AC Care Connect Director's Report

January 19, 2018

Overall Progress of Pilot

Care Coordination:

The December Problem Solving Learning Community marked a shift in structure to generate tangible and active work from the group of over **60 participants from over 30 organizations**. The group learned about how to refer clients effectively for specialty mental health services through ACCESS, and developed immediate ways this information could be used and disseminated to their organizations. Participants also worked on developing improvement projects in the areas of warm handoffs from primary care to housing services, integrated behavioral health, and social services, work that will be completed at the January session. Progress on the improvement project for expediting IHSS applications was reported out to the group by project team representatives from Social Services and CHCN.

Improvement progress and opportunities for the Follow Up After Mental Health Hospitalization metric were discussed at January's Clinical Implementation Work Group with representatives from Alameda Health System, Pathways to Wellness, Behavioral Health Care Services, and Care Connect. The group articulated the following next steps:

1) Additional data needed to modify interventions for subpopulations,
2) Activities to better encourage patients to connect to Level 3 providers including a brochure describing services available beyond medical management, and hosting a field trip for John George social work staff to see the Pathways to Wellness facility and staff so they can speak to clients with experience, and
3) Digging into a few cases where clients presented in primary care post-discharge with necessary information to inform those providers about what care is needed. This work may result in additional PDCAs.

Congratulations to Alameda Health System for meeting their improvement target for improvement in this area!

Care Integration:

BHCS AC Care Connect, Care Integration Team and Quality Improvement Unit (QIU) Consultants are engaged in a PDCA to improve the percent of Level One Adults enrolled in Alameda County operated Community Support Centers who receive primary care services. In the past month, the PDCA Team conducted additional site visits at the Valley Adult Community Support Center to meet with the clinical team, and further understand the challenges of referring clients to primary care services at the local FQHC in Southern Alameda County, including the needs for a warm-handoff process to the FQHC.

Data Sharing

Prototype Community Health Record (pCHR): The pCHR launched in early October; we are currently working on improving user experience and accessibility. A total of **26 out of 35 registered end users across four organizations** are using the tool. Concurrently we are preparing for implementation with Wave B end users (Tri-City Health Center, Pathways to Wellness, CHCN Care Neighborhood) and then Wave C (Abode, BACS and AAH) mid-February (1-month delay due to scheduling conflicts). Among other

things, we are ensuring all appropriate data sharing agreements are in place between our partner organizations, AC Care Connect and CMT (the vendor).

Phase II CHR RFP: A second draft of the RFP is in the review process. Due to the scope and complexity of possible solutions and a delay in securing technical expertise, the target release date has been moved from mid to late-January 2018.

Data Sharing Governance: Wave B participants, including Tri-City Health Center, CHCN Care Neighborhood, and Pathways to Wellness, are in the process of reviewing data sharing agreements. The Data Sharing Sub-Committee will be convening two new workgroups focusing on data transmission and SUD privacy and security during the first quarter. These workgroups will developing/expanding content for the Health Data Repository Data Sharing Agreement Policies and Procedures.

Data Sets: We have successfully launched the data matching system for partial matches. We are learning more from this as we adjust thresholds for potential matches with the hopes that we will find more unmatched individuals in HMIS and other hard to match datasets. We have refreshed the dataset from Anthem and are continuing to refine the process to routinize the refresh going forward. The datasets included so far:

- BHCS
- DHCS
- Alameda Alliance for Health
- Anthem Blue Cross
- CHCN
- Housing and Community Development
- Home Stretch
- Alameda County Sheriff

Homeless Management Information System (HMIS): The new HMIS will support the Housing Resource Centers and Coordinated Entry for homeless services by providing key functions such as assessment, prioritization, and matching to resources. HCSA, EveryOne Home and the Housing and Community Development Department continue to work together to support this effort. Housing Resource Centers began assessment with the new prioritization assessment tools in November. Each region has focused on assessment of clients previously identified as high need individuals (in the old system), as well as those in existing programs such as shelters and transitional housing, or on existing prioritized lists. An initial **214 Care Connect clients** were identified as eligible for the housing navigation bundle in this group; **867 assessments have been completed** and entered into HMIS. The total number of clients that have undergone CES reassessment to date is **935**.

Housing & Homelessness:

Housing & Homelessness

Implementation tasks such as hiring and training new staff, screening, housing problem solving, assessments, and preparing for full launch of coordinated entry continued through December in preparation for the full launch of coordinated entry with the new HMIS (anticipated in February or March 2018).

Status of housing related services contracts:

- Community Living Facilities contract with Community Health Improvement Partners (CHIP) was approved by Board of Supervisors December 19th.

- Amended contract with Eden I&R (2-1-1) to improve upon an existing website for housing resources, in order to **create a robust, practical, and accessible online housing resource** to individuals and families seeking resources towards securing housing was approved by the Board of Supervisors December 19th.
- **Eden I&R implemented changes on November 1st to the 2-1-1 call center,** offering 24-hour support for those seeking housing support services. For callers experiencing a housing crisis, the call flow includes a health and safety screening, housing crisis screening, housing problem solving support, and referrals to regional housing education and counseling workshops. **2-1-1 handled 1,223 calls for all callers in the month of December who indicated they were homeless or experiencing homeless.**
- **Bay Area Community Services regional Housing Education and Counseling Workshops continue to be offered daily** and are open to anyone experiencing a housing crisis. For a schedule with their locations, visit: http://www.bayareacs.org/wp-content/uploads/2017/10/HEC-Schedule.pdf. BACS is planning to add two more weekly locations starting in January.
- Housing Legal Services launched in December 2017. **Bay Area Legal Aid has served 39 clients** with legal needs, including **6 cases of legal representation** for clients. A total of **10 legal workshops** have been held by Bay Area Legal Aid, **serving a total of 102 clients** across all of these workshops.

Housing Bundle Enrollment:

- **60 clients have been enrolled in Housing Navigation Service Bundle** and an additional **19 clients may be enrolled** upon eligibility determination.
- City of Oakland has started serving clients in Housing Navigation but have not yet submitted their first enrollment log or invoice.
- City of Berkeley will begin enrolling clients in Housing Navigation bundle in January.
- **Four** clients have been enrolled in SNF Transition Service Bundle. An additional four clients are in process of eligibility determination. They have successfully housed **3** individuals and one additional signed a lease and will be moving in February.

Behavioral Health Crisis Response System

John George/Trust/HIP Mini-Pilot:

The John George/Trust/HIP Mini-Pilot began on Tuesday, September 5, and focused on the highest utilizers of John George's PES between January and June 2017. As of Dec 27, 2017, **36** patients visited the PES **151** times, and **11** of the 36 patients have agreed to participate in the pilot. Participants convene at the Trust Clinic and are at various stages of engagement and care. The John George/Trust/ADHIP Mini-Pilot and Case Conference series is multi-faceted and represents the next step in developing a more complete understanding of the needs of the highest utilizers in order to inform the development of specific interventions that will bolster care coordination and promote appropriate crisis system utilization in this population.

During the patients' crisis presentation, data from this pilot will be used to accurately identify patients who are high utilizers which will cascade a series of events. Once a patient has been flagged, staff will be alerted of the chronic pattern of these individuals and alternate dispositions will be offered to the patient after staff have been notified of the request. In the post-acute state, this pilot connects the clients to a clinic with the capacity to offer whole person care. Between visits to the clinic or the PES, coordination occurs between providers either in person, via email, or by phone. And lastly, case

conferencing occurs where patient cases are presented to a group of providers involved in the patients' care. This allows for opportunity to build human infrastructure among providers and evoke collaborative learning to positively impact patient care.

Children's System of Care – Behavioral Health Crisis
As an offshoot to the Mini-Pilot, we are beginning dialogue between Willow Rock (the adolescent CSU and inpatient unit) and John George in order to begin earlier interventions with youth who are currently high utilizers of the youth crisis system.

Community Assessment and Transport Team (CATT) for 5150 Patients:
In the last quarter of 2017, we successfully worked with EMS and BHCS to submit the Community Assessment and Transport Team proposal on November 30, 2017. The focus populations for this pilot will include the following: 1) people who are experiencing a behavioral health crisis in the community and are placed on or believed to be eligible for an involuntary psychiatric detention and 2) people in the medical ED who require a mental health evaluation for either the placement of or discontinuation of an involuntary psychiatric hold. This pilot will allow us the opportunity to answer the below questions related to community assessment, treatment and transport.

Can the Community Assessment and Transport Team:

- Redirect a significant portion of clients with an acute mental health crisis toward alternative services (away from John George Psychiatric Hospital or a community emergency department)?
- Assist in the timely evaluation and care of clients on an involuntary psychiatric holds who have been medically cleared in the community emergency department?
- Decrease the amount of time both clients and police wait for transport of clients on involuntary psychiatric holds without compromising medical care?
- Decrease the percentage of individuals transported with a 5150 in place?
- Complete timelier assessments and triage to more appropriate dispositions?

In addition to continuing to support this pilot, we are investigating what other alternatives to our current crisis resources are needed within our county, specifically for our focus population.

State / Federal news

The budget adjustment for PY3/2018 has been submitted and is under review. Rollover requests are due at the end of January, and the team is working with the state on our proposals.

Sustainability

With our consultant, JSI (John Snow Incorporated), the Sustainability work group will convene in March. We are developing a work plan for creating a Sustainability Plan that incorporates analyses and recommendations on: 1) effective and critical components that need to be sustained, 2) how it will be sustained, 3) necessary on-going resources required, and 4) the governance structure needed for successful implementation.