pathways to
HEALTH + HOME

Service Delivery Committee Notes

Date: December 14, 2017
Time: 1:00-2:30pm
Location: Sacramento City Library Galleria, 828 I Street, Sacramento CA 95814

Committee Members in Attendance:

- Paula Ackerman, Director of Medical Management, Health Net
- David Bain, Executive Director, NAMI Sacramento
- Fatemah Bradley-Martinez, Sacramento Self-Help Housing
- Ashley Brand, Director, Dignity Health
- Karen Brockkopp, Director of Program Services, TLCS
- Yanet Burgus, Elica Health Centers
- Linzy Davenport, Kaiser Permanente
- Sergeant Greg Gallian, Sacramento Police Department Impact Team
- Catherine Geraty-Hoag, Director of Social Services, Dignity Health
- Sarbjit Gill, Clinical Manager, Peach Tree Health
- Christie Gonzales, WellSpace Health
- Elizabeth Hudson, Salvation Army
- Reina Hudson, County Administrator, Optum, United Healthcare
- Gwendolyn Jenkins, ICP Manager, WellSpace Health
- Gabriel Kendall, 211 Sacramento
- Nick Lee, Sacramento Steps Forward
- Ryan Loofbourrow, Sacramento Steps Forward
- 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
- Janice Milligan, River City Medical Group
- Tamara Miroshnichenko, Clinic Manager, Elica Health Centers
- Jodi Nerell, Sacramento Covered
- Laura Niznik-Williams, Assistant Director, Government and Community Relations, UC Davis Health
- Leslie Parker, Program Manager, Wellspace Health
- MaryLiz Paulson, Sacramento Housing and Redevelopment Agency
- Liz Roccucci, Kaiser Permanente
- Sydney Ryden, Health Net
- Eric Schwimmer, Anthem Blue Cross

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- Tory Starr, Vice President of Care Management, Care Coordination for Sutter Health Valley Area, Sutter Health
- Jane Tunay, Health Net
- Christy Ward, Chief Executive Officer, One Community Health
- Ane Watts, Anthem Blue Cross
- Hazaiah Williams, Development Director, Elica Health Centers

Early Engagement Update (Karen Linkins, Sacramento Covered, and WellSpace)

- Sacramento Covered provided an overview of the latest dashboard numbers:
  - Enrolled: 173 enrolled as of December 8th
  - Graduations: 9 have "graduated" and are housed and employed; enrollees were literally homeless and one was housed at Mather — Sacramento Covered will pull data to show where the others were housed.
    - Ashley Brand requested that the program look at this cohort's hospitalization over time. Jodi Nerell noted that these enrollees came through IMPACT Team referrals and not through the eligibility criteria, so their outcomes may not reflect hospitalization reductions.
  - Referrals: 63% came from IMPACT; right now anyone from IMPACT is automatically eligible, but the program is looking at hospitalizations. Nick Lee from SSF noted that they took a cross-section of the HMIS queue and checked against Sac Covered to see who has Medi-Cal — they are going to go out and look for the individuals that overlap and find them.
  - Individuals from WellSpace are being referred and have hospitalizations.
  - Services: Still working on how to depict services in the dashboard; Elica's team is providing health care. Karen Linkins noted that WellSpace and Elica are on board to develop referral pathways to the program and getting patients back and providing "light services" and the Shared Care Plans. These contracts were signed recently and both FQs have been working collaboratively with Support Team and Sac Covered to begin providing services. SSHH and SSF are both doing housing work.
  - Outreach: 902 touches
  - Demographics: Showing regions instead of zip codes (most enrollees were engaged in North Sac); other for region means car, street, or shelter. Age and gender are trending the same.
  - Health Plan: "Other" means out-of-county plan
- Update on the Pathways alignment with Winter Triage Center:
  - VOA opened the Winter Triage Center – 25 pets are being housed as well
  - 9 folks from the program are now in permanent housing slots
  - In 20 + days we have permanently housed 9 people (Quinn Cottages, board and care, room and board). Partners at Sacramento Self-Help Housing are helping individuals get into spots.
  - Noted that some of the housing comes with wraparound services some do not and inquired how the program is handing them off. Jodi responded that

they are managing folks with onsite staff at Quinn. At the other housing options, they are reaching out to the providers to see how they would like to work together – that is why they were able to graduate folks that are at Mather.

- Christy Gonzales of WellSpace Health provided an overview of their Whole Person Care related services:
  - Mission is to achieve regional health through high quality comprehensive care, offer behavioral health, AOD, suicide prevention service
  - T3 Program – Triage, Transport and Treat
    - Identify high-utilizers
    - Documentation gathering
    - Service Connection
    - Connecting to other social services
    - Serve about 400 clients a month
    - Total unduplicated clients since 2007 is 2,700 +
    - Total touches since 2007 is more than 100,000
  - Interim Care Program
    - Medical respite program
    - Serves individuals who are discharged from the hospital
    - Transportation, documentation gathering
    - 2 locations with 34 beds
    - Duplicated clients (total stays) 16,000
    - Total touches: 97,500 +

Discussion of Data Sharing and Shared Care Plan (Karen Linkins)

Objective of Shared Care Plan and Core Domains

- Karen provided an overview of the objective of the Shared Care Plan; Pathways is developing a panel of individuals and the Care Teams are managing that panel. That is the hydraulics – expectation is that people will get better. Concept of that panel is that we will manage care. IT Committee is talking about what it will take to manage the care management platform.
- For this group, Support Team needs advice on what is the best information to collect. Don't want to over-collect, needs to be meaningful for Whole Person Care.
- Proposed 5 Domains: 1. Individual Goals, 2. Health, 3. Behavioral Health, 4. Social Services and 5. Housings.
- Questions for the committee:
  - What are your reactions to thinking about this as population health management?
  - Will this help us move to a community-based approach?

Feedback on Objective and Proposed Domains

- Identification of Case Manager and Updating Responsibility:

- Ashley Brand noted that all health care organizations are trying to do this, so what is shared will be very interesting. For the hospital side, they want to know who the identified care manager is, what organizations are going to use what information, and who is responsible for updating. Those are critical pieces.
- Tory Starr noted that the most important thing about this document is knowing who you can call. If that is kept updated, the hospital can facilitate conversations and warm handoffs. Gwen agreed that having phone numbers in the plan is critical. Ashley added that the case manager should always be called. Asked for clarification as to whether their social workers will need to update the care plan.
- Karen commented that the distinctions about who makes the plan, who owns the plan, and who has accountability – those are still being developed. The plan will live the Pathways Care Team, but for example, the prescription piece, who needs that information? Comes into play for medication assisted treatment (MAT) and medication reconciliation.
- Ashley noted that if Pathways is asking hospital staff to go into a system they will need to see a benefit from it. They will want to see what programs patients are enrolled into so that we know what is already in place to direct our treatment.
- Tory Starr noted that medication reconciliation is the holy grail. Knowing which person to contact for that is really important. Hospitals will want to know if someone had a visit on the day and where to go to get additional information.
- Karen agreed that we do not want to create redundancies and need to understand what everyone is doing.

- Inclusion of Behavioral Health, Hospitalization, and Housing Data:
  - Sergeant Galliano noted it is a great approach. Sac PD has surveyed other law enforcement entities to understand is successful, in terms of information platforms, so that law enforcement can see behavioral health info that is beneficial to help individuals slipping through the cracks. Operationalizing this is more complicated.
  - Karen Brockopp echoed Ashley's comments. It is critical for TLCS to be able to see if a person has been at the hospital. She was recently in a meeting with mental health providers and a common issue is that they need to know where clients are housed and/or living.
  - Gwen Jenkins noted that without housing support that there is only so much that can be done. Behavioral health medication data is critical. Knowing who the case manager is will be critical. These are critical components but will take a lot of work. Janice Milligan asked Gwen whether ICP is currently getting information from all the hospital. Gwen responded that for any patient that comes into ICP the information comes from that hospital. They receive information from all hospitals.

- Inclusion of Patient Goals and Progress
    - Karen Linkins noted that there are some complexities on the behavioral health side that the IT team is working on. Aside from HIPAA, this goes back to what do you really need to know to do your job. This concept of sharing is borrowed from behavioral health sector — being able to see patient goals and have data and sharing that information is very activating for individuals. Very interested in building that piece in.
- Platform Design and Incorporation of HMIS (housing) and Avatar (Co BH)
    - Ashley asked what the synergy of HMIS, Avatar, and this looks like conceptually. Karen responded that the IT Committee has been working on a hybrid model — it's not building a whole new system, but will link to the various systems. We want to integrate the HMIS piece. It is evolving and that is the intention. The challenge right now is that we can't help having duplicated data entry. The intention down the line is to have it be streamlined.
- Managing and Incorporating Multiple Goals for Care Plans
    - Tory Starr commented that there may be multiple goals behind the care plan and who is accessing it will have different needs. Is the purpose for this is to know who the member is connected to and working with? Karen responded that it is meant do that and also be an interactive dynamic for the care team working with the patient. We want to be dynamic and responsive and linked to the hospitals. There have been questions about how existing hospital care management programs connect to Pathways and this is a vehicle.
- Key Elements of Shared Care Plan to be Included
    - Demographics and insurance status need to be in there. Diagnoses/problem lists are different for different providers – can be medical, barriers to housing piece.
    - Pathways Care Team contact info – will add other contact info.
- Client Goals and Frequency of Updating
    - Client goals: Karen noted that treatment goals can be a challenge to manage – asked the committee for suggestions on the frequency of updating.
    - Elizabeth Hudson noted that Salvation Army updates a plan every two weeks, but that the VA wants them to update weekly.
    - Karen Brockopp agreed that more frequent updating is always better, but it is difficult to have the time to do it Medi-Cal requirements are every year.
    - Blanca Martinez provided a plan perspective — they level their members. Level 4 requires more touches. Train their staff and they understand that some require more outreach. Follow NCQA guidelines. They e are clear with members when they will call them back and document back. Care plans are member-centric and provide a targeted approach. Care plans should not be so broad, but more targeted to their diagnoses and treatments.
    - Fatemah Bradley-Martinez shared that on the housing piece, Sacramento Self-Help Housing updates goals quarterly and uses that opportunity to engage the individual. If the goal is not reached, they will see if they want to

change or modify it. Would be hard to do it weekly because the housing stock is so limited.

  - Ryan Loofbourrow from Sacramento Steps Forward noted that one requirement for permanent supportive housing is disability certification. If that process can be integrated into this, that would be hugely helpful. Once they are confirmed eligible, just finding people, is difficult. Having that primary contact would be hugely helpful.
  - Sergeant Galliano mentioned that the IMPACT Team develops and then assesses an assertive set of goals. They check whether if they are meeting outcomes each week.
  - Liz Roccucci with Kaiser inquired about the resources for updating so many domains. Karen Linkins responded that the thinking is that this is "Whole Person Care," so we need to address all of these needs.

IT Committee Inquiry on Data Sharing Format (Wendy Jameson/Karen Linkins)

- Wendy Jameson from the IT Team asked the Committee the pros/cons of the following strategies for monthly reporting on services:
    1. Excel template that is filled out and sent to Sacramento Covered
    2. Or would you prefer access to the Member Profile and enter the info into Salesforce?
- Committee members responded with multiple questions:
  - Is the idea that the service providers would consolidate the information and send to Sacramento Covered?
  - Should they download data from their data systems and export data to Sacramento Covered and is there capacity to review that data?
  - Who are the service providers?
  - Is hospital data included? Do you need the number of ED encounters and hospital visits?

Next Steps for Service Delivery Committee (Karen Linkins)

- Service Delivery Team is working on the process for warm handoffs to the Care Teams and will have more updates at the next meeting. Will need feedback/input from Service Delivery Committee.
- In discussions with hospitals on referral pathways. Don't want to duplicate programs and we want to be clear on eligibility criteria. Also be talking to the health plans on referrals and coordination.