PHMI Stakeholder Advisory Committee

October 31, 2022

Agenda

01	**Welcome and Today's Agenda**	**5 mins** *Bobbie, Jennifer*
02	**DHCS Update on Value of PHMI**	**5 mins** *Palav*
03	**Committee Goals & Objectives**	**5 mins** *Jennifer*
04	**Hearing From Partners** • *CHCs* • *CPCA* • *MCP: Partnership Health Plan*	**25 mins** *Partner Speakers*
05	**Updates on the PHMI Implementation Strategy and Technology Value Prop**	**15 mins** *Jennifer, Ed*
06	**Next Steps**	**5 mins** *Stephanie*

Stakeholder Advisory Committee Goals & Objectives

The purpose of the PHMI Stakeholder Advisory Committee is to provide strategic and tactical guidance for PHMI as a whole and make recommendations on key aspects of the program to ensure success.

Goals & Objectives for the Stakeholder Advisory Committee:

- Provide feedback, guidance, and recommendations on program design, roll out and sustainability
- Communication and coordination on overall program development and roll out
- Review and feedback on program milestones and impacts
- Identify key risks and issues to initiative, as well as initiating solutions to resolve them
- Review and feedback on program evaluation and ongoing learnings from the Initiative
- Guidance on efficient and effective use of program dollars

CHC Journey in the PHMI (To Date)

FQHC PHM Readiness and Deep Dive Assessments (fall 2021)

Co-Design: 90+ CHC, DHCS, KP stakeholders scope initiative and priorities (winter 2021)

Design Solution Set: literature review, KP & CHC best practice reviewed with design teams to determine initial solution set (winter/Spring 2022)

Technology Strategy: Assess needs and priorities of CHCs, Select PHM Platform to test with proof of concept (Innovaccer) (winter/spring 2022)

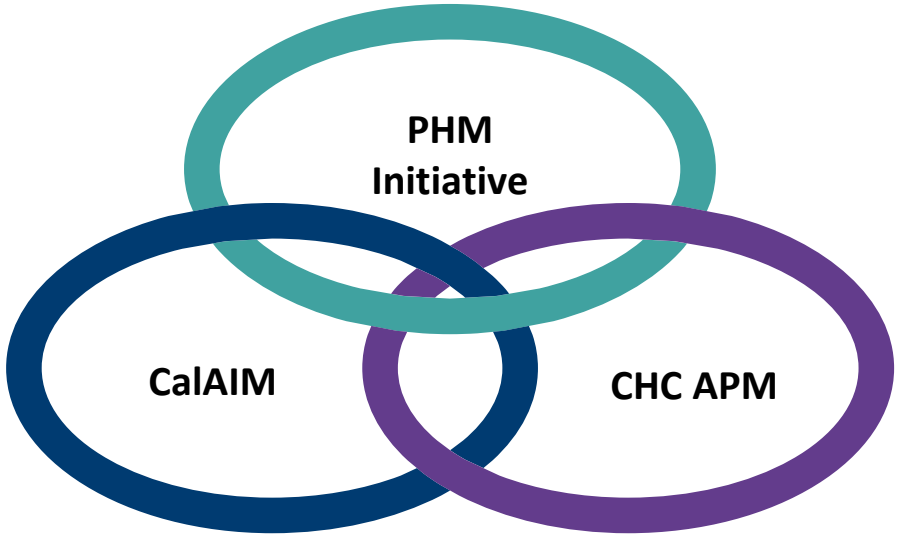
Clinical Guidelines Development: establish clinical advisory group to vet and standardize clinical guidelines for specific populations of focus in the initiative (summer/fall 2022)

Pilot Test Solution Set: 11 PDSAs across 30 CHCs to test components of the PHMI intervention set (summer/fall 2022)

What have CHCs learned through the PHMI planning process thus far?

CPCA Perspective: Alignment Opportunities for Key Statewide Initiatives

Medi-Cal PHM initiative supports the CalAIM vision of Medi-Cal delivery system transformation through population health management, with a focus on improving community health center PHM capabilities to achieve improved population outcomes and succeed in the new APM payment model.



California Advancing and Innovating Medi-Cal Waiver (CalAIM)

- Implements PHM policy and requirements for Medi-Cal delivery system, including standardized population assessment, tiering, and programs
- Promotes whole person care, including social determinants of health through new programs and benefits

CHC Alternative Payment Methodology (APM) 2.0 Pilot

- Transition CHCs to payment model that provides flexibility in how care can be delivered
- Require new care model that focuses on PHM to succeed
- Improved cash flow and financial stability

KP/DHCS/Health Centers Medi-Cal PHM Initiative

- Achieve the CalAIM goals by advancing PHM at the provider level
- Co-Design and implement new PHM care model and enabling technology for CHCs to be successful in APM
- Improve CHC capability to monitor, track and address quality metrics and population outcomes
- Support CHC transformation efforts through focused curriculum design and coaching

Interventions Designed to Impact DHCS Quality Measures

These PHMI Quality Measures were developed and endorsed by DHCS to fulfill the expectation that the PHMI will prepare CHCs for APM and CalAIM by improving their population health management capabilities and achieving key Medi-Cal Program metrics and outcomes.

PHMI Core Quality Measures

Pediatric Prevention

- Child Immunization Status (CIS 10)
- Well Child Visits in first 30 months of life (first 15 months)

Behavioral Health

Depression Screening & Follow-Up for Adolescents and Adults

Maternity Care

Prenatal & Postpartum Care (Postpartum)

Adult Prevention & Management

- Colorectal Cancer Screening
- Comprehensive Diabetes Care: HbA1c Poor Control (>9%)
- Controlling High Blood Pressure

PHMI Implementation Strategy

PHMI Aim

To advance the maturity of PHM capabilities for California Community Health Centers to support CalAIM and APM 2.0 and improve PHMI quality measures

Achieving PHMI Aim

PHMI Quality Measures & Populations of Focus

Foundational Competencies: Empanelment & Care Teams

Pediatrics

Child Immunizations
Well Child Visits (First 15 Months)

Maternity Care

Prenatal and Postpartum Care (Postpartum)

Behavioral Health

Depression Screening and Follow-up

Adults

Colorectal Cancer Screening
Controlling Hypertension
Controlling Diabetes

CHC Selects Population of Focus

Improving PHMI Quality Measures

PHMI Change Package for Population of Focus

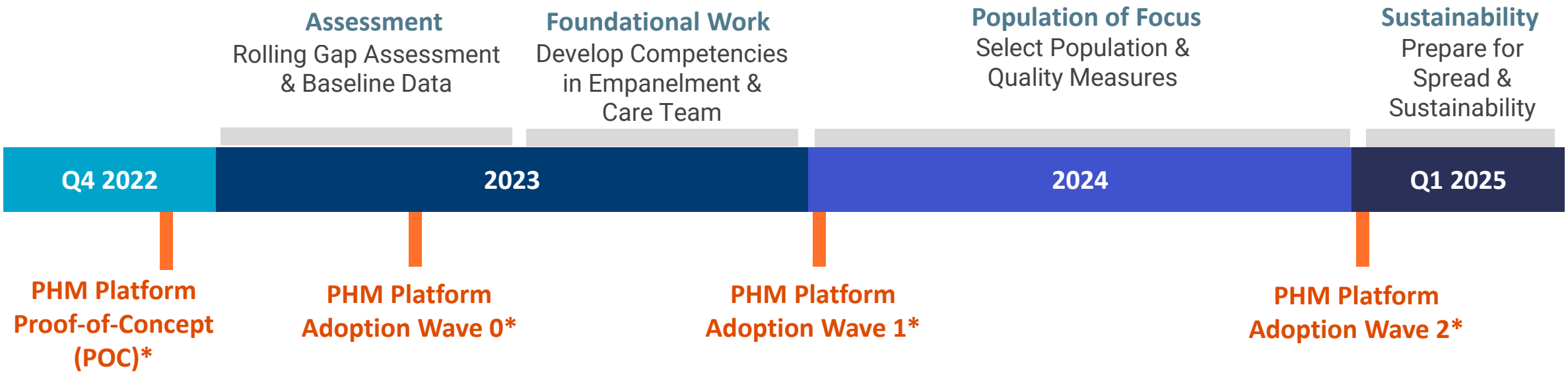
Tailored interventions for selected population of focus

Integrated PHM platform to improve data sharing and to support data analytics and the reporting needs for empanelment and the selected population of focus

Implementation support via grant funding, practice coaching, staff trainings, and learning collaboratives supported by tools and resources

PHMI Implementation Sequencing

The following timeline represents the average sequence and timing of care delivery model and technology implementation milestones. The synchronization of care delivery practice transformation and PHM technology adoption will be coordinated with the practice transformation vendor.



**Four CHCs are participating in the POC. CHC cohorts will adopt the PHM platform in Waves 0 – 2. The minimum viable product (MVP) for the PHM Platform will be available in Wave 0 with ongoing optimization throughout the implementation period.*

Value Proposition: PHM Platform

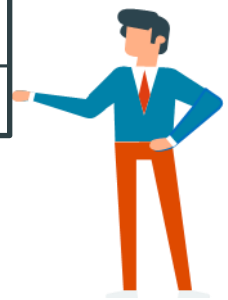
*The PHM Platform will provide **additive** capabilities* by functioning with existing CHC technologies to enable robust, interoperable technology solutions that can intake data from multiple sources, convert them to **actionable insights,** and integrate with new and existing care platforms. The PHMI Platform's capabilities are designed to enable care delivery model interventions and will readily support CHC PHM capabilities such as panel management, care team roles and efficiencies, Medi-Cal performance metric optimization, and population level reporting as required in CalAIM and APM 2.0.*

The PHM Platform strives to achieve:

Insights: Incorporate and harmonize data from multiple external sources (including HIEs, MCPs, the DHCS PHM Service, and others) to provide actionable analytics capabilities and better inform patient level, whole person care

Systemness: Create partnerships amongst CHCs statewide to create aggregate level data to identify high performers and share best practices, and inform and expand future data-sharing capabilities (current and future partnerships)

Acceleration: Expedite implementation and performance related to CalAIM and APM 2.0 through economies of scale and standardization to create a shared vision to wholistic patient care



**Platform adoption is a goal but not a requirement of PHMI*

PHMI Value Proposition: Short- and Long-Term Solutions

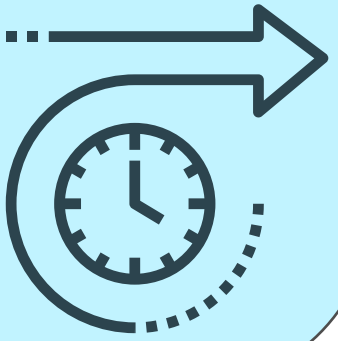
The PHM Platform aims to help solve for short-term and long-term CHC pain points.

Short-term (PHMI Scope)

- Empanelment
- Enhanced Data Management
  - MCP/IPA Data
  - Hospital ADT Data
  - Interoperability
- Complex Care
- Social Health
- External Reporting
- Payment Model Transformation

Long-term (Beyond PHMI)

- APM 2.0
- DHCS/Medi-Cal Ready
- Standard Integration
- Best Practice Sharing
- Future Funding
- 340B
- Research



Next Steps

- Next meeting: January X, 2022
- Agenda will include evaluation design

Care Delivery Model Implementation Approach

Foundational Competencies

Empanelment

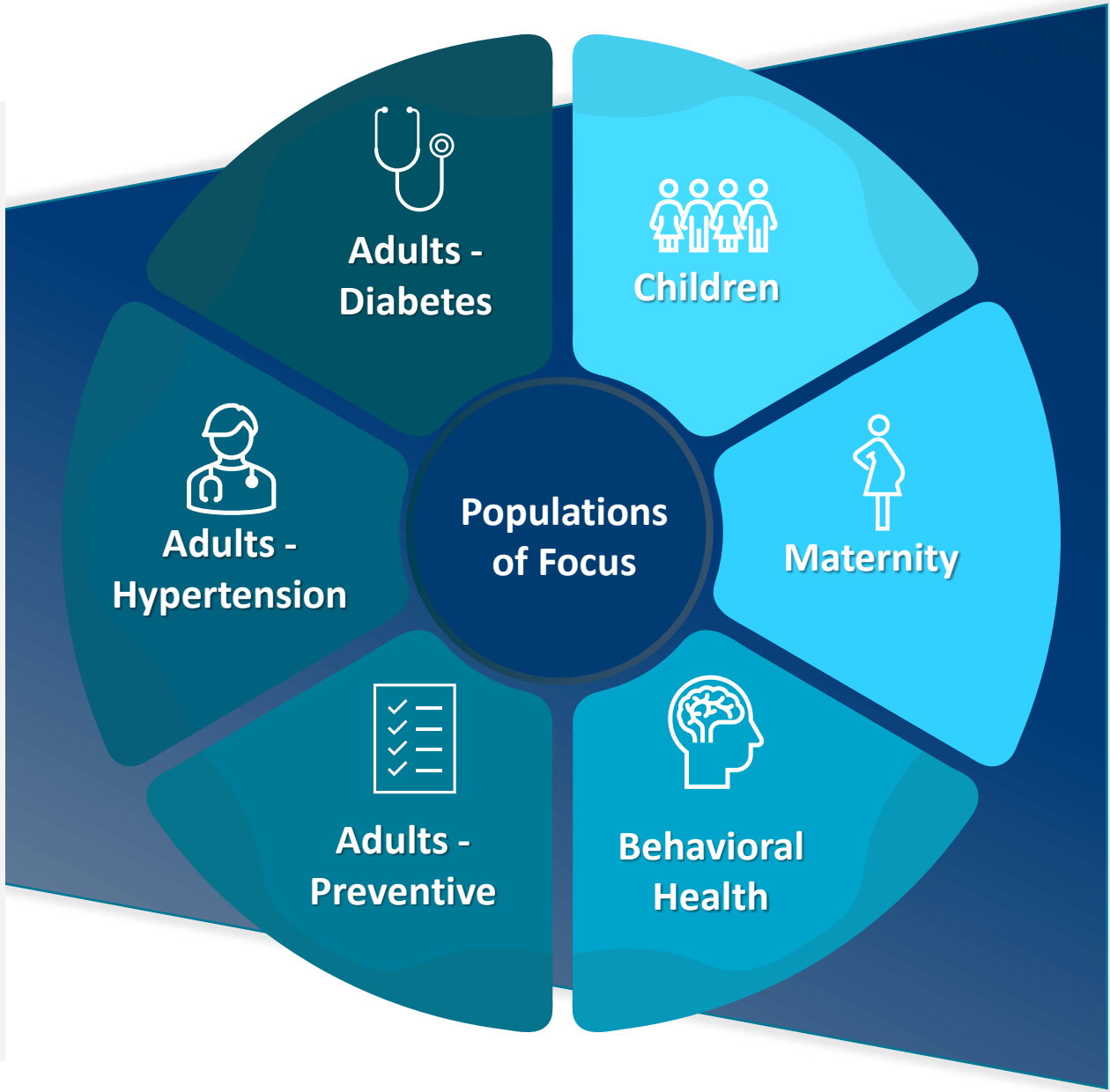
- Select an empanelment methodology
- Develop empanelment reports to track continuity
- Optimize processes to monitor and maintain panels

Care Teams

- Engage leadership
- Identify PHMI-participating clinics/sites and care teams
- Define care team member roles and responsibilities

PHMI Core Interventions

- Adopt clinical guidelines
- Develop standing orders
- Conduct outreach and engagement activities
- Develop pre-visit planning processes
- Behavioral health screening and monitoring
- Social health screening and intervention
- Use of condition-specific registries & care gap reports
- Closed loop referrals



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PHMI Technology POC with Innovaccer

The PHMI Technology Team is proceeding with a POC with Innovaccer to validate preliminary assumptions regarding Innovaccer's ability to meet Medi-Cal needs and identify implications for the broader PHMI tech implementation.

Proof-of-Concept (POC) Overview

During the POC exercise, Innovaccer will:

- Implement defined platform functionality with **2-4 Community Health Centers (CHCs)**
- Focus on **a few specific use cases,** testing functionality in relation to a subset of components from **5 design elements** (Data Driven Improvement & Analytics, Empanelment, Model of Care, Patient Engagement, Social Health)
- Ingest and process data for a **limited volume of patients at CHCs**
- Deliver POC within an **~10+ week timeframe** including **monitoring of key outcomes, gathering CHC feedback** and **assessing platform adoption**

Why is the Proof-of-Concept (POC) Important?

The POC will:

- **Test Innovaccer's ability** to deliver in relation to the co-designed PHMI solution set and initiative goals
- Demonstrate how Innovaccer can use **real CHC data** to illustrate **platform functionality**
- Connect to **existing CHC data sources** to understand how Innovaccer aggregates and harmonizes data
- Evaluate Innovaccer's ability to **collaborate with other program stakeholders**
- Test the **program's implementation approach / structure** across stakeholder groups

Value proposition: Short Term Benefits Based on Current Pain Points

The following are CHC pain points collected through the PHMI that the PHM Platform will aim to help solve.

Pain Point	Description	Potential PHM Platform Remedy
Empanelment	• Inconsistent and often manual empanelment processes. • Mis-aligned patient: provider assignments causing barriers to patient access and administrative burden, uneven panel sizes.	Streamline empanelment through standard methodologies. Reports to assist with correction of mis-alignment and to right size and maintain panels.
Data Firehose	• Too much data coming from multiple sources. • Siloed MCP/IPA portals with large amounts of data. • Not enough staff and time to make data actionable.	Ingest and harmonize data from multiple internal and external sources to produce whole patient view with actionable reports and insights.
MCP/IPA Data	• Large amounts of MCP/IPA data available through portals. • Inaccurate patient assignments and demographics. • Too much data to make actionable.	Ingest and harmonize data from multiple internal and external sources to produce more accurate data for a whole patient view with actionable reports and insights.
Hospitals	• Poor data exchange with hospitals, such as lack of admissions, discharges, transfers (ADT) data, leading to poor transitions of care to CHCs	Ingest ADT data, work to integrate into timely workflows for actionable care.
Complex Care	• Lack of tools to support on-going decision making about patient's care.	Tailored risk stratification tools and condition-specific registries to identify and manage high-risk patients through custom workflow.
Interoperability	• Lack of interoperability with outside data sources, including external providers, HIEs, managed care plan.	Ingest and harmonize data from multiple external sources to enable holistic care.
Social Health	• CalAIM initiatives, such as Enhanced Care Management (ECM), require the need to meet patient social needs through Community Supports (CS) such as food and housing. • CHCs currently unable to address social needs with existing partners .	Ingest and harmonize data from multiple internal & external sources. Integration of SH resource directory (Findhelp.org) Provide standard social health screening and assessment functionality (if, needed).
External Reporting	• Burdensome external reporting requirements for CHCs.	Ingest and harmonize data from multiple internal & external sources for improved capability for external reporting.
Payment Model Transformation	• Coalescing of above pain points regarding data creates mountain of overwhelming uncertainty as CHCs prepare for APM 2.0.	Optimize data curation within standard tools for Quality Measures (e.g., HEDIS) to best position CHCs for APM 2.0 performance.

Value Proposition: Long Term Potential

The PHMI Platform value will increase as more CHCs adopt the tool. The data of 32 CHCs is more powerful than the data of one CHC. Below is a list of potential long-term benefits for the future utilization of the PHM Platform as it spreads across PHMI CHCs and beyond.

Long Term Potential Benefits of the PHMI Platform	
APM 2.0	Identifying entire population attributable to CHC, facilitating outreach to those assigned but not seen, providing insights on how to optimize performance on quality metrics tied to payment.
DHCS/Medi-Cal Ready	Accelerate adoption of future DHCS Medi-Cal requirements across participating CHCs. Creates a standardized approach among CHCs allowing for a unified voice to provide feedback to DHCS with new requirements.
Standard Integration	Standard integrations to common external data sources when they become available (ex. State PHM Service, new data from Medi-Cal MCPs) mean that consumers enjoy the benefit more easily.
Best Practice Sharing	Network wide clinical and operational quality reporting to create aggregate level clinical and operational metrics to establish level comparison to each CHC in the network. Can help identify high performing CHCs and develop collaboratives to share best practices across the network.
Future Funding	Network level data can support collaboration for grant applications to local, county, state, and federal funders for both government and private sector funding.
340B	Use data from the platform as a data source to other analytics applications necessary to monitor and manage 340b programs (Walgreens RxBe, 340basics, etc.).
Research	Network data platform can be used to support a variety of research projects and proposals of interest to CHCs and the Medi-Cal delivery system.