Data as Power: Medi-Cal's Vision for Achieving Health Equity and Population Health

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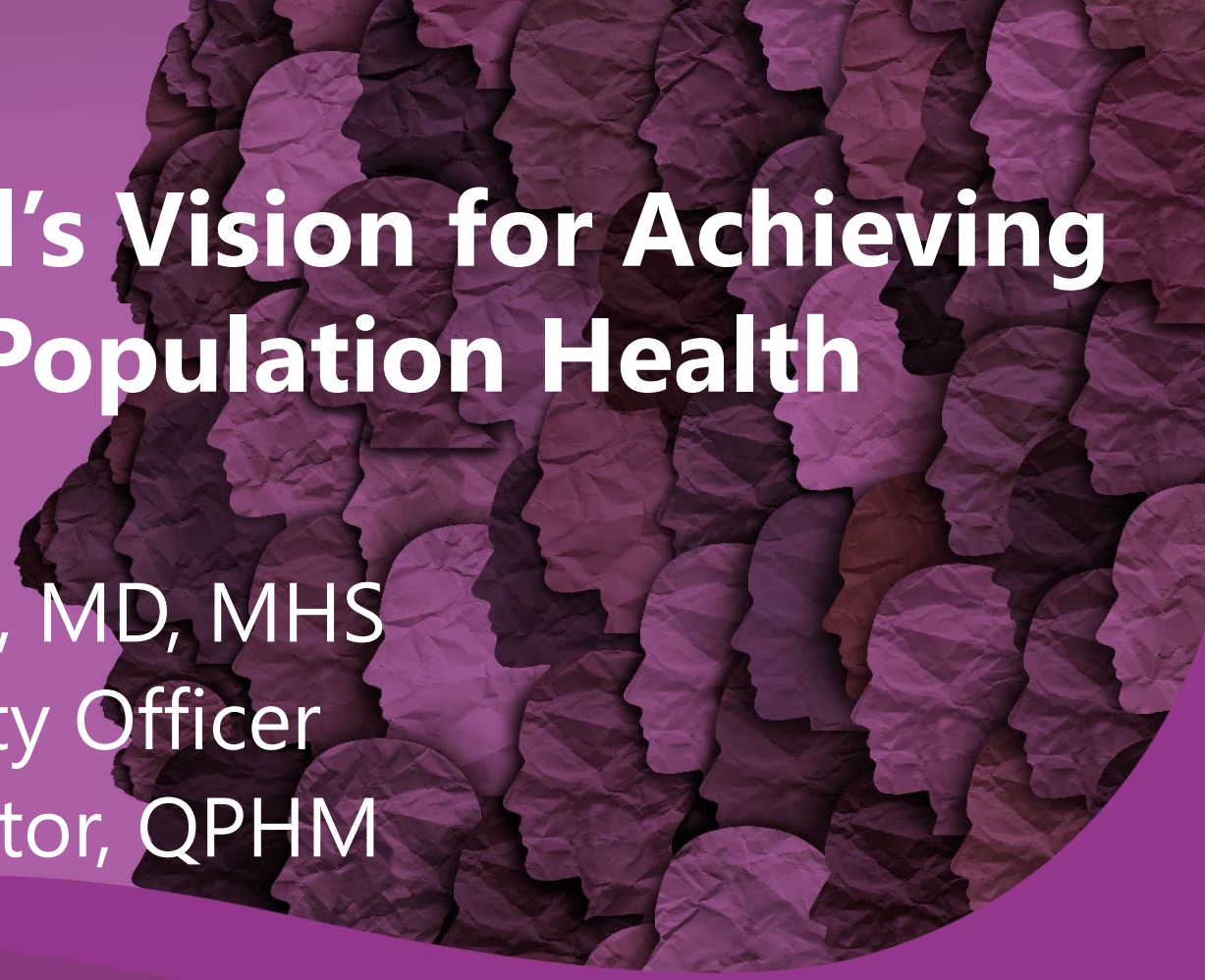


DHCS | Quality and Population Health Management

Medi-Cal's Vision for Whole Person-Centered Equitable Care

Why do we need Whole Person Care?

Issues CalAIM 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**

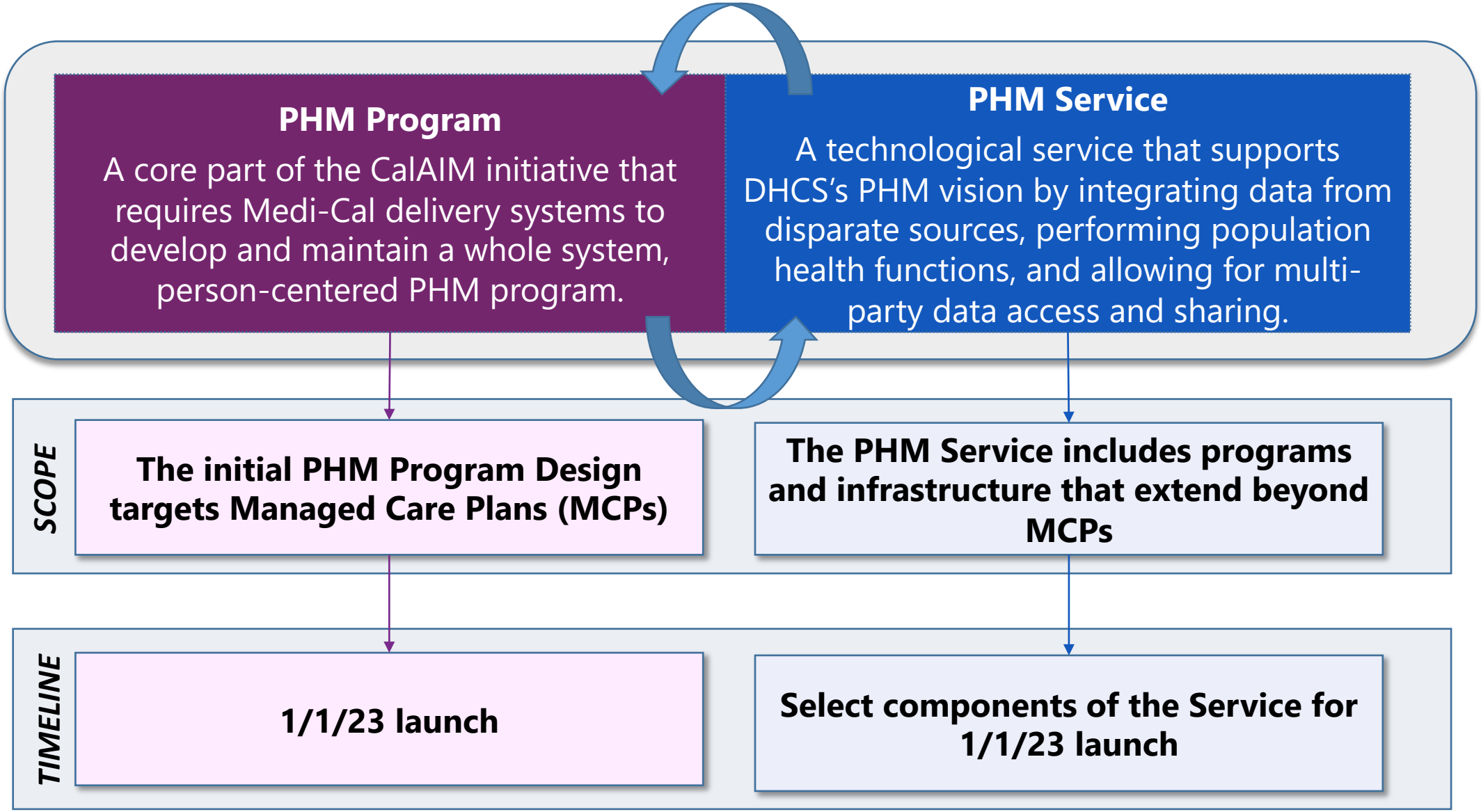
Enrollees with complex needs must often engage in **several delivery systems to access care**

CalAIM Supports Californians' Ability to Stay Healthy in All Areas of Life

Everyone has a stake in a better Medi-Cal program; many of us know someone whose health depends on it.

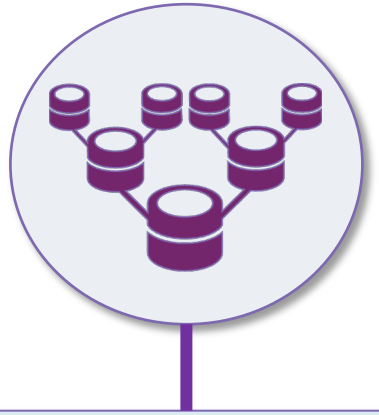
- **Population Health.** One in three Californians are enrolled in Medi-Cal, with more than 65% of enrollees identifying as people of color
- **Children & Youth.** Medi-Cal covers 50% of all births in California, with about two-thirds of children enrolled in Medi-Cal identifying as Black and Latino
- **Complex Needs & Unmet Care.** More than two in three patient days in a California long-term care facility are covered by Medi-Cal
- **Justice-Involved.** At least 80% of justice-involved individuals are eligible for Medi-Cal

Introducing the PHM Program & PHM Service



PHM Service: Overview of Capabilities

The PHM Service will aggregate, link, and provide access to a variety of data types and support key population health functions.



1. Integrate Data from DHCS and Other Sources

Integrate physical and behavioral health data, social services, dental, developmental, home and community-based services, IHSS, 1915c waiver, and other program and administration data from providers, MCPs, counties, CBOs, DHCS, and other government departments and agencies.

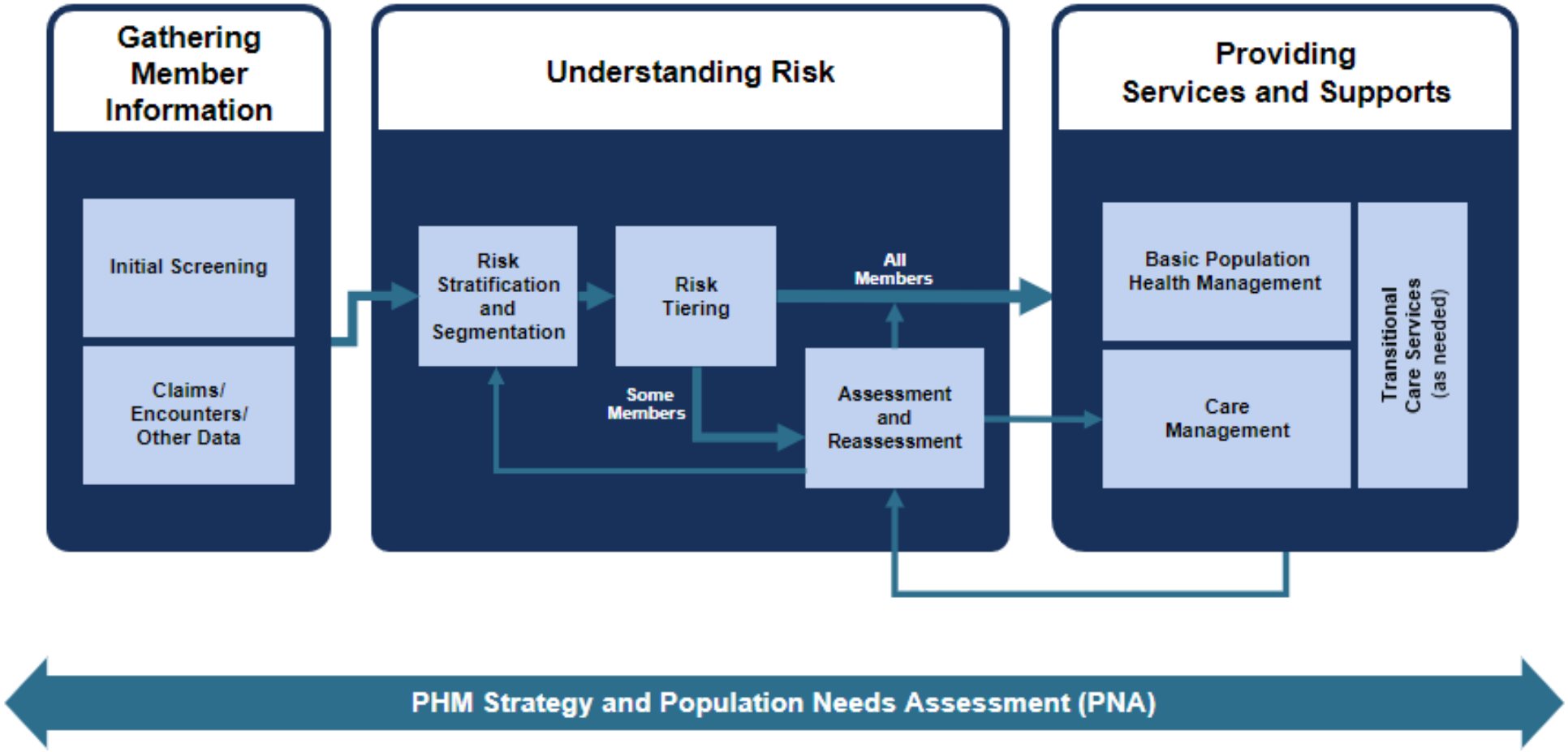
2. Enable Key PHM Functions and Services

Facilitate and support key population health functions such as individual screening and assessment; risk stratification, segmentation and tiering; and gap reporting.

3. Provide Access to PHM Data

Provide users access to integrated data to support population health management use cases and streamline care delivery. Intended users include DHCS as well as MCPs, counties, providers, Members, human services programs, and other partners.

PHM Framework Overview



Getting granular: Data and Equity in behavioral health

Thinking big:

BOLD GOALS:
50x2025

STATE LEVEL

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

New Mental Health Plan accountability measures to support CQS goals

#	MEASURE NAME	Measure Steward	Target (MPL)
1	Follow-Up After Emergency Department Visit for Mental Illness	NCQA	1st year baseline reporting followed by >50th percentile (or 5% increase over baseline if <50th percentile)
2	Follow-Up After Hospitalization for Mental Illness	NCQA	As above
3	Antidepressant Medication Management	NCQA	As above
4	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	As above
5	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	As above

New DMC-ODS Plan accountability measures to support CQS goals

#	MEASURE NAME	Measure Steward	Target (MPL)
1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	NCQA	1st year baseline reporting followed by >50th percentile (or 5% increase over baseline if <50th percentile)
2	Pharmacotherapy of Opioid Use Disorder	NCQA	As above
2	Use of Pharmacotherapy for Opioid Use Disorder	CMS	As above
3	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	NQF	As above