pathways to
HEALTH HOME

Joint Service Delivery/IT Committee Notes

Date: January 18, 2018
Time: 1:00-2:30 pm
Location: City Hall Conference Room 1119, 915 I Street, Sacramento, CA 95814

Committee Members in Attendance:

- Ashley Brand, Dignity Health
- Joil Xiong, Director of Operations, Sacramento Covered
- Stephen Smythe, IT Customer Account Manager / Senior Advisor, Anthem Blue Cross
- Danielle Jackson, Development Director, SNAHC
- Wayne Jeffries, CIO, SNAHC
- Cathy Lumb-Edwards, Kaiser Permanente
- Lauren Nizik Williams, UC Davis Health
- Eric Schimmer, Anthem Blue Cross
- Anai Watts, Anthem Blue Cross
- Jodi Nerell, Sacramento Covered
- Dalip Rai, Wellspace Health
- Leslie Parker, Wellspace Health
- Elizabeth Hudson, Salvation Army
- Emily Halcon, City of Sacramento
- Greg Galliano, Sacramento Police Department
- Lacy Mickleburgh, McGeorge Healthcare
- Dina Maxwell, Anthem Blue Cross
- Ben Avey, Sacramento Steps Forward
- Chris Weare, Manager of Data Analytics and Research, Sacramento Steps Forward
- Christina Kitchen, Interim Shelter Supervisor, Salvation Army
- Paul Hyppolite, Molina Healthcare
- Blanca Martinez, Molina Healthcare
- MaryLiz Paulson, SHRA
- Gabriel Kendall, Director of Community Relations and Program Development, 211 Sacramento
- Karen Brockopp, Director, TLCS
- Michael Marchant, HIE Integration Manager, UC Davis Health
- Yvonne Speers, Kaiser Permanente
- Martin Dias, Kaiser Permanente
- Ryan Loofbourrow, Sac Steps Forward
- Nick Lee, Sac Steps Forward
- Fatemah Bradley-Martinez, SSHH
- Racquel Weaver, Crime Analysis Unit, Sacramento Police Department IMPACT Team
- Alicia Pimentel, Anthem Blue Cross

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- Michael Marchant, UC Davis Health
- Christine Wofford, SNAHC
- Kelly Bennett, Sacramento Covered
- Jennifer Park, Kaiser Permanente

Committee Members in Attendance via Phone:

- Hazaiah Williams, Elica Health Centers
- Sarbjit Gill, Peach Tree Health
- Jennifer Avalon, Kaiser Permanente
- Sundeep Desai, Sutter Health
- Paula Ackerman, Health Net
- Nikki Cotaro, Health Net
- Renia Hudson, United Health Care
- Kevin Isbell, Kaiser Permanente
- Kobi Sonoyama, Director of Clinical Informatics, River City Medical Group
- Bobby Bliatout, HALO

Pathways to Health + Home Support Team in Attendance:

- Lisa Chan-Sawin, Project Lead
- Karen Linkins, Service Delivery Team Lead
- Debbie Maddis, Service Delivery
- Jean-Paul Buchanan, Communications Team Lead
- Mark Elson, IT Team Lead
- Wendy Jameson, IT Team Consultant
- Alex Horowitz, IT Team Consultant
- Josh May, IT Team Project Manager
- Patricia Talbot, Service Delivery Consultant
- Alexis Sabor, Project Coordinator

Welcome and Introductions (Mark Elson & Karen Linkins)

- Karen led introductions and provided a review of the Early Engagement Dashboard
  - As of January 12, 2018, Pathways had enrolled 307 clients with 1,592 touches for a total of 2,154 services delivered (multiple services may be delivered in a single touch)
    - Age distribution of enrollees skews older and male
    - Half of services delivered relate to Care Coordination, remainder split between Housing Coordination and Program Readiness Coordination
      - **Care Coordination:** Scheduling appointments, transportation, social services applications and navigation
      - **Housing Coordination:** Access to rapid re-housing, VI-SPDAT assessments, other housing-related services
      - **Program Readiness Coordination:** Cross-cuts both other service streams, preparation for health & housing coordination
    - Largest referral pathway is through the Police Department's IMPACT Team, with additional enrollees through ICP and FQHC street medicine teams
- Questions from Committee Representatives
  - Q: How many referred clients have declined to enroll in Pathways?

        - A: None, outreach partners have done a good job of explaining the program to clients and getting them well-versed in the program during the consent process
    - Q: Are we seeing any trends in care coordination yet?
        - A: Not yet as current enrollees are relatively evenly dispersed throughout the clinics and difficulties faced thus far are not generalizable across partner organizations. Housing coordination has been going smoothly, there are just a large number of enrollees to coordinate with now. Sacramento Covered is starting to work with health plan partners' complex care management teams with 25 of the Pathways enrollees to test behind-the-scenes coordination. Purpose of Early Engagement phase is to test and improve, including with referral pathways and onboarding.
    - Q: What about care coordination for Behavioral Health?
        - A: Discussions have begun at Sacramento Covered about co-managing enrollees who have self-reported that they receive mental health services through the County and working with TLCS, Turning Point, and El Hogar. Dignity is also performing a point-in-time count including note of individuals with SUD and mental health issues that we may use to estimate prevalence in the Pathways target population.

Integrating IT and Service Delivery: Overview of Work to Date (Mark Elson & Karen Linkins)

- Karen reviewed the Service Delivery model
    - All aspects of program driven by the Pathways mission "to improve health, quality of life, and housing stability for Sacramento's most vulnerable individuals experiencing or at-risk of experiencing homelessness through an **integrated** system of care."
    - Utilize community assets (partners organizations, aligned programs, etc) with a focus on coordinating current care delivery
    - Long-term vision of the program is to create an enduring platform for coordination and collaboration across health, housing, and social services to improve health & quality of life
    - Short-term outcomes through 2020 to:
        - Create capacity for responsive governance structure
        - Align services across sectors to maximize use of capacity and improve connections to the housing continuum
        - Provide outcomes-related data and measures to demonstrate improvements in care and drive PDSA cycles
        - Meet specific service delivery targets as defined in WPC Application approved by DHCS
    - Questions:
        - Q: How are we determining the baseline to measure against for housing 2,000 individuals by 2020?
            - A: Housing 2,000 individuals is the broader City-wide initiative based on the most recent point-in-time count performed by the City and any permanent housing (not just HUD-regulated) provided will count towards the 2,000 housing target. As a Medicaid program, WPC cannot pay for housing directly but instead aligns with other programs that feed into housing
- Mark provided a summary of the work performed to date in developing an IT approach and model
    - Objectives for the Pathways IT approach are to:
        - Enable care coordination
        - Improve service delivery and outcomes
        - Build upon existing capabilities and meet organizations where they are

        - Establish a mechanism to monitor outcomes at community level
        - Build a framework for shared governance
        - Provide a foundation for data sharing to meet the evolving needs, such as the Health Homes for Patients with Complex Needs program rolling out in June 2019 in Sacramento County
    - Data Sharing Components of Pathways
        - Enrollment & Eligibility
            - Validating Medi-Cal eligibility, ID target population, support outreach, consent management, hand-off with care teams and service providers
        - Care Management for proactive care planning
            - Innovative shared care plan requirement for WPC
            - Electronic referrals, including non-clinical
        - Clinical Data Sharing for care coordination and treatment
            - Enabling event notifications, for example on hospital events to care teams
            - Piggy-backing on query-based methods for health information exchange
        - Analytics for program management and reporting
            - Baseline data
            - Data normalization and quality monitoring
            - Performance and outcomes monitoring, PDSA cycles
    - Q: Is there a clear division of labor between Care Management activities and who performs what care team functions?
        - A: We know that the functions of the care teams are, but performance of actual duties depends on the constellation of entities that are selected for the Full Launch. Expectations are that organizations will work collaboratively to field care teams and Pathways staff will work with selected teams to coordinate.
        - Lisa noted that we are providing flexibility around care teams as we acknowledge that the target population is non-homogenous and different populations will have different priority needs.
- Mark provided overview of anticipated data sharing landscape once Pathways is implemented
    - Approach seeks to leverage national standards and networks given that many key organizations in Sacramento have systems that meet these standards and participate in national data exchange networks.
    - Rather than envisioning a centralized Health Information Exchange infrastructure mediating the program, have instead decided on the Pathways infrastructure acting as a single node along with other partners.
    - Care teams will be able to leverage national networks for views into patient information with hospital partners and Pathways team can provide Technical Assistance to increase point-to-point connections between partners as well.
    - Q: How do partners know who the enrollees are?
        - A: We are distributing an e-mail within the next 24 hours with a template for providing lists of individuals and demographic information, along with some care coordination information. Rosters will be generated by Sacramento Covered and distributed to plans/hospitals to communicate who is enrolled for each plan or seen at each hospital.
    - Q: How can hospital system partners flag that they do not have information in their systems on a given enrollee?
        - A: IT team will brainstorm solutions for matching and flagging patients with hospital systems. Hospital alerts will trigger downstream activity with Pathways care teams

but alerts cannot be provided if individuals aren't already flagged in systems as Pathways enrollees.

- Mark provided a brief overview of the Pathways IT architecture model and contracting relationships
    - Webinars will be held next week to discuss the Data Sharing Agreements, Business Associate Agreements, and Consent Form with program, compliance, and legal staff
        - Webinars will be recorded for those who cannot attend
        - At Committee request, a third webinar will be scheduled
        - Request that comments be provided in redline to City Attorney's office ahead of time (please submit via Margaux McFetridge)
    - Q: Do housing and CBO partners need Business Associate Agreements or need to access HIPAA data?
        - A: Teams are currently working on determining appropriate levels of access to data for non-healthcare partners
    - Q: Have there been discussions about mining health plan data to find clients who meet criteria?
        - A: That would be allowable under the DSA, but strategy thus far for referrals has been to perform outreach at the street level for now.

Early Engagement Points of Intersection (Mark Elson & Karen Linkins)

- Pathways has developed reporting templates to gather data from partners, as well as a sample roster file for enrollee data and are working with Sacramento Covered on a secure e-mail submission mechanism for the short-term
- Capabilities have been developed in Sacramento Covered's instance of Salesforce to create profiles for enrollees that will be developed into care plans
    - Participant profiles gather patient information, reduce need for clients to tell their stories repeatedly and provide a key moment where we can ask individuals what their goals are.
    - Becomes basis for shared care plan and is being tested with Elica and Wellspace now
- Pathways team has been building, testing, and refining Referral forms/workflows, Consent form/processes, Assessment forms for intake and acuity scoring
- Q: What is the expectation for getting eligibility information for referrals with non-healthcare providers?
    - A: Have not developed a systematic way for sharing eligibility information given that the DSAs have not been executed yet. Eligibility information is self-reported for now.
- Key areas to prep for full launch:
    - PDSA cycles
    - Co-management of clients for successful transitions between organizations
    - Expedited access for health and behavioral health needs
- Reporting
    - Baseline report deadline extended to likely late summer as baseline period was extended for those who have been enrolled through June 30, 2018 for data on 2016
    - Next major report due is the Annual Variant & Universal Metrics Report due April 2, 2018
    - Q: Please prioritize requests and dates, updates need to be provided as deadlines shift.
- PCP assignments across surprisingly broad set up provider orgs in city, is a challenge to coordinate with this broad set of PCPs
    - Q: Are care plans currently being shared with PCPs?
        - A: Not at this time. Intent to bring PCPs into coordination. May share more information at next Service Delivery meeting that was covered in January Steering Committee

meeting related to PCP care coordination. Pathways will also work to validate if patients are actually receiving care from their assigned PCPs, which is an important verification point for this target population.

Full Launch Coordination (Mark Elson & Karen Linkins)

- Need alignment between RFQ and service delivery partners
- All partners will be contracted with, readiness reviews performed, and a collective action plan developed by Full Launch
- Will work with other partners as we move towards April 2 to develop workflows with hospitals, plans, and others as well as data sharing wins that we can get by then
- Target dates for Pathways IT milestones:
  - Procurement for any new systems to be done by end of June
  - Go-live with core capabilities by late October
  - Intent is to advance as far as we can this year with data exchange connections with core partners, with expectation to continue into 2019 with additional partners
  - Hoping to implement interoperable care plans with some partners in 2019-2020
- Lisa noted that while this program is a large lift, it will provide an infrastructure to support future programs and initiatives, including Health Homes for Patients with Complex Needs

Next Steps for the Committees (Mark Elson)

- DSA webinars will be held on Tuesday, January 23rd, Thursday, January 25th, and Monday, January 29th.
- February Service Delivery and IT Committee meetings have been cancelled, next meetings will occur on Thursday, March 15th