pathways to
HEALTH + HOME

Service Delivery Committee Notes

Date: November 16, 2017
Time: 1:00-2:30pm
Location: Sacramento City Hall, 915 I St. Room #1119
Phone: Conference Call-in Info: +1 (646) 749-3122
Access Code: 148-105-533

Committee Members in Attendance:

- Paula Ackerman, Director of Medical Management, Health Net
- David Bain, Executive Director, NAMI Sacramento
- Alexis Bernard, Housing Director, Turning Point
- Justin Boyd, Police Impact Team, Sacramento Police Department
- Karen Brockkopp, Director of Program Services, TLCS
- Ashley Brand, Director, Dignity Health
- Martin Diaz, Medical Social Worker III, Kaiser Permanente
- Catherine Geraty-Hoag, Director of Social Services, Dignity Health
- Sarbjit Gill, Clinical Manager, Peach Tree Health
- Susan Hamlin, Volunteers of America
- Ann Hollingshead, Kaiser Permanente
- Reina Hudson, County Administrator, Optum, United Healthcare
- Gwendolyn Jenkins, ICP Manager, Wellspace Health
- Hayley Line, Intern, TLCS
- Cathy Lumb-Edwards, Director, Geographic Managed Care, Kaiser Permanente
- Blanca Martinez, Director Case Management, Molina Healthcare
- Jose Martinez, Health Services Program Manager, Utilization Management, Molina Healthcare
- Lacey Mickleburgh, Clinical Legal Fellow, McGeorge School of Law
- Tamara Miroshnichenko, Clinic Manager, Elica Health Centers
- Laura Niznik-Williams, Assistant Director, Government and Community Relations, UC Davis Health
- Abram Nunn, Physician Assistant, Elica Health Centers
- Leslie Parker, Program Manager, Wellspace Health
- Krishna Permaul, Senior Program Change Leader, Health Net
- Dr. A Jonathan Porteus, Chief Executive Officer, Wellspace Health
- Maggy Rowell, Kaiser Permanente
- Effie Ruggles, River City Medical Group
- Gabrielle Salazar, Homeless Outreach Manager
- Yvonne Speers, Social Services Manager, Kaiser Permanente
- Tory Starr, Vice President of Care Management, Care Coordination for Sutter Health Valley Area, Sutter Health
- Mark Talavera, Medical Doctor-California Medicaid, Anthem Blue Cross
- Sarah Thomas, Assistant Director, Sacramento Housing and Redevelopment Agency

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- Abbie Totten, Vice President, Government Programs, Policy and Strategic Initiatives, Health Net
- Jane Tunay, Health Net

Pathways to Health + Home Support Team in Attendance:

- Jennifer Brya
- Jean-Paul Buchanan
- Karen Linkins
- Deborah Maddis
- Malena McFarland
- Margaux McFetridge
- Steven Soto
- Patricia Talbot

Welcoming Remarks and Introductions (Karen Linkins)

- Karen welcomed and thanked group for participating. Pathways Team and Committee Member introductions occurred.
- Service Delivery Committee Charter was presented. The charter was approved by the committee.

Updates and Operational Items (Jodie Nerell and Karen Linkins)

Early Engagement Update

- Progress and Stats of Early Engagement Referrals and Enrollment for Sacramento Covered: In 10 days of operation: 79 enrolled, 11 pending since Nov 14th, 85% eligibility criteria, 62% referrals from IMPACT Team, ICP/16% and ICP+/17% accounts for 33% of referrals, SHRA accounts for 5%
- Sac Self-Help Housing came on board and are paired up with outreach and getting them connected with housing; out of County and uninsured enrollees was higher than expected
- Documenting steps with Sac Covered and tracking referral forms; 39% of enrollees are 50-69 years of age.
- Enrollment has been happening rapidly and speaks to the engagement process and working closely with IMPACT team

Discussion/Questions:

- Karen Brockopp with TLCS asked what the 15% housing intake means. Jodi responded that it speaks to when the Sacramento Self-Help Housing coordinator comes out and completes the application, background check, and income evaluation to gear up apartment searches. They have already taken folks out to look at apartments; they do an intake evaluation and get them connected to housing.
- Blanca Martinez Of Molina asked whether enrollees already have a health plan and who Molina should collaborate with at Sacramento Covered to connect with on their members. Jodi Nerell noted that 12 enrollees are Molina members to reach out to her to connect on them.
- Karen Linkins noted that the program is working towards the enrollment goal of 250 to meet our numbers. There are data sharing issues and we need to be cautious moving forward until those agreements are in place. Coordination with county behavioral health, resolution has occurred to move forward with WPC, we anticipate working more collaboratively with the County in January, there are informal things happening now and partners at the table that are County providers.

- Jodi Nerell noted that uninsured folks will get enrolled in health coverage and as long as they are Medi-Cal eligible.
- Sarah Thomas with SHRA expressed how impressed she is working with Sacramento Covered. She would like to see dashboard progression over a period of time and not just an updated dashboard; the progress is important too.

Review and Endorsement of Pathways Tools and Forms

- Karen Linkins provided an overview of the current Pathways forms: Referral, Screening/Assessment, and Participant Profile. Asked for input and explained that committee engagement on these tools is tied to incentive payments. Forms are being tested in the field right now to provide insight into changes that need to be made prior to full launch in 2018. WPC incorporates PDSA cycles for quality improvement.
- Jennifer Brya noted that the Support Team is working closely with Sacramento Covered fielding those forms and making changes to streamline processes as needed. The assessment form has an acuity scale worksheet that was adapted from a functional assessment form used in Oregon. Community health Workers feel comfortable asking questions, can get through the content in 10 minutes and report that this has been a really great process for engagement. Trying to learn at every step and improve things.
- Karen Linkins noted that the Early Engagement providers are learning a lot about the individuals for the ultimate shared care plan. Goal is to make sure that the program is really client-centered and minimize the times people tell their stories. Part of the importance of the Member Profile is that we do not want to lose information about the individual. Information is compiled into the Member Profile, which will be transferred to the Pathways Care Teams fielded by Elica and WellSpace into a Shared Care Plan.
- Karen Linkins noted that the forms and tools will go to Steering and Executive Committees for adoption. Recognize that forms and processes may need to change, but this is where we are now. Asked the committee to communicate any red flags that the Service Delivery Team needs to be aware of.

Discussion/Questions:

- Ashley Brand of Dignity noted that a lot of this information will be critical for hospitals to know. Adding a barcode would take four years. Asked whether there be a template of key elements that can be sent to upload it in their chart. Jennifer Brya responded that Service Delivery and IT teams are working together on the IT platform and to let the team know what elements of the profile that you would like transmitted to plans and hospitals.
- Effie Ruggles of River City Medical Group asked whether this a universal referral form for all partners and whether it is for individuals and families. She noted that the form does not collect information on children and asked whether the needs for childcare or child healthcare are assessed and will be met. Noted that it could be advantageous to capture that information if the enrollee has a child. Jodi Nerell explained that assessment is on individuals to determine whether he or she meets the eligibility criteria.
- Dr. Porteus brought up that County Behavioral Health uses Avatar and that no health record is linked with Avatar – someone needs to do it. Karen Linkins noted that an HIE discussion is going on concurrently. IT meeting is identifying initial drafts of data sharing platform and walking through pros and cons and IT counterparts. Karen Brockopp noted that if the County is not participating in that meeting, then Avatar won't be part of the discussion. Having a different system is troublesome.
- Karen Linkins explained that the team is aware of this issue and the idea is to harmonize and integrate. This is going to be a process to integrate various systems; need to look at vertical and horizontal integration.

Full Launch RFQ Timeline and Key Dates (Steve Soto)

- Early Engagement phase provides opportunity to launch a set of initial services and learn from a smaller set of community partners. Reminded committee that RFQ for Full Launch would be coming out after the Thanksgiving holiday.
- RFQ requires an introductory Letter of Interest. Submitters then share an overarching approach. City is contracting for services for the program. Three buckets of service entities:
  - Pathways Health Home Entity
  - Pathways Assertive Outreach and Referral Entity
  - Pathways Housing Services Entity
- Timeframe:
  - Support Team fine-tuned the range of services that are asked for since the last meeting. Expecting as much participation as we can get. Updated timeframe as of today:
    - Dec 1st- New release date
    - Jan 19th- Announcement of pathways provider entities
    - April 2nd- Launch

Navigation Pilot Examples: Outcomes & Lessons Learned (Jennifer Brya and Debby Maddis)

Dignity (Ashley Brand):

- Most programs are with community organizations. Patient Navigation Program has program navigators that are employed by Sacramento Covered and help patients get access to care outside the hospital walls, follow up calls happen when navigators are not present.
- Behavioral health and community programs: Turning Point Crisis Intervention Specialist, SSF, Loaves and Fishes, Health Net and Lutheran Social Services, and El Hogar create access to outpatient services within 24 to 48 hours.
- Key to success is having direct service providers in the hospitals. All of these programs demand a tremendous amount of collaboration and engagement in the process.
- We capture our outpatient data and we ask them to fill out patient logs, we internally need to do better tracking of the health plans, we are working on finalizing an ROI.

Questions:

- Jennifer Brya aked about a communication workflow. Ashley responded that navigation is coordinated directly with Health Net, we do send out daily ED utilization reports.

TLCS (Karen Brockopp):

- Navigation program includes a staff person in EDs in Sac : UCD, Kaiser South, Methodist, Sutter General, Dignity San Juan and Dignity J Street.
- Two staff at the jail – work with the "quicks"
- Two staff at Loaves & Fishes
- Six peer navigators total. The staff in the EDs and jail refer the individual to a Peer Navigator.
- All navigators are funded through the Sacramento County Department of Behavioral Health
- Goals is to identify individuals with mental health issues and support them
- Navigators have access to Avatar (County BH data system) and can connect people to their mental health home, can see if they are still open with providers
- Receive referrals from ER and jail — if individuals are interested in ongoing services, they are referred to 6 peer navigators
- Navigators offer resources and connections to services (PCP, County mental health); navigators walk them through the systems
- Offer services for 60 days. 65-75% of the population served are experiencing homelessness

- Difficult when there is hope or belief from the client that they can get into housing and we all know how difficult that can be
- Because the navigators are co-located in the EDs and Jail, communication and collaboration through check-in meetings are critical
- New Direction program does intensive case management (chronically homeless), caseloads are 1:15
- Have HUD money for rental subsidies, but even with subsidy takes 3-4 months to get an apartment

NAMI Sacramento (David Bain):

- We are part of the cohort that serves Dignity hospitals under Turning Point's leadership and referrals come from Turning Point staff. Have one advocate, Myla, who does whatever it takes to get a person stabilized, she also works with family members and helps them with how to support their family member who is in need and seeking services, we provide resources.
- Myla has an 88% connection rate, she tries 10-12 times. The challenge is communication and transportation services. She tracks phone calls, and visits.
- There are Dignity custom forms that are turned into the Turning Point office. Dignity and Ashley Brand would have access outcomes based on those forms.
- After 60 days, there is no follow up. Turning Point turns in reports to Dignity and we capture that and look at readmission of those patients and we focus on complex and ER admitted patients; caseload size varies.

Health Net (Abbie Totten):

- Health plans are required to provide care coordination and case management. We are in the process of developing a specialized unit.
- We deal with mild to moderate population. Given the complexity, we contract with River City Medical Group.
- We have disease management programs and have developed a coach model (based on Camden model). It is a joint collaboration with the member connections team and is an incredibly interactive program and we have made it a priority.
- We have a targeted cohort of 70 individuals and are making sure these members are connected with services in the community. We have had a positive response so far and members with frequent ED visits are flagged and passed on to the small pilot program.

Sacramento Steps Forward (Gabrielle Salazar):

- Outreach: We have 11 contracts. We partner with TLCS, WIND, Sac Self Help Housing, as well as others. We are client driven, have 10 navigators and have housed 65 residents.
- Our target population is the chronically homeless, but work with anybody who is in need. We have a placement rate of 4-5 people per navigator per month.
- We have smaller caseloads and have found that we are able to house more clients that way.
- To obtain subsidized housing, navigators are out there helping clients obtain identification cards, pet tags, and connect with mental health services, primary care physicians, helping with family reunification, SSDI, General Assistance and help provide transportation.
- We have an Assisted Resolution number we believe we will be able to build up and make a greater impact. Assisted Resolution is the ability to find market rate housing, connection to employment, family reunification, connection with rapid re-housing any alternative to permanent supportive housing.
- We also have a navigator in each hospital and leverage whatever benefits the client has.

United Healthcare (Reina Hudson):

- Use Whole Person Care model, which is an integrated model. We strive to not have silos of providers. We have one leadership team, it is fatiguing for someone to re-tell their story over and over so we have one universal assessment and care plan in which we create short and/or long-term goals with the client.
- This is done telephonically as well as in the field, we work with persistent super utilizers and make sure we are creating appropriate discharge plans and referrals from the County and Health Plans.
- Our outcomes include lower inpatient ED and ER visits and we get them reengaged with their provider.

Questions:

- Karen Linkins inquired about how the program defines who is at risk for specialty emerging risk. Reina responded that they use a predictive modeling tool that obtains age, ethnicity, utilization patterns etc. and we look at the constellation of systems and mine our own data to identify members that meet super utilizer threshold. We are just starting to roll it out in Sacramento and San Diego County and other states as well. Case management numbers right now are small but it does depend on membership. Persistent super utilizers 10-12%, expands by 2% for emerging. We need to improve communication with community partners to share that this program exists—if people need help, we would enroll them in the program. In terms of bi-directional referral with community partners, we just document touches. It's less standardized than with County partners.
- Jennifer Brya noted that there are a ton of program resources that are here. Part of our work is to create coordination and communication pathways for existing partner programs. This is a complex county with many players and we will be looking for ways to develop referral pathways.
- Reina explained that currently they are dependent on member disclosure. There is an 800 number to call. They do not have standardized referral processes outside of County Behavioral Health, we just document touches and interventions.
- Abbie Totten noted that getting the release of information forms signed is critical for partners to share information on patients—getting releases finalized sooner rather than later is key.

Molina Healthcare (Blanca Martinez and Jose Martinez):

- Case Management: They have case managers, community connecters and transition of care coaches. Clients go through a psychosocial assessment that is used to build the care plan and guide the work of an interdisciplinary care team.
- They have 11 case managers and 3 community connecters (health educators) who try to locate those members on our behalf, connect them with long term support services and are able to go to medical appointments with them.
- Of those who have more complex needs, the caseload is at about 16. The average caseload is around 30-45 per case manager.
- They flag re-admittance and do outreach and target those members as well. They do not delegate case management. They provide re-admission review, assist with transportation and authorize medication. Work closely with Kaiser at decreasing utilization and refer high-utilizers to Blanca's team.

Questions:

- Jennifer Brya asked to what extent there are homeless members and who community partners are. Blanca responded that they identify homeless members but it is challenging to find them after they leave the hospital. They try to dispatch our staff to the hospital to

engage them, working collaboratively to connect them with resources. Not as successful as we would like to be at maintaining that relationship after they are discharged. Loaves and Fishes are a resource and one of our community partners.

- Jose Martinez noted that they have some clinical RNs and LVNs that are on the inpatient team for Molina who assess patient needs and facilitate connection after discharge. They are at Sutter, Dignity, and Kaiser.

Next Steps for Service Delivery Work Group (Karen Linkins)

- Next Meeting: Thursday, December 14th, 1-2:30pm. Location: Library Galleria, 828 I street, West Wing Room, Sacramento CA, 95814
- Program is currently bringing on Early Engagement FQHC partners (Elica and Wellspace) and working on the development of a Shared Care Plan and connecting enrollees to health and behavioral health services. Sacramento Self-Help Housing are actively working on housing connections for current WPC enrollees. We will be able to talk about the work they are doing at our next meeting.