pathways to HEALTH HOME

Key Facts about Pathways to Health + Home

Pathways to Health + Home (Pathways) — the City of Sacramento's Whole Person Care (WPC) program — is a four-year pilot to improve the health, quality of life, and housing stability for the City's most vulnerable individuals experiencing, or at-risk of experiencing, homelessness. Led by the City, the program brings together local hospitals, community clinics, health plans, homeless services and housing providers, first responders, and community-based organizations to create an integrated system of care.

WPC is a pilot program administered by the California Department of Health Care Services (DHCS) and authorized by the Centers for Medicare & Medicaid (CMS) through the Medi-Cal 2020 Waiver. The overarching goal is to increase the coordination of health, behavioral health, and social services in a patient-centered manner by allowing pilots to use Medi-Cal funding for innovative services and infrastructure that Medi-Cal does not normally pay for. There are 25 WPC pilots throughout the state. The City of Sacramento is the only municipality in the state implementing a pilot.

Timeline: July 1, 2017 through December 31, 2020.

Target Population: Pathways targets Sacramento's most vulnerable individuals experiencing or at-risk of experiencing homelessness. 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.

Eligibility Criteria: Individuals must be eligible or enrolled in Medi-Cal, either homeless or at-risk of homelessness, and meet the following health and crisis system utilization criteria:

- One or more inpatient hospital stay in the past 12 months OR
- Four or more emergency department visits in the past 12 months OR
- Four or more crisis interventions in the past 12 months

Capacity: At full capacity, 1,000 individuals can be enrolled and receive services.

Budget: Up to $64 million based on the volume of services provided, infrastructure developed, and the program's achievement of key outcomes.

Funding Sources: The City and partnering organizations contribute funding for the program, which is matched with federal Medicaid funds.

Partners: Thirty organizations representing local government, first responders, hospitals, community clinics, behavioral health providers, managed care organizations, outreach and enrollment organizations, homeless service providers, and shelters participate in Pathways.

Service Providers:

1. Sacramento Covered (Data Management, Eligibility & Enrollment, Outreach, Hub, and Housing)
2. WellSpace Health (Hub and Respite Care)
3. Elica Health Centers (Hub)
4. Sacramento Native American Health (Hub)
5. One Community Health (Hub)
6. Sacramento Self-Help Housing (Housing Services)
7. Lutheran Social Services of Northern California (Housing Services)

Service Areas: Pathways provides services in four main areas:

1. Assertive Outreach and Engagement
   - Assertive outreach and engagement of referred clients in the field
   - Assessment at enrollment of acuity-level and health, behavioral health, housing, and social service needs, as well as their self-identified goals and priorities
   - Warm handoff to Enrollment and Eligibility Office for program enrollment
   - Development of enrollee "profile" in the Shared Care Plan that identifies key needs, including the individual's self-identified priorities and goals
   - Ongoing coordination and support for client's day-to-day needs, including transportation assistance, documentation retrieval, and benefits advocacy, throughout program enrollment
   - Championing and advocating on behalf of enrollees

2. Enrollment and Eligibility
   - Referral management
   - Medi-Cal eligibility and enrollment
   - Identification and/or assignment of client's health plan and primary care provider
   - Determination of eligibility for Pathways and program enrollment
   - For individuals not eligible for Pathways, referrals and warm hand-offs to other services
   - Consent management
   - Assignments of enrollees to Pathways providers

3. Connection to Integrated Services through Pathways Care Teams
   - Interdisciplinary Pathways Care Teams comprised of an Outreach Community Health Worker, Hub community clinic provider, and housing specialist work together to co-manage enrollees
   - Team members develop enrollee Shared Care Plans and update care plans in real-time
   - Teams provide expedited access to primary care, specialty care, behavioral health, and social services and benefits
   - Housing services include assistance in locating, accessing, maintaining, and retaining housing, as well as housing move-in assistance, including one-time funds for utilities, security deposits
   - Working together, the teams provide "whatever it takes" complex care management services, care coordination, and follow-up across organizations and service systems

4. Expanded Intensive Respite Care Services (in development)
   - 20 additional beds for post-acute 24-hour residential respite care up to 90 days
   - Services including nursing, monitoring of medication management, and oversight during recuperation

IT Infrastructure and Data Sharing: Pathways has made significant progress in enabling data sharing to support the integration of service providers and better care coordination for the target population. The core components of the Pathways data sharing and IT infrastructure include:

- Enrollee Consent
- Partner Data Sharing Agreements
- Online Shared Care Plan

For More Information: Visit www.p2hh.com or email pathways@transformhc.com.