be the most helpful in ensuring the MCPs are able to take the best action to improve the health of all members and to advance the health of all members. So still very much under discussion.
Slide 23	Dr. Maya Petersen – 00:53:27	I think the one other thing that I'll say, just to call it out, is one thing that we've heard a lot is, even going beyond these sub-domain and domain risk scores and tiers, the potential to use a platform like this to really understand at higher granularity, what types of services might be the most effective for members. I think the potential is certainly all there. And again, this is really envisioned as a starting point from which the entire system can kind of improve over time, and speaking to Peter's point, with feedback as well. So that will not be coming in the first version, but there's potential to go in that direction. I don't know if David or Palav want to add anything to that.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Amy Salerno – 00:54:23	Great. And then a question I think probably also either to Palav, most likely, about social needs screening in order to capture people's health related social needs and what... I guess the question was, isn't that needed? But I think the broader question for you, Palav, is that currently that's not necessarily available at DHCS, so wanted to pose that to you.
Slide 23	Palav Babaria – 00:54:58	Yeah. So I think definitely both within our MCP contracts, our PHM policy guide, as well as other both state and federal requirements, we know health related social needs screening is happening at multiple layers of the ecosystem, whether that is in the initial screening that is done by the managed care plan or our FQHCs are using different health related social needs screening tools that are built into their electronic health records. Our ECM care managers are required to include this as a part of their assessments. So the screening and referrals are happening. I think the challenge with the RSST process is that not everyone is using the same standardized tools.
Slide 23	Palav Babaria – 00:55:38	So CMS did issue guidance for some of their, I think it's either managed MA plans, and they have a laundry list of approved tools that can be used to do SDOH screening. All of them have slightly different worded questions. All of the data is stored in different ways. So I think for the RSST purpose, the real challenge is there is no single tool and single discrete data field where we can aggregate all of those screenings across the state level and then have it inform this effort. So that is definitely also an area we're looking into. But I think, going back to Peter's comments, that's where other sort of statewide aggregate databases like HMIS are really helpful because they help us overcome the sort of lack of standardization in how these questions are asked, where they're stored, and in what format at the local level. So I hope that helps, Kristen.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Amy Salerno – 00:56:40	Great. I think that we've addressed most of the questions that are in the chat. And I do appreciate those who put in suggestions for areas to think about and consider on either the predictor or the outcome variables. If you have any further questions, especially as an advisory group member, and we didn't address them, please go ahead and raise your hand and you can ask it out loud.
Slide 23	Amy Salerno – 00:57:16	There's a question about incorporating data from Healthy Places Index, which includes indicators of community conditions into the system.
Slide 23	Dr. Maya Petersen – 00:57:27	Yeah. So I think the short answer to that is that while this will be an individual level prediction, and really an individual level time specific prediction that can change over time, where an individual lives will allow us to bring in things like Healthy Places Index, which capture sort of community conditions that may impact the risk of that individual. I think, again, given that we're taking a flexible machine learning risk, we are not making assumptions a priority about how that will play in or how that may interplay with individual level risk factors, but we'll be considering that sort of predictor in the larger set of predictors. And then really learning from the data which predictors and which combination of those predictors really do the best job of predicting risk for an individual.
Slide 23	Amy Salerno – 00:58:38	Great. I think with that, we're at our time for RSST. If people have further questions, go ahead and please place them in the chat and we can try to address them if time at the end. But otherwise we'll move on to the next topic.
Slide 23	David Tian – 00:59:00	Oh, great. I was supposed to go over this slide, so before I pass it over to Bonnie about transitional care, just a reminder for advisor group members, you'll be receiving more information once ready about more detailed predictors and outcome variables. And then also everyone is welcome to share additional feedback, even after the session, to the Population Health Management Section inbox, which is linked to here. And with that, I'll pass it over to the transitional care team.

VISUAL	SPEAKER – TIME	AUDIO
Slides 24-25	Bonnie Kwok – 00:59:28	Thanks, David. Good afternoon everyone. I'm Bonnie Kwok, a family medicine trained medical consultant at DHCS in the Population Health Management division. I am the Population Health Management lead for transitional care services and really appreciate the opportunity today to share with you the updates for our lower risk members, as well as some clarifications for our high risk transitioning members, and allow some time for discussion at the end of the presentation. Next slide, please.
Slide 26	Bonnie Kwok – 01:00:08	You saw this slide already in the RSST presentation and we're focusing on the right side of the screen in the provision of services and supports. And we have... I think of this, in our Population Health Management program framework, I think of a three layered cake. And in the bottom tier of this cake, we have basic population health management for our members who need routine care, preventative care. And moving up one layer on this cake is our medium risk members with chronic conditions, for example, who need further care management, and that's in the complex care management category. And moving at the very top of this cake to the highest tier is our enhanced care management, where we have members with the most complex medical needs, as well as social needs. Like for example, our members who are unhoused or have substance use disorders or severe mental health issues. And what we're focusing on today is in the red box, transitional care services, which, starting on January 1st will be available for not just our high risk members, but for all members. Next slide, please.

VISUAL	SPEAKER – TIME	AUDIO
Slides 27-28	Bonnie Kwok – 01:01:42	And just a quick overview of our definition of care transitions and our goals for transitional care. We define care transitions as when a member transfers from one setting or level of care to another, and that includes transitioning from hospitals or skilled nursing facilities to home or other community-based settings. And our goals for transitional care is really to transition our members to the least restrictive level of care that meets their needs and preferences, as well as providing the needed support and coordination to have a safe and secure transition. Next slide, please. So our current guidance on transitional care services, which was published in our Population Health Management Policy Guide in December of 2022, outlines that, as of January 1st of this year, that plans must ensure that transitional care services are complete for all high risk members, and that includes having a single point of contact or care manager. And for all members, plans must process prior authorizations in a timely manner and know when all members are admitted, discharged, or transferred. Starting January 1st, 2024, which is just a few short months away, we are requiring that plans ensure all transitional care services are complete for all members. Next slide, please.
Slide 29	Bonnie Kwok – 01:03:27	And this is a pretty dense slide, but I'll walk you through it. So this is our updated approach for 2024 and 2025, and this is based on feedback we've heard directly from plans and plan associations, as well as responses from our transitional care survey sent out about two to three months ago. And the request was to have revisions in the policy and further guidance for transitional care services, particularly around the lower risk members and removing that single point of contact requirement and tailoring the transitional care services requirements differently for our high risk members versus our lower risk members. And plans and plan associations also asked for more clarity around the roles of discharging facilities, and in particular the processes around discharge planning and completing the discharge risk assessment, as well as more clarity on how facilities, plans, and providers can work more collaboratively on implementing these policies.

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Bonnie Kwok – 01:04:52	And our response was definitely an acknowledgement that some of these implementation can bring forth practical challenges and additional resource needs, especially as we are ramping up to serve all our members who are transitioning. And what we've done, or currently working on, is to clarify the transitional care requirements for the high risk populations around that discharge planning and discharge risk assessment in our 2024 plan contract to better align with federal and state requirements.
Slide 29	Bonnie Kwok – 01:05:34	And we are currently revising our transitional care services policy to share a model for transitioning care services for our lower risk members. And in this new model, we are removing that single point of contact requirement for the lower risk members. The rationale for this is to emphasize current existing requirements on hospitals around discharge planning and the discharge risk assessment, and also to create and implement a plan or plan delegated telephonic team that would be available for all transitioning members for a minimum of 30 days to support all members' transitional care needs. And last but just as important is to emphasize primary care provider follow-up or ambulatory follow-up within 30 days post discharge. Next slide, please.
Slide 30	Bonnie Kwok – 01:06:40	Excuse me. This is an even more dense slide, but I will walk you through. We've gone over some of the things on the very top blue. Just as a refresher, the general requirements on plans is knowing when any member is emitted, discharged, or transferred. Plans must process prior authorizations in a timely manner and, whenever possible, to process these prior authorizations prior to a member's discharge. And also assisting with in-network placement when necessary. And the plans are responsible for risk stratifying members in the high risk category or in the lower risk category for transitional services.

VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Bonnie Kwok – 01:07:36	Moving to the orange, what our current requirements entail are, under a plan responsibility, is assigning a single point of contact or care manager. And the care manager responsibilities include coordinating with the discharge facility on the discharge risk assessment and ensuring that the discharge planning document is shared with patient, plan, patient's caregiver, or family members, or other providers, as well as coordination with the discharging facility. And then follow up with medical appointments, completing medication reconciliation, and other referrals, ensuring that those are complete. And the transitional care services ends once these requirements are met, in addition to all the needs of the members are met, as well as a screening and referral for further care management, if necessary, into enhanced care management or complex care management or community supports as appropriate. So moving to the green-
Slide 30	Bonnie Kwok – 01:09:03	... as appropriate. So moving to the green part of this slide is where these modifications come in. For our lower risk members. The plan or planned delegate must ensure that transitioning members have a dedicated phone number to call. And with this number comes a dedicated transitional care services team who can access discharge documents and provide support if needed. The plans must also directly notify these members of this dedicated team as well as this team's contact information. And that could be through via text messaging or other modalities.
Slide 30	Bonnie Kwok – 01:09:45	What the discharging facilities are required to do is to complete that discharge planning process. And plans must oversee that the facilities are completing this discharge planning process in accordance to federal and state requirements. Facilities must be able to identify members who may benefit from the transitional care services and be able to refer members to the plan for high risk transitional care services or ECM or CCM or community supports.

VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Bonnie Kwok – 01:10:20	And for these high risk transitional care services members, plans must consider that member to be in that high risk pathway. And plans are responsible for conducting. Excuse me... Facilities are responsible for conducting discharge planning activities, including the discharge risk assessment, the discharge planning document. But plans are accountable to ensure that these activities are completed.
Slide 30	Bonnie Kwok – 01:10:49	And moving to the second from the bottom row in green, the plan and plan delegate or plan delegate must ensure that an ambulatory or PCP follow-up appointment with a physician or NP or PA is completed within 30 days for necessary transitional care needs such as medication reconciliations.
Slide30	Bonnie Kwok – 01:11:16	And lastly, for plans or plan delegates must also continue to offer transitional care support through this dedicated telephonic team for a minimum of 30 days post-discharge. And plans are required to use whatever available data sources they have to identify new members who may qualify for further care management or supports, and refer if members are eligible to the enhanced care management, complex care management or community supports. Next slide please.
Slide 31	Bonnie Kwok – 01:11:57	And that brings us to our discussion question, which is two parts. And as we're striving to provide all our members with timely and safe discharges, this requires significant coordination between plans, skilled nursing facilities, providers, and hospitals. What are some of the pain points that you're seeing with the model that we just showed and how can we provide further technical assistance around these pain points? I'm going to open it up to the group.
Slide 31	Bonnie Kwok – 01:12:43	I haven't heard this silence before when talking about TCS and I'm wondering if we just got it absolutely perfect, which would be totally okay. Tangerine? No? Okay. Nope, we don't. So I'm all ears, Tangerine.
Slide 29	Tangerine Brigham – 01:13:18	Yeah. Yeah. Could you do me a favor? It'll help with my question. Could you go back to the slide where you describe what will be happening in 2024 and 2025? So I'll make sure I've got my question correct.
Slide 29	Bonnie Kwok – 01:13:33	Is this the one?

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Tangerine Brigham – 01:13:35	Yeah, the one before this one. I'm sorry. Yeah.
Slide 29	Tangerine Brigham – 01:13:45	I appreciate that the state has really tried and is listening to health plans and providers when it comes to TCS, and as you note, the practical challenges, particularly around access for this population. And when you talk about the follow-up visit with the PCP, and I think in your next slide you indicate that it has to be a visit. Correct?
Slide 29	Tangerine Brigham – 01:14:27	I guess if you could talk a little bit more about that. So for example, if we've got care managers who are outreaching or a health to home or from hospital to home program, why is it from your perspective, if we've got those kind of touch points that help us identify if someone needs a further primary care visit, is it important to start with that provider visit first? Does that make sense?
Slide 29	Bonnie Kwok – 01:15:01	That makes sense. And I just wanted to clarify one point before I answer your question. Is this question based off of our lower risk model in particular? So our lower risk-
Slide 29	Tangerine Brigham – 01:15:14	Yes.
Slide 29	Bonnie Kwok – 01:15:15	Yeah, okay. That makes sense. Okay.
Slide 29	Bonnie Kwok – 01:15:20	So we think that a primary care or ambulatory care follow-up is needed, especially for our lower risk members, because we want to be able to make sure that some of the things that a licensed provider can do, like completion of a medication reconciliation after a hospital or SNF discharge, that those things can be completed. And that's a requirement that we are recommending for both our high and low risk, that a med rec must be done. And so having a care manager, maybe an LSCSW or a CHW, they won't have the authority to perform some of those required TCS items.

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Bonnie Kwok – 01:16:22	And we also see this as an opportunity for our lower risk members who may not have been in follow-up with their PCP to have another touchpoint so that they can connect with their PCP and follow up on other issues that may not have been touched upon during their hospitalization or in the nursing facility for general routine care, chronic disease management, vaccinations, et cetera. And so we want to make sure that this follow- up can be more comprehensive, not just a completion of what was needed in the transitional, excuse me, in the hospitalization, in the immediate period post-discharge, but also as getting routine care that they might not have.
Slide 29	Bonnie Kwok – 01:17:18	And I see Palav has unmuted, so I'm going to pass it on to her.
Slide 29	Palav Babaria – 01:17:22	Yeah, no, Bonnie, I think you covered it. But just to underscore, when we've looked at the literature in this domain, Tangerine, as you're aware of, certainly for certain populations, that seven day post-hospital... We're giving 30 days because they're lower risk, but that seven day post-hospital discharge follow-up is associated with lower readmission risk, improved long-term health outcomes and improved sort of cost curve in general. The data and evidence is more robust for certain populations, especially duals, seniors. But Medicaid, there have been some studies done in Medicaid as well. So there is an evidence base to support this recommendation.
Slide 29	Palav Babaria – 01:17:57	The other two things I would say is there's also really good studies out there that look at, for example, follow-up rates for ambulatory care after hospitalization for children and have found widespread disparities where commercially insured children get that recommended follow-up at much higher rates than children covered by Medi-Cal and Medicaid.
Slide 29	Palav Babaria – 01:18:15	There's both California and national data to support this. So we also see this as a health equity issue that this is the standard of care that is not being provided to the same degree of robustness within Medi-Cal that we want to correct.

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Palav Babaria – 01:18:27	And then as Bonnie said, I think not surprising to anyone on this call, re-centering primary care and ensuring continuity and engagement with primary care is the foundation of our pop health strategy. And we know that certain Black and brown communities have less access to primary care and have less continuity with their PCPs. And this is an opportunity because you have them, they're hospitalized, they're in the hospital to really do that warm handoff and get individuals plugged back in even if they don't necessarily need follow-up of that specific condition that resulted in the hospitalization.
Slide 29	Tangerine Brigham – 01:19:03	Thank you.
Slide 29	Amy Salerno – 01:19:09	Caroline, I think you had had your hand up. Did you still have a question?
Slide 29	Caroline Sanders – 01:19:14	Thanks. I think, Bonnie, you mentioned this. I just had a general question about how you envision or this plan envisions the role of community health workers. I think certainly with some of the care management, that that could be a great role for this workforce, and at different points throughout this process, whether it's screening or some of the other aspects of population health management. But I'm just curious how you're thinking about it because I didn't see that called out.
Slide 29	Bonnie Kwok – 01:20:01	Yes, thanks Caroline for bringing that up. Is it Caroline or Carolyn?
Slide 29	Caroline Sanders – 01:20:05	It's actually Carrie.
Slide 29	Bonnie Kwok – 01:20:07	Oh, Carrie, okay.
Slide 29	Caroline Sanders – 01:20:08	You can call me Carrie. Sorry.
Slide 29	Bonnie Kwok – 01:20:11	No, that's fine. Well, thank you for your question Carrie. I think that you bring up a really important point because this is really... The glue to this transitional care services is really the care coordination, and we envision CHW as being a core part of TCS and we want to utilize the CHW benefit that launched fairly recently for our transitioning members.

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Bonnie Kwok – 01:20:49	I'm curious, I want to ask a question back to you. What I've heard from discussion with other plans or providers is a lack of CHW workforce, and as CHWs could be considered the crux of providing care management services for TCS, how do you think we could harness existing CHW workforces or expanding that? What can we do at DHCS to improve the existing state of that workforce?
Slide 29	Caroline Sanders – 01:21:36	Yeah, thanks Bonnie. We have a lot of thoughts about this and I think we've been raising them elsewhere too.
Slide 29	Caroline Sanders – 01:21:45	I'll just say that we know of a lot of groups, community-based organizations that have trained CHWs, that really want to engage with managed care plans and with this program. And it's taking a while to contract and there's a lot of questions around billing and the infrastructure that's needed for them to really provide those services and work with health plans.
Slide 29	Caroline Sanders – 01:22:17	So I think that's something that... I understand, you're talking about the workforce, the ratio, but what I would say is I think there are a lot of folks who are trying to figure out how to contract with the health plan in order to bill for and provide these services. The infrastructure and then the way that the services are paid for at the rate that they're paid for is also making it very difficult because it's per unit, it's a fee for service, $26 per unit. And so if what we really want is a more integrated system of care, then I think we need to think about how we're paying for this service and the workforce. But I'm happy to talk offline as well. I just...

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Palav Babaria – 01:23:19	Thanks Carrie for that feedback. We'll definitely take that back. And also for you or anyone else on the call, I think we as Bonnie said, absolutely recognize the potential here of community health workers for all of pop health but also for transitional care services. So if there are specific examples you have of models that are out there, whether in our state or elsewhere around TCS or some of these pop health requirements, please feel free to send them our way. We'd love to lift them up for our health plans because I do think that integration piece is critical, right? For some of these functions, a standalone entity that contracts with the health plan may be best. For others, they may be better positioned sort of having the hospital direct their activities or a medical group or a primary care provider depending on what the specific model or need is.
Slide 29	Caroline Sanders – 01:24:09	Thanks.
Slide 29	Bonnie Kwok – 01:24:16	Any other thoughts on further TA?
Slide 29	Amy Salerno – 01:24:29	I think Natalie in the chat had raised up some areas of difficulty or challenges with the current system and discharge care managers, and the gap in communication and knowledge of MCP sort of transitional care services, and suggesting standardized systems or all available services post discharge are listed and centralized electronic health record systems. So I just wanted to raise that up.
Slide 29	Amy Salerno – 01:25:11	I don't know if you had specific comments on that, Bonnie.
Slide 29	Bonnie Kwok – 01:25:29	I think the very first statement is a huge pain point that was raised in other avenues, in discussion on TCS about how can we ensure that discharge care managers are aware of these resources and expectations. And that's exactly what we would love more feedback on, is how can we promote or disseminate what these TCS policies are as we're wrapping up for all members starting January 1st, 2024.

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Bonnie Kwok – 01:26:19	And some of the best practices that I've seen and heard are embedding plan staff or plan-delegated staff into hospitals, so they're sitting literally side by side with the discharge care managers and doing warm handoffs. And so we really welcome best practices from anyone in the advisory group or others on the call. What have you done that can help promote this communication with the necessary information of the contact information of the care manager to the discharging facility? How can we promote greater communication? I think that that's really the key question.
Slide 29	Bonnie Kwok – 01:27:21	And that's because I just saw the time.
Slide 29	Amy Salerno – 01:27:27	Yeah, I think just real quick, there's only one minute left. Deepa had just asked a question about standardization of requirements on hospitals, specifically around social risks and social needs, and just wanted to... Palav, I don't know if you want to take that real quick about the hospital based requirements and DHCS's role.
Slide 29	Bonnie Kwok – 01:28:00	Currently we don't have... Palav, do you want to go?
Slide 29	Palav Babaria – 01:28:04	No, I was just going to say obviously we don't directly oversee or have necessarily contractual relationships with the hospitals. Where we have tried to align is there is a significant number of transitional care requirements both in California state statute as well as national CMS sort of conditions of participation and joint commission requirements that we are aligning with. So there are other ways that those entities are monitoring hospitals. So the way we envision our DHCS policy flowing down to hospitals is really via our managed care plans, but we are exploring alignment opportunities in other programs we do have with hospitals such as our directed payment programs.
Slide 29	Amy Salerno – 01:28:47	I think that is all that we have time for today. So just thank you everyone for participating and really appreciate all of the robust conversation and feedback.
Slide 32	Tangerine Brigham – 01:29:06	Can I ask one last question? It's pre-decisional, it said. What exactly does that mean?

VISUAL	SPEAKER – TIME	AUDIO
Slide 32	Bonnie Kwok – 01:29:18	Thank you for setting us up for this last slide that we are going to publish the population health management policy guide updates with these TCS revisions. This month it will happen. And the revisions will include what I've shared about the lower risk members as well as those clarifications for the higher risk members. And we are amending the 2024 MCP contract. So that is coming your way very, very soon. And thank you Tangerine for setting that up for us.
Slide 32	Bonnie Kwok – 01:29:56	And with that, thank you so much everyone for joining us today to talk about RSST and transitional care services. Really looking forward to our next call. Have a good afternoon everybody.