Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

Contents

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Alice Keane – 00:00:13	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 field, which is located on the Zoom panel at the bottom of your screen. We encourage you to submit written questions at any time using the Q&A. The chat panel will also be available for comments and feedback. Finally, 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, Deputy Director and Chief Quality and Medical Officer with the Quality and Population Health Management Division.
Slide 1	Palav Babaria – 00:00:59	Thank you so much. Thank you all for joining us on this lovely Monday morning to hear about the revised transitional care services policy that went live on January 1st, 2024 as a part of our population health management program. Before we kick into the details and the update, I will just say that I think transitional care services is probably one of the hardest parts of our pop health program that we are trying to implement. I can say as a clinician, both having worked as a hospitalist and as a primary care provider, when I think about those really tough patient situations where we know something could have gone better and gone differently, usually it ties back to a poorly coordinated discharge, where we didn't get someone in fast enough to follow up on whatever condition they were hospitalized with, or there was a medication error and medication reconciliation wasn't done, or an individual got home without all of the DME and equipment they needed to thrive post–hospitalization.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
	Palav Babaria – 00:01:57	And so we also know this is one of the hardest areas of health policy and clinical care delivery to transform, because it really requires a lot of fragmented parts of our healthcare system working effectively and seamlessly together, from hospitals, to nursing homes, to primary care providers, to health plans. I'm really proud today about the revised policy we'll be showing you because it really reflects the culmination of a year of really robust stakeholder efforts to bring all those parties together and figure out, what is the best way we can do this to really improve the care and safety, most of all, that we provide to our members during these really high risk periods of transition. So really excited to introduce Bonnie Kwok, who is a medical consultant on the Quality and Population Health Management team, who's going to be walking us through all of the final policy. And really look forward to all of the questions and dialogue that you all will help us have as we get to the Q&A.
Slide 2	Bonnie Kwok – 00:02:54	Thanks so much, Palav. Appreciate your introduction. I'm Bonnie Kwok. As Palav mentioned, I am a medical consultant in the Population Health Management division, and the Transitional Care Services lead. I'm a family physician by training, and prior to joining my role here at DHCS, was a primary care provider in FQHC, and very excited about sharing more with you on these updated transitional care services policies. I'm really looking forward to having a robust discussion today. So on the agenda, I'm going to provide an overview of transitional care services within the population health management program. A brief explanation of our phased approach for launching our transitional care services policies.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 2–3	Bonnie Kwok – 00:03:57	We started off on January 1st, 2023 with our high risk members, and as of January 1st, 2024, we have expanded these transitional care services to all members. And lastly, we'll go over upcoming events and activities for transitional care services in the coming year. And we'll have questions and answers at the end. Next slide, please. So population health management, or PHM, within this framework, really our goal for transforming Medi–Cal is to provide a statewide approach that encompasses a comprehensive platform to ensure that all members have access to programs and services that lead to healthier, longer lives, and improve quality outcomes, and also to reduce health inequities.
Slide 3	Bonnie Kwok – 00:05:08	Our goal with population health management incorporates an action plan that builds trust and put members at the center of our work, and gathers, shares, and assesses timely and accurate data that incorporates members' preferences and needs to identify services and benefits effectively. And also, we want to connect them to members to preventive care with basic population health management, and provide transitional care services, which is the focus of today's webinar. And last, but certainly not least, our goal is to reduce health disparities by connecting members through care coordination to public health and social services that address their health–related social needs. Next slide, please.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Bonnie Kwok – 00:06:08	You might have seen this before. This is our population health management program framework. And on the far left boxes, you'll see that under member information gathering, we start with screenings and reviewing data sources, such as claims and encounters. And in the middle of the slide, we conduct risk stratification, segmentation, and risk tiering, and provide an assessment for all members. After the assessment is completed, we provide a treatment with services and supports to a program that's tailored for them, and whether that's population... Excuse me, basic population health management, or complex care management under that care management bucket, or enhanced care management, or transitional care services, this is available to the full spectrum of needs our members have. And the focus of today is encompassed in that yellow box for transitional care services. Next slide, please.
Slide 5	Bonnie Kwok – 00:07:26	The definition of transitional care services is when a member transfers from one setting, or a level of care, to another. And that includes, but it's not limited to, discharges from hospitals or other acute care facilities, and skilled nursing facilities, to home or community–based settings, incorporating services such as community support services, their housing transition services, or other post–acute care facilities. Next slide, please.
Slide 6	Bonnie Kwok – 00:08:04	Our goals for transitional care services is threefold. Really, we want to get our members to that least restrictive level of care possible that meets their preferences and needs. And we want to provide the needed support and coordination to have a safe and secure transition. And lastly, we want to make sure that these connections to services and programs help them be as successful as possible in that new environment. Next slide, please.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Bonnie Kwok – 00:08:41	So going back to what I mentioned in the beginning about our phased approach for transitional care services requirements. We started on January 1st, 2023 for our high risk members, and we highlighted the care coordination as one of the most important aspects for our high risk members in receiving transitional care. And our goal is to have all high risk members receive this single point of contact, or care manager services, to assist in that transition. And that started on January 1st. Our second phase, which began just 22 days ago. We've brought in these TCS requirements for all members, and there are different levels of requirements for our high risk versus our lower risk members, which I'll outline in the next couple of slides. Next slide, please.
Slide 8	Bonnie Kwok – 00:09:55	Our high risk members, again... Excuse me. Our transitional care services requirements for all members began January 1st, 2024. And our high risk members, those groups are defined here in blue. And that includes members with long–term services and supports needs, those who are already enrolled in care management programs, such as enhanced care management or complex care management, children with special healthcare needs, all pregnant individuals up to 12 months postpartum, seniors and persons with disabilities, and those members who have been deemed high risk by the risk stratification, segmentation, and tiering. On the right, you'll see members with severe mental health conditions, those with substance use disorders, members transitioning in and out of skilled nursing facilities, and members who are identified as high risk by a discharging facility, such as a hospital or a skilled nursing facility. Our lower risk members are those who don't fit any of these categories, for the purposes of transitional care services. Next slide, please.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 8 –9	Bonnie Kwok – 00:09:55	I think there's one more slide. Yes, thank you. So beginning of this year, plans are required to implement transitional care services for all members, and that they are supported from the discharge planning perspective until they're connected to all the needed services and supports for their transitional care needs. The general plan requirements for all members are in yellow. So plans need to know when a member is admitted, discharged, or transferred, to ensure that members are evaluated for all care settings appropriate to their needs, ensure that the completion of discharge facilities, discharge planning process is in place, and that after discharge they have primary care follow up.
Slide 9	Bonnie Kwok – 00:12:24	Also, plans should ensure that referrals to other services, including care management programs, such as enhanced care management, community supports, other waiver agencies, those referrals are in place and followed through, and also to ensure timely prior authorization. The main difference, as you'll see in the next slide, between high risk members and low risk members is that... I'm sorry, we can go back to that one slide. Thank you. The main difference is that high risk members have a lead care manager, or a single point of contact. For our lower risk members, we do have a requirement for plans to staff a telephonic team for a minimum of 30 days to support these members during this transitional period.
Slide 9	Bonnie Kwok – 00:13:24	For both high and low risk members, our goal is to have the necessary follow up. That includes primary care follow up post discharge, and following up on the referrals and referrals and follow up as needed. And that process includes having a medication reconciliation completed, as well. Next slide, please.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Bonnie Kwok – 00:13:58	This is a very detailed slide, but this outlines the main requirements for high risk transitioning members in blue, and the lower risk members in green. I'll start off with the blue, our high risk members. As I mentioned in the previous slide, the main takeaway is that high risk members have a single point of contact, or lead care manager, and if they're already enrolled in a care management program, such as enhanced care management or complex care management, that lead care manager will also be their transitional care services manager. The plan is responsible for identifying who that lead care manager is.
Slide 10	Bonnie Kwok – 00:14:46	And that care manager's responsibilities are listed in the four buckets below. And that's the overseeing that discharge planning process, reviewing the information provided by the discharge facility, and ensuring that that data or information is shared with the appropriate parties, such as the member themselves, and also the post discharge providers in the ambulatory setting. Also, completing all follow ups, as outlined in the discharge plan, including completion of a medication reconciliation, follow up with appointments and referrals. And also to refer members to care management programs, such as ECMCCM, or other services, such as community supports, and determine eligibility, and also make referrals as needed.
Slide 10	Bonnie Kwok – 00:15:46	Moving to the right, in green, requirements for lower risk members. The most salient point is that the plans are required to have this 30–day telephonic team, so that members can call and be connected to a staff member to address their transitional care needs during this 30–day minimum period. And the discharge planning process, completion of an ambulatory follow–up visit, is also in place for our lower risk members. And evaluation of continuing supports and services as needed is similar to those for members who are high risk. Next slide, please.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Bonnie Kwok – 00:16:52	So in order to effectively implement transitional care services, we've had multiple opportunities to engage with various stakeholders to get their feedback and input, and see what's really happening in the field. And what we've done so far is conduct a survey with stakeholders, I believe last fall, to get their feedback on how transitional care services was going for our high–risk members. We've also updated our transitional care services policies, and published an updated population health management policy guide, I think back in October of 2023. And we've also been engaging, through direct calls, with associations who represent a variety of stakeholders, including hospitals, skilled nursing facilities, and primary care providers.
Slide 11	Bonnie Kwok – 00:18:00	One example of what we've learned as emerging or innovative practices includes daily sharing of eligibility, a file that includes members' eligibility, from hospitals to plans, containing specific data elements to help with this timely exchange of data. And we want to make sure that we're clear. We're here to provide ongoing technical assistance as needed, and really, we see our role as just gathering information, finding what best practices there are, eliciting feedback on specific pain points so that we can provide more TA. And next slide, please.
Slide 12	Bonnie Kwok – 00:19:07	That's the end of our slide deck, but we really want to make sure that we have time to get your questions and feedback. I have some questions here, but I'm happy to just see what questions you have in the chat, and if there aren't any we can take on these questions.
Slide 12	Alice Keane – 00:19:36	Okay. Bonnie, I think we're going to start by sharing some of the questions with you all. I think the first question is, if a member is not in ECM or CCM, and is also identified as high risk, who is the care manager?

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:20:03	If a member is not in ECM or CCM, but they are identified as high risk, who would be the lead care manager for transitional care services? The TCS lead care manager can be staffed by the plan, or the plan can delegate this role out. So that could be with the hospital, or through their primary care provider's team. So that role can be part of the plan, or that role can be delegated out. Ideally, the TCS lead care manager can, if we already know that a member is high risk, they can refer to ECM CCM and community supports to check for eligibility, and the member can, during that transitional period, can be enrolled in one of those programs.
Slide 12	Palav Babaria – 00:21:05	Okay. And I think this is implied and covered in some of the slides Bonnie went over, but I will just reiterate that if a member is high risk, the requirement is that they have a specific dedicated named individual. Obviously, if they're an ECM or CCS, that individual should be the same as their already assigned care manager. If they're not in ECM and CCS, there has to be... It can't just be a random generic email or phone number. It is a specific human being who's responsible for that member. Most of the time this will be at the plan level, but plans can delegate that function to other contracted entities. But it is the plan's responsibility to make sure that that member is assigned to a specific individual, and that the name and contact information of that individual is shared with others who need to coordinate care.
Slide 12	Alice Keane – 00:22:02	Thank you, Palav. Thank you, Bonnie. Our next question is from David. What data reporting is available to assess implementation, and what metrics are being used?

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:22:15	We currently have two measures. One is through our incentive payment program, or IPP. That's a, excuse me, a three–year program that supports the implementation of enhanced care management and community supports through Medi–Cal managed care plans. And one of those measures is a seven–day hospital discharge follow up. We also have our population health management monitoring key performance indicators, and one measure is follow up with lead care managers. I believe also within a seven–day period. Those are the two that we're tracking. Monitoring and data collection and reporting is really a key focus area for us at DHCS. And we've recently launched, or excuse me, we are going to launch soon, our Kelly dashboard, and that includes enhanced care management measures, as well.
Slide 12	Bonnie Kwok – 00:23:29	And so we're working on being more transparent with the data that we collect and receive from plans, and we want to show what their progress is, and key areas of focus, including transitional care services. Palav just went off mute, so I'm going to–
Slide 12	Palav Babaria – 00:23:50	Yeah, and I'll just, obviously you all know we love data and we love measurement, but we also really are mindful of not adding to the reporting burden, especially for our plans. And so there are other measures that we already collect that aren't necessarily appropriate to track month to month, but should improve as transitional care services rolls out. So we already receive data from all of our health plans on readmission rates, plan cause, all readmissions, which should improve over time with the effective rollout of transitional care services. Similarly, as Bonnie lifted up, all pregnant and birthing individuals are considered high risk, right? So if they have a dedicated care manager, there is no reason that our postpartum visit rates should not steadily improve over time with that additional support and navigation through transitional care services, and getting to that postpartum visit.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:24:41	We are also working with our hospital partners and are interested, are there other perspectives that we need to consider, such as admin days, or avoidable days, that are also sort of process measures on how effectively plans and hospitals and other discharging facilities are working together to navigate transitional care services. So lots more to come in this domain as we start to ramp up monitoring and publicly sharing that data over the course of 2024.
Slide 12	Palav Babaria – 00:24:41	And I saw, so I'm going to jump ahead because someone... We have been talking about the seven–day post–hospital discharge measure, which many of you have heard me speak before. This, along with FUM and FUA, is one of my favorite measures. And the question is, we are hearing more and more from our TCS team, as well as providers, that PCPs and specialists are highly impacted, and it is extremely challenging to complete an ambulatory appointment seven days post inpatient discharge. Hence we are requesting if DHCS can reconsider changing the requirement to scheduling an ambulatory visit, and not completing the visit within seven days.
Slide 12	Palav Babaria – 00:25:48	So I totally hear the question. We had a lot of back and forth around this. And I will say, I think this is a process measure, right? So we do not expect a hundred percent of individuals to be seen within seven days post discharge. That's not sort of the threshold that we are holding plans accountable to. There are always going to be scenarios where someone misses an appointment, doesn't show up, despite the best ability of all of the healthcare providers and system involved. And so the target is not a hundred percent. But we will be looking at how, in general, plans are performing across the state, and really looking for outliers. Where are these plans who are doing this really well, that we can learn from and share those best practices? And where their plans and facilities that have really, really low rates that are clearly not at the performance level that everyone else across the state has been able to achieve, where we need to focus our monitoring and compliance efforts?

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:26:43	I will also say the seven–day number is not made up out of thin air. There is actually robust evidence and literature that supports, especially for duals, low–income populations, and vulnerable populations, the seven–day post–hospital discharge follow–up. And I will also lift up our equity and practice transformation payments program went live. We know that there are access and workforce issues across the state. There are also numerous solutions and best practices, again, in the literature, in our state, in facilities, that have figured out how to improve access for post–hospital discharge, and improve timely access to primary care. And we'll be certainly supporting the primary care practices that were accepted into the equity and practice transformation payment program in making that change. But we also look forward to our plans and providers on working on those improvement efforts in the months and years to come, as well.
Slide 12	Bonnie Kwok – 00:27:34	Thank you, Palav. That is super helpful. I think related to that question, there's also a comment about for the seven–day requirement for follow up with a network adequacy issue, do telehealth appointments with vendors fill this need? Could you quickly touch on that?
Slide 12	Palav Babaria – 00:28:02	I will take that back, to just make sure that our key performance indicators, how they're constructed, but in current states, telehealth and in–person visits, for the most part, as long as they're coded properly, do meet the requirements for a post–hospital discharge or outpatient visit. But we will take that back and confirm and can clarify in forthcoming FAQs.
Slide 12	Alice Keane – 00:28:27	Great.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:28:29	No, I will just add, the goal is to get the member the care they need, and so there certainly are urgent care models, telehealth models, that can ensure some of the safety aspects of post–hospital discharge follow–ups, such as ensuring that the member's needs are met, that they have the DME, that medication reconciliation is done, and we totally support that. I will explicitly say the other huge part of this is really strengthening primary care engagement across our state. We know that there are significant disparities in primary care engagement between Medi–Cal populations in our state, and other lines of business, as well as significant racial and ethnic disparities. And so I do think centralized models that leverage urgent care, hospital–based discharge clinics, and telehealth vendors, can certainly solve part of the problem, but it will likely not solve the primary care engagement and continuity problem, which we're also very closely looking at, both in transitional care services and population health management.
Slide 12	Alice Keane – 00:29:30	Thanks. Switching topic questions. There's a question in the chat about the role of the medical director/physician at the plan, and what their role is in transitional care services, with a request to clarify what that is, so it's clear to those who are non–clinician and plans, to not squeeze out the importance of the medical directors and their quarterback role in transitions of care. So a little bit of comment on the role of the medical director.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:30:08	I can start, and then feel free to layer on, Bonnie. So by definition, individuals who have been hospitalized or are being discharged from a skilled nursing facility often have complex medical and behavioral health needs. And so while a lot of the efforts and requirements around transitional care services are around that care coordination and making sure their needs are met, this specific population and those that are classified as high risk often will have significant complex clinical needs. And so I would be surprised if any transitional care services program doesn't have frequent complicated questions that need a medical director or other clinical personnel to weigh in and help problem solve. And so they should be the backbone, pretty much, of every single transitional care services team, and working with whoever the lead care manager is. But Bonnie, feel free to layer on.
Slide 12	Bonnie Kwok – 00:31:05	I agree, Palav. I don't have anything further to add to that.
Slide 12	Alice Keane – 00:31:13	Thank you both. The next question is on a slightly different topic, in terms of roles and responsibilities for transitional care. The question is, who completes the discharge plan and discharge bricks assessment for a member?
Slide 12	Bonnie Kwok – 00:31:31	The discharging facility is required to complete the discharge risk assessment and the discharge plan planning document. The plans are accountable to ensuring that those requirements are met, and those requirements are both, excuse me, state and federal requirements. So again, it's the facilities who are required to complete the discharge plan and discharge risk assessment, but plans are held accountable for ensuring that those requirements are met.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:32:14	I also want to just say here, that particular question is a really good one. I want to lift that up, because we have gotten that question fairly frequently in last year. And one of our main goals is to really minimize duplication of services. And so what we've done in our recent policy guide policy updates for transitional care services in the population health management policy guide, is to really outline the responsible entity for which task that is needed to be completed in this transition process.
Slide 12	Alice Keane – 00:32:59	Thanks for helping to clarify that. Another question, actually related to coordination and data sharing with different entities, came up around, the lead care managers have been having difficulty communicating with hospitals and facilities due to the organizations' privacy requirements. Oftentimes lead care managers may not have assigned ROI ready for the facility to coordinate the transitions of care. Is there any way to address this or to educate hospitals or facilities regarding ECM providers and their responsibilities of transitions of care management? So, difficulty between the discharging facility and the lead ECM care manager, communication and data sharing.
Slide 12	Bonnie Kwok – 00:33:49	Thanks for that question. If I could simplify the transition process for the discharge planning process, it would be, a main goal is just to have the name and contact information of the lead ECM care manager, or the lead TCS care manager, who may also be the ECM or CCM lead care manager. It's the name and contact information. And really, what we're working on is how to increase that communication between a discharging facility, like a SNF or a hospital, to connect with the plan, most often plan lead care manager. And what we've heard in terms of emerging or innovative practices, or best practices, is having a lead care manager sometimes even embedded in the hospital, so they're working alongside each other, but we're really trying to increase the exchange of data through signed agreements, such as the Cal HHS data exchange framework, data sharing agreement.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:35:13	I think that, for plans that, and most organizations, not all, the deadline to sign that is January 31st of this year. So we're trying to increase the exchange of information, not just member information, but lead care manager information so that's included in that data exchange for ease, efficiency, and efficacy in this process. That's all.
Slide 12	Sherry Dai – 00:35:48	Thank you, Bonnie. We have a few questions related to facilities discharge planning documents requirements. And so the questions are, how does the plan ensure facilities, discharge planner and discharge documents meet all transitional care requirements, especially if the facilities are non–contracted? And will there be any formal communication with these clarifications? And then relatedly, how does the plan ensure facilities, discharge planners and discharge documents meet all those requirements? Those include name and contact information for the members care manager for transitional care services, especially for out of work facilities.
Slide 12	Bonnie Kwok – 00:36:37	There are a lot of parts in that question. I'm going to do my very best to address as much as I can. I think that this is also a really important question about the quality of information shared by the discharging facility. And I'll start with the high risk, excuse me, for the high risk members. The requirement for plans is to have that single point of contact or lead care manager, and their responsibility is to review the completion and accuracy to meet these TCS requirements. They must do that for every high risk member. And our goal is to have timely and accurate information shared between hospitals and lead care managers. I fully recognize also as a provider that that's sometimes challenging, that there could be data lags, such as sometimes several day delay or more, from the lead care manager receiving documents from the hospitals.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:37:58	And so I showed in that slide, I forgot which one, but it was these specific data points that a hospital is sharing with a plan, and they're working on this innovative practice of having daily feeds, so that they can be as up–to–date as possible. I fully recognize and admit that I don't have all the answers to this, and especially being out of network, that can increase the data lag. But this is something that we're trying to address further this year to reduce that data time, and make that, what is the data that is exchanged, accurate as well. Sometimes, this wasn't asked in the question, but sometimes the contact information and name of the lead care manager can change. And so in this, to be as thorough as possible, we want to make sure that not only the discharge plan, but also the contact information of the lead care managers is up–to–date and accurate.
Slide 12	Palav Babaria – 00:39:13	And I'll just piggyback off of Bonnie, because I see a few questions in the chat about this, that our explicit goal as a department is to not require any duplicate work, right? So we recognize partly why transitional care services is so thorny, is because there are activities that hospitals are doing, there's activities that skilled nursing facilities are doing, there's activities that primary care providers, delegated IPAs, and plans are doing, and it gets complicated. We do not want anyone doing double work. It's more that we absolutely, for the benefit of the member, require and need all of those entities coordinating each other's efforts with each other, so that members aren't falling through the cracks.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:39:52	And we recognize that this is an area that's evolving, and depending on what part of the state you're in, and what those arrangements look like, contractually and otherwise, there are different best practices and solutions. We will be, throughout the course of 2024, explicitly lifting up and sharing some of those best practices, both through the DHCS transitional care services website, and other avenues, so that folks who are struggling in this venue can learn from solutions that their peers have found. But just want to acknowledge and name that it is hard, and the solution that works in one part of the state is not necessarily going to transfer perfectly to other parts of the state with different models.
Slide 12	Alice Keane – 00:40:36	Great, thanks. I think next we have a question about EDT feeds, and was just curious, and then also information sharing from DHCS. So question is, DHCS aware of, or heard any challenges related to ADT data, as the first question?
Slide 12	Bonnie Kwok – 00:41:03	Yeah, go ahead Palav.
Slide 12	Palav Babaria – 00:41:05	No, I mean there are all sorts of challenges with ADT data. Let's not beat around the bush and try to sugarcoat that. The general sense is, we have required all of our managed care plans to start leveraging ADT feeds since our population health management program went live in January of 2023. And we know, from IPP data and other incentive programs that we have, that plans have been making progress. Is it a hundred percent? Is it perfect? No. But there has been steady progress to getting more ADT feeds on a regular basis, and supporting that more real–time care coordination that is really needed for transitional care services. We also recognize that as the data exchange framework and our qualified health information organizations across the state get stood up and strengthened, that will certainly improve and streamline the ability to leverage ADT feeds beyond, in a lot of cases, what is currently plans having individual ADT feeds with each facility. But Bonnie, feel free to add on.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:42:11	Sorry, I was finding my mute button, or unmute, or mute. It's the same button. Anyways. No, I don't have anything additional to add on. Having worked in systems where they had very successful ADT feeds, and systems where they did not, there is utmost utility in this area of data exchange. So this is something that we really are emphasizing, or focusing on, for this coming year.
Slide 12	Alice Keane – 00:42:52	Great. And then also related to data, there was a question about whether if DHCS, and then if so, what information the daily file DHCS will share from hospitals to MCPs. And so I guess a first question, like is there a file, and if so, what does it contain?
Slide 12	Bonnie Kwok – 00:43:23	I think, right off the bat, there is no standard file that DHCS requires hospitals to share with plans. Just for full transparency, really, our authority lies with working with plans to implement transitional care services policies, and more indirectly with hospitals, primary care providers, and skilled nursing facilities. Right now we are just exploring some of these best practices. What are the data elements, what is the frequency that would be best to have this exchange? And we're talking to hospital associations to get that feedback. So there is no standard file at this time, but we are in the phase where we're collecting more information, and hope to share more best practices in the coming months.
Slide 12	Palav Babaria – 00:44:28	And I'll just explicitly say that the department does not have any real time data about hospitalizations. And so, really, the expectation around that data sharing for now, it is between managed care plans and there, certainly, contracted hospitals, but other hospitals that their members may get admitted to. The data that we at DHCS have is, for the most part, affected by claims lag, which means that it takes us about six to nine months, depending on delivery system, to have that accurate data, which we then share back to plans as a part of our plan data feed. But it is not useful for real–time care coordination.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Alice Keane – 00:45:11	Great, thanks. And then a question related actually to the justice initiative, and tying to transitional care services, there was a question around, for the justice involved initiative, the 90–day in–reach services will not go live until October of 2024. And the question is, what should transitional care services look like for persons leaving prisons and jails, many of whom could be considered high risk? So whether the transition from incarceration is considered as part of this for transitional care services definitions.
Slide 12	Palav Babaria – 00:44:28	I think it's a great question, and an example of sort of where the phased rollout of Cal–Aim can be challenging. So for the most part, the transitional care services policy really applies to different levels of care. So acute care facilities, skilled nursing facilities, is not contemplated to apply to just being in a correctional facility. Obviously, if you are in the hospital unit of a correctional facility, that would probably be in scope. That being said, we do recognize the vulnerability and high risk nature of individuals who are being released from custody, which is exactly why they are all ECM eligible. And we are working separately through the justice initiative on making sure that our plans have the appropriate data sharing agreements and referral pathways in place from correctional facilities, so that as individuals are leaving custody, even before pre–release services go live, that all of those individuals can be appropriately referred to, and enrolled in enhanced care management, which would then support them through that transition period.
Slide 12	Sherry Dai – 00:47:10	Thank you, Palav. We have a question specifically related to complex care management. The question is, is there an established timeframe to assign a complex care manager to support transitional care services?
Slide 12	Bonnie Kwok – 00:47:37	I don't remember off the top of my head, but I do think that we provided a timeline in our population health management policy guide for the assignment of transitional care services lead care manager. But specifically for CCM, I don't recall. Palav or any, do you know if there's a specific timeline?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:44:28	We can take that back. I don't believe, for a complex care management, our policy, for the most part, aligns with and leverages the NCQA standard, so we can go back and look, but I don't remember off the top of my head a specific enrollment timeline.
Slide 12	Alice Keane – 00:48:34	Great, thanks. And then a question around long–term care residents. So for members who are long–term care residents, for example, are receiving custodial care at a long–term care, so are more longer term long–term care residents, and experience a transition in care, and then discharge back to their normal long–term care facility, is there still a requirement that a transitional care services care manager coordinate care? With a comment after this question that this could be duplicative, as the long–term care staff is also providing care coordination and connecting members to needed services and supports identified in the discharge plan.
Slide 12	Palav Babaria – 00:49:23	So the short answer is yes, right? This individual falls into the high risk category, so they need a dedicated specific care manager who's going to meet all of the requirements laid out in the TCS policy guide. That being said, plans can delegate. So I think this is a good example of, if their plan is contracted with a long–term care facility that has robust transitional care services and can perform some of those functions, the plan can absolutely delegate some elements of that to avoid duplication. If they don't delegate, the plan is also encouraged to play more of an oversight in making sure all the requirements are met role.
Slide 12	Palav Babaria – 00:50:00	So again, if the long–term care manager or coordinator is doing some of the stuff, the plan's job is not to duplicate that stuff, but to just make sure that it's happening. And some areas where this becomes really germane is, even if that individual is a long–term resident of that facility, we do want everyone to be universally screened for community supports and ECM eligibility. And obviously, one of our explicit populations of focus for ECM is identifying those long–term care residents who may be, with additional community–based support and resources, could transition out of long–term care.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:50:37	So I think those are the types of questions that we expect the lead care manager to be asking and screening for, as a part of the transitional care services policy, could absolutely be done by the long–term care staff as well, but that would really depend on the contractual agreements, and arrangements between the plan and that facility.
Slide 12	Sherry Dai – 00:51:01	Great. Thank you, Palav. The next question is related to risk assessment. Are there specific tools or assessments that must be used to identify transitions of care needs?
Slide 12	Bonnie Kwok – 00:51:19	We did not outline specific risk assessment tools. That can vary across by hospitals or facilities. We are working on standardizing referrals to enhance care management and the authorization process, which can... I see those two tied closely in the assessment of a risk for re–hospitalization, or just discharge risk back into the community. And then also, ensuring that there's a thorough review of eligibility criteria for enhanced care management, complex care management, and community support, or other waiver agencies, to make sure that there's additional follow–up beyond this transitional period.
Slide 12	Palav Babaria – 00:50:37	And I'll just add, this is an area where we really got robust support and feedback from our stakeholders, in the time from when Cal–Aim and transitional care services was first imagined to now, and we are going live. There's also been a lot of evolution in federal guidance around transitional care services, as well as joint commission requirements for screening for things like risk, as well as social determinants of health. And so if you read the revised policy guide, and the new sort of revised transitional care services policy that went into effect this month, it really goes into much more granular detail. But to avoid duplication, we are really supporting and reinforcing that federal policy and joint commission standards, which all hospitals in the state are already following, and then really lifting that up.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:53:02	So again, we don't want to do some state–specific thing that is duplicative and hard to enforce and implement, but we do expect those federal standards to be met, and serve as the bedrock for transitional care services.
Slide 12	Alice Keane – 00:53:21	Great, thanks. And thanks for the additional clarification on the non–duplication of services, Palav. I think, noting that we only have about six minutes left, we'll do two more quick questions, and then I know that you all wanted to highlight and request for some best practices, so we'll let you all do that, as well. So I think the next question is around, who does the medication reconciliation? Which is, I know, a key cornerstone for this policy for you all. So does the care manager complete the medication reconciliation, or ensure that it has been completed? And I think a clarifying question we've heard before about that, is there one medication reconciliation, or two, or what does that look like?
Slide 12	Bonnie Kwok – 00:54:17	It's really the latter, ensuring that the completion of a medication reconciliation is completed. There's a wide range of certification, licensing, and training for our lead care managers, and not everyone might be licensed to conduct a medication reconciliation. The goal is to make sure that a medication reconciliation is complete, and that that's documented. For the low risk members, we want to make sure that that is completed through the primary care provider setting, or in the ambulatory setting post discharge. For the high risk members, we want to make sure that this is conducted in a timely manner post discharge, so that those higher risk members can get their medications, or plans can troubleshoot with prior authorizations as quickly as possible.
Slide 12	Sherry Dai – 00:55:42	Okay. So we have one last question before I think we turn over to you, Bonnie and Palav, to ask about promising practices. I think this question is, what is DHCS position on DRG admissions, in terms of reimbursement and plans responsibility, in the event that the member was omitted prior to January 1st, 2024?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:56:10	We can take that back for our finance team, but I will lift up that this policy is really around care management and care coordination around time of discharge, and does not change or affect DHCS hospital payment policy. But we can also pass that specific question on to our healthcare financing team.
Slide 12	Palav Babaria – 00:56:37	And I will also say, I see all the repeated questions about updates on the PHM service. We hope to share more with you soon. We are not trying to intentionally avoid them or be vague, but as mentioned earlier, when the PHM service launches, it really will, at the start, be using data that DHCS has, which is affected by claims lag. And so, for the foreseeable future, even when the PHM service is live, it will not necessarily solve some of these challenges that we've discussed and heard from you all today around real time data exchange and notification of admissions, discharges, and transfers.
Slide 12	Alice Keane – 00:57:18	Great. And I think there's actually a question here that relates really closely to what your question is going to be about for best practices. So the last question is related to releasing postpartum members being high risk, a question about what's the estimate of that number, but also just more guidance is needed to see how implementation can come to play with just a lot of questions around that. And I think there've been other questions in the chat around doing this work for the birthing population.
Slide 12	Bonnie Kwok – 00:57:58	I just so happen to be one of the co–leads for our birthing care pathway, and also the lead for our enhanced care management birth equity population of focus, which also launched on January 1st, 2024. I don't have actual numbers for an estimate for our postpartum population, but for both the birthing care pathway and for the ECM birth equity population of focus, we are focusing on conception until 12 months postpartum. And also, in relation to transitional care services, this is one of the three areas of focus for 2024. Our birthing population, our members who are transitioning in and out of skilled nursing facilities, and also primary care follow–up and engagement.

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Bonnie Kwok – 00:58:52	So we fully recognize that the birthing population has a unique set of challenges during this transitional care period, and it's quite a vulnerable period. And there are overlaps. There's intersectionality with the other populations of focus, such as birthing members who also have substance use disorder, or severe mental health conditions. And we're working with ECM providers, hospitals, and other community–based organizations to really rally around this group and see how we can provide comprehensive care coordination, not just for this transitional period, but also throughout this period of conception until 12 months postpartum. So Palav, do you have anything else to add for that particular part about birthing?
Slide 12	Palav Babaria – 01:00:00	No, I think you covered it well. Just really that lots more to come, as all of you are aware, and we can drop the link in the chat. Our birthing care pathway project is sort of in active flight, and we hope to release a policy strategy by the summer of 2024. And for those of you who want more specific numbers about births, we do DHCS have a file on the open data portal. I was looking for it, couldn't easily find it, but it has granular data about all the births that Medi–Cal covers annually.
Slide 12	Alice Keane – 01:00:33	Great. And I think we are actually one minute over time. I don't know, Bonnie or Palav, if you wanted to... Palav, if you want to wrap up and–

Population Health Management (PHM) Updated Transitional Care Services (TCS) Policy Webinar

January 22, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 01:00:41	Sure. Yeah, no, we don't want to keep you longer. I will just say, this is hard work. If it was easy, we wouldn't be here talking about it and trying to solve this problem. And it is hard work around the country, and the literature is littered with studies upon studies of how you fix transitional care services, and really improve care for members. And I'm sure we all have our own personal horror stories of loved ones who've had really bad transitions in care. It is far too common. And so we really need all of your help and support in figuring out those best practices and solutions. Please, please, if you have figured out something that is working and is positive, we want to hear from you. The slides will include our email address. Please send us ideas and suggestions. And a lot of 2024 is really going to be spent on technical assistance and helping and sharing those best practices. Bonnie, anything that I missed?
Slide 12	Bonnie Kwok – 01:01:34	No, I think you covered it well, Palav. Just deep appreciation for everyone's hard work, and we really look forward to continuing this discussion in the coming months. Thank you.
Slide 12	Palav Babaria – 01:01:51	Bye everyone.
Slide 12	Bonnie Kwok – 01:01:53	Bye.