Director's Report
December 21, 2018

"People come fully integrated."
Mitch Katz, MD, former Director and Health Officer, San Francisco Department of Health

UPDATES

Enrollment strategies

- Beneficiaries who are in the prototype CHR with at least one care team member having access will be administratively enrolled, adding nearly 4,000 to the total and moving Care Connect past the goal of 5,300 enrolled by the end of the year. Notification of enrollment and opt-out instructions will be sent out before the end of December.
- Care Connect is proposing a simplified population definition to make it easier to identify and reach eligible consumers. Individuals currently need to be in at least two crisis systems; we are considering changing the formula to include those who are in any of the four systems: severe mental illness, substance use diagnosis, involvement with the justice system or use of acute physical care. These changes will enable expansion of enrollment and services.

Expanded services for 2019-2020

- A number of initiatives are under consideration including engagement and outreach, street-based clinical teams, and respite beds. These ideas are in accord with Steering Committee feedback and the project ideas submissions survey. A new Alameda County Behavioral Health program for post-crisis follow-up is in development. Benefits advocacy and elbow support for clinical and case management are still being explored.

Prototype CHR

- Work continues with a small group of partners who are live on the system including site visits for further testing to enhance care coordination.
- East Bay Innovations (EBI) received pCHR viewing capability for consumers referred from Alameda Health System acute and post-acute settings.
- Pathways to Wellness is generating reports on high utilizers from the pCHR and identified the top 20 for support or outreach to stabilize and reduce crisis utilization.
- Tri-City Health Center Health Homes CBCME uses the pCHR to monitor complex patients and improve coordination with Washington Hospital providers. ED patient alerts help Tri-City focus on reduction of inappropriate crisis utilization, maintain consistent messaging to consumers, and proactively schedule primary care following hospitalization or ED encounters.

Data Exchange Unit

- Data Governance Committee membership and decision making discussions are occurring including who has access to what data (by organization and by user role). The team is finalizing the charter and recruiting members to join in early 2019.
- Demos of the new system were provided to Care Connect management and program teams, the End User Focus Group, and FQHC Chief Medical Officers. Demos will continue with stakeholders including the Steering Committee on December 21.
- Thrasys delivered the first project schedule draft with Wave 1 go-live next summer which is later than planned due to delays in data feeds from key partners. User Acceptance Testing is expected to begin next spring.

HMIS Phase II Implementation

- The housing Continuum of Care is overseeing standardization of legacy service categories to achieve uniform data entry and deliver meaningful reporting.
- Enhancements to the Coordinated Entry By-Name List (BNL) will occur in January to make the tool more useful for the Housing Resource Centers (HRCs).
- Customization to track additional consumer contact detail was designed and deployed by Housing and Community Development. Data collection for "housing document readiness" is in design for planned rollout in early January.

Case conferencing

- Abode Services will start regular East County regional meetings in January.
- The Housing Team is communicating the need for providers to help obtain housing documents for all high priority households on the By-Name List to improve readiness.

Health Housing Subsidy Pool (Flexible Housing Subsidy Pool)

- The first two patients recently transitioned from the acute setting to housing thanks to the new subsidy pool. The challenges of discharging patients with housing barriers and complex need surfaced earlier this year during an Executive Case Conference with HCSA, Alameda Alliance for Health and Alameda Health System.
- Partnering with AHS' Highland Hospital and post-acute sites provided early learning around barriers to discharge and led to a streamlined workflow for housing placement.

Skills Development Unit

- The Pacific Aids Education and Training Center (PAETC) and the Community Health Center Network (CHCN) lead skills development aligned with Care Connect's vision for whole person care.
- The team has produced 20 trainings with companion resources and served over 730 attendees since January 2018. Topics include housing services (coordinated entry for the non-literally and literally-homeless), safety-net services and public benefits, mental health first aid, trauma informed care, and how to share for whole person care.
- The Care Coordination Academy has hosted over 66 agencies to date, facilitating relationships across agencies through cross-sector training.
- In Q3 2018, the HPAC clinics reported that their staff were able to provide better support to approximately 5,700 unduplicated consumers as a result of the trainings.

DECEMBER ROADMAP MILESTONES

Care transition goals

Several interventions are proposed for consumers and providers during the vulnerable moments of care transitions:

- Refine and implement technology and workflow support for use of the CHR to support care team planning, collaboration, and communication.
- Improve follow up after mental health hospitalization linkages and processes (state required pay-for-performance metric).
- Provide support and technical assistance for the Care Transitions expectation in the Health Homes Program set of services.
- Provide technology and workflow support for the SB 1152 expectations of hospitals discharging consumers experiencing homelessness.

The team is seeking input on opportunities to consider pursuing, or related work in organizations where Care Connect should align and coordinate efforts.

Universal Authorization

- Form development continued through a third workgroup session last month. The County Council Round Table will review the latest draft and language may be added ensuring data will not be used for contract monitoring or incentive purposes for a period of three years.

Culturally Affirmative Practices (CAP) Strategies Development

- Care Connect Fellows participated in an orientation to the pilot, the eligible population, and program services. Fellows also trained in areas relevant to their engagement and participated in system planning including critical observations and recommendations for language used with Universal Authorization, housing flex funding, the CHR.
- The Fellows have provided over 200 hours of input since September and Care Connect has maintained 100 percent retention.

Health in Housing Regional Coordination

- Housing Resource Centers (HRCs) contracts were amended to include specific goals for collaboration with their health partners.
- The housing team is helping HRC leads develop work plans with neighboring community clinics to coordinate care for the highest priority consumers enrolled in the Health, Housing, and Integrated Services Bundle. Plans include points of contact and liaisons between health care and housing, bi-directional referral protocols, and procedures for regional case conferencing participation.
- The Housing Team provided training for members of the Northern California Hospital Council to support implementation of SB 1152 the Homeless Patient Discharge bill that will become law on January 1, 2019.

Treatment of agitation in the field

- Care Connect is working with Alameda County Emergency Medical Services (EMS) to bridge the gap of access to timely treatment of acute psychiatric agitation. The new program treats psychiatric crises with the same urgency as other distressing ailments.

MILESTONES: Q1-2019

Sustainability Planning

- Care Connect will transition into the next phase of sustainability planning in January, guided by the Sustainability Leadership Task Force which includes Steering Committee members and other strategic partners. The task force is the decision-making body for sustainable activities, services, and infrastructure initiated by Care Connect and identified for sustained operation beyond 2020.
- The Sustainability Workgroup includes subject matter experts and County staff who provide technical expertise on sustaining program components such as housing, care coordination, IT systems, data exchange, and financing.
- A preliminary sustainability plan will be drafted, discussed, and refined in collaboration with these groups throughout 2019.

Behavioral Health Crisis System - Treatment of Agitation in the Field

- The program will be fully operational by January 1, 2019 with more than 4000 EMT's and 1000 paramedics trained by the end of the year.

LOOK AHEAD

January 2019

- **Prototype CHR** feedback to inform a critical step in the move to integrate health and housing is expected in January from Abode, the main housing partner for Care Connect.
- The team is exploring the addition of the Care Neighborhood staff at the Community Health Center Network community clinics.

February 2019

- **SB1152** follow-up meetings are planned in February to discuss standards for communication between emergency departments, hospitals and shelters. Participants will include HRC leads and Eden Information and Referral (2-1-1). Data collection is scheduled for a future meeting.