Population Health Investment Advisory Council

June 2024

Health Equity & Quality Transformation (EQT) Division

AGENDA

Topic	Time
Welcome	10:30 am - 10:35 am
Population Health Investment (PopHI) Presentation: Equity and Practice Transformation	10:35 am - 10:55 am
Discussion	10:55 am - 11:50 am
Public comment	11:50 am - 12:00 pm

MEETING PROTOCOLS

Advisory Council Members

- Please mute/unmute yourself as necessary throughout the meeting.
- If you have any questions, concerns or items you would like to share during the meeting, please email marisol.meza-badran@covered.ca.gov for assistance.

Public

- Public comment will be open at the close of the Advisory Council discussion. Please use the Teams function to raise your hand 

and limit comments to 2 minutes.
- The Teams chat function will also open at the close of the Advisory Council discussion.
- Written comments regarding this meeting are welcome and can be sent to EQT@covered.ca.gov by July 10th.
- Materials will be posted at https://hbex.coveredca.com/stakeholders/plan-management/qti/.

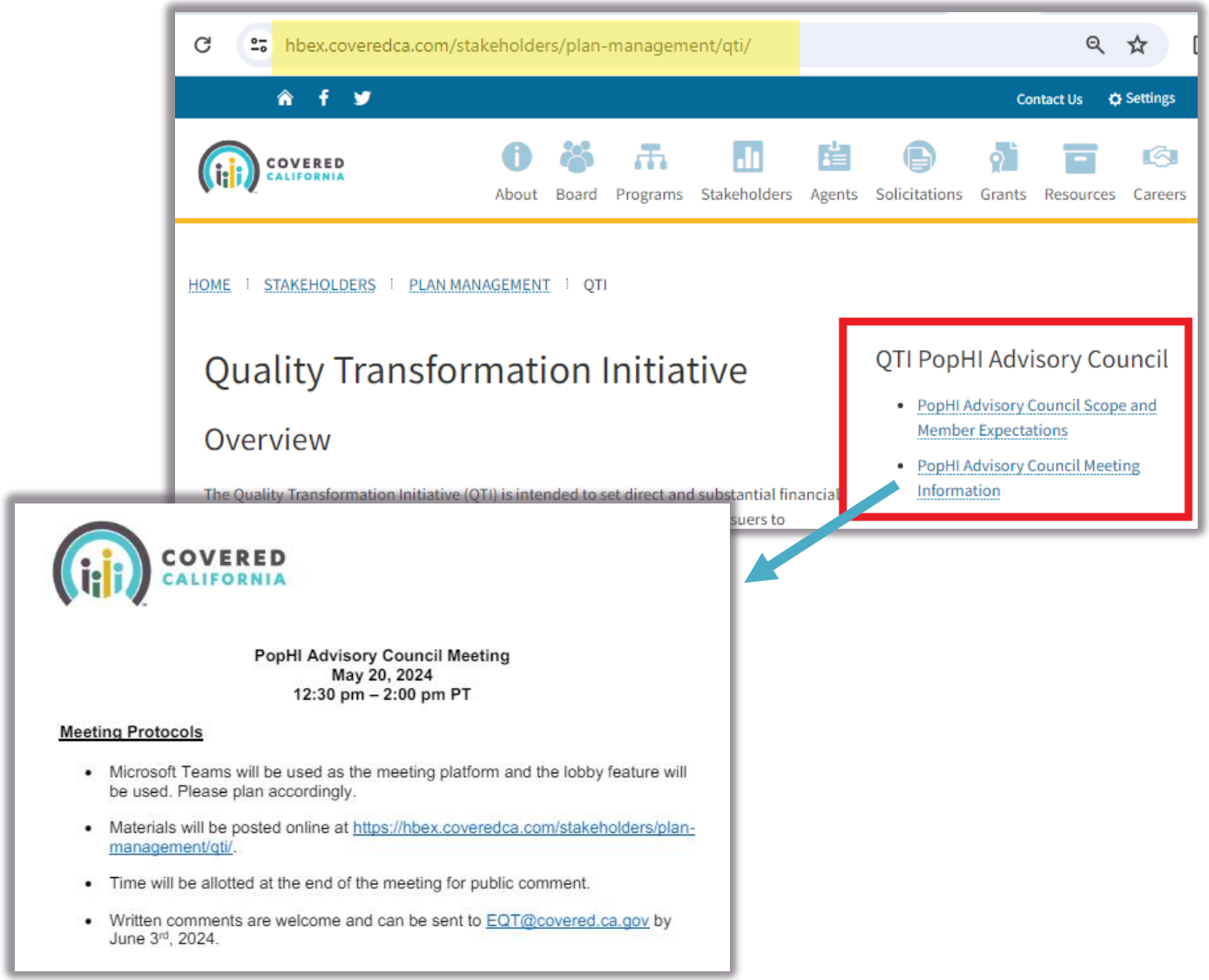
ADVISORY COUNCIL MEETING SERIES

- July Meeting
  - July 24, 2024
  - 10:30 am – 12:00 pm PT

- August Meeting
  - August 19, 2024
  - 1:30 pm – 3:00 pm PT

- Information about the PopHI Advisory Council and how to join the monthly meetings can be found at https://hbex.coveredca.com/stakeholders/plan-management/qti/

- Upcoming meeting details and how to attend will be updated monthly, following the completion of every meeting



POPULATION HEALTH INVESTMENT ADVISORY COUNCIL

The Council is a **trusted advisory body** consisting of stakeholders and subject matter experts selected by Covered California who support **successful deployment of PopHIs** to improve the quality of healthcare and to reduce health disparities for Covered California enrollees.

- Advise Covered California in the **selection of initial Population Health Investments** (PopHIs, pronounced “Poppy”).
- Guide and **inform program design features** of selected PopHIs, such as: member eligibility, program operations, and key performance indicators and evaluation approaches.
- Establish a forum that **supports successful deployment** of PopHIs through expert and trusted counsel.

The PopHI Advisory Council **does not have decision making authority**, and Covered California is not bound to adopt any of the PopHI Advisory Council’s recommendations, but the input shared is critical to sculpting both design and implementation.

POPULATION HEALTH INVESTMENT ADVISORY COUNCIL

Membership:

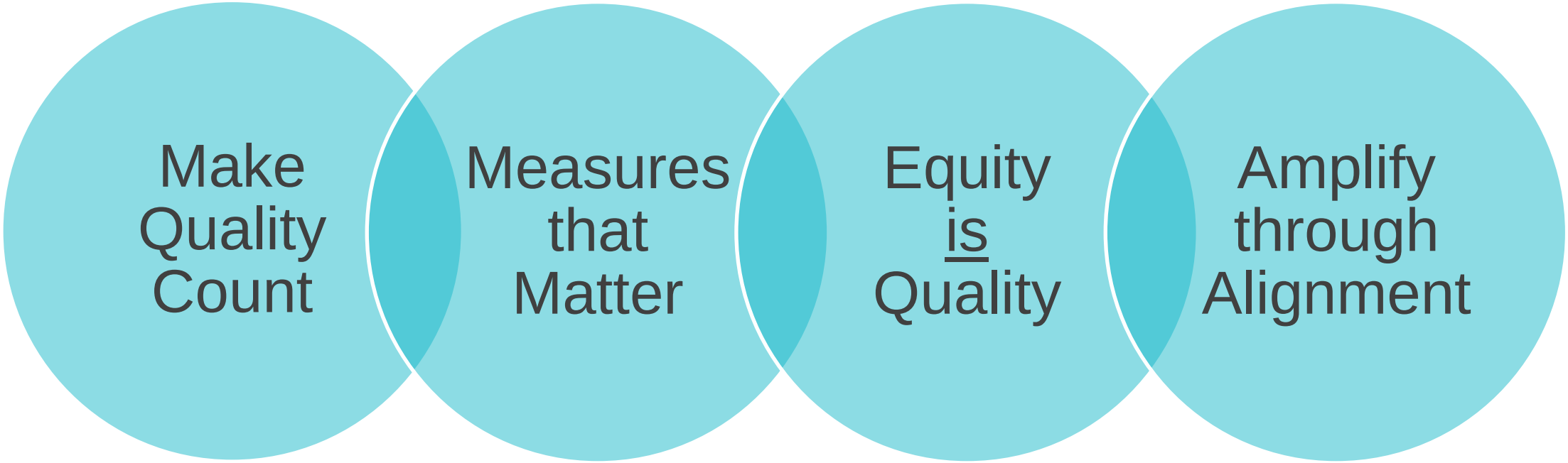
The Advisory Council consists of 10 to 12 members plus Ex Officio, including the following:

- Qualified Health Plan Issuers (2-3)
- California-based Government Officials (2)
- Consumer, Consumer Advocates, Thought Leaders, and Experienced Professionals (4-6)
- California-based Providers (2-3)
- Ex Officio (2)
    - California Department of Health Care Services
    - California Public Employees' Retirement System

Participants:

- **Tomás Aragón, MD, DrPH -** Director and State Public Health Officer, California Department of Public Health
- **Palav Babaria, MD, MPH -** Deputy Director & Chief Quality and Medical Officer, QPHM, Department of Health Care Services
- **Corrin Buchanan, MPP -** Deputy Secretary for Policy and Strategic Planning, CalHHS
- **Tracy M. Imley, MD -** Regional Assistant Medical Director, Quality and Clinical Analysis, Southern California Permanente Medical Group
- **Amanda Johnson -** Deputy Director, State and Population Health Group, CMS Innovation Center
- **Edward Juhn, MD, MBA, MPH -** Chief Quality Officer, Inland Empire Health Plan
- **Julia Logan, MD -** Chief Clinical Director, Clinical Policy & Programs Division, CalPERS
- **Peter Long, PhD -** Executive Vice President, Strategy and Health Solutions, Blue Shield of California
- **Bianca Mahmood** - Covered California Consumer
- **Sarita Mohanty, MD -** President and Chief Executive Officer, The SCAN Foundation
- **Cary Sanders, MPP -** Senior Policy Director, California Pan-Ethnic Health Network
- **Kristof Stremikis, MPP, MPH -** Director, Market Analysis and Insight, California Health Care Foundation
- **Sadena Thevarajah, JD -** Managing Director, Health Begins
- **Raymond Tsai, MD, MS -** Vice President, Advanced Primary Care, Purchaser Business Group on Health

QUALITY TRANSFORMATION INITIATIVE



0.8% to 4% premium at risk for

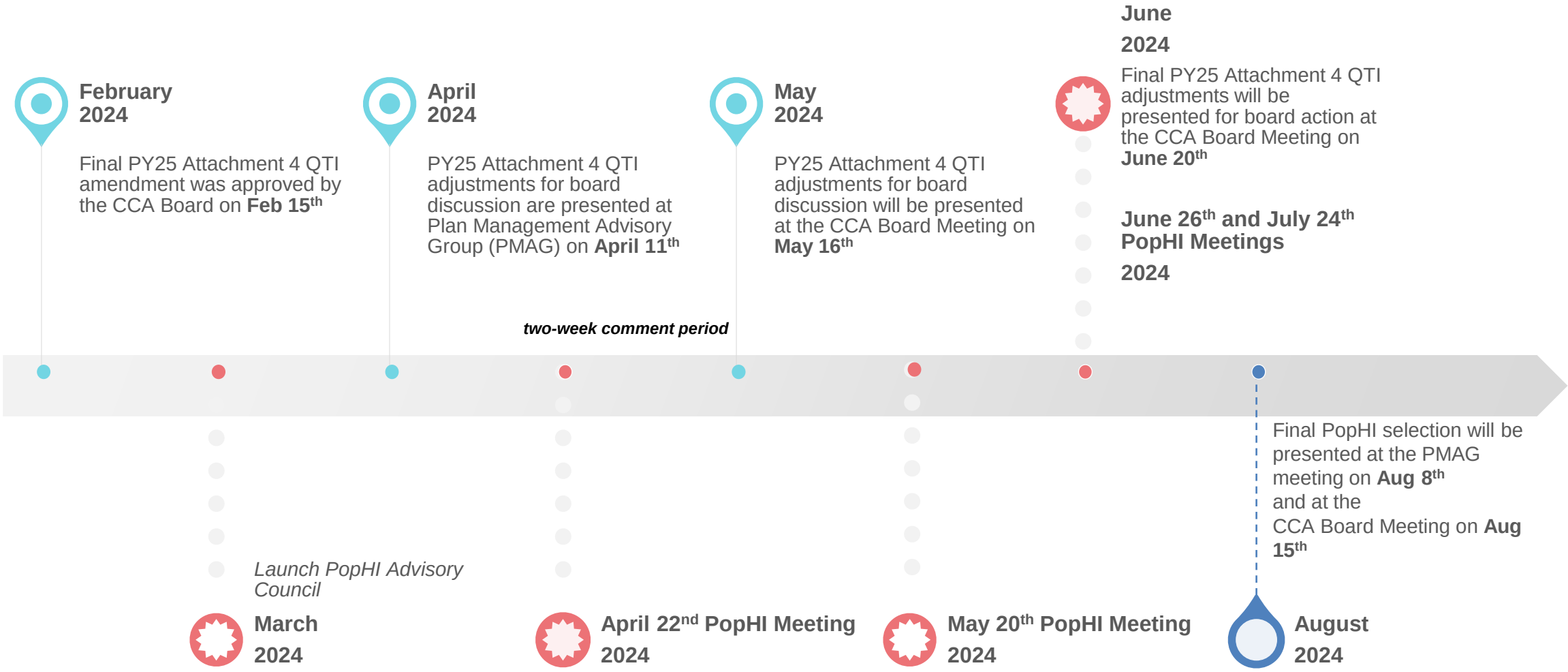
a small set of clinically important measures

stratified by race/ethnicity

selected in concert with other public purchasers*

*Public purchasers includes CalPERS and DHCS/Medi-Cal

TIMELINE


February 2024
Final PY25 Attachment 4 QTI amendment was approved by the CCA Board on Feb 15th
April 2024
PY25 Attachment 4 QTI adjustments for board discussion are presented at Plan Management Advisory Group (PMAG) on April 11th
two-week comment period
May 2024
PY25 Attachment 4 QTI adjustments for board discussion will be presented at the CCA Board Meeting on May 16th
June 2024
Final PY25 Attachment 4 QTI adjustments will be presented for board action at the CCA Board Meeting on June 20th
June 26th and July 24th PopHI Meetings 2024
Final PopHI selection will be presented at the PMAG meeting on Aug 8th and at the CCA Board Meeting on Aug 15th
Launch PopHI Advisory Council
March 2024
April 22nd PopHI Meeting 2024
May 20th PopHI Meeting 2024
August 2024

GUIDING PRINCIPLES: USE OF FUNDS

Centered on goal to improve health outcomes for Covered California enrollees

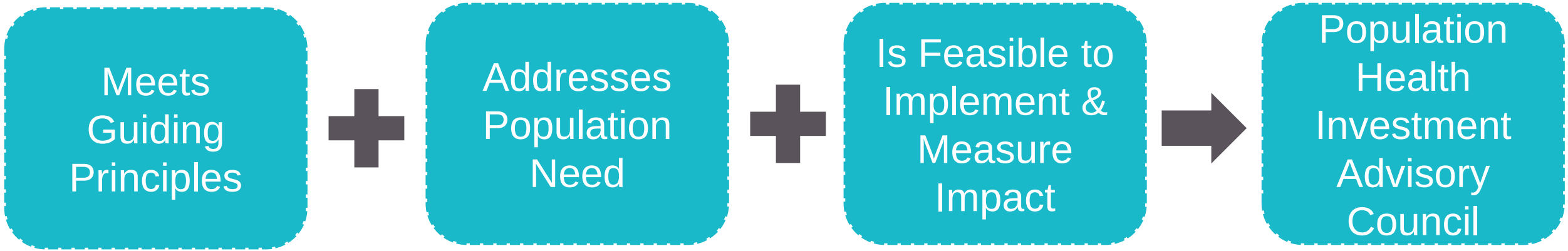
Equity First: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations

Direct: use of funds should lead to measurable improvements in quality and outcomes for enrollees that are related to QTI Core Measure performance

Evidence-based: use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes

Additive: funds should be used to advance quality in a currently underfunded arena.

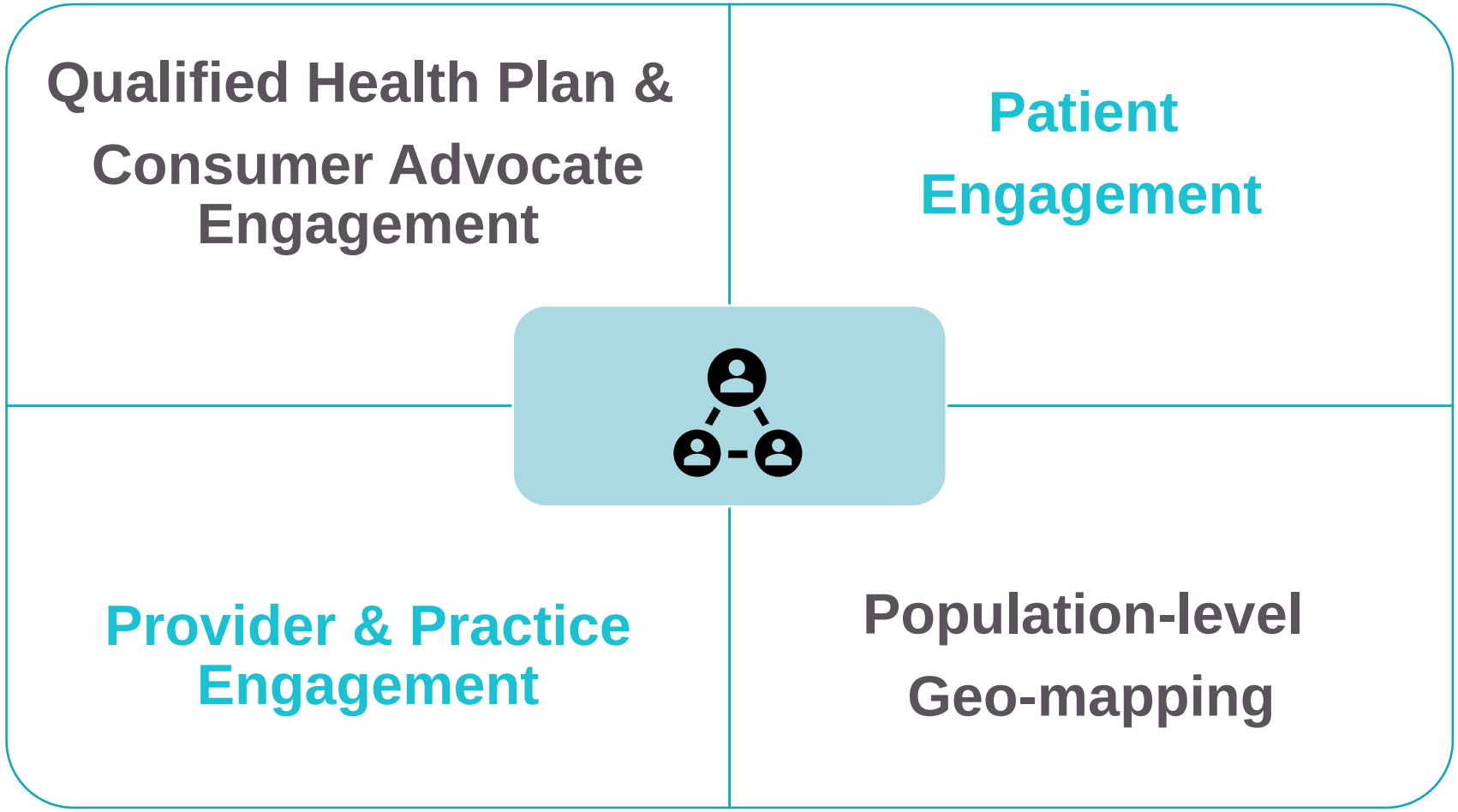
POPULATION HEALTH INVESTMENTS: SELECTION CRITERIA



A prioritized list of Population Health Investments will be presented at Plan Management Advisory Workgroup and Covered California Board in 2024

POPULATION NEEDS ASSESSMENT

Covered California is currently leading a multipronged assessment to understand existing supports and barriers to enrollees achieving good health and wellness to inform selection of Population Health Investments.



PRELIMINARY FINDINGS: PATIENT OUTREACH

Population Focus of Members with Chronic Conditions and FPL<250%

As of June 17, 2024

English	Spanish
500 Respondents (0.49% Response Rate) Survey Released June 6, 2024 (Reminder June 20th)	55 Respondents (0.64% Response Rate) Survey Released June 13, 2024 (Reminder June 27th)

Response Insights

Needs

- High rates of food insecurity
  - 36% of English respondents
  - 55% of Spanish respondents
- Transportation insecurity is prevalent
  - 16% of English respondents
  - 32% of Spanish respondents

Desired Help

- Assistance with food and transportation are most cared about
- Followed by financial support for higher education for kids

Maximizing Impact of Funds

- Minimum amount for impact is $80/m
  - 32% of English respondents
  - 53% of Spanish respondents
- Prefer smaller amounts but more frequent
  - 44% of English respondents
  - 47% of Spanish respondents

"I live in a rural area. The only grocery store is very **expensive**. Therefore, I have to **drive an hour** to a major chain grocery store. **The cost of transportation** is a major factor for me."

"Eating **healthy costs more** than, you know, than eating junk."

"It would have been helpful if someone had been like, oh, here's a **taxi voucher or let us call an Uber** for you."

"We **need assistance** with the cost of utilities, food, and medical. All have increased so much that **we cannot make it**."

PROVIDER ENGAGEMENT

Goal

To gain insights into the challenges and barriers practices face in delivering quality care for Covered California members for consideration in Population Health Investment selection

Methods

1:1 listening sessions with practices with large volumes of attributed Covered California members

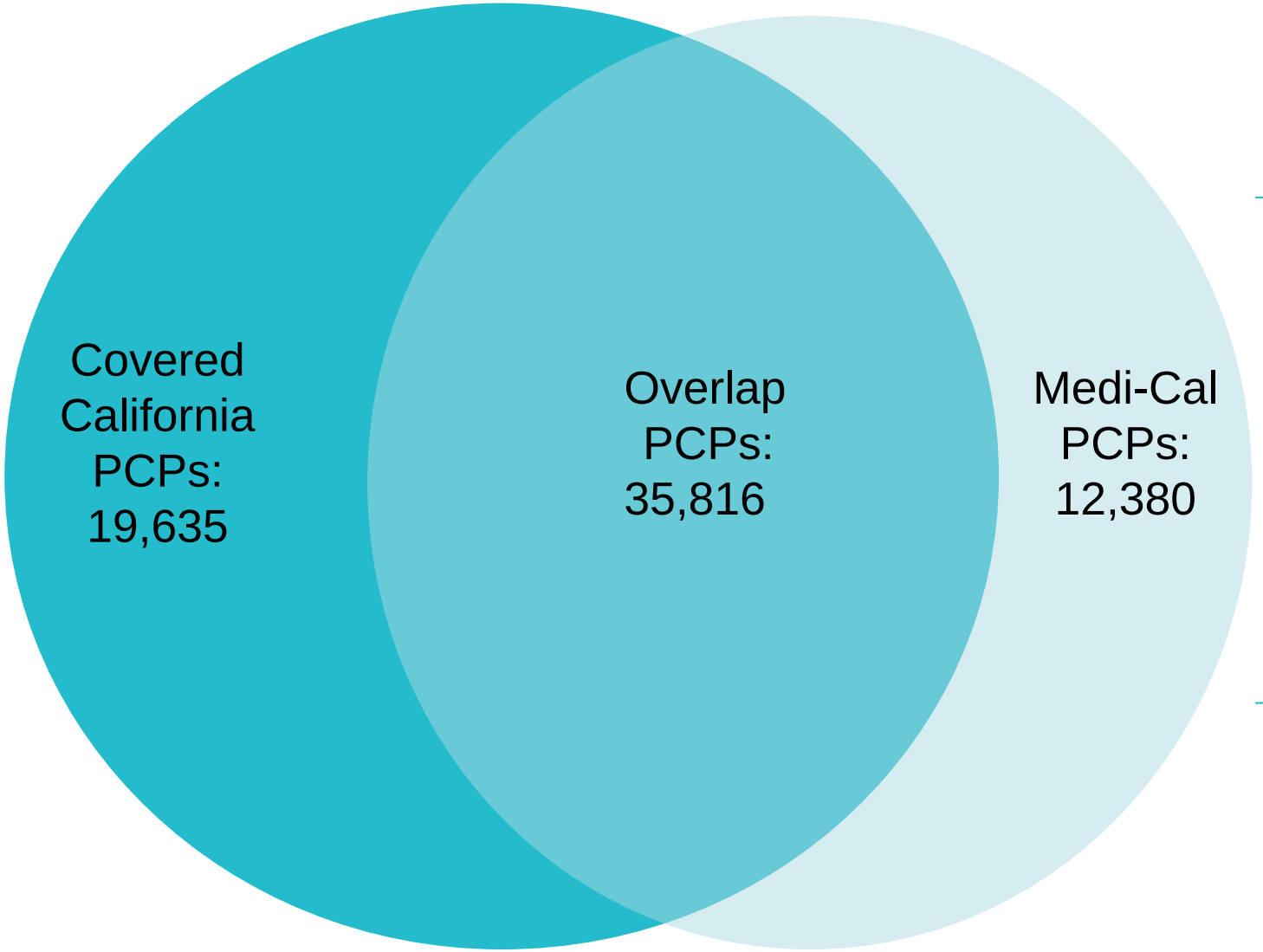
Themes and Learning

- ❑ Payor-agnostic practice patterns and workflow
- ❑ Challenges with access for patients in primary care, pediatrics, and ancillary services/preventive screenings
- ❑ Struggles with workforce turnover: both provider and nursing staff
- ❑ Sub-optimal data exchange, lack of interoperability & inconsistent EMR use in small, independent practices
- ❑ Desire to engage with CBOs, but varying levels of capacity and maturity

Next Steps

Engagement sessions will continue in 2024 to inform Population Health Investment selection

PRIMARY CARE PROVIDER NETWORK OVERLAP



74% of all Medi-Cal primary care providers are in-network for Covered California enrollees

Analysis used Primary Care Provider NPI from October 2023 Provider Files

Achieving Health Equity in CA Requires a Pivot

Call to Action

Break through competing and piecemeal population health transformation approaches to achieve impact at scale in California.

Current landscape:

- Known, pervasive health disparities.
- Health equity efforts siloed and not designed for sustainability and scale.
- Resources often duplicative, and do not leverage shared models and infrastructure.
- Learnings are not systematically shared to inform other efforts.
- Primary care practices overwhelmed and confused by various efforts that compete for their attention.

The Population Health Learning Center
Achieving Impact at Scale

Align to achieve impact

We partner with providers, payers, & purchasers to scale common models and evidence-based practices that align policy, payment, and practice standards.

Implement best-in-class technical assistance (TA)

We bring together the best thinking and experts in the field to advance population health capabilities through peer learning and practice-level technical support.

Accelerate efforts to address health equity

We concentrate efforts to advance population health practice in communities that need it most.

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Medi-Cal EPT Program

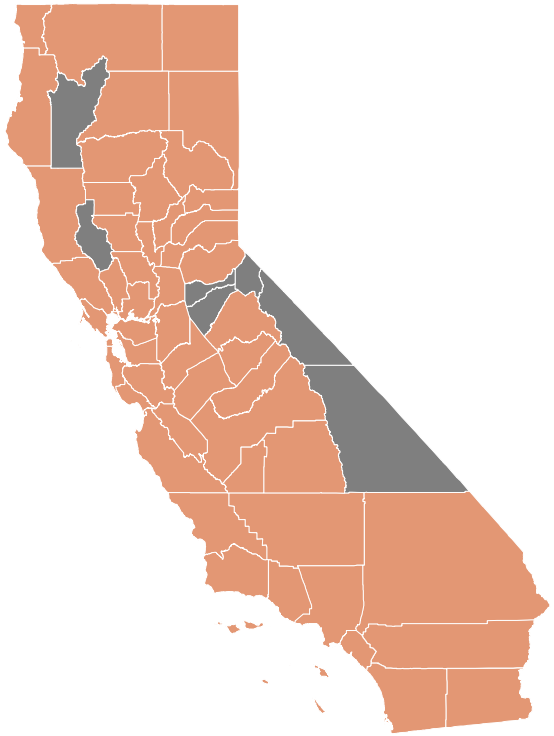
Investment to Advance Equitable Care Statewide

Goal: Improve primary care for Medi-Cal enrollees
Advance equity · Reduce COVID-19-driven care disparities · Invest in upstream care models · Fund practice transformation aligned with value-based payment models

EPT funding supports direct practice payments and technical assistance through the Learning Center to advance population health practice & outcomes in primary care

Practice transformation is achieved through:

- **Technical Assistance** to participating practices including training, tools, resources and peer learning to advance specific PHM capabilities.
- **Direct payments** to practices when program milestones are met, as evidenced by deliverables that demonstrate PHM competencies and achievement of outcomes

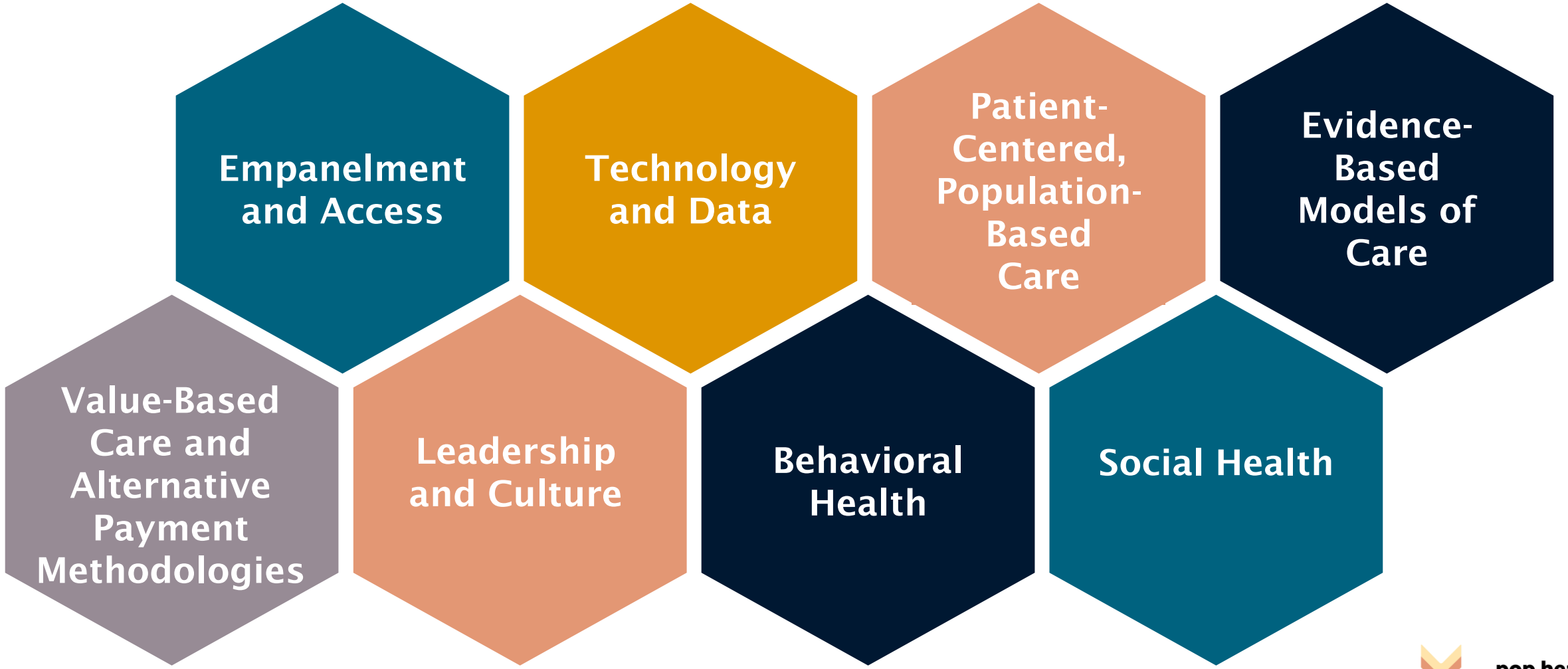


Practices accepted to EPT program include:

- Health Centers
- Independent Practices
- Public / County Hospitals
- Tribal Healthcare Practices

Many practices are small and in **under-resourced communities** (83% in Healthy Places Index Quartiles 1 or 2). Most CA counties are represented.

Population Health Management (PHM)
Building Blocks in EPT Program



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Understanding Baseline PHM Capabilities

Results from EPT Population Health Management Capabilities Assessment Tool (PhmCAT)

Limited Capabilities

Behavioral Health

Social Health

Business Case for PHM

Technology and Data Infrastructure

Some Capabilities

Care Team & Workforce

Patient-Centered, Population-Based Care

Stronger Capabilities

Leadership & Culture

Empanelment & Access

*Based on April 2024 PhmCAT results for all 208 Practices in the EPT program.
The PhmCAT is a self-administered tool to assess the population health management capabilities of EPT practices and capture change over time.

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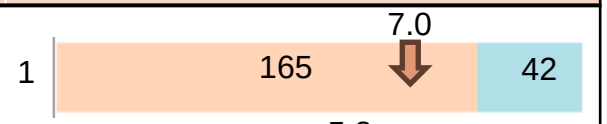
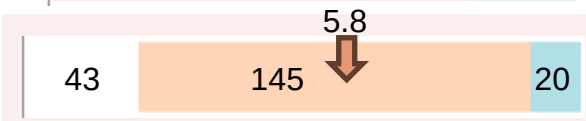
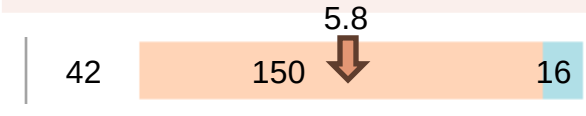
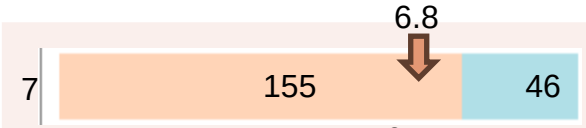
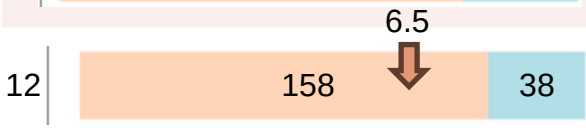
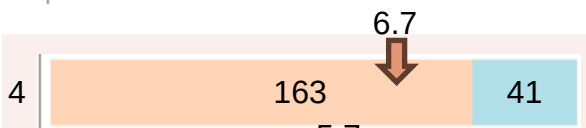
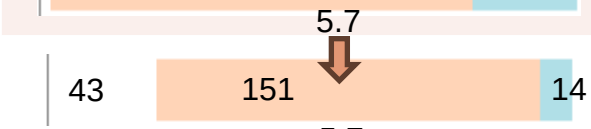
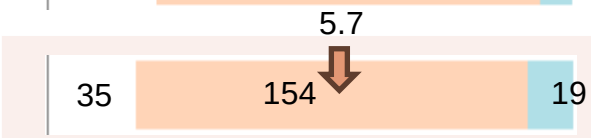
A Closer Look at Baseline Results

Room For Improvement Across All Domains

Legend:
- # of Practices with Limited Capabilities
- # of Practices with Some Capabilities
- # of Practices with Strong Capabilities
- Domain average

Domain	Capability Optimized	Results at Practice-Level
Leadership & Culture	Quality work is everyone's responsibility and leaders systematically use data to drive clinical and business decisions.	
Business Case for Pop Health Management	Solid understanding of financial performance, capacity to manage performance-based and VBP contracts.	
Technology & Data Infrastructure	Multiple data sources integrated into EMR to address disparities and close care gaps both with engaged and unengaged patients.	
Empanelment & Access	Provider continuity with assigned PCPs; timely care accessed in person, through telehealth and patient portals.	
Care Team & Workforce	Multidisciplinary team performing at top of their license with documented workflows, standing orders, and self management support.	
Patient-centered population based care	Registry data used for pre-visit planning and to proactively outreach to patients on overdue care or in need of referrals.	
Behavioral Health	BH services readily available through onsite staff or agreement with outside organization that includes routine screening and referrals.	
Social Health	Universal screening identifies patients' high impact social needs and referrals to community-based services are tracked and followed up on.	

Proposed PopHI: Equity and Practice Transformation

Our Technical Assistance Model

eLearning Resource Hub

- Organized by geography and practice track
- Quarterly learning sessions provide technical training on Pop Health curriculum
- Monthly check-ins by practice track to promote peer sharing of best practices and challenges

Regional Learning Communities

- A common curriculum featuring the best collective thinking in pop health topics
- Provided through online courses, and supplemented by implementation guides, tools, and live webinars
- Collaborative spaces for peer sharing and joint problem-solving in real time

Accelerating Practice Change

PopHI's investment will leverage EPT infrastructure **to accelerate adoption of PHM capabilities** in practices serving both Covered California and Medi-Cal enrollees. As EPT infrastructure focuses on general technical training, **PopHI's investment enhances the technical assistance** through the addition of:

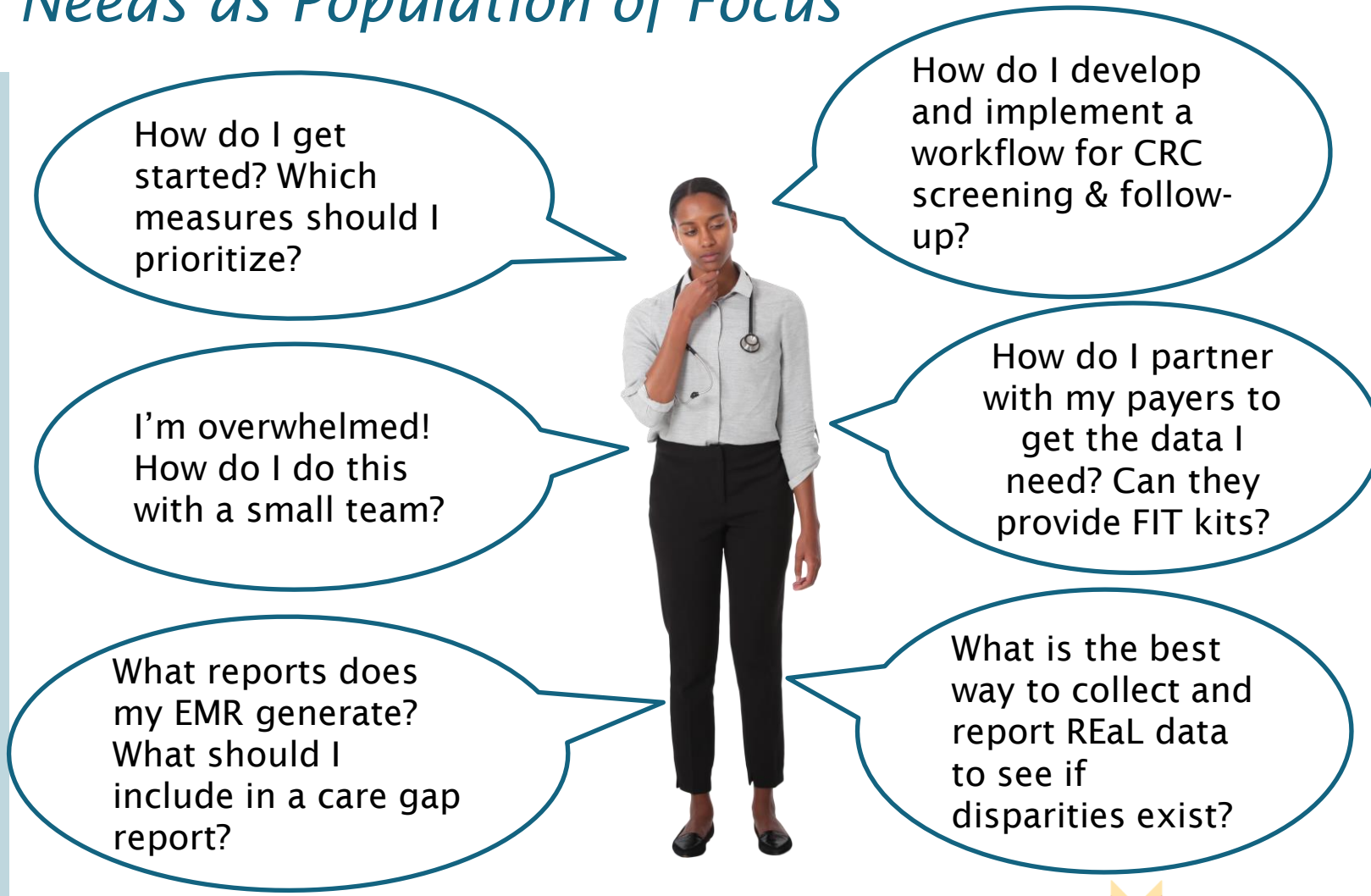
- **High quality, 1:1 coaching** to support EPT practices to translate curriculum and tools into workflows and best practices that improve PHM capabilities and enable practices to meet milestones.
- **Subject matter experts (SMEs)** to work deeply with practices to address barriers and create sustainable practice change in specific areas/populations of focus (e.g. advanced access, social health, value-based payment).
- A responsive **learning system** to distill insights from a diverse practice cohort and disseminate promising models to primary care practices across the state.

Meet Doctor R

Dr. R is a doctor in a small practice participating in EPT and chose Adults — Preventive Care Needs as Population of Focus

Dr. R attended a quarterly training on person-centered, population-based care with other EPT practices, which covered how to:

1. Operationalize clinical guidelines.
2. Implement condition-specific registries.
3. Conduct proactive patient outreach and engagement.
4. Conduct pre-visit planning and care gap reduction.
5. Identify and reduce disparities.
6. Integrate behavioral health.
7. Address social needs.



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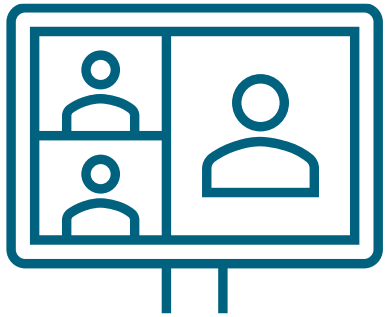
CCA Funds Would Accelerate and Sustain Improvements

Dr. R received high intensity coaching and SME support for 6 months

- We reviewed P4P data with our coach. We learned that we have low CRC screening rates and we're leaving money on the table.
- We worked with our payers to get data on members in a standard format. We also received FIT kits.
- We looked at race/ethnicity and language data with our coach and learned that our Black patients have lower screening rates.
- We reached out to patients and staff to identify barriers. Our coach helped us address these through a patient journey map.
- We don't have standard screening across providers, so we implemented CRC screening guidelines and developed a registry.
- Our coach helped us create a monthly care gap report to proactively monitor our progress.

A Responsive Learning System to Scale PHM



Spread and scale best in class content on the Learning Center's eLearning Hub

Create "bite sized" content and courses, offered in interactive, modalities

Promote curated, evidence-based guidelines & tools

Impact healthcare policy, including benefit and value-based payment design

Monitor and refine leading models for practice transformation

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Understanding Impact of EPT and Related Investments

1. Improve quality & reduce health disparities
2. Improve PHM Capabilities
3. Improve provider/ care team satisfaction & reduce burnout
4. Improve patient experience
5. Create pathways for sustainability

Population	HEDIS© Measures
Pregnant People	Prenatal & Postpartum Care
Children & Youth	**Child Immunization Status** Well Child Visits-First 30 Months
Adults - preventive care needs	**Colorectal Cancer Screening** Breast Cancer Screening Cervical Cancer Screening
Adults - chronic conditions	**Controlling High Blood Pressure** **Comprehensive Diabetes Care**
People with Behavioral Health Needs	Depression Screening & Follow-up

EXAMPLE METRICS & MEASURES OF SUCCESS

- Practice self-reported data collected annually on the Population Health Management Capabilities Assessment Tool (PhmCAT).
- Progress on successfully meeting EPT milestones.
- Practice level HEDIS measures, including the 4 QTI core measures.
- Engagement of EPT practices in technical assistance offerings as evidenced by attendance by team and individuals.
- Experience surveys administered to participating EPT practices and individuals.

EQUITY AND PRACTICE TRANSFORMATION

Meets Guiding Principles

- ✓ *Equity First*
- ✓ *Direct*
- *+/- Evidence-Based*
- ✓ *Additive*

Addresses Population Need

- ✓ *Supports needed workforce investments and point of care transformation*

Is Feasible to Implement & Measure Impact

- ✓ *Aligned with DHCS, infrastructure in place*
- *+/- Measures of success for impact*

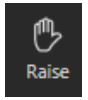
DISCUSSION QUESTIONS

1. What should we be measuring to capture impact of this PopHI (less around individual practice transformation but rather the full initiative at scale)?

2. When attempting to prioritize practices equitably what factors should we consider (regional factors, volume of Covered California members served, provider demographics)?

3. How might we maximize this “seed funding” to sustain impact and transformation over time?

PUBLIC COMMENT

- Please use the Teams function to raise your hand 

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- Materials have been posted at: https://hbex.coveredca.com/stakeholders/plan-management/qti/

FUTURE MEETINGS

Dates

- July 24th 10:30 am – 12:00 pm PT
- August 19th 1:30 pm – 3:00 pm PT

Appendix

EPT Program Office: Population Health Learning Center

The Population Health Learning Center (Learning Center) is contracted with DHCS to serve as the Program Office for the EPT Program, and fulfill the following functions:

1. Program oversight, design and coordination across practices, managed care plans/delegated entities, and other key stakeholders.

2. Design and coordinate the Technical Assistance strategy for EPT practices, including peer learning and expert consultation.

3. Facilitate continuous learning and best practice sharing across all stakeholders in EPT. Develop insights and share what works and what doesn't.

A Model to Accelerate Equitable Outcomes

PARTNERS

Align Partners on PHM Approach

Public Purchasers
Payers/Plans
Philanthropy
Other Investments
Technical Assistance Partners &
Experts in Field

Learning Center
A Common Infrastructure for Population Health Equity

Program Office

Design & Implement Learning Communities

Practice Standards for Population Health

Leadership & Culture	*Empanelment*
Technology & Data	*Populations of Focus*
Value-Based Care	*Evidence-Based Models*
Behavioral Health	*Social Health*

TO ACHIEVE

Improve Quality Metrics for Primary Care

Reduce Disparities in Populations of Focus

Implement Value Based Payment

Improve Provider Experience/Reduce Burnout

Improve Patient & Family Experience of Care

Cohort 1 Accepted Practices Selections

Optional Activity	% Practices
New/Expanded Care Delivery Model	94%
Behavioral Health Integration	91%
Social Needs/Risk Screening & Intervention	90%
Patient and Community Partnership/Engagement	78%
Strategic Planning	70%
DEI Strategy	60%
Risk-Bearing Contract	42%
FQHC APM	16%

Population of Focus	% Practices
Children & Youth	40.6%
Adults with Chronic Conditions	29.2%
Adults with Preventive Care	18.4%
Behavioral Health Conditions	6.6%
Pregnant People	5.2%

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Health Plans: Providing Vital Support for EPT Practices

As the program office, the Learning Center engages Health Plans in the program design and implementation in the following ways:

- Co-design of initial training materials through prior work together (PHMI)
- Recommend practices likely to succeed in EPT
- Distribute payments from DHCS to practices
- Share resources to supplement EPT curriculum; adopt curriculum framework; customize to specific MCP environment when appropriate
- Attend the learning sessions and monthly meetings to support their practices with challenges and implementing best practices
- Reconcile primary care data assignment and quality metric performance with practices on an ongoing basis
- Actively engage in standardized data sharing activities with practices

Coaching Enables Improved Outcomes for CCA Focus Populations

General, broad education and training of evidence-based practices is not sufficient to guarantee uptake into primary care.*

Coaching would:

- Provide customized, hands-on support that is responsive and designed for each practice's needs.
- Assist practices to implement and adapt EPT curriculum to practice culture.
- Support practices serving the CCA focus populations, including adults with preventative care needs, with chronic conditions, and pediatrics.

PopHI's investment supports practices in building patient centered, sustainable processes and systems to manage population health for CCA populations of focus.

This will enable ***meaningful implementation*** of evidence-based practices which leads to equitable patient outcomes and improved quality scores.

*Leeman et al, 2021, *Aligning implementation science with improvement practice: a call to action,* Implementation Science Communications.

Two Models of Coaching To Accelerate Practice Change

Generalist Coaching support uses improvement science and QI methods to support practices to make and sustain improvements across the EPT domains and populations of focus, including to:

1. Support practice with root cause analyses and idea generation;
2. Help practices prioritize PHM projects;
3. Provide implementation support;
4. Develop and implement workflows;
5. Identify which changes to spread and scale

Specialist SME support provides practices with in-depth, subject matter expert support, including to:

1. Provide technical coaching within specialized subject areas, including access, data and IT, and providing care for the populations of focus;
2. Support practices through 1:1 assistance, group coaching, and/or onsite visits;
3. Provide targeted, customized training on specific changes within the specialty area

Practices select the intensity, modality, and focus of their work

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The Learning System Will Support Alignment to Achieve Maximum Impact

PopHI's investment will enable broader replicability and scale across CA.

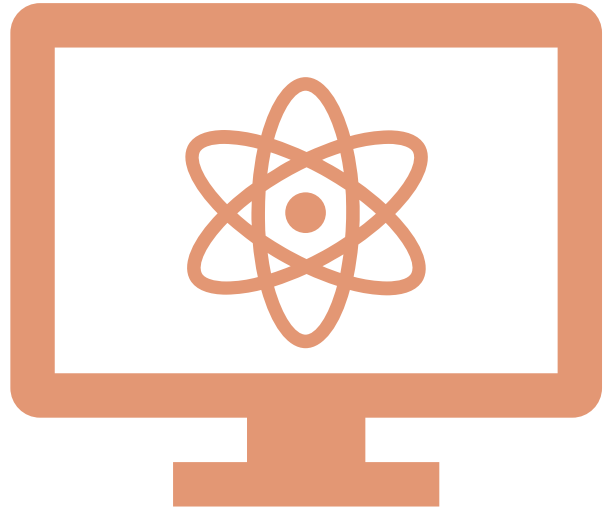
- The learning system will distill and spread best practices, implementation guidance, and policy recommendations to best achieve change.
- This system will also promote the use of a standardized approach for use by practices working with multiple purchasers and payers, creating alignment that reduces noise and maximizes impact.

eLearning: a **responsive** and **scalable** approach

We're procuring a digital learning management system (LMS) to provide an integrated set of interactive online services for the EPT program.

- EPT Practices staff will be the "learners," accessing curriculum, resources, and submission forms for EPT deliverables through an online portal (see next slide).

- The Learning Center and our TA/ Practice Transformation Partners will use the LMS to develop/curate curriculum and resources for the learners, track and support learner engagement, and review submitted deliverables.



eLearning Platform: Key Activities for Learners

Communicate and share tools with peers and SMEs in digital forums, live webinars, and group chats.

Submit deliverables, get feedback.

Explore evidence-based curriculum by accessing mini courses, implementation guides, and workflow templates.

Track progress on curriculum courses, milestones, and deliverable submissions.

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Strengths and Opportunities

PHM Capabilities of EPT Practices*	% of Practices
Demonstrated ability to solve problems by making a serious effort to figure out what's going on	80%
Leadership creates an environment where things can be accomplished	75%
Staff operate as a real team	71%
Workflows are in place to proactively engage patients overdue for chronic and/or preventive care	22%
Behavioral health (BH) data is available and is consistently used to inform pre-visit planning and outreach activities	2%
Workflows are in place for Primary Care Providers (PCPs) & BH providers to develop integrated treatment plans for patients	2%
Patient and family feedback is incorporated into Quality Improvement (QI) activities	5%
Data analysis and performance reporting inform practice improvements	7%

*Based on April 2024 PhmCAT results for all 208 Practices in the EPT program. Higher is better. The PhmCAT is a self-administered tool to assess the population health management capabilities of EPT practices and capture change over time.