pathways to HEALTH HOME

Steering Committee Meeting Notes

Date & Time: May 3, 2018, 1:00-2:30 pm
Location: Room 1119, Sacramento City Hall
915 I Street Sacramento, CA 95814

Committee Members in Attendance:

- Jennifer Ablog, Kaiser Permanente
- Michelle AlaChappelle, Consumer Representative
- Kelly Bennett, Sacramento Covered
- Ashley Brand, Dignity Health
- John Foley, Sacramento Self-Help Housing
- Kristine Gual, Sacramento Native American Health Center
- Emily Halcon, City of Sacramento
- Holly Harper, Sutter Health
- Beau Hennenmann, Anthem Blue Cross
- Paul Hyppolite, Molina Health Care
- Erin Johansen, TLCS, Inc.
- Kevin Kandalaft, UnitedHealthCare
- Gabriel Kendall, 211 Sacramento
- Nick Lee, Sacramento Steps Forward
- Blanca Martinez, Molina Health Care
- Jodi Nerrell, Sacramento Covered
- Sandra Poole, Molina Health Care
- A. Jonathan Porteus, PhD, WellSpace Health
- Captain Martin Ross, Salvation Army
- Effie Ruggles, River City Medical Group
- Sydney Ryder, Health Net
- Ane Watts, Anthem Blue Cross
- Laura Niznik Williams, UC Davis Health

Phone Attendees:

- Giselle Castro, Access Dental Plan
- Ryan Loofbourrow, Sacramento Steps Forward
- Cathy Lumb-Edwards, Kaiser Permanente
- Janice Milligan, River City Medical Group
- Sarah O'Daniel, Sacramento Housing and Redevelopment Agency
- Krishna Permaul, Health Net

2k by 2020

- Greg Stone, Peach Tree Health
- Teresea Sundstorm, Volunteers of America of Northern CA and Northern NV
- Abbie Totten, Health Net
- Hazaiah Williams, Elica Health Center

Pathways Support Team:

- Lisa Chan-Sawin, Project Lead
- Gretchen Schroeder, Project Manager
- Karen Linkins, PhD, Service Delivery Lead
- Mark Elson, PhD, IT Lead
- John Freeman, Service Delivery Consultant
- Alex Horowitz, IT Consultant
- Alexis Sabor, Project Coordinator

Program Updates (Karen Linkins and Jodi Nerrell):

- Service Delivery Updates
    - Full Launch orientation was held April 19 —30 individuals attended from the six service providers contracted for Full Launch. Discussed roles, new procedures, forms and eligibility and enrollment. Next learning session is coming up on May 17.
    - Dashboard will be updated to show data from the Hubs. Current dashboard has new Dignity and Molina referrals data. Jodi Nerrell noted that for disenrolled individuals, about half were disenrolled due to no contact in 3 months and the others moved out of the county or graduated out of the program, meaning they are no longer classified at a high acuity level and can self-manage (about 10-15 have graduated out of the program and into housing). Karen Linkins added that graduation is not the only goal — about connections and getting people the care they need in the best possible way. Want people to be moving and improving but want to frame success as connection and not just getting into housing. Jodi agreed and shared an example of a hospital referral in which the man was not eligible for Pathways but was connected to housing three days later.

Partner Spotlight: Molina Healthcare (Sandra Poole and Blanca Martinez)

- In 1980, an emergency physician started a Molina clinic and then launched the health plan. Molina Health is in six regions in California. Main mission was and remains caring for the underserved. Molina participates in three Whole Person Care pilots in California including Pathways.
- For Pathways, Molina looked at the list Pathways enrollees assigned to Molina and added data elements to the list, for example PCP, name, contact, medical group. Then we assigned our 63 homeless members to Molina case managers. Created medical alerts for Sac Covered to help

keep in contact with members. In-house alerts notify the health plan when members are in the emergency department, which are then communicated directly to Sac Covered.

- Molina staff reach out to Sac Covered CHWs, get the participant profile and exchange information. CHW provides client goals, needs, and how they can contribute with Molina to help with these goals. When members are enrolled, they are given an acuity level. The higher the level the more severe they are.
- Sac Covered trained Molina case managers and community connectors for population-specific support. Management also got trained since they are in charge of authorizing treatment. We try to be as involved with our members as possible. Our utilization management team joins together with Sac Covered on the best ways to place people.
- We started Pathways referrals in December 2017. 13% of homeless members are in housing (11 members total) and 1% in transitional housing. Have not graduated anyone yet.

- Questions
  - Captain Ross: How do Pathways enrollees choose their health plans?
    - Sacramento Covered: Some members are able to select a plan when they start to get enrolled. Others are already assigned a plan but do not know what plan they have. We try to avoid switching plans — we encourage enrollees to go to the clinic and request a change of provider before switching health plans in general.
  - Michelle AlaChapplle: How are you managing mental health? Is there an agency you specifically utilize?
    - Sacramento Covered: Behavioral health support depends on their primary care provider. Most Hubs (FQHCs) have the full spectrum of behavioral health treatment that keeps everything in the same place and that is better than having folks get mental health meds elsewhere. For a clinic that is not an FQHC, we go through the health plans for SUD or mental health services. If the enrollee looks like they would fit into the County Mental Health Plan, we do our best to get them in there.

    Karen Linkins: Do you have any advice for the other health plans?
    - Molina: The biggest piece is that we set a tone with Sacramento Covered on communication. That strong collaborative effort made working together more successful. We wanted to ensure to be responsive as Sacramento Covered, who was very strong at setting that foundation right away. We knew this was important and that we could really make it work. We also want to keep this same standard with our members.

Pathways Preview: Full Launch & Health Homes (Lisa Chan Sawin)

- Full Launch
  - Program is shifting into Learning Community mode.

- Full launch model – we are not blanketing the City with navigators. More targeted referral process and intentional use of dollars.
- Broadening number of partners – expanding hubs, and having conversations with outreach and housing partners.
- We are now in a more contract management phase versus design so we really want to think through the best ways we can all work together. Will continue to share data with you all so we can make sure we are being effective. We are excited to have these conversations and want to build the right infrastructure to make deeper engagement/performance improvement possible.

- Health Homes
  - Another Medicaid waiver program is going live in Sacramento County in July 2019. Health Homes will be run by the health plans across counties.
  - Requirements Include:
    - 2+ Chronic Conditions, or Hypertension and: COPD, diabetes, coronary artery disease, chronic or congestive heart failure, or Major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia), or Asthma and a risk of at least one of the following: diabetes, SUD, depression, or obesity.
  - Enrollees must also have: A chronic condition predictive risk score above 3, or At least one inpatient stay in past year, or 3+ ED visits in past year, or Chronic homelessness, and At least 2 separate claims for the eligible condition.
  - Our goal is to not have this program compete with Pathways. Whole Person Care has broader enrollment criteria and Health Homes is very specific, so we hope both can fit together.
  - Questions:
    - John Foley: This population is going to include people who have a history of messing up their housing placements. What is Health Homes going to do to support these populations? Lisa: Still needs a lot more work to flush out those details in the County.
    - Erin Johansen: How are we going to look at Health Homes in context with state programs? Lisa: Other counties will be implementing this before we do so we can learn from them.
    - Ashley Brand: How are the health plans going to implement this across plans and counties across the state? And how can we learn from Whole Person Care while respecting county differences? Beau Hennenmann: Health Homes is much more prescribed. It will be structured the same county to county. There are strict guidelines that will lead to a standardized program. As for plans, it is doable to have all sixhealth plans work together. San Francisco is starting in July and we have already opened the lines of communication across all health plans in preparation. Want to be as aligned as possible and I think we can get to that point.