STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

HYBRID IN-PERSON/ONLINE/TELECONFERENCE MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET, 2nd FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, MAY 18, 2022

1:00 P.M.

Reported by: Ramona Cota

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APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Bill Barcellona

Dannie Ceseña

Alex Chen

Diana Douglas

Tiffany Huyenh-Cho

Edward Juhn

Jeffrey Reynoso

Richard Riggs

Kiran Savage-Sangwan

Rhonda Smith

Kristine Toppe

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Stesha Hodges

Julia Logan

Robyn Strong

APPEARANCES

DMHC Attendees

Mary Watanabe, Director

Nathan Nau, Deputy Director, Office of Plan Monitoring

Chris Jaeger, Chief Medical Officer

Sara Durston, Senior Attorney

Shaini Rodrigo, Staff Services Analyst

Sellers Dorsey Attendees

Sarah Brooks, Project Director - Facilitator

Alex Kanemaru, Project Manager

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Mari Cantwell, California Health Care SME

Meredith Wurden, Health Plan SME

Janel Myers, Quality SME

Others Presenting/Commenting

Katie McMahon
Molina Healthcare

Beth Capell
Health Access

Reverend Mac Shorty
Community Repower Movement

David Lown, MD
California Health Care Safety Net Institute

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PROCEEDINGS

1:04 p.m.

MS. BROOKS: Good afternoon and welcome to the fourth Department of Managed Health Care Health Equity and Quality Committee. My name is Sarah Brooks. I am a consultant with Sellers Dorsey, a consulting firm that has been brought on by the DMHC to help support this effort.

AB 133, the budget built from last year, charges this committee with making recommendations to the DMHC specifically on health equity and quality measures and benchmarks that should be utilized for oversight of managed care plans overseen by the DMHC.

So as discussed in previous meetings, these recommendations will be made and put forth to the DMHC in the form of a report developed by Sellers Dorsey and representative of the committee's positioning.

During last month's meeting we continued our discussion with our data quality subject matter experts from NCQA, IHA and RAND and from our quality and health equity subject matter experts on guiding principles for measure selection. We also began the candidate measure selection process by focus areas that we will continue today.

The last month's meeting was very fruitful. Just wanted to thank everyone for their contributions to the discussion. Lots of active discussion by committee members allowing for consideration of measures and priority areas; and just encouraging you all to continue those dynamic discussions today.

Thank you to those of you who did come in-person today. We recognize that there are different dynamics going on and obviously people will attend based on their own comfort. I do want to flag that in June meetings, so

we have two meetings in June, June 8th and June 22nd, we will be voting and so are looking for people to attend in-person in those meetings as we do need to have a quorum in-person for voting purposes.

So with that, we have a very packed agenda for you today. We are excited about the discussions and we will go ahead and get started. I am going to go ahead and hand it over to my colleague Alex Kanemaru who is going to go over housekeeping.

MS. KANEMARU: Thank you, Sarah. All right, so housekeeping. This meeting is being conducted in a hybrid format with the opportunity for public participation in-person or virtually through video conference or teleconference.

Please note the following items for those joining us in-person today: There is a sanitation station located in the back of the room where you will find masks and hand sanitizer. Masks are strongly encouraged. The women's restroom is located at the end of the corridor toward the left. The men's bathroom is located just beyond the women's restroom on the other side of the catwalk. The entryway is near Suite 200. Both the men and women's restrooms can be accessed using code 5314. The code is also posted on the conference room doors.

Please remember to silence your cell phones. For our Committee Members here in person, please do not join the Zoom meeting with your audio. To ensure that you are heard online and in the room please use the microphone in front of you and push the button on your microphone to turn it on and off. The green light will indicate that it is on, red will indicate that as it is off. Please remember to turn off your microphones when you have finished. Please speak directly into the microphone and move it closer to you if you if you need to.

Questions and comments will be taken after each agenda item, first from the Committee Members and then from the public. For those who wish to make a comment please remember to state your name and the organization you represent. If any Committee Member has a question, please use the Raise Hand feature. All questions and comments from Committee Members will be taken in the order in which raised hands appear.

Public comment will be taken from individuals attending in-person first. For those making public comment at the podium here in the front of the room please be sure to leave your business card or write down your name and title and leave it on the podium so that our transcriber can accurately capture your information.

For those making public comment virtually please use the Raise Hand feature.

For those joining online or via telephone please note the following. For our Committee Members attending online please remember to unmute yourself when making a comment and mute yourself when you are not speaking. Please state your name and organization before speaking. For our Committee Members and public attending online, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

For those attending on the phone, if you would like to ask a question or make a comment please dial *9 and state your name and organization.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question and leave a comment. To raise your hand click on the icon labeled Participants

on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment please lower your hand.

Written public comments should be submitted to DMHC using the email address at the end of the presentation.

Members of the public should not contact Committee Members directly to provide feedback.

As a reminder, the Health Equity and Quality Committee is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is essential to preserve the public's right to governmental transparency and accountability. Among other things, the Bagley-Keene Act requires the committee meetings to be open to the public. As such, it is important that Committee Members refrain from emailing, texting or otherwise communicating with each other off the record during committee meetings because such communication would not be open to the public and would violate the Act.

Finally, likewise, the Bagley-Keene prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of Committee Members emailed, texted or spoke with each other outside of the Public Health Equity and Quality Committee meeting about matters within the Committee's purview. Such communications would be impermissible, even if done asynchronously. For example, member one emails member two who emails member three, et cetera. Accordingly, we ask that all members refrain from emailing or communicating with each other about committee matters outside the confines of the public committee meeting. Thank you.

MS. BROOKS: Thank you, Alex. All right, that was quite a bit,

thank you. We are ready for housekeeping today, all right. So as Alex mentioned, I think one key point is that this meeting is governed by Bagley-Keene and we will be following all the requirements specific to that Act. All right.

So slide 9; we are going to look a little bit at the agenda now. So we have started off, we will start off with welcome and introductions. Quickly talk about the meeting summary from the last meeting. We will have a discussion about the data quality expert panel, so a continued discussion from our last two meetings that we have had. A discussion on measures and disparities by focus area, so that will be the continuation of the discussion we started last time on the different focus areas and different measures that we would like to select. And then continued discussion after our break on that same issue and then public comments as well. And we do have a break. I did want to mention we will have a break today and so just flagging that for you all. But as Alex outlined, people please leave as you need to. All right, so next slide, please.

Okay. So at this time I would like to do a quick roll call of DMHC representatives, Committee Members and introduce the Sellers Dorsey team.

Mary Watanabe is joining us today, she will be here in just a few moments. Nathan Nau?

MR. NAU: Here.

MS. BROOKS: Chris Jaeger?

Okay, he will be here soon.

Sara Durston?

MS. DURSTON: Here.

MS. BROOKS: All right. Next slide, please.

Anna Lee Amarnath?

MEMBER AMARNATH: Here.

MS. BROOKS: Bill Barcellona will not be joining us today.

Dannie Ceseña?

MEMBER CESEÑA: Present.

MEMBER BARCELLONA: Present.

MS. BROOKS: Alex Chen?

MEMBER ALEX CHEN: I am here.

MS. BROOKS: Cheryl Damberg will not be joining us today.

Diana Douglas?

MEMBER DOUGLAS: Here.

MS. BROOKS: Lishaun Francis? I believe she is not joining today.

Next slide.

Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: Here.

MS. BROOKS: Ed Juhn?

MEMBER JUHN: Here.

MS. BROOKS: Jeff Reynoso?

MEMBER REYNOSO: Present.

MS. BROOKS: Rick Riggs?

Bihu Sandhir is not joining us today.

Kiran Savage-Sangwan? She may be a little bit late I think today, we are expecting her.

Rhonda Smith?

Okay. Kristine Toppe?

MEMBER TOPPE: Here.

MS. BROOKS: Doreena Wong?

MEMBER WONG: Present.

MS. BROOKS: Sylvia Yee?

MEMBER YEE: Here.

MS. BROOKS: Next slide, please. Palav Babaria?

MEMBER BABARIA: Here.

MS. BROOKS: Alice Chen? She will be a little bit late.

Stesha Hodges?

MEMBER HODGES: Here.

MS. BROOKS: Julia Logan?

MEMBER LOGAN: Here.

MS. BROOKS: Robyn Strong? Next slide, please. All right. And just a little, a quick slide that includes the information of the Sellers Dorsey members that are supporting this team; flagging for you that Ignatius Bau is online with us today by video. And then Kristine, it looks like you may have a question.

MEMBER TOPPE: Bill Barcellona is online.

MS. BROOKS: Oh, Bill is online. Okay, great, Bill, I apologize, my apologies. I thought you weren't joining us today, my apologies. All right, so we have Bill with us. All right, so next slide, please.

All right. So this slide presents information that you should have received in advance of this meeting. So different meeting materials including the agenda, the presentation, the meeting summary and transcription from last month's meeting. a reference and resource document that we have continued to add to based on information that we have received from Committee Members,

and then 12 focus area measure workbooks. I am sure that lots of quick reading there. But we will be using all of these different materials as resource documents today and they will be very informative and helpful to us so we will move forward with those. All right, next slide, please.

All right. So committee meetings have been scheduled through August as of this time. As I mentioned earlier, there are two committee meetings in June on June 8th and June 22nd. The slides here do identify the steps which will be taken at each meeting to accomplish our process but we will go through that a little bit more in detail later today. All right, next slide, please.

So at this time we will take questions from Committee Members based on anything that we may have discussed so far. Are there any raised hands? As a reminder, please raise your hand if you are in the room on your computer and then I will just check with Shaini to see if we have any raised hands from Committee Members.

And do we have any public comments at this time from non-Committee Members? I am not seeing any public comment; is that correct? Okay. All right, next slide, please.

So real quickly, the April 20th meeting summary is included in your packets. Wanted to check with Committee Members to see if there are any changes to that summary that should be made so I will ask at this time if there are any changes from Committee Members that should be made to the April 20 meeting summary?

Shaini, do we have any hands raised? Kristine, and please go ahead and introduce yourself. And make sure you are on the mic. Yes, please, thank you.

MEMBER TOPPE: I had a question just with what was in the minutes. I wasn't at the meeting but what was in the minutes and then put on the slide it looked like in the prevention measure in the minutes there was an additional measure mentioned but it was not included on here.

MS. BROOKS: Would that be specific to obesity or vaccination or something?

MEMBER TOPPE: It looked like it was the adult vaccination measure.

MS. BROOKS: Yes. So that is included later in a different focus area for discussion purposes, yes.

MEMBER TOPPE: Okay.

MS. BROOKS: But thank you for raising that, great question. All right, Shaini, do we have any other Committee Members that may have comments or questions on the summary?

Any public comments on the summary or any changes that should be made to the meeting summary?

All right. So with no changes to the meeting summary we will consider those as final and we will post those online for reference. All right, next slide, please.

One more slide. All right.

So continued discussion on data quality experts. All right. So we are lucky today to continue the discussion on data quality experts, with the data quality expert panel, excuse me, with Anna Lee Amarnath and Kristine Toppe, we are excited to have them both here with us today.

Just a friendly reminder to you both, speak in our language and

limit the acronyms and all of that fun stuff so we can make sure that we are all on track and talking in the same conversation with each other. All right, next slide, please.

During our March and April meetings this group provided us with an overview of the work that they have done to date to enhance health quality and quality in California. And each meeting we just wanted to make sure we opened the conversation back up to the workgroup members to continue this discussion, provide feedback and ask any outstanding questions to the data quality experts. For example, how data may be collected or what type of data is collected today by you all, or that you are aware of.

So we will start now and just see if there are any questions from Committee Members or discussion items that you would like to raise specifically. And there are a couple of questions that are included here on the slide for your consideration. So just:

Would additional information or clarification be useful to further the Committee's understanding of what the data quality expert panelists' organizations are doing to advance health equity and quality in California?

And then just, are there any additional questions or comments from the Committee Members for these experts?

It is okay to not have any questions and comments, we just wanted to make sure that we had an opportunity for this discussion.

And just would encourage you all as we do go through the presentation today, if there are questions that come up to either ask some of the experts that we have here on the panel or to follow-up and provide them to us so that we can incorporate that into our presentations as we move forward. All

right. We have one raised hand, great. All right, Jeff, I see you have your hand raised.

MEMBER REYNOSO: You should never ask me a question. So a quick comment. I think this question relates to a member of the public in the first meeting that we had together that recommended some best practices around data collection, particularly with AAPI populations and ensuring that information was collected in an accurate manner and was disaggregated. I believe Kaiser Permanente is a health system so I was curious whether there might be an opportunity for our experts to bring some best practices from some of these health systems that are doing this work better for us to think about as we are making our determination.

MS. BROOKS: Great, thanks, Jeff. I don't know if Kristine or Anna Lee, if one of you wanted to comment in response? Or both?

MEMBER TOPPE: Thanks for the question, Jeff.

MS. BROOKS: And just a reminder to introduce yourself, sorry.

MEMBER TOPPE: Thank you. Sorry, I was logging in when we were getting our instructions so thank you for the reminder. I am Kristine Toppe, I am with NCQA.

I think that there are a lot of, we have spent a lot of time and energy because of the work we are doing around stratifying HEDIS measures, to really look at kind of what are those best practices and promote them when at all possible. We have resources that we would be happy if -- I don't know that everything that we have published has been shared in prep for this so I would offer to share some white papers that we have produced that kind of explain some of the rationale for where we have landed with our process, but also talking

about kind of those best practices that are out there for data collection.

And actually I can, I can circle, I can send a link to that to the Sellers team for distribution to this group. So it is just reinforcing, I think, what you are referring to Jeff, as, you know, what is happening in the space and really kind of encouraging the best practice to go forward.

MEMBER AMARNATH: Thanks, Kristine. I am Anna Lee Amarnath with the Integrated Healthcare Association. There's a number of steps from the moment a person is receiving care to the end result of being able to use that information in some kind of performance measurement reporting and there's many steps along that pathway where providers, health systems, health plans and state regulators can intervene to help improve the quality of the data so that the data is complete and accurate and able to be used in either aggregated and disaggregated ways, which can really be informative.

One of the ways IHA has been most involved in improving data quality has been in pieces of the pathway between provider organizations and health plans and how they are reporting data to us for purposes of performance measurement reporting. Looking at the differences in the data that we receive from those different levels, provider organizations versus health plan, and being able to try to target -- intervene to identify why we see differences in what is coming in data files to us so that we can help see improvements in the processing of that data through the pathway.

But in a bigger picture there's a lot of challenges that are faced all the way from a clinic setting all the way up to a state regulator like DMHC and a lot of steps along that pathway where information can get lost. One of the activities IHA is involved in right now is working in a cross-industry effort in

California to try to improve all of those places in that pathway where from the moment data is collected to the moment data gets to, for example at DMHC, where there may be data loss, data gaps where data leaks away from that system. At each step along that pathway information gets lost, we lose some of that richness and what we can do with that information.

So while at a provider office a provider might know very specific information about an individual patient; sometimes as that data is transmitted all the way up to the state it gets reduced and reduced so that the complexity and nuance that represents one person is no longer represented in those, in those data files. So we are working on a cross-industry effort to try to identify recommendations and processes that could be put in place to reduce all those times where you see those pieces of data starting to drop off. Beginning phases of that work and hopefully be able to bring more information to this group or others in the future to bring those recommendations more broadly for adoption in California. So more to come.

MS. BROOKS: Great, thank you, Anna Lee and Kristine. Jeff, hopefully that addressed your question. I am looking to see if you are shaking your head yes. Okay, a smile, all right, I like that. Okay, Shaini, any other hands raised at this time?

Do we have any hands raised from the public for public comment on the computer?

Any public comment in the room?

MS. BROOKS: All right, well we will move on. And again, we will have an opportunity to continue this discussion as we move forward and welcome your dialogue on it. All right, next slide, please. One more slide; there

we go. So, all right.

So today we will revisit the guiding principles for measure selection and then continue the discussion around measures by focus area. Next slide, please.

So as mentioned in earlier committee meetings and today, the goal of this Committee is to make recommendations to the DMHC for standard health equity and quality measures, including annual benchmarks used to assess equity and quality in California.

These recommended measures will apply to full-service and behavioral health plans that are overseen by the DMHC. Next slide, please.

All right. So at a higher level, this is the proposed process for measure selection. It may change based on Committee Member needs and expectations as we go along but this is the structure that we are looking to utilize.

During this meeting today we will continue to review and prioritize measures by focus area.

In June with the two meetings our goal is to review the prioritized measures of the top two to three candidate measures by focus area, or however many measures we come up with as we may not have some measures in one focus area and may have four in another, for example, to develop the final measure set. So during this process we may go from, as I mentioned, reviewing 20 to 30-plus candidate measures and narrowing them down to about 10 to 12 measures or less.

In July we will review, identify and finalize benchmarks.

And then during our last meeting in August we will focus on reviewing the draft report of recommendations. So flagging that Committee

Members will have an opportunity to review that report for quite an extensive period of time, both during the August meeting and then after -- prior to the meeting itself and then after the meeting as well. Flagging that we did provide benchmarking data to you all in the focus area books that we provided to you all but just that we won't be talking about the benchmarking specifically today; but obviously, if it incorporates or comes into our discussion that makes sense we will do that.

Just as a reminder, the process is highly iterative and the committee feedback and discussion will support the development of a comprehensive measure set of 10 to 12 measures of existing or proposed measures for the DMHC to consider. All right, so next slide, please.

We will talk a little bit about the guiding principles for measure selection criteria. This is information that you have seen before so I am going to go through it pretty quickly. If you have questions or comments please feel free to jump in at any time, we will have some opportunity for discussion as well.

The principles for measure selection are based on common themes seen at the state, national, federal and other organizational levels and in accordance with the goals of the specific initiative. As a reminder, the criteria are not meant to be absolute or literal but to provide guidance in thinking about each measure and the balance of the entire set as a whole. These principles for measure selection should not limit you from suggesting additional or new measures throughout this process.

As a reminder, the principles include alignment with other measurement and reporting programs including California-specific programs as well as federal initiatives.

Considering the extent to which there is opportunity for improvement within a measure and that an improvement would enhance health outcomes for specific high impact aspects of health care.

The opportunity to identify and reduce disparities in race, ethnicity or other variables should be considered. Next slide please, or we will stay on 30.

The matter of feasibility around the extent to which required data is available or there are capabilities to collect and stratify data without undue burden.

And then the magnitude that other audiences are using or could use the performance data for the improvement should be considered.

As well as how the quality measures fit into California's priorities as a whole. For example, alignment with the governor's priorities or with other state departments. All right, slide 31, please.

As a reminder, our team conducted a scan of the most common focus areas by utilizing national organizations, state programs and best practices from CMS core sets, NCQA HEDIS, AHRQ, Medi-Cal, Covered California and waiver demonstration programs. This scan resulted in a compiled list of 12 focus areas for the Committee's consideration. Those are listed on the slide here today. As you will see when we get to the discussion of measures section, we will discuss California-specific or national disparities throughout the discussion of focus areas and measures for the Committee's consideration. There may be -- as I mentioned earlier, there may be focus areas where We do not select measures in this initial process. While all of these measures and focus areas are important, there may be a measure that aligns with the Committee's priorities, guiding principles and so on. All right, next slide, please.

So just as a reminder about where the information or data came from that we provided to you all in those 12 different focus area books that we, the Excel notebooks that we provided. We used the Buying Value toolkit resource that was created by the Robert Wood Johnson Foundation. That toolkit lists over 800 measures, so 800-plus measures, to assist state agencies, private purchasers and other stakeholders in creating quality measure sets.

From there we organized measures by focus area and narrowed the list of measures that align with DHCS, Covered Cal and IHA, or that are widely used in federal programs. So those are the green measures that are included in your Excel notebooks. So as noted, just flagging for you as I did last time, there are two different tabs in each of the different focus area workbooks, one has a green set of measures, those are the ones that we are proposing be discussed for purposes of today's dialogue, and have been narrowed down based on the different things that I just described, for example, they align with other programs in the state and so on.

There are also another, there's another tab that has a number of other measures that are associated with that focus area. We welcome if anyone would like to recommend one for consideration that we bring that into the dialogue. All right.

So then also just flagging that based on the Committee's feedback in the workbooks we have included a couple of different measures that were raised earlier. I think, Kristine, you raised one from the notes specifically. You will see these later on in different focus areas specific to obesity as well as vaccinations for adults. We will have those in focus areas for discussion later during the meeting today. All right, so we will move to slide 33.

So as a reminder, during the April meeting the Committee preliminarily agreed upon the cervical cancer -- cervical, breast and colorectal cancer screening measures. We will further discuss these measures during the July meetings as we narrow down the list of candidate measures from 20 to 30 to the recommended measure set of 10 to 12.

Discussion, as I mentioned, also occurred around obesity, vaccination and child measures. We will talk about those later.

So I wanted to just pull up really quickly, just flagging for you guys, we are starting a list of these measures so that we can kind of go back to that and look at what we have already. So we will pull up really quick. This is just the first iteration of the list of measures. It will just have the three that we talked about under prevention. I am not sure if we can pull it up or not. Perfect. Oh, it's on this. Okay, it's pulled up. Sorry. Excuse me. So we will come back to this list. The purpose of me showing you this list is just that we are going to come back to this list throughout the meeting so that people can see what measures have been included and the number of measures that we are adding and also just for consideration in terms of dialogue about the different measures themselves. All right, thank you for pulling that up. We will go back to the presentation now.

All right, I am going to start off as you are pulling up the presentation just talking a little bit about chronic conditions, which is where we left off at the last meeting. So during the April meeting there was a lot of discussion and agreement that the hemoglobin A1c control for patients with diabetes measures should be considered as a candidate measure. Several measures remain in the chronic conditions focus area for discussion and I am

going to turn it over to Andy Baskin who is going to walk us through those measures now.

Anna Lee, you had your hand up, my apologies. Go ahead.

MEMBER AMARNATH: Anna Lee Amarnath with Integrated Healthcare Association. I just wanted to make a quick potential suggestion.

MS. BROOKS: Yes.

MEMBER AMARNATH: As I was looking at the preventative measures, it seems if we are headed in that direction of that list of measures maybe we want to refer to them as adult preventative measures, because I think many of the childhood or preventative measures may be coming in a later section. This felt very adult-focused. Just maybe want to reference that in the focus area title might be helpful.

MS. BROOKS: so just flagging that the preventive measures are more focused on adult type prevention measures.

MEMBER AMARNATH: It seems like that is where that is landing and I anticipate in a later conversation we are going to talk about some preventive measures that are more child-focused in the birthing persons and children's section.

MS. BROOKS: Perfect.

MEMBER AMARNATH: That just might be a helpful distinction.

MS. BROOKS: That is very helpful and I appreciate you raising that, Anna Lee, thank you. And yes, we will make that distinction.

Okay, before I move on are there any other hands or questions at this time? Shaini, anybody have their hands?

MS. RODRIGUEZ (OFF MIC): No.

MS. BROOKS: All right. Now I am truly going to turn it over to Andy who is going to take us through discussion around asthma and hypertension measures.

DR. BASKIN: This is Andy Baskin from Sellers Dorsey.

MS. BROOKS: Do you want to move to the next slide?

DR. BASKIN: Yes, the next slide should have the measures on them so everyone can see them. There we go, okay. We had identified three candidate measures, what we call the measures by the selection criteria; and certainly there are other measures and high blood pressure and asthma. But these are the ones that are used currently in the programs that we reviewed and are the most common.

As you will see there is only one blood pressure one. I don't know whether we want to talk about, I think we probably just want to talk about blood pressure first and whether we want to include the measure or not include the measure or whether someone has an alternative blood pressure measure that they would like to consider and then we will go to asthma.

This is controlling high blood pressure. This is the HEDIS measure from NCQA which basically is that the blood pressure has been checked and the last blood pressure is under control in the record. And that is as simple as it is. It was previous identified as a disparity sensitive measure. So open for comments.

MS. BROOKS: So I think certainly -- thank you, Andy, for providing that overview of the initial measure itself. So just opening it up for comment and discussion with respect to this measure and if there are any comments

about it. I see that Bill has his hand up. Bill.

MEMBER BARCELLONA: Hi. Just a quick question on this. Does the asthma medication ratio skew toward a younger patient population?

MS. BROOKS: I see Anna Lee shaking her head, yes. I don't know the answer to that question. Do you want to go ahead and speak to that, Anna Lee?

MEMBER AMARNATH: The asthma medication ratio measure has age bands that can be reported and it can include children. I think it goes down to age five.

DR. BASKIN: It is Andy Baskin. It is actually 5 to 64 but it is reported in different age bands; but the measure encompasses age 5 to age 64.

MS. BROOKS: Okay. Did that answer your question, Bill?

MEMBER BARCELLONA: Yes. I understand that it can be applied to the entire population. I just thought in terms of what it triggers. It records more incidences in the young, the younger spectrum of the population, right? People age out of asthma as they get older.

MS. BROOKS: Well, I don't know the -- I would assume that probably depends on the individual but hear your comments, I appreciate that. It looks like Ed has his hand up. And maybe just a reminder to introduce yourself and where you are from.

MEMBER JUHN: Hi, Ed Juhn, Inland Empire Health Plan. The question is for the asthma medication ratio as well as the medication management for people with asthma. Not a question, it is more of a comment. So for Medi-Cal plans the pharmacy benefit has actually been carved out. So in terms of number 4, feasibility among what we are prioritizing, that could pose

potentially a challenge for Medi-Cal plans in potentially collecting and reporting on this information.

The second, medication management for people with asthma. I guess this is maybe a question to NCQA but I am not sure if this measure is being retired by HEDIS-NCQA for that specific medication management for people with asthma. And if it is, something to maybe keep in mind.

MS. BROOKS: I don't know, Kristine, if you have any comment in response to Ed's question.

MEMBER TOPPE: Thank you, Kristine Toppe, NCQA. I have to check. I had another comment and now I can't remember what it was so I will hold it and regroup, hopefully it will come back quickly.

MS. BROOKS: Sounds good. Thank you, Kristine. All right, Rick.

MEMBER RIGGS: Hi, Rick Riggs from Cedars-Sinai. With regard to the high blood pressure piece. One is it says during the measurement year, so the denominator would not include anybody that wasn't seen in the measurement period of time and it wouldn't include any readings prior to that. So if we are doing like January to December then it would just include anybody that was measured during that time and not before and if they weren't measured then they would not be in the set.

DR. BASKIN: This is Andy Baskin. That is correct, thank you for pointing that out. There are -- each of these measures has some limitation to time when the -- it is meant to be the current blood pressure so that certainly blood pressure taken the year before don't count. But you are right, somebody actually has to have shown up and had their blood pressure taken to get into the measure.

MEMBER RIGGS: Right, as opposed to your entire suite of, say, folks that are of age that should have colonoscopies, right. You would look at your entire population perhaps in a measurement like that. As opposed to this one, you have to actually have a recorded visit.

DR. BASKIN: And a diagnosis of hypertension submitted and on a claim so that you are known to be hypertensive.

Just because someone mentioned it, the asthma medication ratio I believe is currently reported in the Medi-Cal program. And I realize that there may -- I don't know that that issue is with the medications but it is currently being done.

MEMBER TOPPE: Made me remember what I was going to say. This is Kristine Toppe, NCQA. Dr. Juhn, I had a question about the kind of mechanics of how the pharmacy carve out is going to work because my understanding was that the data feed was going to be real-time back to the plan so that those issues around like care management and being able to do HEDIS reporting would not be a barrier for, for that kind of work. And I don't know, you know, what real-time may be happening and inhibiting that but, so I just want to pose the question for the -- to address the point that you made.

MEMBER JUHN: Thank you. So I think the carve out because it happened earlier in the year we are still kind of thinking through how those mechanics look so I think it is something that, something that we are internally confirming whether or not we will be required to report out on some of these pharmacy related issues. But we could definitely connect and provide updates at the next meeting on that piece.

MS. BROOKS: Palav, I see, sorry, Palav, I see your hand is up.

We will get to your question but just wanted to see if you had any response or reaction to the discussion that was just being had in the room with respect to the carve out for Medi-Cal Rx and the measures that may or may not be reported on moving forward.

MEMBER BABARIA: Yes. No, that was exactly why my hand was up so thank you for seeing that, Sarah. Palav Babaria, Chief Quality Officer and Deputy Director for Quality and Public Health at DHCS. So just in response to Ed's comment, even though the Medi-Cal Rx or the, you know, prescription and pharmacy benefit is carved out, obviously from a quality perspective we view the provision of those prescriptions, et cetera, as a key part of the provider responsibility and managed care plan oversight and so the Department has set up via the Medi-Cal Rx program data feeds two plans to send all of that carve out data in, you know, as close to real-time as possible back to the plans.

I do understand that I think many plans used to rely on their PBMs to ingest that data and do some of the quality work and transmission of that information to providers especially so there is a gap there that I think all of our plans are working through to figure out in this future state since the data comes in in a different way, how that is integrated into the systems. But absolutely, you know, it is the Department's expectation that plans will be using that data that now they get from us and other PBMs to continue doing these quality activities.

MS. BROOKS: Thank you, Palav. Just Ed, Kristine, any follow-up questions or comments in response to Palav?

MEMBER JUHN: Ed Juhn, IEHP. No, I think there's alignment there.

MS. BROOKS: Great, thank you.

Nathan, I see your hand is up.

MR. NAU: Hi, Nathan Nau, DMHC. A question for Kristine and if you need to follow-up that's fine. I noticed that some of the measures are noted as Candidate for NCQA Stratification by Race and Ethnicity. Do you know when you are going to make the next announcement for the next set of measures?

MEMBER TOPPE: Thanks for the question. We are, we are closer now than we have ever -- I actually think we are supposed to announce them in June. They were presented to our Committee on Performance Measurement. There is a subset that has been identified and we are just kind of getting into that final phase of review and approval. But those will be available, I am not sure by our next meeting, but as soon as they are released we will make them, we will share that information with the Committee.

MS. BROOKS: Great, thank you. Julia.

MEMBER LOGAN: Hi, thank you; this is Julia Logan, Chief Medical Officer at CalPERS. I just wanted to emphasize this controlling high blood pressure measure because it is one that we at CalPERS require our health plans to report on, and we have for quite some time, for several reasons. One, because hypertension affects so much of our CalPERS population, and because it leads to -- poor blood pressure control can lead to some of the drivers of mortality and morbidity among our members. And because there is quite an opportunity for improvement with this measure and so we are really working to focus on this measure with our plans.

MS. BROOKS: Thank you, Julia.

Anna Lee, I see your hand is up.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated

Healthcare Association. I think I just wanted to second what Julia Logan was saying. Controlling high blood pressure I think needs to, in my opinion, needs to remain on the list to be considered. There's a lot of advancements in diagnosis and care for blood pressure and ensuring that there is equitable access to those advanced methods of treating blood pressure would be, I think, an important aspect of the work that we could do as part of this Committee.

And returning to the asthma conversation, I also would be a proponent of ensuring that we include a measure in our, as we are thinking about chronic conditions and care for chronic conditions, a measure that does touch into the child population and asthma being a critical, chronic condition to potentially improve the quality of care, especially in children, adolescents, teens in particular, ensuring they get controller medications. I think it would be really important to continue to keep an asthma medication measure on the list. And my understanding is that NCQA has retired the medication management for people with asthma measure and so I -- and I would think asthma medication ratio measure would be the one I would argue to maintain on the list to consider.

Because I looked at the birthing persons and children's list and I don't believe I saw any measures for consideration in that bucket that touch on chronic conditions for kids so I think this would be the place to do so.

MS. BROOKS: Great, thanks, Anna Lee. Sylvia.

MEMBER YEE: Hi, Sylvia Yee with DREDF. This may have been asked already, I just want to be very clear. So if there's racial and ethnic stratification of these measures you would capture those who are already diagnosed with these conditions, it wouldn't necessarily capture individuals who haven't been diagnosed yet. Inequities in diagnosis. I just wanted to ask that.

And the second is just the difference between the asthma medication ratio and the medication management for people with asthma, number 3 and number 4. I personally would love to hear someone tell me the difference.

MS. BROOKS: Thanks, Sylvia. I am going to let Andy speak to those questions.

DR. BASKIN: Sylvia, hi, it's Andy Baskin from Sellers Dorsey. So yes, this is not screening for hypertension or screening for asthma so these diagnoses already have to be in place, that's the first, the first part.

The second part is the medication management, if I am not mistaken here means that you are on an asthma control medicine, which means the medicine you take pretty much every day to control asthma as a baseline to prevent attacks from happening.

The first measure, which is the ratio, is that you are on more controller medicine then you are on acute treatment. Acute treatment is I am wheezing, I take the -- I take the medicine now. And the idea being that if you are on the denominator is if you are taking a lot of acute treatment medication you are not very well controlled and therefore your ratio will go below .5, so it means that you are being treated more appropriately with the two different kinds of medicines. Does that answer?

MEMBER YEE: Yes, it does, thank you.

MS. BROOKS: Great, thanks, Andy and Sylvia. Other comments or questions on these measures specifically From the Committee Members?

Do we have any other hands up, Shaini?

MS. RODRIGO: We have one.

MS. BROOKS: But none other from the Committee Members; is that right?

MS. RODRIGO: No. Oh, sorry, Julia.

MS. BROOKS: Oh, Julia, okay, great. Julia, if you wanted to go ahead.

MEMBER LOGAN: Yes, I -- it was -- sorry. It is my understanding that medication management has been retired but I could be very much mistaken,, but we just might want to check on that.

MS. BROOKS: I think, yes, you are making an accurate statement so that is perfect, perfect timing. So given that it has been retired maybe, Kristine, could you talk a little bit about what being retired means, just for the Committee.

MEMBER TOPPE: Sure. Basically measures that have either kind of met, have been -- so NCQA does a routine reevaluation of measures in the suite of all of the HEDIS performance measures that we maintain and develop. And as part of that continuous evaluation of measures they are updated with current evidence based on best evidence at the time, and technical experts go through a whole review process and vet that and it goes to our committee on performance measurement. So as part of that review process we also assess measures that have kind of -- not the client -- what's that?

DR. BASKIN: Topped out.

MEMBER TOPPE: Topped out. Andy, Andy Baskin was adding that they have kind of met their maximum improvement opportunity. Or there is something better. We have developed a better version of a measure that addresses the kind of clinical need or the patient need in a better way. This

measure must have been proposed for retirement because of, for one of those reasons. So I don't have the specifics but I can provide them, I can, I can ask a performance measurement team.

MS. BROOKS: That would be helpful if you could follow-up on that and we can circle back with the team.

MEMBER TOPPE: Sure.

MS. BROOKS: But it looks like Andy may have a comment on that and then I think we will -- I have some thoughts based on what the Committee is hearing and we want to hear from the public also and then we will kind of talk about how to move forward here.

DR. BASKIN: Yes, it is Andy Baskin again. My recollection is it was that the clinical value of the management measure was essentially all copied over in the medication ratio; it didn't add enough clinical value to warrant having an additional measure and they were trying to keep, you know, the list down and to make room for other more measures that had more value to them. That is my recollection of how that went.

MS. BROOKS: All right, thanks, Andy. Ed, it looks like your hand is up.

MEMBER JUHN: Ed, IEHP. I think we are making recommendations based on the conversations here. You know, I think hemoglobin A1c, controlling high blood pressure and asthma medication ratio would be for me something to consider making.

MS. BROOKS: Great, thanks, Ed, for those recommendations. Any other Committee Members have questions or comments on this on these measures?

Shaini, I know you said we had a public comment hand, do we still have one?

MS. RODRIGO (OFF MIC): Yes, we have (inaudible.)

MS. BROOKS: Great.

MS. MCMAHON: Hi, good afternoon. This is Katie McMahon with Molina Healthcare. Thanks for the opportunity to speak.

I just wanted to echo IEHP's initial thoughts on the asthma medication ratio. We have struggled with this measure in the past. We know that a lot of our PCPs don't necessarily have access to the information that is triggering a member to fall into this measure. And when we do a lot of digging members actually should not have been diagnosed with asthma so we have just had difficulty in that; and then exacerbated with the carve-out. So just wanted to put that on record. But I do appreciate Ed's comments on diabetes management and controlling high blood pressure.

MS. BROOKS: Great, thank you for your comments. All right. Beth, Beth, we are able to take comments from you now if you can hear us.

MS. CAPELL: Great. This is Beth Capell with Health Access. Just two quick points. And I apologize for my home phone ringing. Two quick points. Not everyone ages out of asthma. I did not and I have a brother who aged into it in his sixties so just worth noting that it does affect adults as well.

Secondly, on the retirement of measures, and this is a more global comment. Because you are going to be adopting these by regulation and because of the inflexibility and time, and time involved in the regulation process, I wonder, and it may not be a question that the Department can answer today. I wonder if there is a way to, if not, if there would be a way under the regulatory

package to provide for retirement of measures? I am assuming that given what I know about the Administrative Procedures Act, you could not add a measure so that if you, if the medication management for people with asthma has been retired you couldn't then replace that with the asthma medication ratio without going through the rightful regulatory process. But I do, I do, I have wondered whether we could allow for retirement of measures. And I mention this because it did not, it came up here but I think it cuts across the entire discussion because measures do get retired from time to time, as a number of folks have noted. So it seemed pertinent here but it probably applies to everything so thanks.

MS. BROOKS: Thank you, Beth, we appreciate the comment.

MS. WATANABE: Yes, hi, Beth, it's Mary. We actually have Sarah Durston here who is going to be helping draft our regs. I have actually been thinking about that too. I think there may be a way to craft language about the retirement of measures but I agree, I don't think we could just say it will be replaced with whatever version or something similar, so. But we will take that back and maybe at the next meeting provide some additional comments on what we think we might be able to do through regulation. But appreciate the comments.

MS. BROOKS: Thanks, Mary and Beth. All right. Any other public comment online, Shaini?

MS. RODRIGO: No.

MS. BROOKS: Do we have any public comment in the room? Yes, if you would like to please make your comments. And if you could please state your name and your affiliation prior too. Thank you so much. One more thing, I apologize. The mic is not on. If you could -- It needs to be green. And

maybe we can run and help him real quick. There we go, it's on. Thank you.

REV. SHORTY: Reverend Mac Shorty, founder of Community Repower Movement. I am glad to see that some of these measures and causes are great to be followed up and looked at.

The Coronavirus piggybacked off a catastrophe of poorly-treated chronic illness rampant in California. Heart disease, high blood pressure, lung cancer, kidney disease, asthma, arthritis, depressions and diabetes. I would like to see it looked at, every patient dealing with asthma sometimes don't have resources to get to a pharmacy to pick up the medication. There should be a way for those underserved communities to have those high blood pressure medications and asthma medications and, and diabetes. You know, their needles and their medication. Is there somehow that it can be mailed to the patients or some type of delivery service such as Uber or Lyft to deliver the medication to those that are not able.

A mother with a five or six year old child that is suffering from asthma may not be able to put that five or six year old on a bus and ride down to the local pharmacy without that child having an asthma attack between getting there and getting the proper medication. It could be the smell from somebody's cologne could trigger a reaction. It could be just the way the weather is in California can trigger a major reaction.

I had an aunt die from asthma. She was healthy. We believed she was healthy. She suffered from severe asthma. She was elderly, of course. Not elderly to the point where she wasn't getting around but it bothers me because what if these people are living alone, don't have family members, don't have neighbors or friends who try and look out for these kind of people. We should,

you know, look at our have people, different agencies look at how to best get the medication out to the patients. I think that would be helpful in a lot of communities.

Just not in Southern California or even Northern California, some rural areas don't have, you know. In my community I can count the pharmacies. They are represented by CVS or Rite-Aid. Little mom and pop stores take too long to get the medication so you don't want to deal with them because they don't keep it in stock. And then when they keep it in stock they want to make sure they give it to the elderly people first before they give it to the younger people to make sure that the ones that really need it the most have it.

MS. BROOKS: Thank you so much for your comments, we really appreciate them. Any other public comments in the room? All right, so I am going to -- just any other comments from Committee Members real quick based on public comments before I kind of tell you what I am hearing?

So what I am hearing from you all, and we talked about this last time, that we would include the hemoglobin A1c control for patients with diabetes measure on our list that we would be moving forward. I am hearing from you all that we should include controlling high blood pressure; and that at this time asthma medication ratio should be included. I know there is some further discussion that may need to be had around that one and I think we can talk about that when we, as we move forward and look at narrowing the measures down specifically.

That is what I am hearing, please let me know if you disagree or have a comment or feedback, anything of that sort. Shaini, any hands raised?

All right, so we are going to move on to the next focus area, which

is mental health. All right. So, Ignatius, are you online?

MR. BAU: I am.

MS. BROOKS: Great. I am going to turn it over to you to talk a little bit about mental health disparities.

MR. BAU: Great. So thanks, everyone. As we go through this next topic area we will talk about mental health, which obviously encompasses lots of conditions. I just wanted to highlight some of the data from the California Health Care Foundation charts around serious mental illness, particularly among American Indians and Alaska Natives, Blacks, and multiracial Californians.

We are going to look at a variety of measures that aren't solely focused on serious mental illness but this just gives you some snapshot of the fact that obviously disparities are a big issue, particularly after COVID has exacerbated some of those conditions. So let me turn it to Andy to run through some of the measures that we would welcome conversation from the Committee about.

MS. BROOKS: Maybe next slide. And I think there's a couple of slides in here that demonstrate, Ignatius, just some of that information that you went through for background purposes for people. So go ahead, Andy. Slide 39, I think.

DR. BASKIN: Thank you. It's Andy Baskin again. So we have taken these measures and we have grouped them into two. Understanding, by the way, just to let you know, we certainly know that mental health and substance abuse issues are related in many instances. The substance abuse is the next focus area. So we will get into those measures separately because the measures really do lend themselves to a different discussion.

You will see on this slide there's three measures, all related to depression. And just to peek ahead to the next slide so you will see the other set of I think three additional ones are not specific to depression, they are specific to mental illness in two of them and one in ADHD. So let's talk about those separately because that does include depression but it includes many other mental illnesses as well, it is a different type of measure.

So let's go back to the depression measures and you will see there's three of them. Anti-depressant medication management, which has to do -- it is someone who is put on the medication for depression has essentially maintained on that medication appropriately for a period of time, which is a best practice.

The depression remission is a measure that actually is based on a measurement of depression through a tool, most commonly the PHQ-9 tool, which is a very common tool. I think it actually has nine questions now that I think about it. That can be scored. And it is, and it is basically a measure that shows Remission being if the score went down below a certain number and Response meaning it went down appreciably, although it may not have gone below that number.

And the third one is depression screening and follow-up in adolescents and this is more of a routine screening to be done, and should the screening show positive that some action had been taken.

So that's what the three measures are. I think the age grouping on those, if I got this straight here. So for the medication management is 18 and older so no, it is an adult measure in that respect.

The remission and response measure is 12 years and older. It's on

the wrong slide here, go back to the depression slide.

And the depression screening is 12 years and older. So the bottom two are 12 years and older and the top one is 18 and older.

MS. BROOKS: All right, thank you, Andy. So I think just opening it up for some initial discussion on these depression screening measures and then we will move into the other, others that are more based on follow-up after care. So initial thoughts on slide 39, the measures that are listed specific to anti-depressant medication management and so on? I see Rick, you have your hand up.

MEMBER RIGGS: Yes, hi, Rick Riggs from Cedars-Sinai. So the first one, the antidepressant medication management, the verbiage in, at least in the table that we got, said that it was for effective -- it said, effective acute phase treatment. Or is it the medication management for continued phase treatment? Which of those was?

DR. BASKIN: it is both in that it -- both numbers are reported in the measure so it is actually two, two results in the particular measure. Now, this group could, could divide it up and just ask for one or it could ask for both together but the measure as, as it is used today has two different results.

MEMBER RIGGS: So that, so that would necessarily mean, so just practically, if someone comes in with a -- comes and transfers into your practice or your health plan with a condition of, a diagnosis of depression and they are currently being treated, then it would be, you would only report one of those measures on that particular person?

DR. BASKIN: So it is Andy Baskin again. If you decide to put the patient on an antidepressant medication it is basically saying, did you keep the

patient on them. Did the patient maintain being on the medicine for a 12 week period of time, which is the acute phase. Those same patients are, in fact, are included in the second number which is, so you may have had, let's say, 25 percent stayed on for, let's say 75 percent stayed on for 12 weeks, but that after six months how many had remained on for the entire six months. That number is obviously going to be lower because some people have dropped off. And what it is trying to do is saying there's at least a minimum period of time you should have patients on. But the recommended time is six months or greater and how successful are you at keeping people on the medicine for the, for an appropriate period of time? So you actually report both numbers. And the people that are in the six months obviously were already counted at 12 weeks because you couldn't get to six months if you didn't get to 12 weeks. Does that make sense?

MEMBER RIGGS: Yes, I was -- yes, that's -- I think that there's flexibility in the measures for folks to be able to understand how they would report if they were switching plans.

DR. BASKIN: Yes, I believe there's some -- this being an NCQA measure there's probably an eligibility part to this that you had to be with the plan for a period of time with one plan now. You know whether that would be done differently if somebody moved from one Medicaid or MCO plan to another or one commercial plan to another, right now that would be some significant difficulty. So it is usually at the moment you have a continuous period of time with a plan, it is usually easier to look at the steps.

MEMBER RIGGS: Okay, great, thank you.

MS. BROOKS: Thank you, Rick. Dannie, I see you have your

hand up.

MEMBER CESEÑA: Hi, this is Dannie Ceseña with the California LGBTQ Health and Human Services Network. I am wondering how you are going to measure medication management and follow-up for youth and adults who are unhoused who might not have the means to go back to a medical provider or to access their medication, especially if a medical provider cannot contact the patient due to lack of address, lack of access to a cell phone or any type of cell phone, or are those numbers not going to be counted?

MS. BROOKS: Go ahead, Andy, and then I have a comment.

DR. BASKIN: So it's Andy Baskin. So I mean, certainly for these particular measures, because they are MCO measures, whoever the patient would be would have to be enrolled in the MCO. In other words have that, that particular insurance. Now that doesn't mean you can't be homeless and have insurance, because it certainly may be the case. But what you are pointing out is some of the difficulties in getting the highest, you know, score on this, the highest performance. And certainly people that are homeless or transient or have other, you know, issues where they are unable to maintain on medication, that would be for the, the MCO and the providers to do their darndest to come up with innovative solutions for that. But you certainly pointed out a difficult issue and a subset of patients that are very difficult to have compliance with these medications.

MS. BROOKS: Great, thank you, Andy and Dannie, that was a great question. Ed, I see your hand is up.

MEMBER JUHN: Hi, Ed from Inland Empire Health Plan. So I think for me number 3, depression screening and follow-up for adolescents and

adults might be a good measure to move forward to the next list because it hits both the adolescents and the adult populations.

MS. BROOKS: I didn't hear what you said, I am sorry.

MEMBER JUHN: Yes. Number 3, the depression screening and follow-up for adolescents and adults because that measure addresses both adolescents and adults.

MS. BROOKS: Okay, got it, thank you.

MEMBER JUHN: (Overlapping) considering moving forward might be a possibility.

One comment that I had regarding number 2, depression remission or response for adolescents and adults, number 2. That this potentially represents a very small population. looking internally, for example, for our measurement Year 2020 for this specific measure, the denominator was quite low. I don't have the exact numbers on hand but somewhere less than 200. So I just wanted to make sure that if the Committee decides to proceed with this that of the three that are listed there, number 2 sticks out as something that potentially might have low denominators. Something to keep in mind, thank you.

MS. BROOKS: And just to kind of ask a clarifying question for me, sorry. The 200 is for Inland Empire Health Plan, which is a larger plan in the state, correct?

MEMBER JUHN: Correct.

MS. BROOKS: Okay. Very helpful, I appreciate your comments, Ed. Kiran, I see you have your hand up.

MEMBER SAVAGE-SANGWAN: Thanks. Kiran Savage from CPEHN. I, you know, second, third on number 3 here, the depression screening

and follow-up. I think my question is just confirming that will get you the people who screen positive for depression if they get the appropriate follow-up, if I understand correctly. And so I am wondering if there's anything a little bit more longitudinal because I think one of the concerns we have from a racial disparities perspective is we do less screening for depression for people of color. We might screen for other types of mental illness. There is a bias there in terms of who gets diagnosed with depression that is not necessarily clinically accurate and so I don't know if there's anything that can help to capture that piece too if it is not included in this measure.

MS. BROOKS: I don't know if there are thoughts from Committee Members on that issue specifically, the question that Kiran raised? So maybe, Andy, if you want to weigh in really quickly on that.

DR. BASKIN: I am almost going to weigh in by asking a question because I don't have the spec in front of me but I believe the measure says it is the percentage who were screened. And secondarily, if you were screened, posits that you had follow-up, and I think you report out the percent that are actually screened. So if you are under-screening that would be known. I believe, that's how the measure works but I would need confirmation for someone to go back either to Kristine or we have access to it to make sure that that's it. And that would solve at least part of the question, short of a concern.

MS. BROOKS: Do you have it pulled up? All right, go for it, Sarah.

MS. DURSTON: This is Sarah Durston from the DMHC. So all of the worksheets are available online. If you are having problems accessing it you can just email one of us. I can read the measure for you. It says: Percentage of members 12 years of age and older who are screened for clinical depression

using a standardized tool and, if screened positive, received follow-up care. So there's two sub-points. Depression screening, the percentage of members who are screened for clinical depression using a standardized tool; and then the second sub-point is the follow-up on positive screen, the percentage of members who screened positive for depression who received follow-up care within 30 days.

MEMBER SAVAGE-SANGWAN: So does that mean there would be two benchmarks associated with the measure for the two components?

MS. BROOKS: I think that's what we need what we need to clarify. It is a good question that you are asking, Kiran. Apologize that we don't have a response for you but we will get one and follow-up with the workgroup on that so thank you so much.

MEMBER SAVAGE-SANGWAN: Okay.

MS. BROOKS: Diana, I see your hand is up.

MEMBER DOUGLAS: Thank you, Diana Douglas with Health Access California. I think looking at these three my concerns with the first is that it only seems to capture, first of all, the older age group but also only those who are prescribed medication and I wonder if the second and third measures also would capture other non-medication treatment paths as well. I think kind of -- and maybe to Kiran's point too, the third one, if that does, in fact, include a way of capturing both sort of rates of screening but then also follow-up I think that would be my preferred measure.

Noticing on the second measure, it is just for those who are diagnosed, correct? So it seems like 3 might be cast a little bit wider of a net in terms of capturing who is screened in addition to who receives the diagnosis or

screened as positive. And I think, you know, just in general, while medication is often, I think, the preferred route, I wonder if the second and third are also able to capture, sort of, you know, behavioral health therapy and other modes of treatment as well and capturing who is able to get better as a result.

MS. MYERS: Hey, Sarah, this is Janel, I just need to jump in and address the question. This is Janel Myers from Sellers Dorsey. As it pertains to the second measure, it is two separate reads. So it is a read of the depression screening and then separately the follow-up on positive screening.

MS. BROOKS: Thank you, Janel. So I think that answered Kiran's question. Diana, I think, excellent comments and appreciate your input from everyone and from you in particular as well here right now. Let's see. I see that Anna Lee has her hand up but before I move on, Diana, did you have any additional questions or comments?

MEMBER DOUGLAS: No, I think that's fine, thank you.

MS. BROOKS: Okay, thanks. Anna Lee.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. So I think that when it comes to thinking about the depression measures one of the things that's a little bit challenging is sometimes the feasibility of the data collection; despite that, I think it is incredibly important that we include one of these measures.

So for example, Ed Juhn, you spoke earlier about the challenges with claims for medications with the pharmacy carve-out and that could impact the antidepressant medication management measure. That might not be a reason I would necessarily say we shouldn't use that one but I don't personally

gravitate towards that one, again, because it is targeting a very small population of people who have been diagnosed, who had been prescribed a medication and in an adult population. So I just want to second.

A number of people have said and I would agree with the third measure because screening for depression is incredibly important across a broad swath of our population. This measure captures adolescents and adults and the fact that screening being done would be a critical first step in order for people to be appropriately identified as being at risk or having depression.

NCQA has, I believe, recently updated through the public comment process, through feedback, raised some of the when you are screened and you get a score on one of these tools, NCQA has raised the bar on what would qualify as meeting a positive screening that then requires follow-up to ensure that care is directed to those most at need. That that's where care coordination efforts are really going and to ensure follow-up. I believe that was the change that happened in the last couple of years. So I do believe that I would argue that the third measure would be one I would be a larger proponent of than a measure such as medication management which is dictating how that treatment and follow-up has been done. Even though I recognize that medication is often the gold standard and as a primary care provider is often what I would be doing.

MS. BROOKS: Thank you, Anna Lee. All right, Julia.

MEMBER LOGAN: Hi, Julia Logan, CalPERS. I just wanted to emphasize this third one, depression screening and follow-up. It is a requirement in our current CalPERS contracts with our health plans already because it is, as Anna Lee and others mentioned, it is such a critical first step in mental health management. It is also a US Preventive Services Task Force

recommendation and so our plans and providers should be doing this. And it also includes pregnant people and postpartum, those who are postpartum, which are also, it is a vulnerable time for people and their family. So for all those reasons that is why we are continuing to require it in our contracts.

MS. BROOKS: Thank you for that information, Julia. All right, Rick. Oh, okay, Rick.

MEMBER RIGGS: Hi, Rick, Riggs, Cedars-Sinai. Just I agree that I think 3 casts a wider net with regard to the screening and follow-up. There are for the folks that are experiencing homelessness, they often are utilizing emergency departments for their care. And of course, as you know, when we do the two and PHQ-9, if they trigger that and so I think there will be -- if they touch the hospital then there will be significant data there for the health plans that are covering them. So it is an interesting loop to close for folks with this measure but I think we get great information back to include all those touch points.

MS. BROOKS: Thank you, Rick. Shaini, I don't see any other Committee Members hands up. Do you at this time? I know we have a few more measures. Kristine, do you have a comment?

MEMBER TOPPE (OFF MIC): Am I supposed to be raising my hand?

MS. BROOKS: Yes, please raise your hand online.

MEMBER TOPPE (OFF MIC): (Inaudible).

MS. BROOKS: Sorry. No, that's, I apologize if I wasn't clear about that. Yes, Kristine, please go ahead.

MEMBER TOPPE: Sorry, Kristine Toppe not following the rules, from NCQA. I just, I know it is noted in the slides but I do, I did want to just

refresh folks, you have got a double-asterisk on this measure also, the one that folks have just been speaking to. This is up for the proposed set of measures NCQA would plan to stratify. And I would just remind the Committee that those stratifications will be required of all health plans that have NCQA health plan accreditation, and given that as a requirement of both the Department and -- well not both but of Department of Managed Health Care, Covered California, DHCS and CalPERS, it just is one more kind of alignment opportunity from that standpoint as well.

MS. BROOKS: Great, thank you so much, Kristine.

It looks like, Andy, you have your hand up.

DR. BASKIN: I just learned to raise my hands as well. (Laughter.) I had been doing it in person.

MS. BROOKS: We have an IT session going on.

DR. BASKIN: I just wanted to set the point of information because it was brought up on one of the comments that we will be discussing the pre and postpartum depression measures, even though they are also depression, because it is under the women's health or the birthing measures. So just be prepared, it will come back to us for that specific population.

MS. BROOKS: Be prepared. All right, thank you, Andy. All right.

So just a reminder to folks not to use the Chat. We have a couple of people using Chat, using the Chat, but Bagley-Keene does not allow us to do that. So, Bill, I see you have a comment in the Chat, I am going to ask you to say what you said on the Chat if that's okay. We can't --

MEMBER BARCELLONA: Thanks, Sarah.

MS. BROOKS: Now we can hear you.

MEMBER BARCELLONA: Okay. Yes, I am persuaded toward the depression screening and follow-up for adolescents and adults because of the connection to the NCQA stratification.

MS. BROOKS: Thanks, Bill. All right. So why don't we move on. Oh, go ahead. No, Palav, I see your hand is up. Thank you. Sorry about that.

MEMBER BABARIA: Hi, Palav Babaria from DHCS. Just if it is helpful to other Committee Members, I think we at DHCS also really like measure 3 and I think it is for a few reasons. One, because it really tackles the screening issue. We know that there's such under-diagnosis of depression for adolescents and for adults.

And to reference back Ed's point of sometimes for number 2, you get small Ns. We have found that, you know, often the small Ns for number 2 is because we are not doing enough screening to identify people who then would benefit from follow-up and treatment of some sort.

And then also to the earlier comments, number 3 is broader and includes sort of appropriate follow-up, not necessarily medication but some intervention to address those needs, whether that's psychotherapy, brief intervention or otherwise, so it is just a broader treatment modality.

MS. BROOKS: Thank you, Palav. Stesha.

MEMBER HODGES: Hi, Stesha Hodges with California Department of Insurance. I also agree that number 3 is an important measurement based upon its breadth and that it will -- also due to the NCQA stratification by race and ethnicity.

MS. BROOKS: So I am hearing number 2 from everyone? No, I

am just joking, okay. (Laughter.) I am hearing number 3. I think we have support for that measure and we are going to go ahead and add that one to the list.

I know that we have another set of mental health measures to get into on the next slide here so, Andy, I will turn it over to you and have you talk a little bit about,

a little bit about those measures.

DR. BASKIN: So hi, it's Andy Baskin, if we could change the slide, please.

MS. BROOKS: Slide 40, please.

DR. BASKIN: I believe there's three measures.

MS. BROOKS: There we go.

DR. BASKIN: So these are all follow-up measures. Follow-up after hospitalization for mental illness. This is where somebody with mental illness is the purpose of the hospitalization. And this is a follow-up, there may be a couple of different times, if it is 7, 30 days, I don't recall. I should have just had that off the top my head. There's a 7 day follow-up and a 30 day follow-up, right, that's what I thought.

And there is similarly one for emergency department visits for mental illness.

And then the last one is a little bit different in that it is very specific to children who are put on ADHD medications and whether there's follow-up; and there's a couple of follow-ups that have to occur during that period of time. So it is a follow-up, there is a short follow-up and longer term follow-up similar to the measure we talked about with earlier. But anyway, that's a very specific, more

limited population but it is apparently a very large population because it is very common for kids to be on ADHD medication nowadays.

So we will open those up for discussion.

MS. BROOKS: Thanks, Andy. All right, Anna Lee, I see you have your hand up.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. And it is more of maybe a question for some our Committee Members who have some experience with these measures. I know Medi-Cal and Medi-Cal health plans have been trying to utilize these measures in their accountability set. And in past when looking at data sometimes these can be measured, my understanding is, with small populations of people who may fit into the criteria of the measure, making it difficult, potentially for all the health plans to be able to report them. And so I just wanted to ask if any of the Medi-Cal plans or DHCS had any experience with how they have been able to utilize those measures for purposes of accountability because I know that's the direction we need to go with DMHC.

MS. BROOKS: So I am going to -- those that have their hands up we will definitely come back to you but want to just follow-up on Anna Lee's question. Ed, I know you are on point for responding here.

MEMBER JUHN: Yes, thanks, Anna. So totally agree. I think that's why number 4 and 5 jumped out. Because in terms of data collection there are some data challenges in obtaining this type of information, especially if we have to go through our behavioral health county departments to grab that information. So that is actually what my hand raised comment is so yes, there are data collection and obtaining issues, especially if they receive it from the

county department, and that might also impact how we measure this.

MS. BROOKS: Thank you, Ed. All right. Let's see. It looks like, Kiran, you have your hand up.

MEMBER SAVAGE-SANGWAN: Yeah, I mean, just sort of to follow-up on that line of questioning. Like, I wonder if Palav can chime in because I thought one of these was proposed in the DHCS quality strategy and there were some questions raised about how it would work between the managed care plan and the county and getting the data but I feel like you resolved that. Maybe you came enlighten us with sort of where this landed in terms of feasibility because I do think it is important to consider one of these measures; they are also really important from a care coordination standpoint.

MEMBER BABARIA: Yeah, happy to take --

MS. BROOKS: Palav, oh, yeah, there you go.

MEMBER BABARIA: Happy to take it on, Palav from DHCS. So these are measures that we are looking -- that we have included in our quality strategy and on our managed care accountability set, both for our Medi-Cal managed care plans as well as our county behavioral health plans as well so this should not be a surprise to anyone. I will drop, or I can send it to you, maybe start a send-out, DHCS as a part of CalAIM did issue data sharing guidance for all health care entities about, you know, where the federal and state statute limitations are.

There are, obviously, 42 CFR regulations, especially around substance use data sharing, I think that is less of a concern on the mental illness side of these measures, where consent is needed, but there is more flexibility and we are, you know, certainly encouraging both our behavioral health partners

and our managed care plans to avail themselves of all of the data sharing opportunities that they can do safely within the confines of federal and state regulation.

So I don't think from a statute perspective these are as, these are surmountable goals. Obviously, there's operational considerations about just, you know, what format is the data in, do they have data sharing agreements, all of those logistics, but it is doable for both of these measures. And I think the Cal HHS data exchange framework, which I can also send you the draft guidance, which is going to be finalized in July, will address some of those operational issues in terms of just data formatting to make this data sharing easier.

MS. BROOKS: Thank you, Palav. And, Kiran, hopefully, and others, that was helpful for me so hopefully helpful information there.

MEMBER SAVAGE-SANGWAN: Yes, thank you.

MS. BROOKS: All right, Alex.

MEMBER ALEX CHEN: Hi, Alex Chen from Health Net, Chief Medical Officer. I just want to respond to the earlier questions. The primary concern, I think, as Ed pointed out, is really about sample size. As a Medicaid plan we have not had a lot of experience with the first two measures here because they are not often required as part of the core set. And I sat on several technical advisory committees before on selecting core sets and part of the reason why they were not selected was concern about sample size for those two measures.

Now regarding the third measure, the ADHD measure. Although I think there's a lot of sample size there in the denominator, but there's a lot of studies that show that ADHD is over-diagnosed in children. I am not the only

clinician on the panel here but I think I am one of the few, if not the only, pediatrician. So I would have a strong concern about using ADHD follow-up as a part of a measurement set for disparity.

MS. BROOKS: Thank you for your comments, Alex. Jeff, it looks like you have your hand raised.

MEMBER REYNOSO: Yeah, just Jeff with LCHC. Just as a follow-up with Dr. Chen. I think for us, we were concerned with what measure would be the appropriate measure for that, I guess, 11 and under population. So, you know, we agree with the screening measure but that only captures the 12 and up. So, you know, I think, what is the appropriate kind of screening and follow-up measure for children, particularly younger children, that have been, you know, I think we have seen some increases in anxiety, stress, particularly around COVID and stay-at-home orders.

I know that there have been some initiatives with, you know, the Office of Surgeon General and Department of Health Care Services around the ACEs Aware initiative and screening for ACEs so was curious whether there might be an opportunity there or whether, you know, that, you know, if the type of measure or the tool that the ACEs Aware initiative is outside of our scope is there something that kind of meets that, that gap of trying to identify, you know, these mental health conditions earlier and, and being able to treat them, you know, with a broad range of interventions, you know, outside of medication.

MEMBER ALEX CHEN: So, thank you for that comment. I cannot agree with you more. I think you are absolutely right. I think my point is that there's a lot of childhood mental health or behavioral health issues that haven't been validated as a measure yet and I think anxiety is definitely a big one in the

younger kids population range. And I will certainly endorse if there is a valid, you know, anxiety screening measure for younger kids rather than going with the ADHD just because we have a valid measure available today.

There is over-diagnosis and misdiagnosis in ADHD, I think that is pretty proven by the literature. But certainly we are worried about disparity, which means we are worried about under-diagnosis. So I will certainly be a much better, stronger supporter of an anxiety measure or even the previous measure in terms of screening for depression and follow-up. I don't know where NCQA sits on this and I certainly would welcome any comment on that.

I used to sit on NQF NCQA steering measure selection committees. And the PHQ-9 certainly can go all the way down to age 6 or 7, I don't know why they limit it at age 12. I know it doesn't always pick up anxiety for PHQ-9 but it certainly will pick up depression in children as young as age 7, I think. Excuse me.

MS. BROOKS: Great questions, Jeff. And thank you, Alex, it is wonderful to have experts such as you all on this group, can I just say. I don't see any other hands up. Shaini, do you see any Committee hands up at this time? Oh, Doreena, you have raised her hand, I apologize. Go ahead, Doreena.

MEMBER WONG: Oh yes, thank you. As I was looking at the different measures I didn't see anything that was related to like suicide ideation or suicide prevention. I know that suicide is like the second leading cause of death for those 25 to 35 and actually it is the leading cause of death for Asian Americans 15 to 24. So I was wondering, is there some measure that we could use to try to get to that? You know, especially since it would be good to use, you know, use that perhaps as a, as a measure, you know. Either to include a

screening measure or any other kind of a measure but you know, and follow-up to that.

MS. BROOKS: Janel, are you on by any chance? I know you are -- is it beyond? Yeah.

MS. MYERS: Hi, Sarah, I am here.

MS. BROOKS: I wondered if you were able to hear that question and if you had a response to it by any chance? Just about if there is a measure that is specific to suicide ideation that we are aware of or something of that sort?

MS. MYERS: Not at this time. And again, using the process that we kind of laid out earlier in terms of leveraging the Buying Value toolkit and then the other, the other measures being reported by programs. At this time there hasn't been anything in there but we can definitely go back and see if there's something more widespread perhaps.

MS. BROOKS: And I know, Sarah Durston, you noted one. I don't want, I am afraid to open my Chat because I don't want to lose the screen, if you want to mention that.

MS. DURSTON: Sure. This is Sarah Durston from the DMHC. Going back to the pediatric mental health issues. If you look at the worksheet there's two tabs at the bottom. If you go to the All Mental Health Measures tab, measure number 33 has a Pediatric Preventive Care measure for Adolescent Mental Health and/or Depression Screening and it measures percentage of patients ages 12 to 17 years old. So it is still the --

MS. BROOKS: Like adolescent.

MS. DURSTON: Yes, 12 and older, but I just wanted to highlight that, it is another measure.

MS. BROOKS: Thirty-three?

MS. DURSTON: Yes.

MS. BROOKS: Thirty-three. So, Doreena, I think you have raised an important issue, perhaps that's a measure that we need to look at further. I don't know if there are specific comments on it from Committee Members or -- and I think, you know, just open for discussion in terms of if it is appropriate for us to include it or not. Andy, did you have some initial comments?

DR. BASKIN: Only specific to one comment Doreena made about suicidal ideation. And if you look at the PHQ-9 questionnaire itself, the number nine question is thoughts that you would be better off dead or of hurting yourself in some way. So just to note, while this is --it is an aspect of the PHQ-9, which is the depression screening tool that we have been talking about, it is one of the nine questions and it is scored appropriately. So at least in some respects if you are utilizing the PHQ-9 for depression screening you are, in a sense, doing some screening for suicide ideation already.

MS. BROOKS: Thank you, Andy. So I think it sounds like we will go back and look at 33 -- you have another comment, Sarah? Go ahead.

MS. DURSTON: Yes, this is Sarah Durston from the DMHC. Also, measure number 39 encompasses both pediatric and the suicide risk assessment, it is Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment, and it considers percentage of patients ages 6 through 17. So it assesses them for major depressive disorder with an assessment for suicide risk.

MS. BROOKS: Sarah, all right. Let's see. Silvia, you have your hand raised.

MEMBER YEE: Thank you. This is Sylvia with DREDF. And I was just looking at the, at the Excel sheets between number 4 and number 5. I mean, am I correct that there is overlap between but there are things that would not be caught by one or the other in 4. So the emergency department visit wouldn't necessarily catch individuals who either enter the hospital on their own volition or a family member brought them to the hospital and they were -- not to the emergency department necessarily but for to enter the hospital. And the other would not necessarily catch just an ED visit?

MS. BROOKS: So I think your question, Sylvia, is just like what are the specific differences between measures number 4 and 5 that are included on the slide; is that right?

MEMBER YEE: Right, and whether one is broader than the other.

MS. BROOKS: Okay, okay. So, Andy, correct me if I might be wrong, but it looks like number 4 is specific to hospitalization so it would be in-patient utilization. And then number 5 is emergency department visit so it would be, it could be something that eventually could turn into in-patient. But go ahead if you have any comment.

DR. BASKIN: It's Andy Baskin. If it is an emergency room visit that turns into a hospitalization then it doesn't count in the emergency room department measure. If you are hospitalized because of going to the emergency room for mental illness and you go, and you are hospitalized for mental illness, that becomes a hospitalization. So it does separate the populations out.

MS. BROOKS: Hopefully that answers your question, Silvia.

MEMBER YEE: (Shook head.)

MS. BROOKS: Maybe not so let's -- is there anything we can dive

into a little deeper there for you?

MEMBER YEE: No, I just was wondering how to capture the breadth of people who are basically reaching out for assistance because of a mental health, some relatively urgent mental health issue.

MS. BROOKS: All right. Well, thank you, Sylvia. Thank you, Andy, for that follow-up. Shaini, do we have any other hands raised from the Committee Members?

Any public comment hands raised on this issue?

MS. RODRIGO (OFF MIC): (Inaudible.)

MS. BROOKS: Okay. Yes, we will take that for sure. One moment, sir, we just want to take the on the line first, first, thank you so much.

Elham, you are open, your line is open for comment if you can unmute yourself, please. You should be open for comment at this point. Elham, so you are unmuted and it looks like you should be able to speak, if you can go ahead.

All right. So we have public comment in the room. Why don't we go ahead and take the public comment in the room and then if you want to work on unmuting yourself we will come back to you, Elham, in just a minute. Sir.

REV. SHORTY: Reverend Mac Shorty again. My comment is, it is a great list of six measures. But what you don't see on here is what is the incentive for the patient or the family return. Our streets are filled with mental health people. One of the Committee Members spoke about the homeless people. You need to see about some type of incentive to -- it would be hard enough to be told that you have a mental health disease. It would probably be even harder to follow back up with it. We have to find some kind of incentive for

the patient or the family to continue the therapy or their treatment. If not, this goes on and then it balloons into another different effect of suicide or something else, or killing the whole family because we let it balloon out of control. We hear about these stories every day. We read them in the paper, it is going on all across the country. But what is -- we need to see some type of incentive to get these people to actually -- it is one thing to go to the emergency room for help, there's another to return. Now they lay in the hospital for 30 days. Then there's another thing of I am making sure that person get the right therapy after being hospitalized.

I cannot be diagnosed with cancer if I am not recommended on how to treat it. Mental health is a cancer. We need to figure out not only a way to treat it, to address it, but also to create some type of incentive because the families are the ones who suffer who are suffering the most. Family members because it is a stigma. In every community, the Black, the Brown community, it is a stigma to be diagnosed with mental health family members if you don't have that access.

Nobody wants to call -- when you call 911 for a family member that has a mental health issue two things are going to happen. Somebody is going to die. Somebody is going to die because they send in a law enforcement agent who don't know how to deal with a person with a mental health disease. I don't care, you can hear cities and police department, we gave them training, we gave them training, but yet they kill that mental health patient. It is not acceptable. Thank you.

MS. BROOKS: Thank you for your comments. Very, very important comments, thank you.

IS Elham unmuted at this point? Well, we will just check one more time, Elham, to see if you are able to comment.

MS. WATANABE: Maybe, Elham, I will make a suggestion. There is a little up arrow next to your microphone or your audio and sometimes switching your microphone setting will help. Just something you might try i we are still not able to hear you, you can continue to try to raise your hand.

MS. BROOKS: Okay. Well, Elham, we certainly welcome you to come back and make comments later if you are able. Just to kind of see, are there any additional comments based on public comment on this area specifically? Robyn, you have your hand up.

MEMBER STRONG: Thank you. This is Robyn Strong with the Department of Health Care Access and Information. I just had a bit of a question. Something I heard early in our, in our discussion about these topics was about the low or small denominator. And given that part of our charge is making sure that these measures that we select reach or cover a broad amount of the members.

And I heard somebody asked about anxiety and screening for anxiety and I am wondering with that tool that you mentioned, Dr. Baskin, if the tool for depression screening also covers anxiety or if there is any other standard measure out there that covers that? I am looking at the spreadsheet that we were, we were given with the measures and I can see that there is number 35, for those looking at the spreadsheet, a Mental Health Service Penetration, a Broad Version that looks like it is homegrown by the state of Washington. So being a big fan of measures and standards and that thing, that gives me a little bit of pause if it is not a standard measure, but I am curious about that screening

for anxiety as Reverend Shorty mentioned that, you know, he is looking at the broad community and making sure that those things are picked up.

MS. BROOKS: Thank you, Robyn, for your -- thank you, Robyn, for your comments and questions. Andy, I know you have a couple of comments to respond to that.

DR. BASKIN: Yes, so it's Andy Baskin. Because you were looking at me and mentioned my name I'll respond but I will be brief. I mean, the present screening tool was not in and of itself meant to screen for anxiety. That's not to say that, as Alex mentioned, you can't find some people with anxiety, but it is not, it is not created for that purpose and it is not as sensitive as it need be so wouldn't find enough people with anxiety. I am not aware of a, of a measure out there today that is commonly in use anywhere for screening for anxiety or even treatment of anxiety or around anxiety. I believe there's some great difficulties in that because defining anxiety is a little different than depression. You know, it is such a wide range of what is considered anxiety and it would be maybe a little difficult to define what is the population that screens positive or doesn't. So anyway, it is not out there. It is certainly a big problem as several people have mentioned today but it is not ready for prime time from at least the quality measurement point of view this in existence. Hopefully somebody is taking up somewhere.

MS. BROOKS: Anna Lee, it looks like you have your hand up and then I have a couple of comments. All right, go ahead.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. To Andy's point, I think we are just a little bit early to be talking about a measure for screening for anxiety. I believe it was only maybe

recently the US Preventive Service Task Force came out with a draft recommendation around a universal screening for anxiety in adolescents and older.

So I think we are in a stage now where the groups within our -- that guide us in our clinical recommendations are starting to move forward and heading towards making recommendations around universal screening for anxiety. As those recommendations become more formalized and are published and adopted what I anticipate we would start to see then is measure development around how do we measure the performance on complying with that type of recommendation.

I think we are probably still a little bit early. And given how long these go into regulations, I don't know that we can predict what those measures will be and when they will be available to then have benchmarks that we could use. So I would imagine that could be like a next phase that we will all start to see and, you know, in five years we will all be talking about adopting the anxiety screening measure that NCQA is probably going to develop if those recommendations do go forward.

And similarly I just wanted to comment. Another Committee Member previously mentioned something about depression screening and how those tools can be used younger than age 12. And while that's true clinically, again, I just would emphasize the fact that when we think about broad screening and looking at measuring performance on how we are doing screening our population we should make sure to consider what those clinical recommendations are for providers in that screening. And generally right now we look at what US Preventive Service Task Force recommends or the American

Academy of Pediatrics.

Screening recommendations are broadly recommended for all children starting at age 12 and aren't necessarily being recommended for all children starting at age 6. So I think there you have providers who should make determinations in their office about who may need that screening in a younger age group but it may not be appropriate to look to expand the age ranges beyond what is being recommended kind of from our, from those types of groups.

MS. BROOKS: Perfect, thank you, Anna Lee, that was really helpful and hopefully that responded a little bit to your comments and question, Robyn. All right.

So what I am hearing from the group is that with respect to mental health, the depression screening and follow-up for adolescents and adults is the measure that we would like to include.

And then I think what I am also hearing is that the two measures 4 and 5 here are likely ones that we want to continue to include but may want to have further discussion about in terms of identifying maybe one of the two that might be applicable, but we haven't landed there yet. Is that a good read of the room or am I, did I misread anything? Welcome comments or feedback.

All right, I see no hands so I am going to keep us moving into our break. So we are going to go into a ten minute break now if that is all right for you all, I am sure it is. We will come back -- excuse me. We will come back in ten minutes so just about 3:00 o'clock. Thank you so much.

(Off the record at 2:51 p.m.)

(On the record at 3:02 p.m.)

MS. BROOKS: All right. Welcome back, everyone; we appreciate your rejoining.

So we are going to talk a little bit about substance use now and we will start with some information on substance use disparities. So, similar to what Ignatius shared with us earlier, the California Health Care Foundation has issued some data specific to health disparities by race and ethnicity in California. This was a report in 2021. Just flagging on here the information that's reported on the slides, that the highest rates of drug-induced deaths were among American Indian, Alaska Native, Black and White Californians. And that the highest rate of alcohol-induced deaths were among American Indian and Alaska Native Californians. So with that we will move on to the next slide, please.

Hold on one moment, we are just going to take a break for just one moment, I apologize. All right, so we will just move on to the next slide and I am going to pass it over to Andy who is going to walk through -- we will go one more slide, sorry. All right, Andy, who is going to walk through the measures. Thank you so much, Andy.

DR. BASKIN: Oh, sure thing. So we have a series of measures here on substance use. To understand substance use, focuses on the utilization of substance that leads to significant impairment such as health problems or disability. And you will see that some of the terminology, if you are familiar with some of the older measures and the names may have changed recently. So it includes alcohol, it includes opioids, but it may include other drugs as well that have potentially, that are being used/abused.

So it is a series of measures. They get a little bit complicated. I think we have six of them total that we are going to -- that we have once again

highlighted but you are welcome to add in any of the other measures that you may be aware of.

So we will start out with initiation and engagement of alcohol and other drug abuse. So this is after a diagnosis is made; so a new diagnosis of an alcohol or drug abuse issue. And this is two parts, an initiation phase and an engagement phase. So initiation means that, you know, something has happened in terms of treatment within a 14 day period and then there's a engagement over a longer period of time, I guess it is 34 days.

Follow-up after emergency visit is very similar to some of the follow-up ones we have already seen. So the initiation is that you have gone to the emergency room and the principal diagnosis is alcohol or drug abuse and that some follow-up has occurred within a period of time after that. I don't know whether we are going to slip the slide.

The next one I believe in the order is concurrent use of opioids and benzodiazepines. Obviously a known dangerous combination. And this is literally looking at patients who may be utilizing both of these drugs categories at the same time.

Use of pharmacology for opioid use disorders is rather specific and that is, once again, a diagnosis of opioid use disorder and are they -- is the patient actually receiving medication as part of the treatment plan. Oh boy. And to differentiate that between that one and the pharmacology use even I have to remember.

So the pharmacology. Oh, and this is using pharmacology for a period of time, the pharmacology. They have come from different sources and they look at it differently. So the use of pharmacology is that they are being

treated with medications for the opioid use and the pharmacology use disorder one, number 5, is that they have been on it for a period of time.

And number 6 is literally a measure that when opioids are prescribed that they are prescribed within a dosing amount that is considered less risky, not that all opioids aren't potentially risky, but it is people that are prescribed high doses and how often does that occur; with exceptions for patients with cancer.

They are all different parts of substance use and you -- well, I will open it up for, you know, if anybody has any questions or comments on any of them.

MS. BROOKS: Yes, thanks, Andy. I think a good opportunity for us to just talk a little bit about these measures. If there are any that seem more applicable or appropriate, or kind of what thoughts are from, from the Committee Members. And, Palav, I see your hand is up.

MEMBER BABARIA: Yes, just to help provide some context for number 4 and 5; and they had to look this up to remind myself too because the measures are very similar. And number 4 is the OUD measure, which is on the CMS core set; number 5 is the POD measure, which is on the NCQA HEDIS list, and we at DHCS also went back and forth on both of these measures and which one we wanted to include on our managed care accountability set.

We finally landed on number 5 and the reason is number 4 is really just, it looks at whether you were dispensed one prescription for an opioid use disorder, pharmacotherapy. Number 5 actually looks at how long you are on the treatment for and the percentage of people who had 180 or more covered treatment days for members 16 years and older with a diagnosis of opiate use

disorder. And we felt, you know, in consultation with our clinical experts that that was a better measure because it really got to this idea of, you know, longitudinal treatment of an opiate use disorder and not just a one-time fill which may or may not result in ongoing treatment. So we at DHCS, if it is helpful to others, have been favoring using number 5.

MS. BROOKS: Thank you, Palav. Rick.

MEMBER RIGGS: Hi, Rick Riggs with Cedars-Sinai. So I just want to, I just want to observe that there is really not, in need at least, I was looking at the table, a screening piece, right. So the net is, or the funnel is pretty narrow with regard to initiation and engagement of alcohol or other drug abuse. We are looking at, you know, the initiation, but I don't know where the screening, you know, piece comes from with regard to that. And certainly many of these deal with opioid but I would suspect that alcohol is our biggest offender nationwide in general for all populations. So just some observations. I don't have any recommendations but it is just, just a comment.

MS. MYERS: This is Janel from Sellers Dorsey. I would just point the Committee to the entire list and there are some measures around alcohol screening and follow-up. So if you look on the All Substance Use tab, measures 16, 17 and 18, those seem to be, you know, more pertinent to what you are recommending there. So for those interested I would just direct you to that area of the workbook.

MS. BROOKS: Thank you, Janel. Other comments or questions from Committee Members on these measures specifically? It sounds like -- let me just see if there are any hands. Janel, did you say 15 and 16? Just clarifying.

MS. MYERS: I believe 16 is the start of the alcohol use screening measures.

MS. BROOKS: Sixteen?

MS. MYERS: Mm-hmm.

MS. BROOKS: Okay, perfect. And 17, 18. Thank you.

SPEAKER: I'm sorry, can I just follow-up? The one, it looks like 15 though, is it 15 or 16? I guess it is 16 that is the NCQA measure? Okay.

MS. BROOKS: Doreena.

MEMBER WONG: Yes, thank you, Doreena Wong, ARI. You know, I am not as familiar with the specific usage of the different opioids and alcohol abuse but I guess I was leaning towards -- there's so many here six.

SPEAKER: Four.

MEMBER WONG: They are different but they do seem to be rather, some seem to be a little more narrow. But I was thinking that those that are the candidates for the stratification by race and ethnicity seem to, I guess I was leaning towards those so that we could actually get to, to kind of analyzing it in terms of the racial and ethnic disparities. And so if we had to use some form of screening I might try to use that as one criteria.

MS. BROOKS: Thank you, Doreena. So I think your comment is that with respect to choosing a measure you might take into account what the stratification opportunities are for those measures. Is that what you are saying or am I misunderstanding you?

MEMBER WONG: Correct, yes.

MS. BROOKS: Okay.

MEMBER WONG: I think that, I think that captured it. There

seems to be more opportunity for those that are already identified as possible NCQA stratification measures.

MS. BROOKS: Okay, thank you, thank you for your comment. Other contributions, feedback, thoughts about these measures from Committee Members?

Do we have any non-Committee Members with their hands raised, Shaini?

Do we have any public comment in the room specific to these measures? Yes, sir. Please turn the mic back on, thank you. Sorry, we turned it off earlier. Thank you. There it is.

REV. SHORTY: There we go. Reverend Mac Shorty again, Community Repower Movement in Los Angeles. Substance abuse has been an issue. I was in downtown shopping. Two Caucasian people laid out of their car with their lips turning purple, dying literally in front of me, ODing off of cocaine and fentanyl. I was just on a call maybe two weeks prior with the Drug Enforcement Administration advising that the cartel was attacking citizens of California by making their drugs more addictive.

But what I was happy to see that there are organizations in Los Angeles, pharmacies that are passing out OD kits, little grab bags with NARCAN. I would like to see something like that. More education about it. So because we do have a high rate of ODs among Blacks and Brown and Caucasian people in Los Angeles it is a great subject matter I am very supportive. Whatever we can do to get it down would be greatly appreciated.

But it was just something I had never seen that before myself in my presence. A body literally, I mean, I. My God-brother called me and told me his

25 year old daughter with four kids, two kind of semi-teenagers and two kids that are four and six. She ODed in a mobile home with her boyfriend getting high. The hardest thing was looking at my God-brother trying to explain to his grandkids that perhaps she could have been saved. I know you have only got ten minutes, right, when they OD or they start turning purple. You got ten minutes to get the NARCAN in their system to try to bring them back.

Whatever the state can do. I mean, I don't know what organization when I get back. I mean, a friend gave me three kits I keep in my cars to help people, but it would be a great training for community members because you shouldn't have to see dying like that in front of you.

MS. BROOKS: Thank you, thank you for your comments. Any other? Oh, yeah. So I think just kind of circling back looking at what we have heard from the public and from the Committee Members. Anything? I see your hand up, Andy, but I just want to see if there's any, and Anna Lee, maybe just see if there's any comments from Committee Members that may want to kind of weigh in. Anna Lee, I see your hand up if you want to go ahead.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. I have just always felt like this is an area where measurement has not necessarily always been as robust as what we could hope for, for what we are trying to do from a perspective of improving outcomes. Actually appreciated, Richard, your comment around screening and looking for a measure around screening. I just, I might second a consideration of the NCQA measure for screening for unhealthy alcohol use. I don't know if NCQA is moving in the direction of modifying that measure in the future toward alcohol and drug screening. I think with the relatively recent in the last couple of years

updates to clinical recommendations that might be something we could see happen. But at this stage since that hasn't come out I want to consider that as one that we consider raising up as a possibility in that green list that we can continue to talk about.

And I think it was Doreena, I just appreciated her comment of thinking about which ones might be available for stratification, benchmarking purposes from NCQA. I thought that a comment you had made earlier around what was being used in health plan accreditation might be another way to look at what alignment of these measures, and I didn't know off the top of my head which ones of these might still be part of health -- might be part of health plan accreditation but I was wondering if it might be the ones that are also being proposed for stratification then that could just sort of second Doreena's comment.

And so I am not asking you to answer that question now but maybe that's something we could follow-up on later to see which ones were.

MS. BROOKS: You're getting a lot of homework, Kristine.

MEMBER TOPPE (OFF MIC): (Inaudible.)

MS. BROOKS: Oh, yes, please go ahead and respond.

MEMBER TOPPE: Thank you. I was looking to raise my hand and didn't get there fast enough so thank you for the prompt, Anna Lee. I actually do have that list. Have gone through and like to, as you are discussing the measures to see which ones that we feature as part of health plan accreditation, and the majority of these are. And so they are -- I think that's, that's -- to your point, it is another way we evaluate plans in their, in their annual annually rating plan, so those measures are synched up, the ones that you have chosen so far.

And I think, to circle back to your question or the point about the screening measure, I think that there has been some issues around data access, big surprise. And so that has been one of the challenges with that measure. So I think I can certainly go back to our performance measurement team who is focused on the behavioral health measurement work to see if there's any further exploration. I don't know that that should hold up this round of voting and whatnot, or the decision-making to put measures forward but there is some consideration and I appreciate your points, which I will bring back to our performance measurement team.

MS. BROOKS: Great, thank you, Kristine.

MEMBER TOPPE: Yep.

MS. BROOKS: All right. Stesha, it looks like your hand is up.

MEMBER HODGES: Yes. Stesha Hodges, the California Department of Insurance. I wanted to agree with Doreena's point regarding looking at stratification regarding race and ethnicity, especially when we looked at those previous slides regarding how it is so different and how SUD impacts people based upon race/ethnicity. So I just wanted to echo Doreena's point.

MS. BROOKS: Thank you, Stesha. All right, Diana.

MEMBER DOUGLAS: Thank you. Diana Douglas with Health Access California. Also echoing Doreena's points on which measures have a better ability to be stratified by racial and ethnic data. I think in terms of narrowing it down at all I think measures 1, 2 or 5 stand out to me as the ones that might be most useful in terms of being able to capture who is actually getting treatment.

I do wonder on the second measure related to screening for folks

who are at the emergency department. It does say with a principal diagnosis of alcohol or other drug dependency so I wonder does that, does that exclude those who might have a different principal diagnosis but also need treatment and follow-up for substance use? And if that's the case, then, then if perhaps the first measure that looks at new episodes might be a little bit more useful?

MS. BROOKS: I don't know if any of the clinicians or Andy certainly feel free to weigh in, have any thoughts on Diana's question with respect to measures 1 and 2 here and kind of the differentiation.

DR. BASKIN: Yeah, it's Andy Baskin. It was my understanding of number 1, the initiation engagement, that principal diagnosis is, is it the reason that you, you were in for care. In other words, if you saw a clinician for any reason and, you know, they put a new diagnosis in. It essentially means that you were there because of the, the abuse. The emergency room one is that, it is not like you were in the emergency room because your arm hurt and, and they noted that you have a drug abuse problem after asking you questions.

Once again, it is the diagnosis for which you were discharged from the emergency room, meaning it is the reason you were in the emergency room. So it won't capture all of the folks that have drug abuse but it captures those that theoretically have a new episode or they were sick enough that that's the reason they sought emergency care. It is not all encompassing but there are problems with expanding that to beyond the principal diagnosis because a lot of other things creep in and you don't get a very homogeneous set of patients if you start allowing secondary diagnoses to drive some of these measures so it makes it, makes it rather difficult.

MS. BROOKS: I think, Andy, what I hear you saying is that they

are somewhat similar but capture different. One is specific to the reason for care and one is specific to the diagnosis at discharge, basically, is what you are saying. Okay. Kiran, I see your hand up.

MEMBER SAVAGE-SANGWAN: Yeah, thanks, Sara. Just one clarifying question on I think it is numbers 1 and 2. What age group does that cover? I know it says adolescents but I just want to clarify what age group that is?

MS. BROOKS: Let me take a look. Is that 12 and up or can we take a look at that real quick?

MEMBER SAVAGE-SANGWAN: And then I will just ask my second question. Oh, go ahead.

MS. BROOKS: Go ahead, Kiran, and we'll come back.

MEMBER SAVAGE-SANGWAN: So then my second question is just kind of a curiosity on number 3 and 6 I think, which seemed to get at inappropriate prescribing practices. Which I think is sort of interesting to consider because we know that's a problem in terms of the opioid epidemic and sort of part of what's driving it. But I am just curious if any of our state departments are using those measures and if we are finding, I don't know if this is going to make sense, that using those measures in quality measurement is an effective intervention for that problem of over-prescribing. Like, are we finding success with using those measures in terms of getting to that problem? I am just curious.

MS. BROOKS: So let's start with your second question. Can I ask the state departments if anyone has any kind of thoughts in respect, with respect to Kiran's question?

MS. KANEMARU: Covered California reports on 6, Alice Chen is --

MS. BROOKS: Oh, okay. So sorry. Alex is sitting next to me telling me Covered California reports on 6, reports on number 6, but Alice is not on the line at this time. So number 6 is reported on by Covered Cal. Thank you, Alex. Andy, did you want to speak to Kiran's first question? Anna Lee, did you have thoughts on? Go ahead, Anna Lee.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. I think I heard that the first question was about the first two measures on the first, on the other slide, follow-up from emergency department and initiation and engagement. Both of those measures age range goes to -- starts at 13, my understanding of those NCQA measures.

MS. BROOKS: Okay, so 13-plus, okay. Thank you, Anna Lee. Okay. All right.

MEMBER BABARIA: I'm sorry, was the question just are we reporting on these right now, Kiran?

MEMBER SAVAGE-SANGWAN: The question is, does reporting on those, does it seem to be an effective way of changing prescribing practices? I am just curious. Like is it working? Is having, is having plans report on those working in terms of changing prescribing practices?

MEMBER BABARIA: Yes, I think we have had all of these on the MCAS, some held to the accountability level, many just reporting only. I will say for the same reasons I mentioned earlier we switched from number 4 to number 5 because we found it to be a more meaningful metric.

We had a good internal analysis that Kelly Piper really weighed in on for number 3. And 6 we actually, I need to go back and check if we formally

retired them or we sort of deprioritized them. But for both of those there was feedback and concern that reporting on these actually sort of encouraged patient dumping for those who are on high doses and, you know, the providers either were not equipped or unable to safely taper.

And then same with the opioids and benzodiazepines. Not that they are not clinically important but the behaviors, we wanted to see sort of what happened out there and so we purposefully are moving away from number 3 and 6 for those reasons.

MEMBER SAVAGE-SANGWAN: That's super helpful. That's kind of what I was wondering, what happens when you use those measures, so thank you.

MEMBER BABARIA: The other ones there's lots of opportunity. I mean, I think there are limitations that you have a diagnosis but, you know, we are nowhere near sort of the higher end of some of these other measures.

MS. BROOKS: Thank you, Palav. Rick.

MEMBER RIGGS: Rick Riggs, Cedars-Sinai. So I just wanted to point out with the primary diagnosis piece that it is not unusual in our trauma center for folks to come in and they are, you know, they have fallen or they have had some type of accident or involved in some kind of altercation and it is doubtful that that number one diagnosis is going to be, you know, drug abuse or intoxication; and yet there's a lot of presenting, you know, patients in that particular arena. So I know, I understand to try to help report on follow-up pieces of it with regard to these, these two. And it also gets to your point, it reinforces the point that they are going to have to have follow-up for the other stuff that they are there for, right? So it may dilute out the actual alcohol and other drug use

treatments. So it is just, just attention that I think I don't know how to solve but it is also part of -- that's, that's the presenting. Not many people come in and say, I am here to, I need to get enrolled in some type of treatment, I need help.

MS. BROOKS: Thank you, Rick. Silvia.

MEMBER YEE: Hi, thank you. This is Silvia with DREDF. And I actually, it is great, I wanted to follow on the point that Rick was saying too, and I am thinking of the race and ethnic implications of that. Particularly individuals who might have been, you know, they get to the hospital through some kind of altercation, the police were called or something else happens, and they are not necessarily going to wind up with a primary diagnosis of substance abuse. Other things will be on that record that yes, may seem to confuse the issue, but I think it is more likely to happen to people who are non-white and also people with disabilities who may be presenting with other things as well, possibly pretty urgent things, multiple conditions, and it is not, again, not a primary diagnosis. But I think that is likely to happen more to populations who are already vulnerable for other factors.

MS. BROOKS: Thank you, Silvia, great comments. Kristine.

MEMBER TOPPE: Hi, Kristine Toppe, NCQA. I wanted to follow-up the point I shared earlier following Dr. Amarnath's point about accreditation and use of measures. And just to confirm that of the six measures chosen or selected here, 1 and 5 are also used in health plan accreditation and our ratings.

MS. BROOKS: Thank you, Kristine. One and 5, okay. Julia.

MEMBER LOGAN: Thanks, Julia Logan, CalPERS. I just wanted to let you all know that we are, CalPERS is moving away from 3 and 6 for the

very reasons that Palav mentioned around unintended consequences and focusing on 5,e pharmacotherapy for opioid use disorder.

MS. BROOKS: Thank you, Julia. Go ahead, Andy.

DR. BASKIN: Quick question. I don't know whether Kristine may know the answer or could quickly find out or maybe Janel on the phone can. The principal diagnosis is the emergency room visit follow-up but I don't think it is the initiation and engagement of alcohol, right? It is just a new episode. It doesn't have to be -- you could go into your doctor's offices and have gotten that diagnosis, I think. We would should check into that because I am not, I don't think that is necessarily a principal diagnosis issue on number 1. I think it is only the emergency room follow-up where it has to be a principal diagnosis.

MS. MYERS: Hey, Andy, it's Janel. That is correct, there is a principal diagnosis required for the initiation measure.

DR. BASKIN: New diagnosis is what it is. It is a new episode of -- for the number 1 measure.

MS. BROOKS: Okay, that's helpful. All right. Well, just to kind of wrap back around in terms of what I am hearing from the group here. There was a, there were a lot of comments on number 5, pharmacotherapy for opioid use disorder. Sorry, I'm great with all these words. So I definitely heard some reinforcement for including that.

I didn't hear a lot on the other metrics in terms of consensus and so just wanted to kind of put that out there before we move on to the next focus area, see if there are any comments? All right. We have comments, I put it out there. All right, Bill, go ahead.

MEMBER BARCELLONA: Okay, Bill Barcellona, APG. Yeah, I am

persuaded to go with number 5.

MS. BROOKS: Thank you, Bill.

MEMBER RIGGS: This is Rick Riggs, Cedar-Sinai. I do think we should maybe consider the screening piece, the one that was on the second list. The NCQA measure, number 16 maybe I think it was, is that right?

MS. BROOKS: Number 16?

MEMBER RIGGS: Yes, that one.

MS. BROOKS: Okay. Alex, all right. So we will add that, number 16, I'm sure it has a name. There we go, thank you. All right. So substance use measures. We have talked about substance use measures and we are going to move into the next slide, please. And the next slide.

All right, we are going to talk about birthing persons and children disparities. So according to the California Health Care Foundation, the lowest rate of first trimester prenatal care are amongst American Indian and Alaska Native, Native Hawaiian and Pacific Islander and Black Californians, so they have the lowest rate of first trimester prenatal care.

The Black Californians have the highest rate of maternal mortality.

The highest rate of infant mortality was among Black, American Indian and Alaska Native and Native Hawaiian and Pacific Islander Californians.

So with that we are going to talk a little bit about some of the measures specific to this area. Andy, you are going to walk through them. They are on the slides just like we have been going through them and we will keep on with our discussion here.

MS. BROOKS: Thank you, this is Andy Baskin here. So this set of measures, we will talk about birthing first. Let's see, there's three on this one

and there's how many on the next one? Okay -- (off-mic discussion). Well, the birthing first we'll do so that will be the first six, I think, right? Yes, okay, I think it's about five or six, okay. I get the list in front of me.

The cesarean rate for nulliparous. So this is basically your first birth. This is your basic low-risk pregnancy and therefore the likelihood that you have a cesarean section should be very, very low. And we know that there is a cesarean section issue in this country compared to many other countries where there's just a lot of cesarean births that are thought to be potentially unnecessary. So this is a theoretically uncomplicated pregnancy that should have a low cesarean rate.

The prenatal immunization status is basically the immunizations that are specific to -- checked at the time of pregnancy which is basically influenza, tetanus, diphtheria, and pertussis. So what's called a TDAP, that's a combination of tetanus, diphtheria and pertussis, which is given to all of us when we are children as well. And the influenza vaccine to make sure that the mother is up to date on those at some point during the pregnancy.

Prenatal depression screening is pretty obvious what it is, it is depression screening prior to the birth.

But the next one is the postnatal or postpartum depression screening, which is the one you hear about more, even in the lay press. I mean, we are all aware of an issue with postpartum depression and there's actually some new recent treatments for that which make it even more important to screen for postpartum depression.

Prenatal postpartum care is essentially that you have gotten visits in a timely fashion and enough visits prior to birth and then after birth.

And contraceptive care. While there are a bunch of measures out there, the only one that is being used with any real frequency at all seems to be the one that we put here as a contraceptive care postpartum. This is basically the provision of a long-acting type of contraceptive, a long-acting, reversible method of contraception is what LARC stands for, LARC. Oh, it not even in the title, okay, but it is part of the title long.

And there's a couple of rates and that is the one that's where you can actually introduce this contraceptive care during the hospitalization for the pregnancy before the mother is actually discharged or within days of discharge and then there's a longer time period of doing it within 60 days. And is an interesting measure. It gets into a topic that is potentially controversial but nevertheless it is something that is recommended to be offered and it seems to be under-utilized and therefore the risk of a recurrent, another pregnancy very early after a recent pregnancy is a great problem.

Anyway, I will stop with that and entertain questions and, of course, open the discussion.

MS. BROOKS: Thanks, Andy. So we will open it up and talk about the initial kind of birthing, postpartum, prenatal measures that Andy just outlined and I see Kiran has her hand up.

MEMBER SAVAGE-SANGWAN: So my kind of question is, or comment. Like I think, I think it is important to do the prenatal and postpartum care one. But I am curious about number 1 and why that is not a candidate for stratification, NCQA stratification? Is it that is too small a number? Is it, you know, because it surprises me that we can't at least look at that and see that we do more inappropriate C-sections on Black women than white women, right?

And I think that from the perspective of the big, the sort of biggest disparities, both in health care and specifically for birthing persons, like, that is one where we understand the problem not only to be inappropriate or lack of prenatal care but really the problem to be how Black women who are giving birth are treated in a hospital, right, and that it is different, and that it leads to worse outcomes.

And I am not sure that any of these measures except for maybe number 1 get at that and I think it is really important that we, we sort of very squarely target that problem. And so I am just curious if there's any other measures that departments have considered that sort of get more at that as well or why number 1 can't be stratified or isn't a candidate for stratification?

MS. BROOKS: Let me have Kristine address the stratification question specific to NCQA first.

MEMBER TOPPE: Thanks, Kristine Toppe, NCQA. So this particular measure is not an NCQA measure, it is a joint commission measure, so I don't know if they are exploring how to stratify or what the application of stratification would be to another measure developer's measure. So just, unfortunately, I don't have that, the detail for how that would go.

MS. BROOKS: And you do not have all --

MEMBER BABARIA: I can maybe speak to that if it's helpful. So yeah, we in, at DHCS this is one of the measures that we actually added to our managed care accountability set for this year for that very reason, Kiran. We as a state have made progress on reducing C-section rates for nulliparous singleton vertex births and yet there are deep disparities with significantly higher rates for Black California birthing persons. When you do look at the facility level or the

plan level, the Ns can get small for the stratifications so we are still going to be looking at the stratifications but, you know, the Ns may be too small to report or do any sort of accountability on it. But you can still look at it, it is just that you will have some small Ns.

And I will say for California, because of the California Maternity Care Coordinating Committee and their data center that almost all of our state hospitals participate in, we do have more of this data and more of this data stratified by race and ethnicity down to the provider level than many other states do, which makes it an easier lift.

MS. BROOKS: Thank you, Palav.

MEMBER SAVAGE-SANGWAN: Thanks, that's helpful, and in that case I would, I would advocate to put number 1 on the list as well as the prenatal and postpartum care one.

MS. BROOKS: As well as which one, I'm sorry?

MEMBER SAVAGE-SANGWAN: I think it was 5, the prenatal and postpartum care.

MS. BROOKS: Oh, 5, okay, perfect. Sorry, I just want to make sure I got it from you, thank you so much. All right, good discussion. Ed.

MEMBER JUHN: Ed from Inland Empire Health Plan. Are we just making comments on the six that have been shared?

MS. BROOKS: Just the six to start.

MEMBER JUHN: Okay. So two things that come to mind are number 2, the prenatal immunization status. Again, you know, I think there could potentially be challenges with flu data sources if flu is included in that measure. And again, I think there is a lot of great birthing persons and children measures

but I just wanted to make that call-out as a potential thing to keep an eye on for the prenatal immunization status.

And the second in this list is around contraceptive care postpartum. And I am not sure if I am most up to date but I do believe these measures were removed from MCAS measure set and replaced by the contraceptive care all women measure. So I just want to, again, make note of that, that number 6 on that list may not be the most up-to-date measure as it I believe was replaced, so.

MS. BROOKS: Okay. Palav, do you have any specifics on that measure and if it was replaced or not or? I think it is number 6, the contraceptive care.

MEMBER BABARIA: I am refreshing my memory right now and yes, that is correct. We replaced it. Well, we narrowed. We had I think like ten contraceptive measures and then we narrowed it down to contraceptive care, all women, most are moderate. Effective contraception as well as contraceptive care postpartum women, most or moderately effective contraception, which is a little bit broader than the LARC measure. So it is the CCP MME CCP.

MS. BROOKS: Thanks, Palav. Any other comments or questions about these initial six measures that we have looked at? Kristine is raising her hand.

MEMBER TOPPE (OFF MIC): (Inaudible) Sorry.

MS. BROOKS: You have raised your hand, go ahead.

MEMBER TOPPE: Technically challenged today. I just wanted to confirm that number -- measure -- sorry. Of the six measures, number two and number five are also part of the NCQA required measures for health plan accreditation.

MS. BROOKS: Thank you, Kristine. All right, Jeff.

MEMBER REYNOSO: Just Jeff with LCHC. A quick clarifying question for the prenatal/postpartum care. Does the postpartum care component include education and interventions for supporting breast-feeding individuals and persons? I believe that's also one of the US Preventive Task Force proposed recommendations; just curious around that.

MS. BROOKS: I will look to my clinical experts. Go ahead, Anna Lee.

MEMBER AMARNATH: Hi, Anna Lee Amarnath, Integrated Healthcare Association. I think you make a great point because the content of a visit is incredibly important if we are thinking about outcomes for patients. But I believe these two measures are more about the visit occurring and not the content of the visit. So just simply that a visit has occurred within a recommended window of time for that visit. So I just think you make a wonderful point about the content of the visit potentially being something that might be valuable to consider, which gets at other types of measures on the list like immunizations being done, depression screening being done. I am not aware of a measure around feeding support but there may be something out there I am not aware of.

MS. BROOKS: Thank you, Anna Lee; and great question, Jeff. Other questions or comments? What I think I hear -- oh, we have one, Doreena, I apologize. Go ahead, Doreena.

MEMBER WONG: Thank you. Doreena, Doreena from ARI. This is a question and I am not sure if there is a measure for this per se but if -- the health disparities in terms of mortality rates based on race. Are we going to try

to collect data on that from the plans?

MS. BROOKS: Your question is if we would be collecting data. Can you --

MEMBER WONG: Right. Well, well, just having a measure, a measure to look at the kind of the maternal, you know, maternal death rates or even infant mortality death rates, you know, from their members overall. Just because we already know there are disparities around that, to see how if there's a problem and then seeing how it might be addressed?

MS. BROOKS: Well, I think certainly --

MEMBER WONG: Does that make sense?

MS. BROOKS: Oh, go ahead, sorry.

MEMBER WONG: No, no, I am just, I am just trying, and perhaps I am not articulating it very well. But I guess I am trying to get to some way to, to evaluate how the, how the plans are doing in terms of providing, you know, prenatal and pregnancy care and preventing maternal and child, you know, death rates for the mothers or birthing persons and their children.

MS. BROOKS: So I think you are raising a very important issue, Doreena. And just to kind of clarify, right now the process that we are going through is identifying the measures that we may look at and then we will certainly have, potentially have discussion around what kind of potential stratification might need to occur and what is possible given the data that is collected and not collected and what is the wish list and all those different things. So that's a part of our discussion, but we are -- so I just want to be clear that we are not, not addressing that right now, we are just looking at the measures themselves specifically and then highlighting and looking at what kind of disparities we know

already exist in California and at the national level specific to these measures.

Palav, it looks like you may have a comment.

MEMBER BABARIA: Yeah, just in response to Doreena.

MS. BROOKS: Yes.

MEMBER BABARIA: You know, I think this is something that we struggle with a lot at the state level where we certainly have morbidity and mortality data at the state or regional level. When you get down to the individual plan level, you know, thankfully, because this is, you know, it is a horrible event when it occurs, but relative to population size it is still a relatively infrequent event so the sort of individual denominators and numerators for each plan became really small. So doing mortality at the plan level, you know, not just for maternal mortality but a lot of different mortality N points is really challenging.

I think we do, you know, the whole country but especially California recognizes how limited some of these measures are, right. Just someone shows up for a prenatal visit or a postpartum visit, it doesn't actually tell you what the quality of care was that was provided at that visit and was everything done that was possible to prevent an adverse outcome for that birthing individual and their child.

So we are working in collaboration with Covered California and CalPERS and the national partners to think about sort of measure development in this space and what can we do to create better, more robust measures around clinical interventions that we know that work to reduce morbidity and mortality. And so over time, you know, I think the hope of all of us state partners is definitely to bring those measures forward to this committee and replace some of these more utilization-based measures with actual, clinical interventions that we

know drive ultimate morbidity and mortality reduction.

MS. BROOKS: Thank you, Palav. Hopefully that addresses a little bit of your question and comment, Doreena. Other questions or comments?

MEMBER WONG: Yes, thank you.

MS. BROOKS: Thank you, Doreena.

What I am kind of hearing from you all is around these six measures here is that the cesarean rate for nulliparous singleton vertex, I am sure I said that wrong, is one that we should highlight for inclusion on the list. And then prenatal and postpartum care, the fifth measure specifically, are ones that we should highlight. Are there, am I misreading the room? I want to also make sure that we have an opportunity for public comment as well on these measures. Just wanted to kind of see before we move forward to the next section of measures that we, that I kind of get a read. Go ahead, Rick, I see you have a question.

MEMBER RIGGS: Sorry I didn't get to the Zoom. It is a comment, Rick Riggs from Cedars-Sinai, that our problem with that particular measure, number one --

MS. BROOKS: Number one.

MEMBER RIGGS: -- is really in relationship to high SCS populations. So just that people want theirs scheduled on this date and this time and that's often what drives our rate. The measure in and of itself I think points to appropriate care and we continue to drive that down where we can, but it does, it may vary from community to community.

MS. BROOKS: Okay, thank you. That's a great comment, thank you for sharing that. Okay. All right.

So we are going to move on to the next section of measures. You know, we heard a little bit or a lot last month from you all and it was important with respect to comments on discussing well child visits and annual dental visit measures and we have included those here for some discussion. I know, Andy, you are going to dive into those now.

DR. BASKIN: Okay, so this is an interesting list. Some of them are pretty obvious.

So developmental screening in the first 36 months of life is pretty obvious and there's ways to build for that so it is pretty easy to capture nowadays. So that's the content within a visit so that is something that occurs within the visit, so the visit actually has to occur for that to happen.

The second one, number 8 there, is well-child visits in the first 30 months of life. So, you know, there's a certain number of visits that have to occur by certain dates, this is essentially what these are. And once again nothing to do with the content of the visit, simply that the visit did occur.

The well-child visits you can see then we go past the first 30 months of life into the third, fourth, fifth and sixth years. So once again there's a pretty prescribed list of recommended numbers of visits and the frequency of those visits. And this is that they have occurred and occurred on time, by the way. So you know, if you made your third and fourth year one but you didn't make the fifth one by a certain date relative to your birth date then you wouldn't have met the measure.

Child and adolescent well-care visits just continues on into a later age group where the visits become less, less frequent and over a period of time. And the next slide.

Childhood immunization status. Now here there's a whole series of measures. Those of you familiar with NCQA HEDIS know there are many, many combinations that are being measured. Did we particularly do combo, a particular combo on this one? I thought we picked 10 as the most --

MS. MYERS: Hi, this is Janel. We didn't specify a combo but combo-10 is the one that is being more widely used in the California programs, yes.

DR. BASKIN: Yes, 10 is the most commonly used in programs but it doesn't have to, we don't have to limit ourselves to that. And the 10 just means that in includes ten vaccinations so it is more inclusive of how many different vaccinations are appropriately recommended to be -- so it is the widest view.

Immunizations in adolescents is a much smaller subset of vaccines which includes, where are they, meningococcal and the tetanus-diphtheria-pertussis combination. And then there's also the HPV or Human Papilloma Virus series. And that can also be reported out in different ways with or without the HPV, I think, is generally what comes up in those conversations because there's a little more controversy of the HPV part and so you can consider which way you'd want to do that.

Weight assessment and counseling. This is a -- this is a screening measure for obesity that we talked about earlier. This one is specific to children, the age group being, does anybody have it in front of them? Let's see. Three to 17 years of age. And that's because there is a specific guideline out there by a national organization recommending this. And this is not just the screening but it is that if they screened positive that there's some counseling or some initiation of some recommendation being made.

And I think that's the set of measures for children that we have --

MS. BROOKS: There's four more. You don't get off that easy.

DR. BASKIN: Oh, there's one more? Oh, I forgot about those, yes. It did seem a little too easy, you're right.

Appropriate testing for pharyngitis. This is basically that, that if you have a sore throat that you were tested for strep throat before you are prescribed an antibiotic. It is a very focused one, but a very common problem and one that is not always met from the clinical recommendation.

Metabolic monitoring. So this is specific to children and adolescents who are an antipsychotic medications and there are some issues with risks of diabetes and other, other changes in the blood that can occur where children should be monitored on a regular basis. It is a very focused population but nevertheless it is one that is used in some of our programs today.

Topical fluoride varnish for children is what it says, it is a recommendation that it occur. And the questionnaire of course.

That and the next one, the annual dental visit, is that in the Medicaid plans maybe it is a, it is a covered benefit but it is not necessarily in the commercial plans, just as a point of information, so it is not a measure. These are not measures that are often used in commercial core sets but certainly could be entertained.

I think I truly can say that was the last now.

MS. BROOKS: Especially the last one, you're right. All right. So I see Ed's hand is up.

MEMBER JUHN: Thanks. Ed from Inland Empire Health Plan. I just want to clarify for numbers 17 and 18 for the dental measures. I believe that

we are not covered by the -- these are not covered by the health plans so these two measures will be a little bit harder for us to track and report on.

If we go to the top, the two things that jump to mind is for well-child visits in and the third, fourth, fifth and sixth year. Again, if I am not mistaken, this measure was retired by HEDIS NCQA, I believe it was replaced by the child and adolescent well-care visits.

SPEAKER (OFF MIC): (Inaudible.)

MEMBER JUHN: No, for the well-child visits in the third, fourth, fifth and sixth years, that's number 9, bullet number 9. And I believe those were replaced with the ones below, child and adolescent well-care visits. So just to call that out.

And the other piece is for, let me see, for the immunizations for adolescents. There were two in the chart but I am assuming that that's referring to combo-2, is that correct?

DR. BASKIN: Adolescents. And I believe, as I --

MS. MYERS: Hi, this is Janel from Sellers Dorsey. Combo-1 and combo-2 are both listed, that's correct.

MEMBER JUHN: So would we be proposing to do both or one or the other?

MS. MYERS: I think that would be the decision of the Committee.

MEMBER JUHN: Okay. So I guess for, for me just a potential comment would be if we are to select immunization for adolescents that we focus on combo-2. And those are the only other, those are the ones that I just noticed. The rest, you know, would work well, but the ones I am calling out are the ones that come to mind.

MS. BROOKS: Great, thank you. And I think your initial comment with respect to 16 and 17 is that the Medi-Cal plans are not responsible for the dental care; is that what you were saying?

MEMBER JUHN: Yes, 17 and 18.

MS. BROOKS: So 17 and 18, I'm sorry.

MEMBER BABARIA: It was just -- it was that we actually added fluoride varnish to our managed care accountability set this year as of year 17. Or as of this year for number 17, I should say.

MS. BROOKS: Okay, thank you, Palav. Anna Lee.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. I think I had a lot of similar comments that Ed just had and so I won't repeat them. I think most health plans won't have the data on dental visits if they aren't paying dental providers so that one might be a little bit difficult unless DMHC is thinking of requiring that data to be gathered and submitted some other way, so that's just something I wanted to think about.

When it comes to fluoride varnish I am a huge proponent of primary care providers providing topical dental fluoride varnish in the office because it is not only recommended but really easy to do. Having said that, I was just curious which measure you are actually recommending here because some of the ways that this data is collected and then reported sometimes includes codes that represent the provision of dental fluoride varnish in dental offices. And again, then we have a similar problem where I am not sure where we are thinking of getting from but who are we holding accountable. I would assume that we are targeting the primary care providers that are recommended to do varnish as part of well visits. But I am not sure this measure necessarily

captures that so I was feeling a little hesitant about those.

I also wanted to just mention with measure 14 around appropriate testing for pharyngitis. It is all about making sure we are not over-prescribing antibiotics, but I just recognized in an earlier conversation this Committee wasn't feeling very strongly around a similar measure around appropriate not-prescribing antibiotics for acute bronchitis. And so I was wondering would there be a, I wasn't feeling very strongly about that measure here and I didn't know if the committee would feel that it was a larger problem for kids with sore throats getting inappropriate antibiotics or is it a larger, you know, when it comes to people coming in with coughs getting antibiotics appropriately? I think we see it across the spectrum. But if it -- I was just reflecting that it would seem odd to include it in one area and not the other so I am not sure if we see it as a disproportionate problem with anyone, as an opinion.

And then my last comment was on number 15 where I recognize this is important for a very small group of people who are children, adolescents receiving a specific medication that is not as common. I think we might run into problems with denominator size when thinking about health plans reporting this measure.

So that was my long-winded way of saying the last slide of measures where I wasn't as strongly in favor of, whereas as we looked at the first two slides worth of measures, thank you for pointing out the one that was retired, Ed, I agree with you, I largely felt that a lot of these were quite important to consider moving forward. So I guess that's my way of saying I recommend maybe the last handful don't quite make the cut, in my opinion.

MS. BROOKS: Got it. Thank you, Anna Lee, that is great input.

Kiran.

MEMBER SAVAGE-SANGWAN: Thanks. One question I have is just for the child and adolescent well-care visits. I know that's just assessing whether or not the child made it to the visit and had the visit but is it sort of standard of care for one or multiple of those visits to include the developmental screening that is referenced in 7, is one question I have.

And then for the adolescent immunizations, I think if I am reading the Excel sheet correctly, I agree with combo-2. I want to make sure that's the one that includes the HPV vaccine because I think that we have a huge problem around misinformation in the HPV vaccine, it is important to increase those rates.

And then final comment is I do think we should take a look at the fluoride varnish because I do think, you know, there's huge disparities in terms of the kids who get that and kids who don't and it is, as Anna Lee said, something that can happen in primary care.

MS. BROOKS: Thank you, Kiran. Jeff.

MEMBER REYNOSO: Yes, Jeff with LCHC. I actually was going to make the same comment that Kiran just made on the recommendation to include the fluoride varnish. In our focus groups with Latino community across California this is an area where we see the greatest disparities in lack of access to oral health services so we would be in favor of that.

And also wanted to support in addition to immunizations the weight assessment and counseling for nutrition and physical activity in children. Just from a populational perspective, we have a lot of issues with overweight and obesity in communities across California and would want some greater attention paid or focus on this area.

MS. BROOKS: Thank you, Jeff. Kristine, you have raised your hand.

MEMBER TOPPE: I've learned how to raise my hand. Kristine Toppe, NCQA. I wanted to follow-up on the comment that Dr. Amaranth and Dr. Juhn made around the retirement of the well-child visit measure. We reorganized the well-child visit measures to align on ages so we may need to just follow-up and provide like a new way it is classified. But well-child 30 is the acronym, is the short name for it, which covers zero to 15 months and then 15 months to 30 months. And then well-child visits covers 30 -- excuse me, 3 years to 21 years. So I apologize that I didn't catch that in advance of this but I can circle back, you know, this week, and clarify kind of what those specifications are and then what the (inaudible) so the group has the benefit of that, that reorganizing of the measure.

The other point I wanted to add was that for the purposes of accreditation, measures 11, 12, 13, 14, 15 and 18. While 18 I think we just heard are not necessarily relevant for California are included in accreditation for states that offer dental through Medicaid, that's a Medicaid-specific measure. Do you want me to repeat the numbers?

MS. BROOKS: That would be helpful, thank you.

MEMBER TOPPE: Sure, 11, 12, 13, 14, 15 and I don't think 18 is applicable here.

MS. BROOKS: Okay, thank you, Kristine, that was very helpful. All right. Other comments or questions from the Committee? I know we have a couple of public comments so we will go ahead and take those, Shaini, if that works from the computer online. Oh, I see Bill. Bill, you have your hand up.

MEMBER BARCELLONA: Thank you, Bill Barcellona, APG. I want to join in and on that recommendation on number 17, the fluoride varnish. I remember seeing some data on that and that's a very effective measure so that's my vote.

MS. BROOKS: Thank you, Bill. All right. All right, Shaini, do we have anybody? Doreena.

MEMBER WONG: Yes, thank you, Doreena from ARI. I like the, the idea of including a measure to look at some oral health issues and so I would support actually the -- either, I guess, the fluoride varnish or even the dental visits. I actually like the measure in the prevention section that was broader than just a dental visit, it was an oral health assessment, but understanding that some of the plans, commercial plans aren't required to do it. And if that would make it harder to use then I think I would support the fluoride varnish measure because I do think there might be some health disparities within that particular, you know, that particular service and would like to see that included. There would be one oral health measure in our, you know, in our standards.

MS. BROOKS: Thank you, Doreena, we have marked you down for dental fluoride varnish. All right. Anna Lee.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. I think mine was more of just a specific technical question on that measure because I am all for -- I as a primary care provider, I am all for doing it in the office. I wanted to make sure. I don't know this one because it looks like it was from, you are recommending a measure that the Oregon Health Authority has kind of modified and I just wanted to make sure. Does it include giving credit for dental providers doing fluoride varnish? Because

I just wanted to know if we were thinking about that. That was my question. I think sometimes that can, dental providers providing that service doesn't negate the recommendation that primary care providers should be providing that service. And so one of the things that can sometimes happens when you count that it is being provided in the dental office it is almost like the primary care providers get off the hook. And so I just was wondering if anyone knew, because I am not as familiar with this Oregon Health Authority measure, if they include dental codes and the dentists doing it or are we really targeting the primary care providers with this one?

MS. BROOKS: So I am going to tell you that I think this -- Ignatius unfortunately had to drop off for personal reasons and I know he has a lot of background on this. We will follow back up on this, on your question and circle back; it is a good question that you are asking. Let's see, Sylvia.

MEMBER YEE: Hi, this is Sylvia with DREDF. I was just wondering about number 7, the developmental screening in the first 36 months of life. California has a pretty strong regional system, a system of services for people who have, for children who have developmental needs, and data from that indicates unequal access. And I, so I, I just think that it would be, and so I am one of the few that are really kind of looking at potential developmental disabilities and capturing that in children, so I just wanted to raise that as something to, to really consider as well.

MS. BROOKS: Thank you, Silvia. Janel, I see you put your hand up, do you have a comment on that?

MS. MYERS: I do, Sarah, but this is to the last question so I don't know if you want me to.

MS. BROOKS: Okay, okay. We will come back real quick, Janel, after Sylvia and Diana go, if that's okay.

So, Sylvia, it sounds like certainly well-child visits is something that's a priority to you and is important to you. Kristine kind of outlined that there have been some modifications to some of those measures and so we are going to circle back on that with the group and with her and talk more about that. But I think hearing from you and from others that this is a priority to the workgroup. Thank you. All right, Diana.

MEMBER DOUGLAS: Thank you. Diana Douglas with Health Access California. I think in terms of priorities of these measures I would be looking at number 5, the prenatal and postpartum care, or the measures 7 through 9, the developmental screening or well-child visits. But again, I think also considering which can be best stratified to capture disparities. And I think those are just from, from my knowledge base, the ones that are maybe best, best equipped to capture inequities across the system. Which is not to say that, you know, I wouldn't support potential inclusion of the other ones. I do think it is important at some point as we are considering measures across all of the different areas to include oral health as well. Thank you.

MS. BROOKS: Thank you, Diana.

All right, Janel, did you want to speak to that question that Anna Lee had real quick?

MS. MYERS: Yeah, I wanted to clarify. So that measure by the Oregon Health Authority was recommended to us. But there is a separate measure that is created by the Dental Quality Alliance and it does allow for treatment by, you know, primary care physicians as well as dental physician so

that could be another measure that we incorporate in the list. Because I agree with you that the difference in who can provide the care is something worth considering for this measure.

MS. BROOKS: Thanks, Janel. All right. So, Shaini, I am going to ask you to pull up, it looks like Beth, for comment.

MS. CAPELL: Hi, Beth Capell with Health Access. Can you hear me?

MS. BROOKS: Yes, we can hear you, Beth.

MS. CAPELL: Thank you. Three points. First of all, I think it would be helpful to know which measures NCQA has retired or is contemplating retiring. Not that that should govern everything but it would just be helpful to us to know, to this conversation to know that, it keeps coming up.

Second, and this was triggered in part by the discussion around birthing persons. These measures are going to be in place for at least five years after this committee decides, then there is going to be a regulatory process. So you should think that these will be locked in for five to seven years. So as you think about specifics, whether it is type of contraception or the content of a postpartum visit, I just encourage people to remember that we are locking things in for a long time so we should be pretty confident that we are doing -- that that's what we want.

And then the third point to Silvia. In my experience the only way you get to the regional center is when your child is screened in the first 36 months of life and the physician refers you to the regional center. And so that 36, that developmental screen in the first 36 months of life in terms of developmental disabilities is really important and the disparities are well

established.

MS. BROOKS: Thank you, Beth, we appreciate your comments.

MS. CAPELL: Thank you.

MS. BROOKS: I think we have -- go ahead, Beth, sorry.

MS. CAPELL: Thank you.

MS. BROOKS: I think we have one more. Thank you, Beth. I think we have one more comment; is that right, Shaini?

MS. MCMAHON: Hi.

MS. BROOKS: I think you went back on mute.

MS. MCMAHON: Thank you, yep.

MS. BROOKS: Okay, we can hear you now.

MS. MCMAHON: Katie McMahon with Molina Healthcare. I would nominate the well-child visits, the child and adolescent well-care visits. My hesitancy with including the weight assessment counseling for the BMI nutrition and physical activity is you are excluding the children that haven't had a PCP visit that year. That measure, those three sub-measures are looking at folks that did have a well-child visit so I think the better approach would be looking at assessing the population that is coming in with the assumption that the PCP is doing a complete, robust, well-child visit which should include those three components as well as developmental screening. So the well-child 30, the WCV child, adolescents, and then the immunizations both for children combo-10 as well as immunizations for adolescents combo-2.

MS. BROOKS: Thank you so much.

MS. MCMAHON: And I echo the IEHP perspective on the difficulty as a health plan obtaining the annual dental visit data. I understand the push

and the concern with the dental varnish in the PCP space. Some barriers we have been running into in really stressing the importance of that measure this year is PCPs feeling if the child has recently had a dental visit and it included a dental fluoride varnish application they don't want to re-administer if it is within clinical guidelines. But certainly appreciate if a child hasn't had that they definitely need to but and appreciate needing an oral health measurement of some sort. Thank you.

MS. BROOKS: Thank you so much for your comments. Shaini, do we have any other public comments online?

Do we have any public comments in the room? I don't believe so, so we will move on to our next focus area so next slide, please. Next slide, thank you. All right.

So we are going to talk a little bit about access now. And we have -- you know what, I just, I made a mistake. I am sorry, I'll just own it, I didn't go through and summarize what I heard from you all, I apologize. You could have called me on it, Rick, that would have been, I apologize. All right.

So what I hear from -- what I heard from you all was, in particular, the -- you are not going to make me say it again. The first measure on cesarean rates is one that we should include. Prenatal and postpartum care, which was the fifth measure, we should include. It sounds like well-child visits we need to get some clarification with NCQA but we should include those for future discussion. Immunizations, combo-2 is what I heard. And then topical fluoride varnish for children. Did I miss anything there? Rick, am I good? All right, we are good. All right, thank you, sorry about that and I will be better about that moving forward. All right.

So we are on to access and we are going to talk a little bit about disparities. Ignatius, I think you have joined us again, is that right?

MR. BAU: That's right. So we know that access continues to be a challenge for a lot of folks. So again, looking at this data, the highest difficulty in finding a primary care physician were among Black, multiracial and Latinx Californians. Next slide.

But we also know, unfortunately, aside from insurance, that there aren't necessarily great measures so here are a few measures that we suggest for discussion. But we also know that a lot of folks remain uninsured and have not even gotten through the front door in terms of being part of a managed care plan and those are going to be larger access issues that are not going to be able to be addressed through these measures. So I will turn this back to Andy to discuss these measures.

DR. BASKIN: Hi, it's Andy Baskin again. So you will see there's a paucity of measures here. The measures here, the adults' access is literally a count of how many adults 20 years or older have had a visit over a period of time. It doesn't actually have to be in that year, it could be over a period of a couple of years time. And, you know, it reflects a lot of things as to why people have visits or don't have visits but one of the concerns is, of course, that there are some populations that don't seem to get a visit or access the system as often as others but it doesn't get to anything about why that may be the case.

Children and adolescents' access to primary care. So this is the same thing. Was there a primary care visit during a period of time? This one is stratified by some age groups so it goes from 12 months to 19 years of age but it can be reported in age bands within that.

The CAHPS Survey, Consumer Assessment Healthcare Providers and Systems measures are literally a survey that is sent out to patients and the patient is simply asked, are they getting the needed care? There's actually a couple of sub-questions to getting needed care. A question about are you getting necessary care, tests or treatment and have you gotten an appointment with a specialist as soon as needed after getting the needed care. And getting care quickly is the respondent got care for an illness or injury as soon as needed in their, in their viewpoint, it's the patient's viewpoint. Or the responder got a non-urgent appointment as soon as needed. So it is the perception of the patient or the member as to whether they are getting needed care or getting care quickly enough.

Understand that today CAHPS surveys are sent out to a sample size of patients, which can be somewhere -- it is always 411 I think it is the number but it is somewhere in that, in that area of surveys. And of course surveys are returned 25, 35 percent of the time so it becomes a small group of people that is providing the data here. Now that's not to say you couldn't ask for the survey to be sent out to a larger population but that's not how it is done today, just to point that out.

MS. BROOKS: Thank you, Andy and Ignatius. So we will open up the access measures for the Committee's discussion and it looks like Anna Lee has her hand up.

MEMBER AMARNATH: Anna Lee Amarnath, Integrated Healthcare Association. I think I am having a little bit of a struggle even thinking about this as a separate focus area. When we think about access to care I think it is hard to -- what do we actually mean when we talk about access to care?

Just that visits are available, that someone can schedule? That a visit has actually occurred meaning someone has gone in? Or is it about them accessing and appropriately utilizing care? Health outcomes can also be a way of measuring access. So I am struggling a little bit with it being a separate category of measures.

But then looking at these specific measures, if I were to kind of make that argument, I believe that the children and adolescents' access to primary care measure is one that NCQA has retired. That, again, was simply a measure of a visit occurring. Does that mean that there was good access or it means that that particular children accessed a visit, they went and it occurred. So I just question that again.

The adult access to preventive health care I think is a really interesting measure to consider. I hear a lot of debate and discussion about whether truly every adult needs a recommended visit on a annual or biannual basis, especially young adults, so I think that's something that we could kind of consider if that's a meaningful measure. Or are some of the other measures that we have already discussed around prevention, chronic conditions, mental health screenings, maybe a better reflection of appropriate high quality care.

So those are my comments on the first two. And then thank you, Andy, for pointing out the perceptions. How you perceive the access to your care is important because I think perceptions dictate how people, how people feel about their care and how they utilize care. I do think one of the challenges we will have will be with sample sizes and as we think about using these from a perspective of stratifications for disparity assessment we may start to have some difficulty because of the sample size issue.

MS. BROOKS: Thank you, Anna Lee. Dannie.

MEMBER CESEÑA: Hi, Dannie Ceseña, California LGBTQ Health and Human Services Network. Just some things to keep in mind and think about. We have a lot of intersectional LGBTQ community members who are Latiné, African American Black, API, with the LGBTQ identity, who have severe difficulties in finding a competent primary care provider that will even see them due to their gender identity or sexual orientation.

According to Surveying the Road to Equity, the 2019 state of LGBTQ California Communities Report, 40 percent of LGBTQ respondents reported having to travel long distance just to see a physical provider, with 40 percent of respondents having to travel further than 30 minutes just to see a provider that was willing to treat them, and 52 percent of Latiné Hispanic respondents reported having to travel longer than 30 to 45 minutes in order to find a provider, and our rural respondents have to travel either to the Bay Area or LA just because there's no provider in rural areas that are willing to treat LGBTQ community members.

So as we are looking at these measures that is something to really think about and a very large population that is being left out.

MS. BROOKS: Dannie, thank you for those very important comments, we appreciate them, thank you. Palav.

MEMBER BABARIA: Just to piggyback a little bit off of what Anna Lee was saying. You know, I do think the children's measure, we had been considering that previously and somewhat abandoned it because the well-child visit measures got some of the same concepts of utilization at least. And we know utilization isn't access, there's numerous barriers that you have to dig into,

exactly like the last commenter was saying, to understand why there are disparities and why there are limitations in access.

We have actually added the adult preventative care visit measure to our managed care and accountability set and I think that is -- not that it is a perfect measure, not that we expect that number to be 100 percent because not all adults are going to need a preventive annual visit, but because we recognize that utilization of primary care and having continuity and a regular provider is a major challenge within our Medi-Cal program and one where we see significant racial and ethnic disparities that were already commented on and something that we have to work on.

So we, you know, I think from the DHCS perspective like that measure and are also exploring, are there ways of looking at that measure in combination with something like ED visit utilization or readmissions, where if you have high rates of ED utilization and high rates of readmissions and low utilization of that preventative visit measure, whether it is for the children's well-child visits or the adult measure, that is a clear access problem because the people do not have access to primary care and are manifesting in these other ways. So I think we could also consider combining and looking at some of these measures together to tell a more complete story.

MS. BROOKS: Thank you, Palav. Doreena.

MEMBER WONG: Yes, thank you, Doreena Wong, ARI. I wanted to actually piggyback on Dannie's point and on also Palav's point that there are a lot of intersections. And we know that some of the limited English speaking populations, and those that are not familiar with our healthcare system, they have very, they have a lot of access problems. And I also had a -- and so

sometimes we could look at measures in combination to try to get at that.

And thinking about that, you know, when I was looking at the different questions, the different measures in different areas, some of the patient experience measures seem to go along with these access questions, especially the use of like some of the questions in the CAHPS survey I found might be useful to get at access issues. For instance, I believe in the patient satisfaction section there is a communication question that asks, you know, asks about whether or not you can communicate with your doctor. And especially for those who have language barriers I am wondering if we could, if that question, that question didn't, I don't know if it included, say, needing help with an interpreter or needing help to communicate or talk to your doctor. But I think we could get to some of those kinds of barriers if we could use questions like that, whether it is in this access section or whether it is in the patient satisfaction section, I think it is useful to be able to get to those kinds of barriers and get -- use those kinds of measures to try to get to what is causing some of these problems.

MS. BROOKS: Thank you, Doreena. And trying to remember from the CAHPS survey if there is a language access specific question that's standardized. I don't know if any of the clinicians in the room that are familiar with it remember? That is something we can follow-up and look into, Doreena, if there is a question that CAHPS includes such as that.

MR. BAU: Sarah, this is Ignatius. So there are supplemental items that go to language access and we have them included in the patient experience.

MS. BROOKS: Perfect, thank you for reminding me, Ignatius. Okay, so we will come back to that, Doreena, in patient experience, but important points that you are making. I don't see other hands up. Any other kind

of comments or questions with respect to the access measures from the Committee Members? Ed.

MEMBER JUHN: Hi, Ed Juhn from Inland Empire Health Plan. I agree with Anna that my head feels full when I think about these four because it is incredibly complex. Because for many of the points that were mentioned today access does involve things like transportation and grievances and appeals and the pandemic we just underwent and, you know, over and under-utilization pieces. It also factors in the availability of primary care providers as well as specialty providers. And so when we think about access in these four areas, is there an opportunity for us to think about, in a short amount of time, how you want to define access or is a better path forward to align on some of these more common, well known measures and go from there?

MS. BROOKS: And I see your hand is up, Nathan, do you have a comment with respect to Ed?

MR. NAU: Just a general comment. Each Committee discussion slide prompts us to select two to three measures. It doesn't mean that we have to, we could have zero or one. And it seems like this particular area with the four measures that are listed there is not general consensus. I just wanted to point that out.

MS. BROOKS: It's funny, you would think Nathan and I used to work together or something because I was about to say the same thing. Perfect, perfect. So I think, yeah, so Nathan is making an excellent point. We don't have to select a measure. We also see to Doreena's point and Ignatius pointing out that, you know, some of these measures cross different focus areas and so just because we are not selecting one in access doesn't mean we are not selecting

something specific to access somewhere else. It is just these four measures here that we have identified through the process that we went through it doesn't really fall under. But I think, yeah, so I think excellent point, Nathan, and just wanted to clarify that with the group.

I do see a few more hands up so we will go to Kiran next.

MEMBER SAVAGE-SANGWAN: Just a thought because I think, you know, the Department does other things to monitor access and networks and all of that, right. And I don't know if it would be appropriate but it seems to me like maybe this Committee wants to say something like, you know, we are not going to include access measures in this quality measurement initiative but we do think the Department should look at some of these issues like Dannie raised or whatever and see if they can be incorporated in other ways that the Department monitors health plans. I don't know if we can include something like that in our recommendations.

MS. BROOKS: I think that the direction, the report direction here is coming from the Committee and certainly if there is a recommendation that the DMHC explore some of these other areas we can certainly include those in the report. So great comment and appreciate that, Kiran, thank you for raising it. Rick.

MEMBER RIGGS: That's exactly what I was going to say, but we haven't worked together I don't think.

MS. BROOKS: Oh, okay. (Laughter.)

MEMBER RIGGS: I mean, I think as a quality piece we can't not say that access and accessing care is, like if we can't get in the door then we are not going to get quality care. But I think that those other measures could be

more, I will say, widgets, as opposed to quality pieces.

MS. BROOKS: Great, thank you. And, Kristine.

MEMBER TOPPE: I would like to third that recommendation because I think that there are some other things. I mean, we certainly know that there's a lot of going, a lot of oversight and a lot of focus on access. We fully recognize that -- sorry, Kristine Toppe, NCQA. That, you know, the CAHPS survey is a tool, it is imperfect, it is complicated. To Andy's point, it doesn't necessarily yield all of the things we would like it to yield and so I think that it is important to think creatively and I think that Rick and Kiran's points are really valid.

The one additional part I'd like to just put out for the Committee's benefit is that you can add questions. Going back to CAHPS, you can add questions to the CAHPS survey. So if there was consensus across the various stakeholders on like creating questions that would get at things that you want to that you that aren't in the survey itself, because it is a tool that is already being used across the various populations in California, it might be just a vehicle. So just wanted to share that.

MS. BROOKS: Thank you, Kristine, appreciate your comments. Jeff.

MEMBER REYNOSO: Yeah, Jeff, with LCHC. I just wanted to uplift, kind of going, piggybacking off of what Dannie shared earlier and a critical component of access that I think just hasn't, hasn't been as succinctly articulated that I think is important to the conversation. You know, I think there was a lot of conversations around the Healthy California for All Commission.

There was a report commissioned by some major foundations here

in California around the perspectives of low-income communities of color in California. And I think one of the major takeaways from an access perspective that was highlighted in the report, there was the language access piece. I think something like 60 percent of those surveyed shared barriers around language access. But there was this other piece that I think was highlighted is, you know, the lack of cultural humility, outright racism within the healthcare system and how that experience was a barrier to accessible and high quality health care. I think something like one-third of California low-income Californians of color felt discriminated against by the health care system, you know, whether it is a provider or another part of the, of the system.

So, you know, I think as we think about access, you know, I think that's another critical piece. Language but then also, you know, I think outright racism and discrimination against communities of color but also -- and also LGBTQ populations. And I think that report really highlighted some of those, this other component of access that I think, you know, whether it is captured. I know this is kind of at the vanguard of, of measurement design with how do you measure racism or discrimination within the health sector, but wanted to highlight that piece because I think it is really critical and important in the work that we do in this committee.

MS. BROOKS: Thank you, Jeff. All right, Silvia.

MEMBER YEE: Hi, this is Silvia from DREDF. I am following on what Jeffrey is noting as well. I think this kind of capturing of outright denials of effective care and it can come from discrimination. It can come from what Dannie was saying earlier as well. It also comes when you literally can't get in the door, or when you can't get on the table, or the mammogram machine won't

come down to you. These are -- someone who is deaf won't get translation. And the person, someone who is blind won't get after-care information.

This is all a part of -- I mean I, I know we are talking, you know, it will be raised about like what are the numbers? What is the numerator? Like how many people are we really talking about? But there is a really deep impact on the people who, who face these denials and it just throws you off from ever wanting to go back to a health care provider ever again because a experience is so, is so off-putting. So I just raise it. I don't, you know. To me this is a part of access and I don't think it is captured anywhere else so I raise that as something to consider.

MS. BROOKS: Very important comments, thank you, Silvia. Other comments from Committee Members on this one specifically?

Do we have any hands up, Shaini, from the public? Okay, do we want to go ahead and take those comments? Beth, we can hear you if you want to go ahead.

MS. CAPELL: Great. It's Beth with Health Access. Just building on what Jeff and Sylvia just said and what Dannie said, not only today but at your first meeting. That, and I would commend to everyone who hasn't read it, including our friends at NCQA and IHA, that very powerful study that was done for the Healthy California for All Commission about the disrespect shown to low-income Californians and how it drives them away from care.

And I think and I also want to take seriously the if, if a group like this came forward with some recommendations for additional possible measures, that's a possibility. Maybe not next year or the year after but through the process of developing measures. Because I think in thinking about Dannie's comments

from the first meeting and listening today, that we are not measuring quality if we are driving people away from care. And I don't have magic answers on how to do that but it comes through so loudly in that survey of low-income Californians.

And I think if you survey the community that lives with disabilities or family members with disabilities or people with behavioral health issues you would get a similar result and you will never catch that in a survey sample size of 400 people statewide, you just won't. So I don't know what the right answer is but I know it is the right problem for this group to put on the table. Thank you.

MS. BROOKS: Thanks, Beth. Shaini?

David, you are on, we can hear you. You are muted, David.

DR. LOWN: Okay, how about now?

MS. BROOKS: Now we can hear you.

DR. LOWN: Okay, great, thank you. David Lown, Chief Medical Officer from the California Health Care Safety Net Institute. And I apologize if any of this was already mentioned, my Internet went out right when Anna Lee was speaking.

I want to, A, reinforce what Anna Lee was talking about, about what is access and all the multiple elements of it. And utilization is not necessarily access, so that's one thing.

Second, this may have been repeated, that CAHPS measure, and is it Kristine, can confirm that that's retired as of a year or two ago.

And then another comment on the adult access to primary care. In our conversations with NCQA there is no directionality to the benchmark set for the AAP measure, whereas many other NCQA benchmarks do have directionality, higher is better, lower is better. But there isn't one set for AAP

which also, you know, you could get over-utilization or under-utilization and it is depends on the situation.

The last thing to Sylvia's comments and the last commenter. If folks are familiar with the USCDI, what is it, US Core Data Set for Interoperability, version 3, which has recently been proposed, likely will be adopted as a data standard across country next year, introduces data standards for capturing, storing and exchanging information on disability. And I think that introducing stratification of all the measures you are talking about by disability will be a critical, critical step in addressing some of these issues. Thank you very much.

MS. BROOKS: Thanks, David.

Shaini, do we have any other public comments online? Okay, do we have any public comments in the room?

Okay. All right. So we have, I think -- so let me summarize, sorry, Rick. So what I heard from you all is that we are not going to select any of these measures but we are going to include language in the report that will reflect the Committee's thoughts about access to care and some of the different kinds of limitations and problems that may exist with respect to it. So for example, language access or access for individuals with disabilities and so on. So we will certainly -- you all will see what we put into the report but we received a lot of great input right now during this discussion and appreciate that. So that's my circle back. Anybody have any concerns with what I said? All right.

MR. NAU: Sarah?

MS. BROOKS: Yes.

MR. NAU: Nathan, DMHC. A lot of good discussion but it could be

helpful if they send you more information in writing if they haven't, right, through our email?

MS. BROOKS: Yes.

MR. NAU: Okay.

MS. BROOKS: Yeah, I think that's a great point. So we welcome -- I saw that and even though I have to remind you, please don't use the chat, I saw that the report that Jeff referenced was dropped in the chat. We will get that into the resource and reference document for you all so that you can see that. It is already there, Alex is on top of it. Sorry. But yes, we welcome any written feedback. As we get to the slide in just a minute here, are our email addresses and we welcome you all to provide information to us with respect to kind of this discussion and ongoing in these meetings as well. Thank you, Nathan, for flagging that.

So I am looking at the time and I am guessing we are not going to get through -- okay, what I will say is that the remaining areas have fewer measures in them. Also, some of them are more technical in nature, similar to the access one that we just talked about, so might have a different spin or perspective. But the measures, the measures may not be as applicable, or maybe. But also we have some very important areas to talk about in terms of the focus areas themselves, just the title, utilization, specialty, coordination of care, patient experience, population health and health equity. So we have, we will get into those at the next meeting for discussion.

I wanted to get to where I am supposed to be, what slide I am supposed to be on. So I think I am supposed to be on slide 79. I believe that we will open it up now for public comment if there is any additional public comment

on the phone.

Oh, Rick raised his hand, I apologize. Rick, please go ahead.

MEMBER RIGGS: Rick Riggs with Cedars-Sinai. So back to your prior summarization?

MS. BROOKS: Yes.

MEMBER RIGGS: I am wondering if either not specifically addressing it in like say an access measure piece but if we want to have, say, a preamble to our report that talks about the different levels of we can't measure quality until we get in the door, right, and what those pieces are, whether it is discrimination, like, you know, sort of, the sort of made to feel other or less than. The physical barriers or the, you know, sort of availability in areas. And, yeah, I just throw that out there because it may be, it may be helpful to deliver our report with sort of the context of the other things that we are considering for other agencies to take up.

MS. BROOKS: Okay. I see other hands up so Anna Lee.

MEMBER AMARNATH: To avoid a side conversation I just wanted to circle back to one other summary which was around when it came to the children's measures. I think we talked a lot about the immunization of adolescents because there was a discussion on the HPV version versus not. Glad we are all in agreement about including HPV. We didn't talk about the CIS-10, the childhood immunizations for two year olds, and then when we summarized I didn't hear it floating up. I feel like that would be a miss. I feel like, unless I am mistaken and people would just want to take that off the table right now, I think we should make sure to include it going forward.

MS. BROOKS: CIS-10?

MEMBER AMARNATH: Yes. I didn't -- I wanted to say that so I didn't just say it to Andy, that's not allowed.

MS. BROOKS: Okay. Thank you, Anna Lee. All right, Kiran, it looks like your hand is up.

MEMBER SAVAGE-SANGWAN: Yeah. And just also on that on that last section and sort of the summary. Like a lot of what I heard too was, I think, really about patient experience. And I know, we are not getting to that section today, unfortunately, but I did notice there's really, there's only two that are listed there on the slide under patient experience and they are both from CAHPS and I wonder, just after hearing the discussion from the Committee, if the consulting team would be able to present us with any additional options for measuring patient experience when we get to that discussion at our next meeting?

MS. BROOKS: Kiran, great question. I think we will go back and take a look at what other information is out there. I can tell you that it is somewhat limited with respect to kind of the experience of the patient, I think sometimes, but we will certainly look at what we can find and bring it back to you all for discussion. Weren't looking to limit, I think just used the process that we talked about at the beginning of the meeting in terms of thinking about where there's alignment of measures that are being used and so on in California and nationally already. Tiffany, your hand is up.

MEMBER HUYENH-CHO: Tiffany from Justice in Aging. I would just, going off with Kiran's comment, I agree. A lot of the comments, very valid, were a lot in line with the patient experience piece. And I thought when I was reviewing the measures that you had sent us, number 12 on patient experience

seemed to maybe play into some of the points that were raised. so I don't know if that's a possibility to discuss in our next meeting for that piece.

MS. BROOKS: We will add that, thank you. Number 12 is what I am taking away from -- can you tell me which -- just to make sure that we have the same, that we include the right measure?

MEMBER HUYENH-CHO: Right now it is how well doctors communicate.

MS. BROOKS: Okay, thank you. Other comments? Okay, all right.

Do we have any public comment online, Shaini?

Okay. Do we have any public comment in the room at this time?

All right. So public comment may be submitted to the email address: publiccomments@dmhc.ca.gov that is posted on the slide here until 5:00 p.m. on May 25th. Again though, I think to Nathan's point, welcome kind of feedback and thoughts as to the preamble or anything of that sort that we might consider for inclusion in the report moving forward.

Just a reminder that members of the public should try and -- not try -- should refrain from reaching out to Committee Members directly and email the DMHC inbox if you have questions.

So next, let's see. We are on slide 80. So the June Committee meeting will be held in person at this office downtown here again, I believe we are in the same room, but we will get that information out to you all. We are intending to have a vote in these upcoming meetings and so we will need a quorum in-person to do so, just flagging that for you all that are here and those that are online as well, that will be important. We will post the location, as I said,

for the meeting 10 meeting days in advance. We do need a quorum, as I mentioned, for the vote, and do ask that all Committee Members that can attend in-person do attend.

The public is, of course, welcome to join us in person for the meetings and we will continue to offer the public an opportunity to also participate remotely and include information about those remote options in the agenda itself.

So with that, I believe we will bring the meeting to a close and we will see each other again on June 8. So thank you, everyone and have a great rest of your day.

(The committee meeting concluded at 4:51 p.m.)

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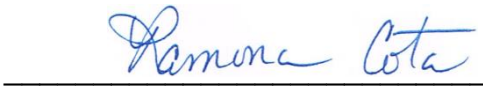
CERTIFICATE OF REPORTER

I, RAMONA COTA, a Certified Electronic Reporter and Transcriber, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Health Equity and Quality Committee meeting and that I thereafter transcribed it.

I further certify that I am not of counsel or attorney for any of the parties to said committee meeting, or in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 30th day of May, 2022.



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