An Initiative of Alameda County Health Care Services Agency

AC Care Connect Director's Report

March 16, 2018

Right Care. Right Time. Right Place.

CARE COORDINATION | CARE INTEGRATION | DATA SHARING | HOUSING AND HOMELESSNESS
BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM | CONSUMER AND FAMILY EXPERIENCE

Overall Progress of Pilot

Scalability and sustainability are high on our priority this year as we enter year three of five. More than 20,000 eligible clients have been identified; in 2017, 1,790 unduplicated clients were served as a result of the cross-sector collaboration through AC Care Connect. Our clear challenge is to increase the level of help provided through both new and existing AC Care Connect services. We have a long way to go, but we are bringing to bear all of the performance improvement, collaborative problem-solving and data access resources that the Care Connect program can provide so, together, we can make our system work better for the consumers.

CARE COORDINATION

Improved and strengthened care coordination across services, so that clients receive the care they need when they need it

CARE MANAGEMENT SERVICE BUNDLE

Between July 2017 and January 2018, a total of **144 member months of comprehensive care management services were provided to 38 unduplicated clients**. Administered by Alameda Alliance for Health (AAH), these services were provided by a growing network of Community-Based Care Management Entities (CB-CME); all but six member months are at the more intensive, higher-rate tier. These services are provided in parallel with AAH's self-funded pilot of the upcoming Health Homes Program (HHP), which is slated to become an entitled benefit for some complex Medi-Cal beneficiaries in Alameda County in July 2019. The same set of services are provided by the same network of providers with coordinated, distinct funding streams to serve both the Care Connect and future HHP-eligible clients. Figure 1 represents monthly Care Connect eligible portion of the population served.

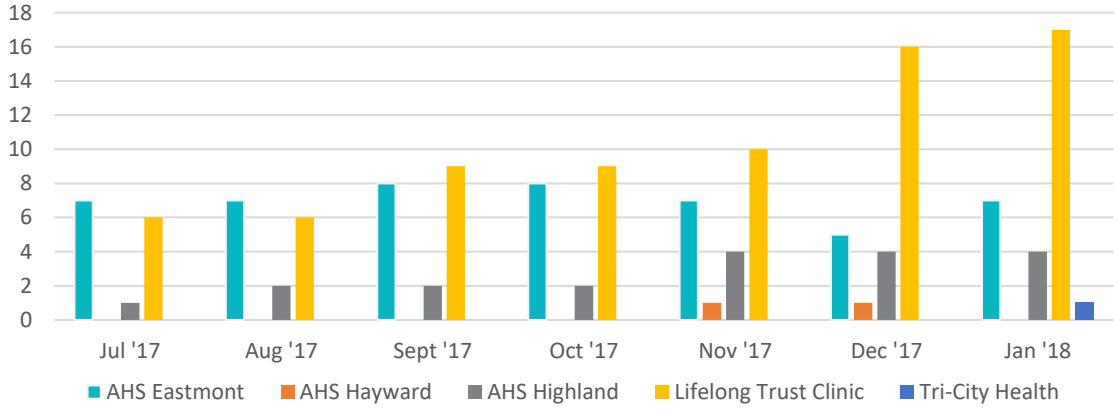

Figure 1. Consumer Enrollment Update by Month and Entity

PROBLEM SOLVING LEARNING COMMUNITY (PLSC)

February 2018 PSLC At-A-Glance

- Substance Use Disorder Mini-Teach: Current and future state of the Drug Medi-Cal Organized Delivery System
- Presented by Nathan Hobbs, LCSW, BHCS Interim County Alcohol and Drug Program Administrator
- 54 participants
- 30 organizations represented

CARE INTEGRATION:

Stronger care integration among primary care, mental health, substance use, housing and the crisis system of care partners, so that our services can be provided with greater efficiency resulting in better client outcomes

Last month, the BHCS AC Care Connect Team, Care Integration Team and the Quality Improvement Unit (QIU) continued their Plan-Do-Check-Act (PDCA) project to connect adult clients enrolled in Alameda County-operated Level-1 Community Support Centers (CSC) into primary care services. In September 2017, the team identified that **110 individuals did not utilize outpatient services in the prior 12 months**. Upon a recent survey conducted in February 2018, it was found that of these 110 individuals, **45 utilized outpatient services**, **indicating a 41% change from September 2017 to February 2018,** thanks to the PDCA improvements such as the implementation of an **"Integrated Health Workflow" and resource list.** Figure 2 shows the relative number of individuals utilizing outpatient services versus those who are not.

LEVEL 1 PDCA COHORT REVIEW – FEBRUARY 2018

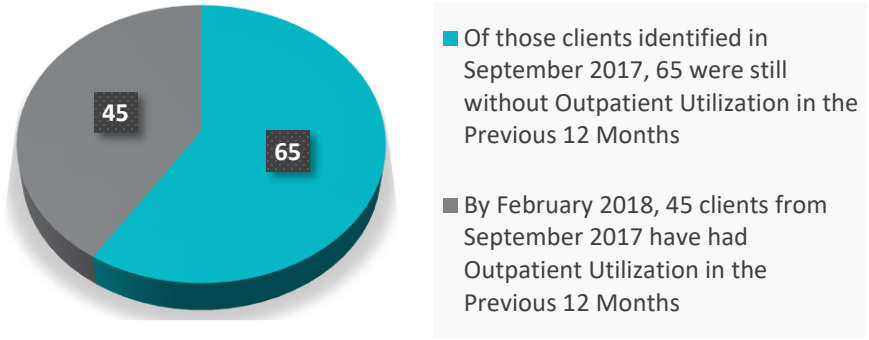

Figure 2. Relative utilization of outpatient services

INTEGRATED BEHAVIORAL HEALTH CARE COORDINATORS (IBHCC)

The Integrated Behavioral Health Care Coordinators (IBHCC) provided care coordination services at 8 FQHCs between July 2017 and December 2017. In total, **279 unique clients have been served and 865 services have been provided to these individuals.** Figure 3 shows the number of clients served and the number of services provided by month.

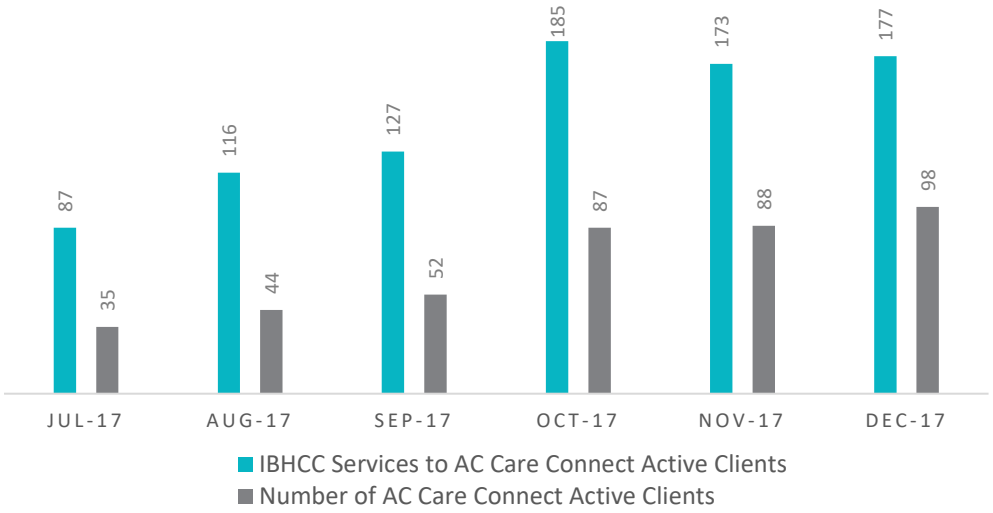

Figure 3. IBHCC Care Coordination services by month

DATA EXCHANGE:

Greater levels of data sharing among primary care, mental health, substance use, housing and the crisis system of care partners, so that providers are better informed about their clients' needs to provide the most optimal care

PROTOTYPE COMMUNITY HEALTH RECORD (pCHR)

We have seen a **120% increase** in the total number of end users, rising from 26 to 57 users across **four organizations**. Wave B and C go-live dates have been pushed back approximately 2 months due to unanticipated end user organization time constraints for pre-implementation work (e.g., review and execution of Data Sharing Agreements, analysis and set-up of eligibility/encounter files and Care Connect resource focus on Wave A implementation needs).

Wave A: *AHS Complex Care, East Bay Innovations, & Lifelong Trust Clinic*
Wave B: *Alameda Alliance, CHCN Care Neighborhood, Pathways to Wellness & Tri-City Health*
Wave C: *Abode*

PHASE II CHR RFP

The Request for Proposal (RFP) for "Social Health Information Exchange and Community Health Record for AC Care Connect" was released on March 9 following reviews by Alameda County Information Technology Department (ITD) and Legal Counsel. The Bidder's Conferences will take place from March 22 – 23.

DATA SHARING GOVERNANCE

The Data Sharing Sub-Committee reviewed and approved the Data Sharing Agreement and corresponding Policies and Procedures on October 18, 2017. Wave A participants have started executing their respective agreements. Wave B participants, Tri-City Health Center, and CHCN Care Neighborhood, are in the process of reviewing the agreements, while Pathways to Wellness and Abode executed the agreements in January and February 2018, respectively. Anthem Blue Cross is now reviewing agreements as our newest partner in our "sharing-positive" approach.

In preparation for Phase II, Data Transmission and the SUD workgroups have been established by the Data Sharing Workgroup in order to expand current policies and procedures to better integrate and promote cross-sector collaboration amongst providers and patients. Two Data Transmission meetings have been held to-date and the workgroup is awaiting feedback from two representatives on current procedures.

HOMELESS MANAGEMENT INFORMATION SYSTEMS (HMIS)

Housing Resource Centers (HRC) continued to use the new prioritization assessment tools. Each region has focused on assessment of clients who: 1) were previously identified as high need individuals, 2) are in existing programs such as shelters and transitional housing, or 3) are on existing prioritized lists. As of the first week of March, **1,532 unique persons have been assessed** and entered into HMIS as shown in figure 4.

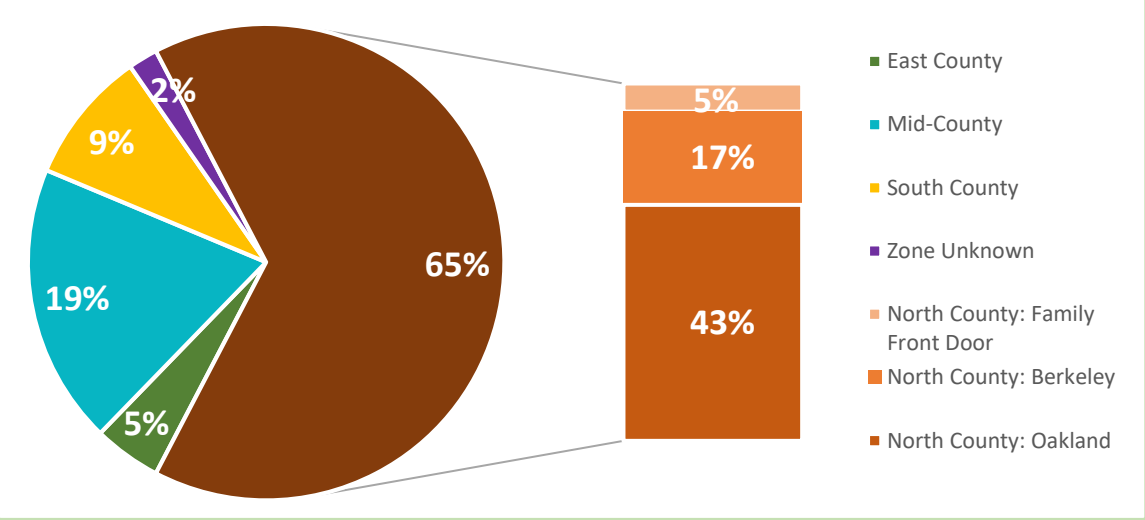

Figure 4. Relative number of assessments completed by region through March 2018

HOUSING AND HOMELESSNESS:

Fully implement a "housing first" approach to the housing and homelessness system through the implementation of Coordinated Entry and the Housing Resource Centers

STATUS OF CONTRACTED HOUSING RELATED SERVICES

January and February data are forthcoming from operator agencies.

Housing Navigation Bundle	Tenancy Sustaining Bundle	Skilled Nursing Facility Transitions Bundle
•From the HRC contracts with Abode Services, City of Oakland, and City of Berkeley, a total of **120 clients have been provided with Housing Navigation** services in this bundle through December 2017	•Abode and Lifelong Medical have enrolled **11 clients in tenancy sustaining services** through December 2017	•East Bay Innovations has enrolled **8 clients in the SNF Transitions bundle.** •East Bay Innovations has **successfully housed 4 individuals** to date, half of total clients enrolled

BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM:

Decrease the unnecessary over-utilization of the most

TREATMENT OF AGITATION IN THE FIELD

In January, Dr. Melissa Vallas, Care Connect Crisis System Liaison, and Dr. Karl Sporer, Medical Director of EMS, presented to and answered questions from the EMS Quality Council on the topic of the **voluntary treatment of agitation with olanzapine by first responders**. The group followed up with additional questions and emails/calls of support following the presentation. In February, we learned that we have been approved to move forward with the Treatment of Agitation in the

restrictive behavioral crisis services in Alameda County by linking people to the right service, at the right place, at the right time

Field pilot. Over the next several months, protocols and training materials will be developed to be incorporated into the Fall 2018 EMS training plan. The program should begin in the late fall.

CONSUMER AND FAMILY EXPERIENCE:

Improve experience and outcomes for consumers and their families. Our consumers and their families come first, and we strive to make sure they feel supported and empowered to be active partners in managing their needs

Building on the momentum from last month, Care Connect is joining Supervisor Miley in hosting a breakfast meeting for Eastmont Town Center providers. Because a high concentration of potential AC Care Connect consumers reside in the areas surrounding the Center, we think this is a significant step in interdepartmental care coordination and integration. The meeting will convene in the next couple of weeks at the Eastmont library conference room.

Goals for the Eastmont Meeting:

- Enhance Eastmont's providers' knowledge of each other's structure, staff, and services
- Identify potential avenues for collaboration and service alignment
- Meet and problem solve around common client concerns

Additionally, we have officially launched our AC Care Connect Internship program with an initial focus of Masters level Public Health (MPH) and/or Social Work (MSW) students from UC Berkeley. In this first year of the program, we have 11 interviews scheduled for the 4 placements we have to offer for both the summer and 2018 academic year. We have been working with the respective schools at Berkeley, while initiating contact with USC, San Francisco State University and Cal State East Bay. We aim to be able to accept student interns from multiple disciplines including social work, public health, nursing and other related fields. By working our way upstream into the workforce, we are looking forward to instilling the Culturally Affirmative Practice (CAP) framework in our future generation of providers.

State/Federal News

The rollover request is still under negotiation, and will be finalized by April 2. The annual report is also due April 2, so it's a busy month! As noted last month, we have not submitted SUD related data specifically to the State in our enrollment and utilization report pending the State identifying the legal authority that allows us to share this information. The State has informed us they believe they have a solution, so we look forward to formal notification that will resolve the issue.

Sustainability

Our partners at John Snow Inc. (JSI) are leading us through our sustainability efforts in tandem with our partners at Resource Development Associates (RDA). Our first sustainability planning session convened on March 7, 2018, in collaboration with several thought partners across various disciplines and sectors. The initial meeting was to begin to generate ideas around collective impact and how to identify key areas of opportunity to allow for effective AC Care Connect activities to continue once the funding runs out in 2020. Our first charge is to identify key stakeholders who will help steer us in this journey. More updates to come as we continue our progress.