pathways to HEALTH HOME

# Steering Committee Meeting Notes

**Date & Time:** November 2, 2017, 1:00-2:30pm
**Location:** Sacramento City Hall, Room 1119
915 I Street Sacramento, CA 95814

**Committee Attendees:**

- Jennifer Ablog, Kaiser Permanente
- Kimberly Anderson, Kaiser Permanente
- Chad Augustin, Sacramento Fire Department
- Kelly Bennett, Sacramento Covered
- Anna Berens, EHS Medical Group
- Ashley Brand, Dignity Health
- Kelly Brenk, Sutter Health (call-in)
- Kristie Brown, Kaiser Permanente
- Andrew Geurkink, City of Sacramento
- Britta Guerrero, SNAHC (call-in)
- Emily Halcon, City of Sacramento
- Holly Harper, Sutter Health
- Beau Hennemann, Anthem Blue Cross
- Erin Johansen, TLCS, Inc.
- Gabriel Kendall, 211 Sacramento
- Niko King, Sacramento Fire Department
- Nick Lee, Sacramento Steps Forward
- Ryan Loofbourrow, Sacramento Steps Forward
- Cathy Lumb-Edwards, Kaiser Permanente
- Janice Milligan, River City Medical Group
- Jodi Nerell, Sacramento Covered
- Laura Niznik Williams, UC Davis Health
- Robert O'Reilly, Molina Healthcare
- Krishna Permaul, Health Net
- Sandra Poole, Molina Healthcare
- Dr. Jonathan Porteus, WellSpace Health
- Amani Sawires-Rapaski, VOA
- Richard Robinson, Kaiser Permanente
- Dalip Rai, WellSpace Health
- Tory Starr, Sutter Health
- Abbie Totten, Health Net

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- Hazaiah Williams, Elica Health Centers
- Joil Xiong, Sacramento Covered

**Support Team Attendees:**

- Lisa Chan Sawin, Project Lead
- Karen Linkins, Service Delivery Team Lead
- John Freeman, Project Manager
- Jean-Paul Buchanan, Communications Team Lead
- Margaux McFetridge, Communications Manager

**Program Updates (Lisa Chan Sawin)**

- Pathways to Health + Home website launched (www.p2hh.org)
- 10/9 Community Education session held
    - More than 60 individuals representing health and housing organizations, the faith community, and advocacy groups attended.
    - Participants shared feedback, reactions, and questions about the program and examples of current partnerships
    - Key themes and quotes are in Compilation of Feedback, which will be distributed in tomorrow's newsletter and posted on website.
- 10/19 Service Delivery and IT Committee Meetings held:
    - Focused on tools for referrals, screening, and assessment — goal is to have as few assessment tools as possible that cover the range of needs.
    - Provided members with copies of a draft Pathways consent form for input; now have an updated version for review.
    - Assessment, enrollment, and consent forms will be shared with the broader group at the next Steering Committee Meeting.
- 10/24 City Council Meeting outcomes
    - City Council received an update on Pathways and voted unanimously on three agenda items related to homelessness, including the agreement with Sacramento Covered for Pathways Early Engagement Services.
    - Triage Center will be run by VOA and connected to services, including Pathways supports.
- 11/1 Exec Committee meeting updates
    - Committee reviewed program progress and approved incentive agreement approach.

**Partner Spotlight: Sacramento Covered (Kelly Bennett & Jodi Nerell)**

- Background and overview on Sacramento Covered
    - Sacramento Covered was launched in 1998 as an initiative from Mayor Joe Serna to insure uninsured children.
    - Evolved into an organization that supports access, enrollment, and education on health coverage.
- Three key program initiatives utilize a Community Health Worker approach
    1. Community Navigation Program where navigators connect with public to teach them about coverage options and facilitate enrollment in Medi-Cal and Covered CA and help them maintain coverage. This is Sacramento Covered's largest service area.
    2. Hospital Navigation Program where navigators are in the ED to help frequent users and facilitate their connection to FQHC partners and providers to establish care outside of the ED. Program is four years in and more than 4,000 individuals have been served, resulting in a 59% reduction in ED visits and 55% reduction urgent care service
    3. Assertive Community Outreach that is field-based and includes 33 navigators (also called CHWs, promotoras, and health access specialists) who are hired from the community and have lived experience.
- Data Sharing infrastructure includes:
    - Salesforce CRM which they are building out to serve as the Pathways portal for enrollment and the shared care plan
    - BAAs with hospitals, health plans, IPAs, and FQHCs
- Overview of Sacramento Covered Early Engagement Services and Partners
    - Full 24 hours since the program launched and 25 individuals are already enrolled.
    - Have received referrals from ICP/ICP + and Sacrament Police Department IMPACT Team.
    - Will be working in the coming weeks on ED referrals and referrals from the Sacramento Steps Forward HMIS queue.
    - Currently testing the referral form, universal consent form, and assessment tool. Tools have been well received, takes about 10-15 minutes for assessment.
    - With the consent form, some individuals had privacy concerns due to psychiatric issues so adjustments have been made.Goal is to talk to referring partners about the form and how to use it — they want to make sure that potential clients meet eligibility criteria.

- Care planning has been initiated with several enrollees and their staff will be augmenting and adding to it
- One member asked whether individuals who have enrolled would need to resign the form the consent form if there are changes; Support Team confirmed that those individuals will need to resign the form.
- It was asked how Pathways outreach and enrollment will align with the Winter Triage Center. Noted that Community Health Workers will conduct outreach prior to opening and be co-located in the shelter along with IMPACT Team.

**Incentive Agreements & Triggers (Lisa Chan Sawin)**

- An overview of the purpose of the incentive agreements was provided:
  - Incentive agreements are an important tool to support partner participation in Pathways to Health + Home
  - DHCS requires WPC pilots to develop deliverable-based budgets that may include incentive payments for downstream providers
  - Incentive agreements and payments are tied to the "achievement of specific operational and quality deliverables that are critical for the pilot's overall success"
- On November 21st City Council will approve the template
- All agreements have specific requirements from the program application that partners will need to meet to trigger payments (e.g. governance participation); triggers are based on DHCS program requirements.
- Agreements with some partners have sent; Support Team needs feedback soon.
- One partner noted that it may be helpful to have a grid that shows how each incentive will be tracked and specifies what the incentive is based on and whether it is something partners will have to document.

**Early Engagement & Full Launch Models (Karen Linkins)**

- The Support Team provided an overview of the four main components of the Early Engagement model: 1) Assertive Outreach and Referrals, 2) Eligibility and Enrollment, 3) Comprehensive Care Plan, and 4) Connection to Integrated Health and Housing Services.
  - Noted that referral pathways will also include MIHS/Sac Fire

    - One foreseeable challenge will be keeping homeless individuals enrolled in the program and maintaining relationships with clients.
    - Care plan will be shared and dovetails into what hospitals and plans are already doing
- Support team described the rollout of referral sources through Early Engagement and into full launch.
    - Noted that SHRA and IPAs need to be added to list.
- Support team described how the Early Engagement model would evolve into the Full Launch Model with multiple Health Homes fielding Pathways Care Teams.
    - It was asked how many enrollees each cohort would oversee and the ratio of providers to patients. Support Team explained that the target is 100-125 using a team-based approach without specific caseloads per care coordinator.
    - Noted that the care management platform is being developed at the IT Committee level.

**Linkage to Health Homes (Lisa Chan Sawin)**

- Overview of Health Home Program and alignment with Pathways
    - An overview of the upcoming DHCS Health Home Program was provided. Noted that the target populations between the Health Home and Whole Person Care are aligned, although on the Health Home the population expands.
    - Health Home Program will require data sharing and providers must meet Meaningful Use requirements use EHR, HIT, and HIE.
    - Opportunity to leverage Whole Person Care to build out Health Home and build relationships with partners. It is critical for Pathways to work with other plan and provider partners to be supportive and helpful in an intentional way.
- Members engaged in a discussion about the model asking the following questions:
    - Which entity will manage the Pathways Care Teams? Support Team responded that accountability processes are still being developed and the idea is to start to standardize the processes across these teams.
    - Will a smaller group be contracted to run trial processes for the Care Teams? Support Team clarified that during Early Engagement Pathways would focus on a smaller cohort to operationalize the Care Teams, specifically the 330(h) clinics.

Contracts should be finalized in several weeks. As part of full launch there will be an RFQ for additional Pathways Care Teams.
    - One member noted that it was important to think early on about resolutions processes when there is not agreement on the direction of the treatment plan and also health plan integration with the plan. Support Team noted that health plan workgroups will be established to address these issues.
    - Will clients that Sacramento Covered are already touching are going to be handed off to the 330(h) to the Early Engagement clinics? Support Team responded that for patients who already have providers, the intent is not to break those relationships. Goal is to have all of the providers serving these patients engaged and provide services. Attendee noted that there is also a difference between being assigned to a PCP and establishing a relationship and getting care from the PCP.
    - Is there any thought around provider staff-level education about the program? Networks are so big that not all employees have awareness that patients might be in the program. Has the program consider a Pathways Card for each individual that has his or her caseworker, provider, etc.? Support Team responded there have been discussions with Sacramento Covered about developing a card and training manuals will be developed for organization staff. Noted that program needs to initiate conversations with the IPAs, plans, etc. to align.
    - Another member pointed out that hospital discharge planners do most of the referrals, but there is large churn. A short YouTube video can explain the process.
- Support team shared the proposed auto-assign and stable enrollment period approach.

**Draft RFQ and Timeline**

- Support team briefly described the broad RFQ requirements
- Noted that timing may change