pathways to
HEALTH + HOME

Total Population: The City of Sacramento's Whole Person Care pilot, called Pathways to Health + Home (Pathways), will serve a minimum of 3,250 individuals from 2017-2020. At full capacity, the program will have 1,000 individuals enrolled and receiving services on any given day.

Who does the program serve?

Pathways targets Sacramento's most vulnerable individuals experiencing or at-risk of homelessness who are enrolled in or eligible for Medi-Cal. The program supports individuals who not only have the highest service needs, but also the highest utilization and costs associated with ambulance rides, fire and police department encounters, health emergencies, and hospitalizations.

Budget: $32 million in federal funding over four years, matched by $32 million in local funding provided by the lead entity and participating partners.

What organizations are participating?

- **Government:** City of Sacramento, including Sacramento Police Department and Sacramento Fire Department, and Sacramento Housing and Redevelopment Agency
- **Community Clinics and Consortia:** Capitol Health Network, Elica Health Centers, HALO, One Community Health, Peach Tree Health, Sacramento Native American Health Center, TLCS, and WellSpace Health
- Health Plans & IPAs: Access Dental, Aetna, Anthem Blue Cross, Health Net, Kaiser Permanente, Liberty Dental, Molina Healthcare, River City Medical Group, and United HealthCare
- **Hospitals:** Dignity Health, Kaiser Permanente, Sutter Health, and UC Davis Health
- **Homeless, Housing, Social Services, and Behavioral Health Providers:** 211 Sacramento, Sacramento Covered, Sacramento Steps Forward, Sacramento Self-Help Housing, The Salvation Army, TLCS, and Volunteers of America —Northern California and Northern Nevada

What services are included?

Pathways provides services in four main areas:

1. Assertive Community Outreach
   - Assertive outreach and engagement of potential clients in the field;
   - Warm handoff to Enrollment and Eligibility for program enrollment, assessment of health, behavioral health, housing, social services needs, and acuity level;
   - Development of Participant Profile that identifies key needs, including the individual's self-identified priorities and goals; and
   - Ongoing coordination and support for client's day-to-day needs and psychosocial support throughout program enrollment.

2. Enrollment and Eligibility:
   - Medi-Cal eligibility and enrollment;

2k by 2020

- Identification and/or assignment of client's health plan and primary care provider;
- Enrollment of clients in housing and other benefits;
- Identification of client's enrollment in other case management programs;
- Determination of clients' eligibility for Pathways and program enrollment;
- Collaboration with outreach workers on development of Participant Profile, including acuity-level assignment and clinical sign-off; and
- Assignment and warm handoff of client to Pathways Care Team based on health plan and PCP assignment, acuity level, geography, etc.

3. Comprehensive Care Planning & Connection to Integrated Health and Housing Supports: Interdisciplinary Pathways Care Teams serve as the "Health Home" for the client using a centralized care management platform to facilitate co-management of participants and providing the following services:
   - Development and real-time updating of the Shared Care Plan;
   - Navigation of and expedited access to health, behavioral health, and social services;
   - Housing supports and services, including transportation, apartment search, application support, landlord relationship management, and deposit and housing setup support; and
   - "Whatever It Takes" complex care management services, care coordination, and follow-up across organizations and service systems.

4. Expanded Intensive Respite Care Services for Homeless Individuals Exiting Hospitals:
   - 16 additional beds for post-acute 24-hour residential respite care program; and
   - Services including nursing, monitoring of medication management, and oversight during recuperation.

How are participants enrolled?

Assertive outreach workers collaborate closely with the Eligibility and Enrollment office and Referral Partners (e.g., hospitals, police, and clinics) to identify individuals who are potentially eligible for the program. They then make persistent and consistent contact with the individual t, establish a relationship, building trust, and engage the individual to enroll in the program. Outreach workers provide warm handoffs and collaborate with the Eligibility and Enrollment provider to ensure timely enrollment in the program, assessment of service needs and acuity, and assignment to a Pathways Care Team to receive more comprehensive health and housing supports.

How are data being shared?

Pathways data sharing is supported by partner execution of data sharing agreements and BAAs and is currently being shared through the use of standardized data collection templates and protocols until collection is automated. The program is in the process of developing a centralized Care Management Platform that will allow partner organizations to share data on enrollees in real-time.