Listening Session Part 3 on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

Presenters:

Subject Matter Experts

• **Chris Chen, MD**, Chief Executive Officer, ChenMed

• **Palav Babaria, MD, MHS**, Chief Quality Officer and Deputy Director, Quality and Population Health Management, California Department of Health Care Services, and

• **Paul Leon, RN, BSN**, Founder, CEO and President, Illumination Foundation
Presentation:

ChenMed

Chris Chen, MD
Chief Executive Officer
ChenMed
ChenMed: InFocus
a company *snapshot*

Exclusively focused on Medicare beneficiaries

One of the largest family-owned, physician-led primary care providers

Pioneer in risk: decades-long experience and track record delivering successful clinical, service, and financial outcomes in “global full risk” models

Pursuing a vision to be America’s leading primary care provider, transforming care of the neediest populations by delivering on our mission of honoring seniors with affordable VIP care that delivers better health

Over 4,500 diverse team members, employing several hundred primary care physicians

Serving the neediest populations: ~40% dual eligible, two-thirds African-American and other underrepresented minorities, average patient has ~5 major chronic conditions, clinics located in underserved neighborhoods

Honoring seniors and delivering better health through 3 brands (Chen Senior, JenCare Senior, and Dedicated Senior Medical Centers) in more than 100 medical centers across 14 states (and growing)

Source: ChenMed internal data.
Our Results
We’re expanding rapidly as we grow to meet the need for healthcare that delivers better health. Our year-over-year membership has grown for 10 consecutive years.

35% FEWER Emergency Room Visits
(Risk Adjusted)

51% FEWER Hospitalizations
(Risk Adjusted)

93.7% of respondents indicated they were highly satisfied with the care received from their provider (top 2 box ratings)*

94.7% of surveyed patients said their doctor listened carefully to them (top 2 box ratings)*

“Love... it’s the number one thing you get here.” - INGA • PATIENT

Source: ChenMed internal data compared to CMS; year 2019.
True Impact on Better Health

Higher screening and care management rates during the Pandemic than industry averages before it

Patients per PCP on average
345 (maximum of 450)

3 to 4 Hours
“Face Time” Per Patient/Year

Source: ChenMed internal data compared to CMS

COVID-19

Higher vaccination rates
Lower hospitalization rates
Smaller differences than industry between duals and non-duals and African American and White patients

22% lower: The risk of stroke for patients with >1 year tenure at ChenMed vs. short tenure patients

Double: The 6-month survival rate of cancer for patients with >6 months tenure at ChenMed vs. short tenure patients
The Three Versions of Primary Care

Traditional Primary Care in America

+ Provide the minimum components of basic care on reactive basis (when sought by the patient)

Only a sliver of the need is met
The Three Versions of Primary Care

**Traditional Primary Care in America**
- + Provide the minimum components of basic care on reactive basis (when sought by the patient)

**“Advanced” Primary Care**
- + Build a risk-adjustment apparatus
- + Negotiate down unit costs
- + Apply aggressive utilization management oversight

Gaps left by typical primary care are filled in with a “wrap around” strategy related to revenue and cost containment
The Three Versions of Primary Care

Traditional Primary Care in America

- Provide the minimum components of basic care on reactive basis (when sought by the patient)

“Advanced” Primary Care

- Build a risk-adjustment apparatus
- Negotiate down unit costs
- Apply aggressive utilization management oversight

JenCare’s comprehensive primary care

- Proactive detection and management of disease
- Holistic clinical, relational, social care
- PCP coordination and accountability through care continuum

Gaps left by typical primary care are filled in with a primary care-led approach to health – byproducts end up including revenue and cost containment

Algorithmically driven, risk-stratified patient engagement frequency
Patient Care Journey

**TOTAL COST OF CARE**
PRIMARY CARE HOLDS ACCOUNTABILITY FOR 100% OF THE CARE PROVIDED ACROSS ENTIRE CARE CONTINUUM

Global capitation given to ChenMed, who then directly provides, or arranges to provide, all clinical services needed by the patient.

“Downstream” can be paid FFS or in a VBC arrangement – up to owner of TCOC risk.

**Comprehensive Primary Care**

- Screening
- Disease prevention
- Chronic condition mgmt.
- Well check
- Social determinants

**What if patient needs something PCP can’t do:**

PCP “quarterbacks” services that are medically necessary and must be provided in the community of specialists, ancillary services providers, hospitals, etc.

**ChenMed value add:**

Leverage internal specialty consultants and data-driven insights to identify where service can be delivered to maximize value (right care, price, place, coordination, access, service).

**Independent Community Providers Services**

Inpatient Services

- Emergency
- Inpatient stay
- Complex procedures

**Ambulatory or Post-Acute Services**

- Specialty
- Imaging
- Home health
- SNF, IRF, LTCH

Acute and specialty care are provided by a curated network of high-quality providers with track record of appropriate clinical care. Patients receive coordinated care.

Patient referred to curated network of providers.

Patient (and clinical information) returns to ChenMed for ongoing mgmt.
Getting more truly “Comprehensive Primary Care”

1. True risk, not partial: Need “carrot and stick”; prevent “squeeze the balloon”

2. Need appropriate risk adjustment: Improve, don’t eliminate current system (more SDOH, more reliance on PCP)

3. Put risk with Primary Care: This is the natural general contractor (status quo has a “bank” as the general contractor”)

4. Need to help providers get there: 180 degree shift requires funds to reappropriate tech & workflows, and protections from market power of insurers and hospitals

5. Status quo/FFS must be less comfortable (and physician training has to be outside the FFS norm)

6. Trust that health equity is best solved locally – create the right incentives for the PCP and the results will come
Locations

100+ CENTERS & GROWING
30+ CITIES
14 STATES

Our Locations

- Chen Senior Medical Center
  - Broward, FL
  - Miami-Dade, FL
- Dedicated Senior Medical Center
  - Cincinnati, OH
  - Cleveland, OH
  - Columbus, OH
  - Detroit, MI
  - Houston, TX
  - Jacksonville, FL
  - Kansas City, MO
  - Lakeland, FL
  - Memphis, TN
  - Orlando, FL
  - Palm Beach, FL
  - Philadelphia, PA
  - St. Louis, MO
  - Tampa, FL
  - Wichita, KS

- JenCare Senior Medical Center
  - Atlanta, GA
  - Chicago, IL
  - Louisville, KY
  - New Orleans, LA
  - Richmond, VA
  - Tidewater, VA

Coming Soon*

- Burlington, NC
- Charlotte, NC
- Columbia, SC
- Dallas, TX
- Ft. Myers, FL
- High Point, NC
- Nashville, TN
- Winston-Salem, NC

*Subject to change
Our Services

- Access to your doctor’s personal cell phone and telehealth appointments
- On-site and home delivery prescription pick-up services
- On-site diagnostics, selected specialists, and care coordinators
- Door-to-doctor transportation

Clinics also provide education, social, physical, and other activities regularly.

*Our centers are designed to be a medical home purpose built to address each patient’s needs and provide clinical and social support*
ChenMed named to Fortune’s “Change the World” list.

The only healthcare delivery company to make the grade.

We were both honored and humbled by our inclusion in Fortune magazine’s 2020 “Change The World” list, which highlights companies around the globe that are impacting lives and tackling society’s toughest challenges and collective problems.

We pledge to build upon the ways in which we are transforming medicine and serving those around us, improving communities and changing lives.
Presentation: 
*Payment Innovation in Medicaid and Systems of Care for Underserved Populations*

Palav Babaria, MD, MHS  
Chief Quality Officer and Deputy Director, Quality and Population Health Management, California Department of Health Care Services, and

Paul Leon, RN, BSN  
Founder, CEO and President, Illumination Foundation
Near and far-sightedness on total cost of care: CalAIM and Medi-Cal’s vision for the future

Palav Babaria, MD, MHS
Chief Quality Officer
Deputy Director, QPHM
Addressing immediate needs with upstream interventions
California Advancing and Innovating Medi-Cal (CalAIM)

DHCS launched CalAIM – a multi-year initiative – to improve the quality of life and health outcomes for Californians by implementing broad delivery system, program and payment reform across the Medi-Cal program.

CalAIM Seeks To:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Drivers of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.
Why Enhanced Care Management & Community Supports?

Issues ECM is Designed to Address

Over half of Medi-Cal spending is attributable to the 5% of enrollees with the highest-cost needs.

Medi-Cal enrollees typically have several complex health conditions.

Enrollees with complex needs must often engage in several delivery systems to access care.
ECM, alongside Community Supports, was informed by Previous Tests

**Whole Person Care Pilots (WPC)**
- Limited pilot program supported by Section 1115
- Coverage and delivery system agnostic (Medicaid Managed Care, Fee For Service, or uninsured); no requirements for interfacing with managed care plans (MCPs)
- Administered by county based “Local Entities”

**Health Homes Program (HHP)**
- Benefit (State Plan service) in select counties
- Medi-Cal Managed Care members only
- MCP administered with care management contracted out to providers

**Enhanced Care Management**
- Care coordination as a MCP contract requirement
- Medi-Cal Managed Care members only
- MCP administered with care management delivered through community providers

**Community Supports**
- Optional services, but strongly encouraged
- Medi-Cal Managed Care members only
- MCP administered with services delivered through community providers and integrated with ECM
What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home.

- ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level.
What are Community Supports?

Community Supports are services that Medi-Cal managed care plans have the option to provide “in lieu of” or to help avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities

- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically-Tailored Meals or Medically-Supportive Foods
- Sobering Centers
- Asthma Remediation
PRESENTED BY

Paul Leon, RN, BSN, PHN, Founder and CEO
What we were seeing in 2007...
Recuperative Care (408) beds

Fullerton

Anaheim

Midway City

Unity House, Fullerton, St. Jude

Whittier

Olive View-UCLA Medical Center, Sylmar

Riverside
Hub & Spoke Model

- Vulnerable homeless are stabilized at hub then moved to micro-community clusters when housing-ready
- If clients at micro-communities relapse or require more intensive services, they are moved back to hub and stabilized again
- Hub is base of operations for supplemental staff to support housing teams working in micro-community clusters
- Single hub and spoke system can easily accommodate 200-300 clients in operationally integrated and cost-effective manner
Supportive Housing:

- Create critical mass of clients within geographical cluster for operating efficiency
- Rooms/units from large SFR, multiplex units, and apartments

Services provided by cluster team include:

- Intensive Case Management Services (ICMS)
- Behavioral health follow up
- Housing Tenancy and Sustaining Services
- Focus on social determinants of health
- Foster creation of community to mitigate social isolation
Street2Home System of Care

SUPPORTIVE SERVICES • CASE MANAGEMENT • BEHAVIORAL HEALTH SERVICES • HOUSING NAVIGATION AND RETENTION

Care Model

Street/Homeless

Navigation Center/ Family Emergency Center

Medical Respite Recuperative Care & Short Term Post Hospitalization

Micro-Community (Permanent Supportive Housing)

Permanent Housing

Funding Source

Funded by the city or county

Funded by CalAIM and hospitals

Funded by HUD (Housing Urban Development), Private Funding, Self-Pay

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Our Data-Driven Approach – Risk Summary

• Average CalOptima HCC Risk Score – 2.079 (twice as risky as the average Medicaid/Medicare client in the population)
• Highest Risk Score – 10.98
• Clients with 10 or more distinct HCC diagnostic groups – 245
# Population Breakdown by Risk Score

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Count</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Risk score &lt; 1</td>
<td>551</td>
<td>44%</td>
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<tr>
<td>Risk score 1 to 2</td>
<td>273</td>
<td>22%</td>
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<tr>
<td>Risk score 2 to 3</td>
<td>172</td>
<td>14%</td>
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<tr>
<td>Risk score 3 to 4</td>
<td>117</td>
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<tr>
<td>Risk Score &gt; 4</td>
<td>141</td>
<td>11%</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>1254</td>
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Top SDoH Risk Contributors for CalOptima Members - Dec ‘21

<table>
<thead>
<tr>
<th>Risk Contributor</th>
<th>Count</th>
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<tbody>
<tr>
<td>Living alone</td>
<td>228</td>
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<tr>
<td>Transportation issue</td>
<td>281</td>
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<tr>
<td>Food insecurity</td>
<td>287</td>
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<tr>
<td>Homelessness</td>
<td>307</td>
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<tr>
<td>Income issue</td>
<td>307</td>
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<tr>
<td>Unemployment</td>
<td>391</td>
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</tbody>
</table>

Obtained via Natural Language Processing (NLP) of EMR notes, PRAPARE and other surveys
PCP Utilization Trajectory
Jan 2014 – December 2019

70% increase of PCP Utilization since 2014

Source: CalOptima Enterprise Analytics Department
ED and Admit Utilization (Before/During/After)

<table>
<thead>
<tr>
<th>Status</th>
<th>Before</th>
<th>During</th>
<th>After</th>
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<tr>
<td>ER Visits</td>
<td>4,138</td>
<td>1,673</td>
<td>3,221</td>
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<tr>
<td>Admit Counts</td>
<td>2,587</td>
<td>666</td>
<td>1,906</td>
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</tbody>
</table>

*Before/During/After Calculation:
The before, during, and after time period is simply filtering down any services that occurred beyond a year before or a year after their initial intake and final exit respectively. During has no time restraints beyond the date of service falling within their initial intake date and final exit date.
Behavioral Health And Substance Abuse

**BH and SMI DX**

- 81% of 1266 have a BH Dx
- 55% of the 81% have both BH and SMI DX
- 1030 BH Diagnosis
- 571 BH And SMI DX

**Substance Abuse and SMI DX**

- 44% of the 1266 have a SUD DX
- 46% of the 44% have both SUD and SMI DXs
- 551 Chronic SUD DX
- 411 Chronic SUD And SMI DX

Source: CalOptima Enterprise Analytics Department
## Comparative Cost Savings in a 6-Month and 1-Year Post-Intervention Period

<table>
<thead>
<tr>
<th>Service Category</th>
<th>PMPM Savings after 6 months</th>
<th>PMPM Savings after 1 year</th>
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<tbody>
<tr>
<td>Behavioral Health Therapy Sessions</td>
<td>$814.54</td>
<td>$964.02</td>
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<tr>
<td>OTC Medication Assistance and Counseling</td>
<td>$805.22</td>
<td>$1007.95</td>
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<td>Multidisciplinary Team Action</td>
<td>$652.33</td>
<td>$1066.25</td>
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<td>Information Meet and Greet</td>
<td>$590.49</td>
<td>$873.35</td>
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<td>Crisis Intervention</td>
<td>$517.59</td>
<td>$754.78</td>
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<td>Medical Advocacy</td>
<td>$489.53</td>
<td>$883.27</td>
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<td>Medical and Case Management Education</td>
<td>$440.06</td>
<td>$740.84</td>
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<td>Housing Case Management</td>
<td>$17.21</td>
<td>$218.14</td>
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<tr>
<td>Basic Needs Assistance</td>
<td>($33.007)</td>
<td>$31.40</td>
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<tr>
<td>Transportation</td>
<td>($203.99)</td>
<td>$152.86</td>
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Cost Savings

Saved Health Plan more than $17 Million while clients were in Illumination Foundation’s recuperative care program, compared to the year before they entered (based on 1,266 clients).

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<tr>
<th>Data Point</th>
<th>Before</th>
<th>During</th>
<th>After</th>
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<td>Cost Breakdown</td>
<td>$25,698,776</td>
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<td>$17,797,206</td>
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# CalAIM Financial Projections

## Revenue

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<th>Claim Type</th>
<th>January 2022</th>
<th>February 2022</th>
<th>March 2022</th>
<th>April 2022</th>
<th>May 2022</th>
<th>Grand Total</th>
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<tr>
<td>ECM</td>
<td>$45,076.82</td>
<td>$43,192.05</td>
<td>$48,439.16</td>
<td>$64,818.89</td>
<td>$25,108.56</td>
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<td>Housing</td>
<td>$84,945.00</td>
<td>$104,616.00</td>
<td>$186,106.00</td>
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<td>$192,252.00</td>
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<td>OC Accompaniment</td>
<td>$5,320.00</td>
<td>$7,860.00</td>
<td>$11,340.00</td>
<td>$11,420.00</td>
<td>$5,280.00</td>
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<td>Recup</td>
<td>$206,338.00</td>
<td>$288,828.00</td>
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<td>$534,994.00</td>
<td>$494,933.00</td>
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<td>Grand Total</td>
<td>$341,679.82</td>
<td>$444,496.05</td>
<td>$685,681.16</td>
<td>$856,516.89</td>
<td>$717,573.56</td>
<td>$3,045,947.48</td>
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<table>
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<tr>
<th>Claim Type</th>
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<td>HealthNet</td>
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<td></td>
<td><strong>Total</strong></td>
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<td><strong>$245,284.00</strong></td>
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<td><strong>$11,420.00</strong></td>
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<td>CalOptima</td>
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<td><strong>Total</strong></td>
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<td><strong>Grand Total</strong></td>
<td></td>
<td></td>
<td><strong>$856,516.89</strong></td>
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</tbody>
</table>
Taking the long view of health and wellness
# DHCS' 2022 Comprehensive Quality Strategy

## QUALITY STRATEGY GOALS

| Engaging members as owners of their own care | Keeping families and communities healthy via prevention | Providing early interventions for rising risk and patient-centered chronic disease management | Providing whole person care for high-risk populations, addressing social drivers of health |

## QUALITY STRATEGY GUIDING PRINCIPLES

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement
PHM Framework Overview

Gathering Member Information
- Initial Screening
- Claims/Encounters/Other Data

Understanding Risk
- Risk Stratification and Segmentation
- Risk Tiering
- Assessment and Reassessment

Providing Services and Supports
- Basic Population Health Management
- Care Management
- Transitional Care Services (as needed)

PHM Strategy and Population Needs Assessment (PNA)
The long view of health and wellness in California
Thinking big:

BOLD GOALS: 50x2025

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children’s preventive care measures
Re-Centering Primary Care

- Investing in primary care transformation
- Reporting on % of spending on primary care
- Alternative payment model arrangements
- Integration with public health and social services