pathways to HEALTH HOME

Steering Committee Meeting Notes

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

Welcome & Introductions

- Michelle AlaChappelle, Consumer Representative
- Kelly Bennett, Sacramento Covered
- Fatemah Bradley-Martinez, Sacramento Self-Help Housing
- Karen Brockopp, TLCS, Inc.
- Scott Crawford, Health Net
- Kate Hutchinson, Lutheran Social Services
- John Foley, Sacramento Self-Help Housing
- Trina Gonzales, UC Davis Health
- Emily Halcon, City of Sacramento
- Holly Harper, Sutter Health
- Beau Hennemann, Anthem Blue Cross
- Elizabeth Hudson, The Salvation Army
- Gabriel Kendall, 211 Sacramento
- Anira Khlok, City of Sacramento
- Ranny Lann, Elica Health Centers
- Summer Makenna, Liberty Dental
- Janice Milligan, River City Medical Group
- Anne Moore, Sacramento Steps Forward
- Jodi Nerell, Sacramento Covered
- Sarah O'Daniel, Sacramento Housing and Redevelopment Agency
- Sandra Poole, Molina Healthcare
- Jonathan Porteus, PhD, WellSpace Health
- Merritt Sheridan, Aetna
- Amani Sawires-Rapaski, Volunteers of America of Northern CA and NV
- Aide Silva, Elica Health Centers
- Greg Stone, Peach Tree Health
- Abbie Totten, Health Net
- Sergeant William Wann, Impact Team, Sacramento Police Department
- Anè Watts, Anthem Blue Cross
- Holly Webb, WellSpace Health
- Hazaiah Williams, Elica Health Centers
- Joil Xiong, Sacramento Covered

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Support Team in Attendance

- Lisa Chan-Sawin, Transform Health
- Gretchen Schroeder, Transform Health
- Margaux McFetridge, Transform Health
- Drew Kyler, Transform Health
- Alex Horowitz, Intrepid Ascent
- Alexis Sabor, Transform Health

Committee Business (Lisa Chan Sawin)

- Lisa Chan Sawin welcomed Lutheran Social Services of Northern California (LSS) to the Pathways Steering Committee meeting. They are Pathways' newest housing entity — program is excited for the additional housing capacity LSS will provide. Kate Hutchinson is the Deputy Director of LSS and she will be representing LSS at Steering.

City Updates (Emily Halcon)

- **Triage Shelter Update**
    - Emily Halcon shared that we continue to see good outcomes for healthcare but the question of housing is always there. There are new resources that will run parallel with Pathways.
    - The Triage Shelter will be closing in December and about 80% of the shelter residents are Pathways enrollees. Working with VOA to keep the ramp down in thoughtful manner. No longer taking in new guests.
    - While the Railroad Drive shelter will close, the City is actively working on securing an additional shelter site. The Mayor and his staff have been full force working on this and hopefully we will have information to share publicly very soon.
- **HEAP Update**
    - City is now also a confirmed recipient of Homeless Emergency Aid Program (HEAP) funding provided by the state. It is a one-time lump sum to address the homeless crisis in California localities. City will have access to a shared $18 million with the County that can be used for housing services. City wants to use half this money on sheltering programs and the other half on rehousing programs.
    - Pathways is one of the programs that will get access to these housing subsidies. Again, does not cover costs of building new housing but will help pay for housing services.
    - Expect the funds as early as late January and will be routed through the County.
- **County Partnership**
    - City has worked towards a partnership with the County since the inception of the Pathways program and last week a DSA with the County was signed. It goes to City Council for approval next week.
    - This DSA will allow the program to engage with the County Behavioral Health system and work with them on the ground. Feeling hopeful for future coordination that is now open because of this.
- **Questions**

- Sarah O'Daniel, SHRA: Is there any incentive we can provide to landlords with HEAP funds to make securing housing easier?
    - Emily Halcon: Yes, this money will be used for the HEAP client but landlord services will become part of what the money can cover. It just has to be directly connected to the client.

Program Updates

- **Dashboard Numbers (Jodi Nerell)**
    - Currently represents the full-year of Pathways enrollment. Pathways currently has 573 clients enrolled right now and 850 total throughout the past 12 months.
    - Impact accounts for about half the Pathways referrals; Elica, WellSpace, SNAHC referrals are just above 30%; and Molina, Dignity, Health Net referrals are at 14%.
    - Still skews to the older population. Housing rate of 18%.
    - Enrollees assigned to health plans: 171 at Anthem, 134 at Molina, 104 at Health Net. United is currently being phased out.
- **Questions**
    - Beau Hennemann, Anthem Blue Cross: Some of the numbers in other counties are lower than they expected. Is our enrollment on track for what we projected at the start of the program?
        - Lisa Chan Sawin: We are also experiencing lower numbers, like other pilots. It takes a lot to lift a program. DHCS shared at the WPC convening in October that the pilots in total are at about 30% of spend and are under capacity. Goal was for Pathways to get to 1,000 enrollees by this point — we are not far off. We are at about a 50% spend; state is at 30%. This means none of the pilots are spending money and providing services at the rate the state expected. Program can roll those remaining dollars over, which can help build additional capacity, but that requires more local match dollars.
    - Abbie Totten, Health Net: Have there been any considerations on new approaches and partners to include to increase service capacity?
        - Lisa Chan Sawin: Yes, the program is constantly looking at what is working and what is not. The Support Team and the City is working through our program budget to get more partners for building capacity. LSS is our newest example of that.
    - Abbie Totten, Health Net: Who else should be at the table?
        - Lisa Chan Sawin: We are currently working on aligning the FQHCs that we do not have contracts with — looking at how we can build capacity with them. The concept of a "virtual hub" is on the table. Program has to be careful and thoughtful about new providers because consistency is important for our enrollees. Talking to other pilots and sharing learned lessons.
- **Committee and Learning Session Highlights (Lisa Chan Sawin)**
    - **9/20 Service Delivery Committee Meeting**

        - The Service Delivery Committee continues to meet and all the materials can be found on the Pathways website (www.p2hh.com).
        - Last meeting focused on client engagement and care coordination. Learned lessons across partners was the theme of the most recent meeting.
        - They are open to all and we encourage you all to keep attending.
    - **9/20 IT Committee Meeting**
        - IT Committee is focusing on collecting, reporting and sharing data appropriately. They also discuss kinks with the Shared Care Plan (SCP). Ggreat opportunity for IT folks to communicate and brainstorm across entities.
        - The last meeting focused on a discussion around improving the SCP portal and leveraging existing networks. Program is working on developing a hospital notification system that will feed into the SCP and provide alerts.
    - **9/20 Learning Session**
        - This meeting is meant for front-line staff who are engaging with enrollees on the ground.
        - The providers reviewed program model, worked on PDSAs, and reported implementation challenges and brainstormed solutions.
        - Breaking down silos is extremely challenging and the program had to determine the best process for getting work done.
        - Fatemah Bradley-Martinez of Sacramento Self Help Housing shared that at the September Learning Session, they developed a new process for completing HCV applications with Sacramento Covered and it has improved our efficiency already.
- **Shared Care Plan & Hospital Notification Pilot**
    - Nearly all Pathways service providers are on the SCP portal. So far, the roll out is going well and has improved communication across entities. However, there is always room for improvement.
    - Program is in the process of creating a ticketing system to track issues partners are having with the portal in an effort to get it at its best. Also working with hospitals on sending manual alerts when Pathways enrollees are in the ED.
    - The Pathways Support Team is creating a high utilizer workgroup to sift through disaggregated data so we can capture and use our data in a more active way to support care on the ground.
    - Also developing a hospital notification pilot to get some of these features automated. We are in the early planning stages and we want to make sure we are building something useful for the long-term. More to come on that as we continue to explore technology. Do not want to recreate the wheel.
- **Environmental Scan**
    - Thank you for your comments on early drafts of the Environmental Scan. All comments were carefully reviewed and approved. It gave us a sense of homeless services available in that point in time. Thank you to all our key informants. The report is now available online.

- **2018 Incentive Agreements**
    - Just about ready to go. We will distribute in the next few weeks with a few changes to the requirements.
        - New incentive requirements for 2018 include:
            - Provide a care coordination point-of-contact
            - Expedited access to services
            - Support for DHCS reporting requirements
    - **Questions:**
        - Amani Sawires-Rapaski, VOA: What does expediting access to services mean? Is it just health services?
            - Lisa Chan Sawin: We can look different definitions depending on the origination. With clinical partners, we know many of our patients are frail. We want to make sure we have a main point of contact for accessing specialty care for these high-risk patients. The goal is to decrease the amount of time it takes to access a service. Heavy emphasis in health care services but we are looking at expedited access for both health and housing.
            - Emily Halcon: To be clear, this is not about holding spots in shelters and bypassing the Coordinated Entry System, it is just getting people through the system that exists.
        - Abbie Totten, Health Net: Given changes in requirements, we need time for legal to review the agreements. Please share new incentives soon.
            - Lisa Chan Sawin: We will push to share the drafts as soon as possible.
- **Health Homes**
    - Health Homes is a new initiative coming online next July. Health Homes launch dates in Sacramento County are set for July 1, 2019 for MCP members with eligible chronic physical conditions and SUD and Jan 1, 2020 for MCP members with SMI.
    - WPC will need to carefully coordinate with CB-CMEs as this program goes live. The goals of Health Homes are very similar to WPC. Program will need to work closely with health plan partners to make sure programs align. Need to think through the best ways to coordinate if someone is eligible for both programs. Trying to avoid duplication. More to come on this. Intersection between HHP and WPC is critical.
    - **Questions/Comments**
        - Beau Hennemann, Anthem Blue Cross: There are several health plans in Sacramento County and we are working to align across all of them. On 11/9, a town hall will be hosted with the County to provide background information on what Health Homes is, what responsibilities they have, and learned lessons from San Francisco and Alameda counties. Will be used to identify which community based providers are interested in the program and also bring stakeholders together. Sign-in sheet going around for those would like more information on meeting.

Partner Spotlight: WellSpace Health (Jonathan Porteus)

- **WellSpace Health Overview and History**
  - Touched to be in this group of people. We have achieved so much together so far. And our mission at WellSpace Health is connected to this because we believe in achieving regional health through comprehensive care. WPC embodies this for us.
  - Many of our programs have been based out of the family service agency side of our clinic. They started in the late 60s and focused on people dependent on opioids, veterans with PTSD and other drug related treatment. We provide services detox all the way to residential rehab.
  - Needed to see the expansion of the health clinic network. Our clinic was doing good work but we didn't have adequate partnership with other FQHCs in Sacramento. We wanted our clients to get better access to care and this lead us into homelessness and now to WPC.
  - Became a FQHC in 2009. Since then, we have opened 16 full time health centers, which include immediate care. With immediate care, we have the ability to serve a family with pink eye all the way to supporting the homeless population. Gives us a wide breadth.
- **Key Services**
  - Medical & Behavioral Health Assistance - Scheduling, Appointment Accompaniment, Patient Advocacy, Treatment Planning, Referrals Management, Hospice
  - Medical Respite - Shelter-based, Food and Lodging, Medically Monitored
  - Documentation Preparation and Readiness - Assist with Obtaining Birth Certificates, California Identification, Bank and Social Security Statements
  - Application Assistance - Short/Long-Term Housing, Medi-Cal, SSI, SSDI, General Assistance
  - Connections- Food Banks, Crisis Respite, Domestic Violence Support, Suicide Prevention, Banking, Legal Assistance, Employment, Transportation and Appointment Reminders
  - Street Nurses - Wound and Medical Care Regardless of Insurance or Provider/Clinic
  - These services are all utilized under Pathways from street nurses to immediate care to our ICP+ respite program.
- **WellSpace Health Programs**
  - T3 Program
    - In 2002 a group of consultants looked into ambulances who were being denied from EDs. Health system felt pressure to provide all services in the ER. Took the meeting minutes the consultants and developed a program from it.
    - As of October 2018 T3 has had:
      - 470 new clients enrolled
      - 22,425+ total touches
      - 2,251 connections to medical and mental health
      - 13,972 Community Resources Provided to 1,547 Non-Enrolled Patients in Hospital EDs
  - ICP+

        - Respite and case management program managed by WellSpace. VOA and Salvation Army have ICP+ respite beds in their shelters. On average, clients stay in the respite beds for 23 days after hospitalization.
            - Average Number of Clients Per Month
                - ICP Plus – 23
                - ICP – 25
            - Total Clients 2018 Year-to-Date
                - ICP Plus – 128
                - ICP – 219
            - Total Touches by Case Management 2018 Year-to-Date
                - ICP Plus – 1,791
                - ICP – 2,323
    - Pathways to Health + Home (Holly Webb)
        - Right now, we are seeing an increase in enrollment. In September we were at 106 enrollees with 470 touches. We now have 140 enrollees in October. 20 to 30 enrollees have graduated from the WellSpace Hub.
        - Already seeing clients engaging and returning to our clinic on their own. Over 40 appointments in October and over 20 were repeat clients. We are seeing people use their PCPs and connecting with our team in the field. We work across the Pathways entities and our assigned CHWs to make sure the client gets exactly what they need. A lot of integration done internally and externally to make pathways successful.

Pathways One-Year Enrollment Anniversary (Lisa Chan Sawin)

- Today is our one-year anniversary. Looking back, some key successes include the execution of 28 data sharing agreements, launch of the Shared Care Plan Portal, and coordination between Pathways provider on a daily basis.