alameda county care connect

An Initiative of Alameda County Health Care Services Agency | A Whole Person Care Pilot | June 2018

Partner Update

Number of Clients Enrolled: 2,282 **Days Until Grant Ends:** 944 (December 31, 2020)

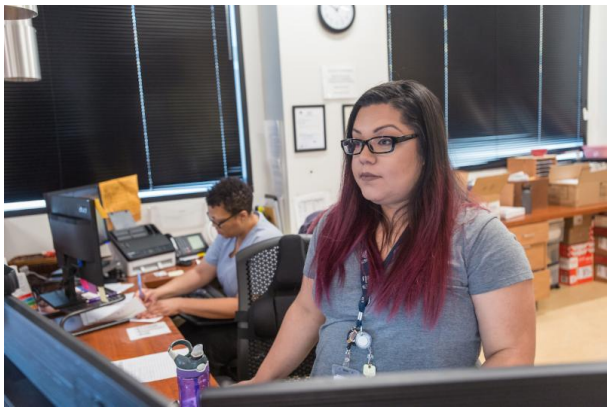
Pathways to Health and Housing

Hannah is a real life example of a person being connected to care when multiple systems and providers work together. She achieved improved health and stable housing, as a result of the collaborative work of John George Psychiatric Emergency Services, Lifelong's Trust Health Center, Alameda County Care Connect, and critical data in the Prototype Community Health Record (pCHR). Health care and social service are being transformed by care providers using data and collaborating together to achieve better patient care and outcomes.

Hannah is living with a chronic health condition and has a history of multiple involuntary psychiatric holds for suicidality. She was estranged from family and living on the streets, cycling through frequent medical and psychiatric hospitalizations. In the last 12 months she had experienced:

- 112 medical inpatient days
- 100 medical ER visits
- 21 psychiatric emergency service (PES) visits
- 5 inpatient psychiatric hospitalizations
- She was not connected to case management

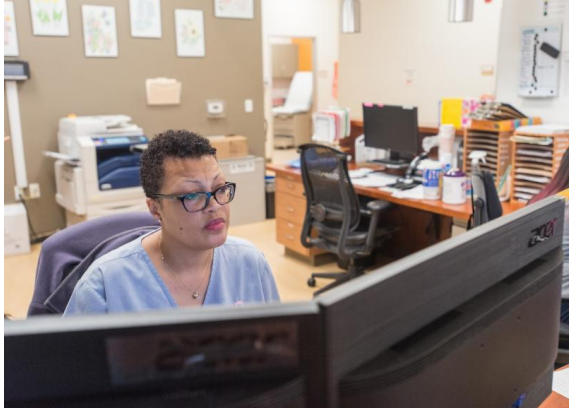
Connections among behavioral health and physical health, including inpatient, outpatient, emergency services, and case management, along with housing services and other community supports helped Hannah move from the streets to housing, and put her on a path toward more stable health. Hannah's pathway to health was experienced when John George referred her to the Trust Health Center for ongoing physical and behavioral health needs. Trust Health Center connected her with a psychiatrist and a Licensed Clinical Social Worker to help her work on a plan for stability. The Trust Health Center also linked Hannah with BACS' Project Connect for intensive case management and help finding permanent housing. They were also able to connect her with Healthcare for the Homeless where she immediately received respite bed housing she could remain in until permanent housing was found.



Lifelong's Trust Health Center

All of Hannah's records, and the new connections and collaboration between her providers prompted them to call Joe, her case manager, in an emergency. Therefore when she arrived at psychiatric emergency services (PES), Joe was called and arrived within the hour. As he continued to build trust and connection with her, he learned that Hannah is very close to her god-mother

and is now working to find housing that would allow Hannah and her god-mother to live together and support each other. Hannah's providers remain updated on her care through ongoing coordination by email, phone, and through the pCHR for those that have access. As a result of the new support and housing, Hannah now has longer periods of sobriety and health while receiving ongoing care at the Trust Clinic.



Lifelong's Trust Health Center

One of the valuable lessons learned: many of our patients have significant trauma in their background and building trust with consistency and relationships are key to the patient's willingness to accept help outside of the crisis system.

Alternatives to Psychiatric Emergency Services (PES)

The Behavioral Health Crisis Response System is making strides toward achieving goals to significantly lower rates of repeated 5150s, lower rates of recidivism, and increase treatment and transport options by 2020. In an exciting collaboration, Alameda County Care Connect successfully partnered with Emergency Medical Services (EMS) and Behavioral Health Care Services (BHCS) to collaboratively develop and submit a proposal through Behavioral Health to the State Mental Health Services Act Board for the Community Assessment Treatment and Transport (CATT) team. The proposal is a request for $10 million over five years to develop CATT which will operate for 16 hours a day, seven days a week in two communities to start with expansion to Oakland within 18 months of starting. When the grant is approved, it will be combined with $1.5 million in Measure A funding that EMS received for the project.

CATT Project Team

The unit will be staffed with a Mental Health Clinician and an Emergency Medical Technician (EMT) in an unmarked vehicle fitted with appropriate safety features. This unit will be dispatched by the 911 system to 5150 calls for an evaluation with the hope of directing people to appropriate services, and redirecting them away from unnecessary acute care and/or incarceration. The Mental Health Clinician will be able to determine the appropriateness and need for a 5150 hold. If appropriate, this unit will be able to transport clients to John George Psychiatric Hospital, a community emergency department based on existing pre-hospital protocols, or to an alternative disposition like a clinic with walk in appointments, a sobering center, peer respite, and more. Finally, the unit will be able to transport clients whether or not a 5150 is placed – an exciting addition to services in our county as currently there are no options like this.

If approved, the CATT project will start in Fall 2018. The focus populations for this pilot will include 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. This pilot will allow us the opportunity to answer the following 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)?
- Can the Community Assessment and Transport Team assist in the timely evaluation and care of clients on an involuntary psychiatric holds who have been medically cleared in the community emergency department?
- Can the Community Assessment and Transport Team decrease the amount of time both clients and police wait for transport of clients on involuntary psychiatric holds without compromising medical care?
- Can the Community Assessment and Transport Team effectively decrease the percentage of individuals transported with a 5150 in place?
- Can the Community Assessment and Transport Team timelier assessment and triage to more appropriate disposition?
- In addition to continuing to support this pilot, in partnership with Behavioral Health and EMS, we are investigating what other alternatives to our current crisis resources are needed within our county; specifically for our focus population.

Alameda County, similar to the rest of the US, is in the middle of a mental health crisis. Nationally, between 2009 and 2014 the number of police encounters with clients in a mental health crisis increased 43-50% while the methods for connecting people to crisis mental health services has remained unchanged. Within Alameda County today, the primary means of establishing this connection is placement of the individual on a California Welfare and Institutions Code Section 5150 hold - a 72 hour involuntary hold for psychiatric evaluation. Patients are taken by ambulance to regionally dedicated psychiatric emergency services (PES) or to a medical Emergency Department (ED) for medical clearance. Wait times in PES can be long and transport to the medical ED can lead to wait times of twelve hours or more before a patient receives any formal treatment or evaluation for the mental health crisis. At this time, few other alternatives, if any exist.

The findings from the CATT project will be used to gain a deeper understanding of the focus population's needs and risks, and provide evidence of successful interventions and patient outcomes. AC Care Connect, Behavioral Health, and EMS will work with stakeholders to implement changes on a larger scale.

For more information, contact Bridget Satchwell at Bridget.Satchwell@acgov.org.

John George Mini Pilot Case Conferencing

The first series of case conferencing was completed in Spring 2018 with nine patients as the focus. There was an unprecedented level of collaboration among health care, behavioral health, and emergency medical services, including inpatient, outpatient, case management, and emergency services, to ensure that consumers achieved optimal health and independence. Focusing on nine patients who have a history of repeat 5150 episodes was important to developing innovative strategies to improve their care and the care of others with complex medical and psychosocial needs. Case conferencing served as a place for learning and intervention.

During case conferences, participants learned that 50 percent of the patients were not case managed and many received no follow-up after a crisis episode. In addition, it was highlighted over and over that trauma and substance use disorder (SUD) as a means to manage trauma are the two main drivers of 5150s in this population. This information has led robust efforts to locate new resources and develop new interventions for follow-up care and increased linkages to ongoing care after a PES episode in hopes of reducing the numbers of 5150 episodes and getting patients to a more appropriate level of care to better meet their needs.

Alameda County has the highest 5150 rates of any County in the State and a small percentage of individuals constitute a large number of repeat 5150 holds. The goal of case conferencing was get immediate help and linkages to care for these specific 9 individuals, but also to gather information for overall system transformation.

AC Care Connect is working with providers on improving discharge plans and connections to outpatient services and mental health providers and eventually hopes that data from the Community Health Record (CHR) will help to identify patient needs while bringing a focus on consumer centered care and linkages to intensive case management where needed.

Lessons Learned from John George/Trust Mini-Pilot Phase 1
Making Connections to Support Whole Person Care

by Kristina Bedrossian and Jenifer Pearce, Bright Research Group and
Dr. Melissa Vallas, AC Care Connect, Crisis System Liaison

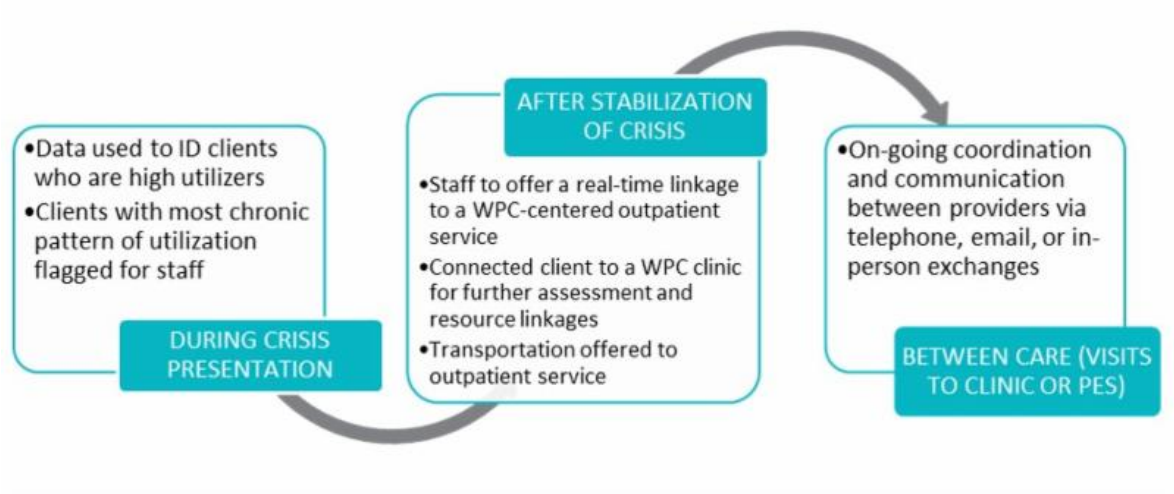
Delivering whole person care to the County's most vulnerable individuals requires collaboration on a whole new level. This is exactly what the John George/Trust Mini-Pilot was designed to do. Alameda County Care Connect, Lifelong's Trust Health Center (Trust), John George Psychiatric Emergency Services (PES), case management, residential facilities, and patient and family advocacy organizations are partnering in a coordinated effort to support 49 persons ("49ers") identified as having used psychiatric emergency services (PES) 10 or more times in a six-month period.

There are two goals:

1. Connect all identified individuals to supportive medical, behavioral, and social services so that crises can be prevented.
2. Develop 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.

Pilot Intervention

The Crisis Intervention Protocol (CIP) consists of three components, each with key elements (see Figure).



Pilot Learnings

Replacing crisis care with care and services designed to prevent a crisis requires change at the individual, organizational and system level. It all starts with having a better understanding of the people who currently rely heavily on PES. Interviews and focus groups conducted with consumers and their loved ones during the pilot revealed a need for reliable, accessible services that are easy to navigate and designed to help people meet basic needs (safety, food, shelter) with dignity; relieve distress and discomfort (trauma informed care, treatment and life-skill development); and increase feelings of control.

Utilization data revealed three major taxonomies within the 49er population characterized by unique combinations of: crisis triggers (substance abuse and mental illness); treatment histories (suspected, diagnosed, treated/untreated); psychiatric inpatient histories; housing and management status; and discharge dispositions (sobering center, outpatient care or other community support). Interventions must therefore be multi-faceted and person-centered. As Phase 2 develops, we are focusing on the following consumer profile types for developing strategic improvements for the pilot.

	Trigger	Mental Illness/ Treated	Psych Inpatient Utilization	Housing	Case Managed	Disposition Option
Patient I	Substance use	Suspected	None/Low	Yes, family or friends	No	Sobering Center
Patient 2	Serious mental illness	Diagnosed/ Inconsistently	High	No, homeless	Yes	Trust Clinic
Patient 3	Serious mental illness	Diagnosed/ Consistently	Low	Yes, public or supported	Yes	Case Manager and/or other community-based option

Care and service providers recognize the importance of identifying people's needs before their PES utilization peaks so supports can be put in place proactively. This requires developing relationships across care-silos, practicing trauma-informed care, and working to reduce stigma around substance abuse. Having visibility into system-wide utilization is foundational to these efforts.

Future Focus

With Phase 1 of the pilot concluded, Alameda County Care Connect is planning next steps. Data shows an opportunity to better support the 65 percent of 49ers discharged home following a PES visit (n = 1140) given that they returned to PES on average 11 days later.

Planned pilot enhancements include:

- Increasing the sample size to include those with 4 or more PES visits in 12 months (n = 713)
- Expanding post-PES disposition support options to also include Dream Youth Clinic for transitional age youth, Alameda Health System wellness centers, and urgent care and case management – all in addition to Trust.
- Implementing targeted post-crisis telephone outreach and case management contact.

Phase 2 will offer an opportunity to strategically apply learnings to date and incorporate enhancements designed to expand the outpatient crisis support network. We'll measure their impact on utilization for unique "patient types" as well as assess the interventions' cumulative impact on how services are delivered, because ultimately whole person care is about connecting each person to the right service, at the right place and at the right time.

To view the full report, visit the Care Connect website at http://accareconnect.org/documents/.

Visit the AC Care Connect Website at www.accareconnect.org.

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AC Care Connect 4-Year Timeline	Start-up: Jan-Jun 2017	Phase 1 Pilot: Jul 2017-Mar 2018	Phase 2 Pilot: Apr 2018-2019	Scale-up & Sustainability Planning 2019-2020	Wrap-up & Sustainability 2021