



A Whole Person Care Pilot

Alameda County Care Connect Steering Committee

September 18, 2020



A Whole Person Care Pilot

Welcome

John Jones, Director of Engagement, East Oakland Black Cultural Zone and Just Cities

Nancy Halloran, Deputy Director, AC Care Connect

Agenda

1. Welcome
2. Consumer Story
3. Director's Report
4. LA Whole Person Care and Reentry Populations
5. Opportunities for Collaboration
6. Adjourn





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Consumer Story

Nathan Hobbs, LCSW, Director, Substance Use Continuum of Care, Alameda County Behavioral Health Care Services

Jennifer Caldwell, AMFT, LPHA Case Manager, Options Recovery Services

Justin Phillips, LMFT, Operations Officer, Options Recovery Services

Options Recovery Services/ Santa Rita Jail SUD Treatment Program

- Focused on providing much needed Outpatient(OP) and Intensive Outpatient(IOP) SUD services, Case Management and Re-Entry Planning to incarcerated people inside SRJ.
- Individual, group, and telehealth services provided to all units within SRJ.
- Aims to reduce recidivism and provide high quality SUD treatment during incarceration.



Options Recovery Services/ Santa Rita Jail SUD Treatment Program

- Prepares clients for and provides linkage to system-wide continuing care.
- Integrated collaborative partnership with ACSO, AC Forensic Behavioral Health and Wellpath.



Challenges

- Unplanned or unpredictable release from custody leads to scrambling efforts and transportation problems.
- Limited access to health care data (housing, behavioral health, medical, etc). CHR will help significantly
- Covid-19-related technological challenges, remote services and telehealth adaptations.



Successes

- Transitioned to Telehealth Services during Covid-19
- Currently actively serving 24 incarcerated clients and growing daily
- As of July 2nd, 51% of clients served while incarcerated were opened to SUD treatment services within 30 days of release.
- Client example



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Director's Report

Kathleen Clanon, MD, Executive Director, AC Care Connect

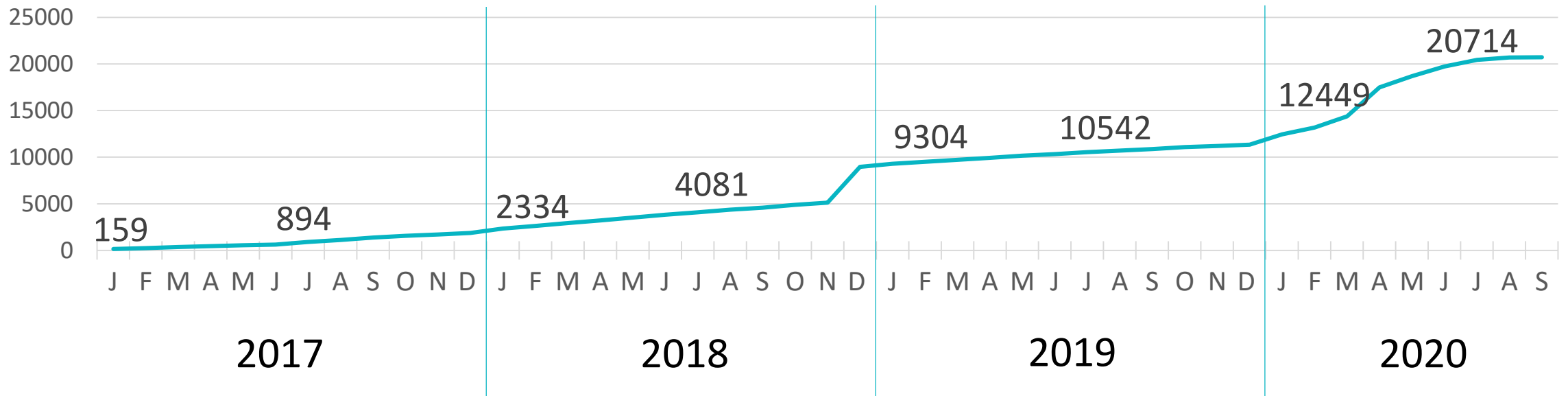


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Care Connect Enrollment Highlights

- **20,714 consumers ever enrolled in Care Connect!**
- Reached our stretch goal (four months early!) of 20,000 enrolled by the end of 2020.

Growth in Care Connect Enrollees over Time



*Data as of September 14, 2020

Peer-to-Peer Advisors: Update

Outreach to guests of Project Roomkey

hotels: Averaging 150 calls/week and 90 conversations/week

Mam Speaking Outbreak Team: Ensuring that Mam speaking residents have information and resources to protect and improve their health

Eastmont Collaborative: Improving health outcomes for eligibles of African descent

Rapid Resource Guide: Making weekly revisions/updates to the Guide



Project Roomkey Updates

- Met goal of securing 1,200 non-congregate shelter rooms
- New Livermore Safer Ground site (112 rooms) opened August 24th
- Total Roomkey hotels: 9 hotels operated by 4 organizations
 - Abode: 3 hotels in Oakland, 1 in Newark, 1 in Livermore
 - Building Futures: 1 hotel in Alameda
 - Berkeley Food and Housing Project: 2 hotels in Berkeley
 - Five Keys: 1 hotel in Oakland
- Project Homekey: County submitted proposals to acquire 4 hotels



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100 Day Challenge and 100 & Beyond

- 100 Day Challenge ended September 4th : 98 households exited into permanent housing
- Emergency Solutions Grant (ESG) secured: funds bridge housing subsidies for 220 households for periods of 12 - 18 months
- 100 & Beyond Collaborative launched (Sep - Dec):
 - Builds hotel staff's capacity to develop viable housing plans
 - Supports care coordination within and across hotels
 - Participating organizations: Abode, Berkeley Food and Housing, Building Futures, East Bay Innovations, Five Keys, Housing Consortium of the East Bay
 - Participants receive incentives to support and acknowledge their work

SHIE/CHR Updates: Training

Wrapping up Wave 4 (Jul – Sep)

- Participants include: Abode, ACBH, AHS, BACH, Bonita House, Cherry Hill, HCSA (EMS), and Lifelong, Bay Area Community Services, Staff at the FEMA Isolation Hotels

Planning for Wave 5 (Oct - Dec)

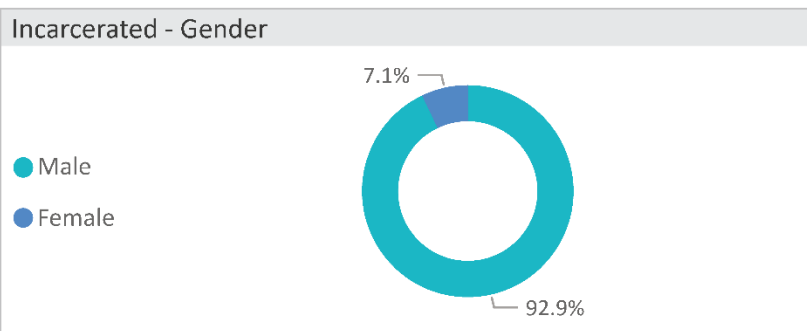
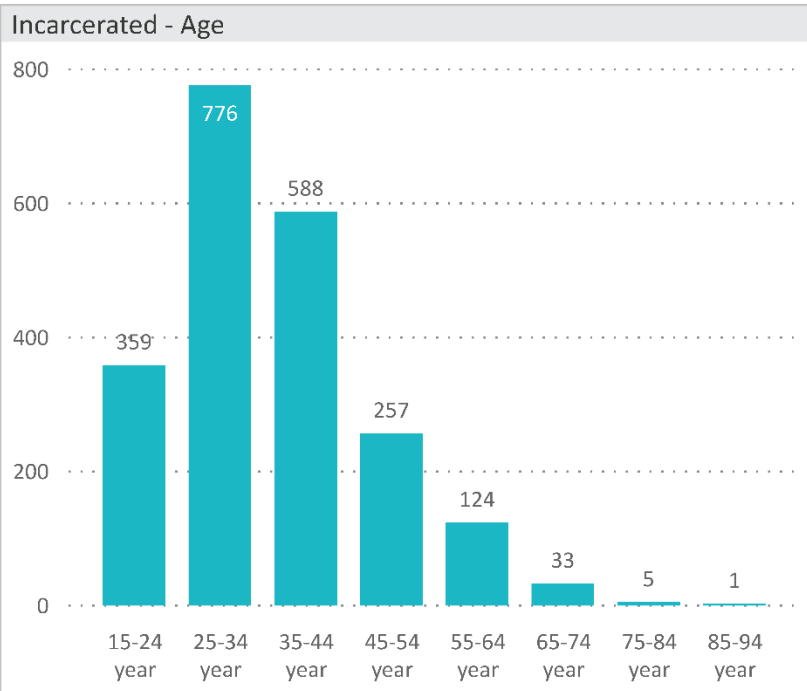
- Participants will include: Roots Community Clinic, Building Futures – Hotel Operators, Asian Health Services, and several SUD and Mental Health partner organizations

SHIE/CHR Updates: Data Feeds and Users

- Outpatient data via CMT now coming into the SHIE, includes expanded hospital and clinic data elements
- Ongoing work matching jail census data to records in the SHIE
- Reviewing EMS (ESO) data feed
- CHR Super User Group (includes users from nearly all participating organizations)
 - Ensures each team receives key updates related to the CHR (data feeds, new features, ISA updates, etc.) and is able to give critical feedback from users on how to improve the CHR.

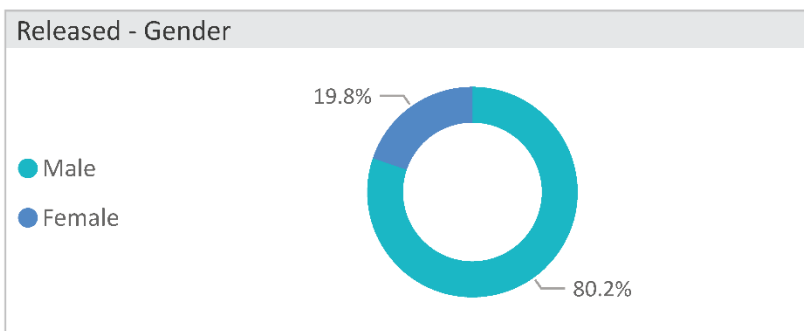
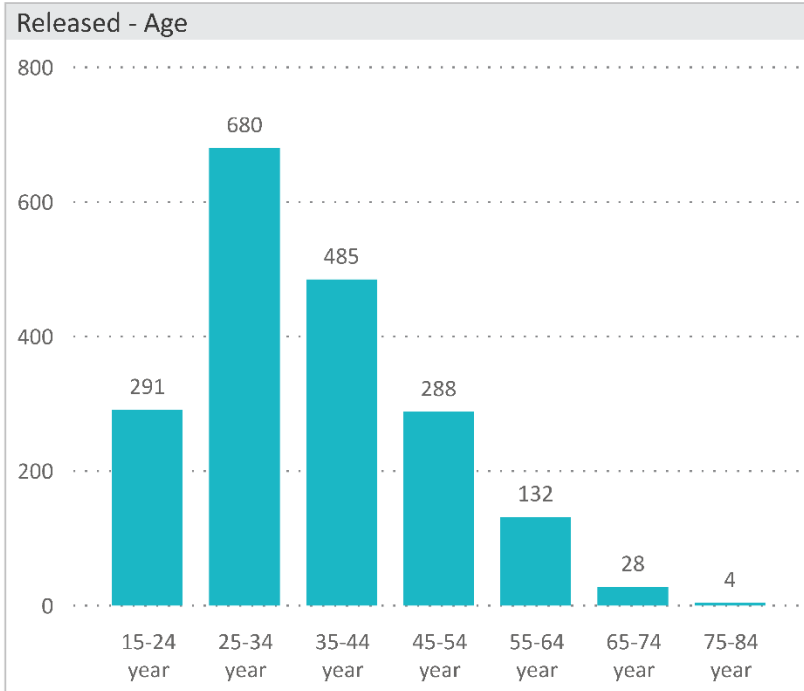
AC Care Connect: Whole Person Care Dashboard

Jail Census (August 9 - September 11)



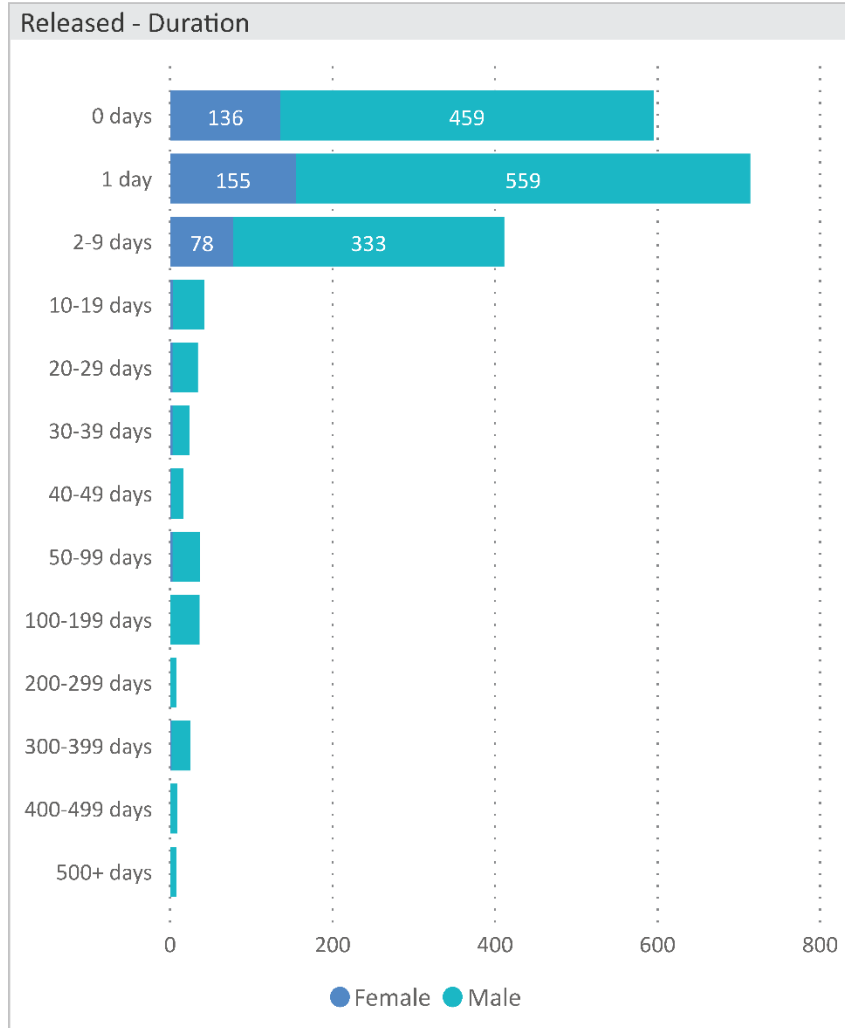
Incarcerated

2,143



Released

1,908



Data source: Social Health Information Exchange (based on Santa Rita jail data).



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LA Whole Person Care and Reentry Populations

Dr. Dennis Hsieh, Incoming Chief Medical Officer, Contra Costa Health Plan

Interactive Panel: Opportunities for Collaboration

Facilitator: Scott Coffin, Chief Executive Officer, Alameda Alliance for Health

Panelists: Dr. Dennis Hsieh, Incoming Chief Medical Officer, Contra Costa Health Plan

John Jones, Director of Engagement, East Oakland Black Cultural Zone and Just Cities

Wendy Still, Chief Probation Officer, Alameda County Probation Department

Panel Discussion

- What critical Data to collect to make a difference in successful re-entry?
- What are the gaps in care/services that you see as major barriers to successful re-entry from Santa Rita?
- How could your organization participate in closing these gaps?

Join the discussion! Steering Committee members and the audience can participate in the discussion via the JAMBOARD link in the chat



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Adjourn

Next Meeting: October 16, 2020



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*For more information visit
www.accareconnect.org*

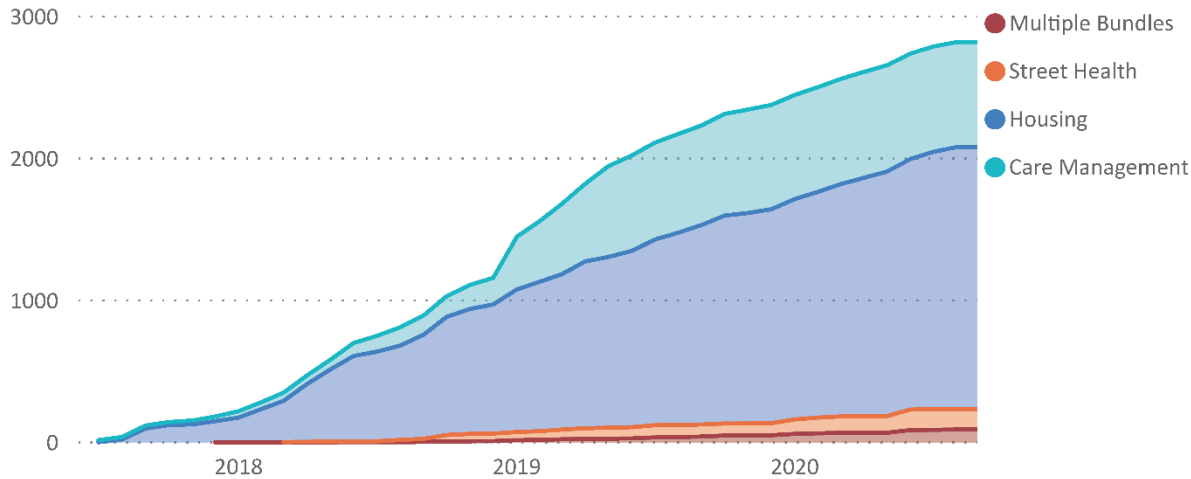


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Appendix slides

AC Care Connect: Whole Person Care Dashboard

People Ever Enrolled in Care Connect Bundles (Jul 2017 - Aug 2020)



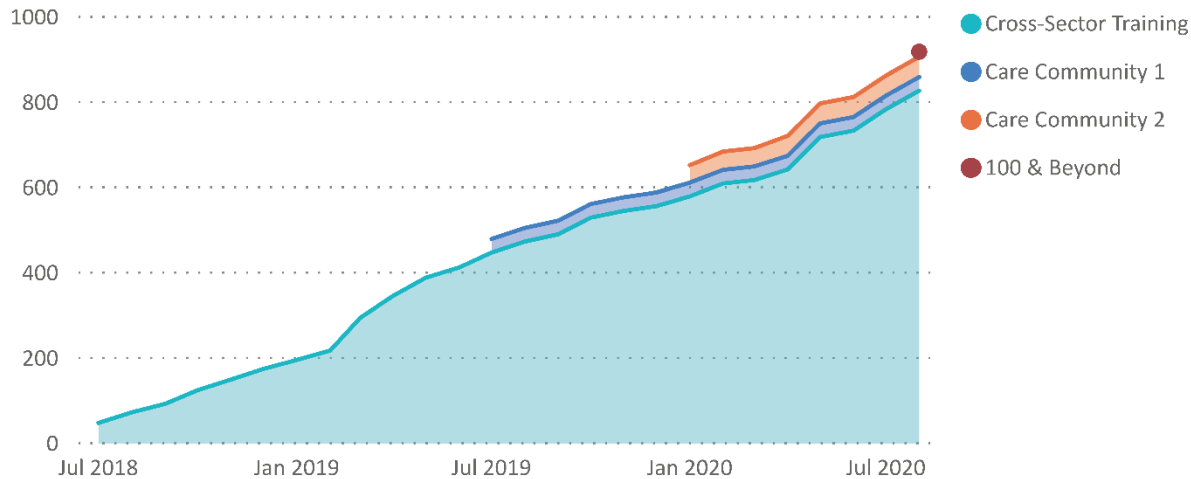
Data source: Enrollment and Utilization report (cumulative count, preliminary data from April).

CHR and SHIE Utilization (Aug 2020)

Unique Community Health Record End User Logins	440
Consumers in SHIE - Currently Eligible	41,370
Consumers in SHIE - Ever Eligible	75,089
Expanded Population (including Ever Eligible)	648,037

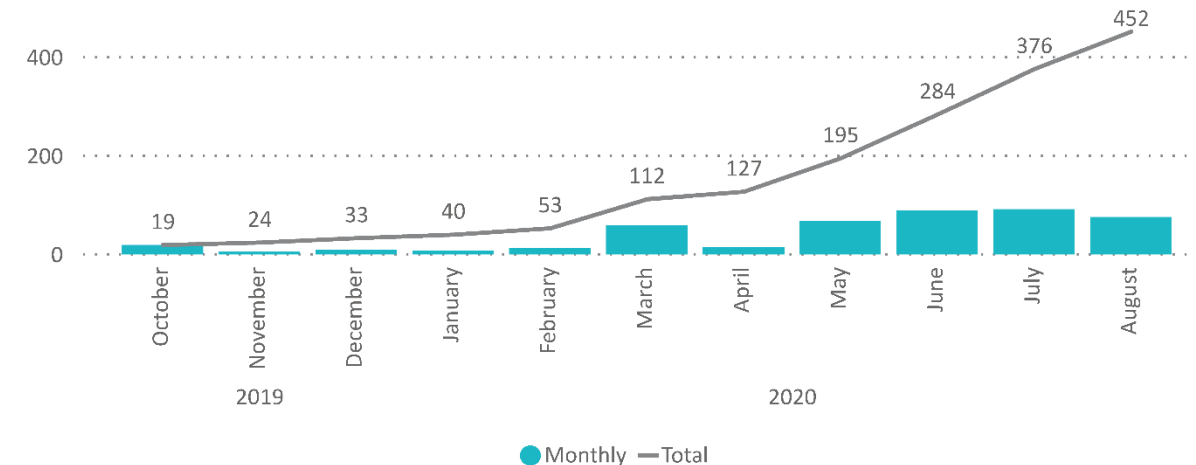
Data source: Social Health Information Exchange (end-of-month data).

Individuals Trained in Cross-Sector Care Coordination (Jul 2018 - Aug 2020)



Data source: Care Connect Academy and Care Community team (cumulative count).

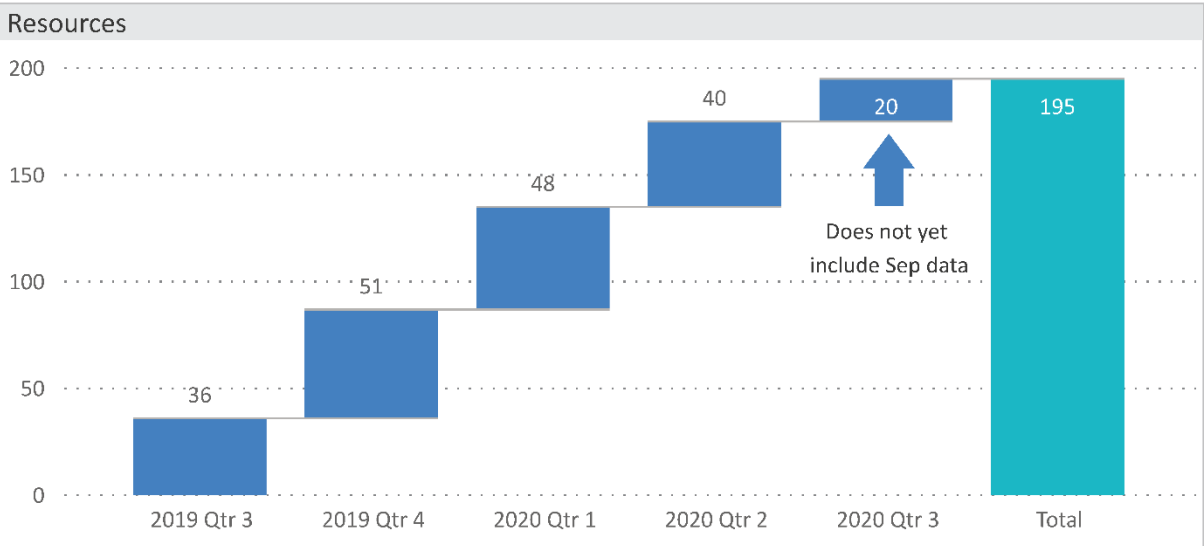
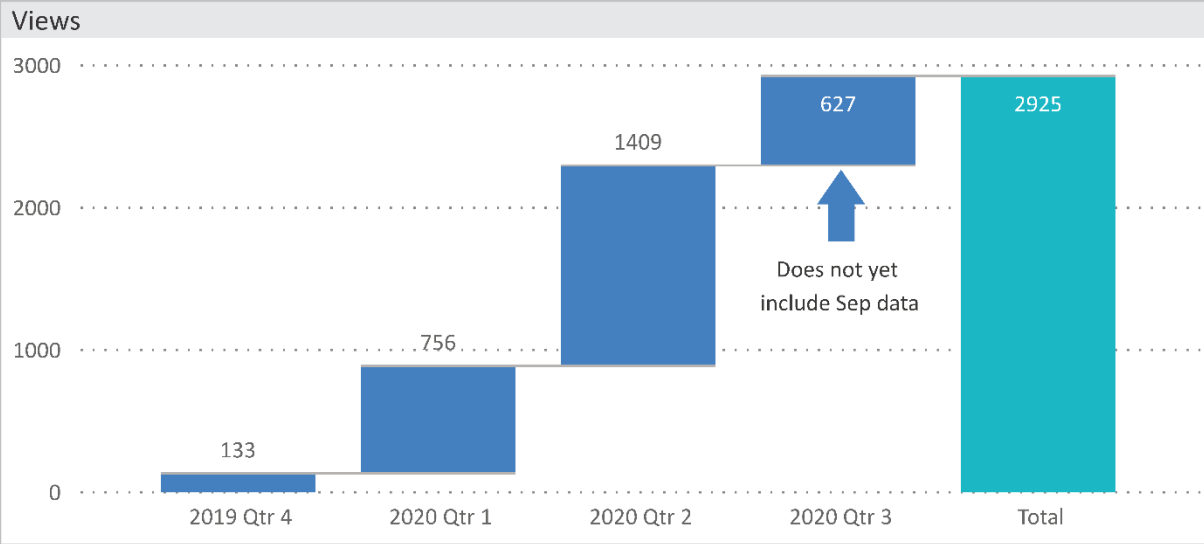
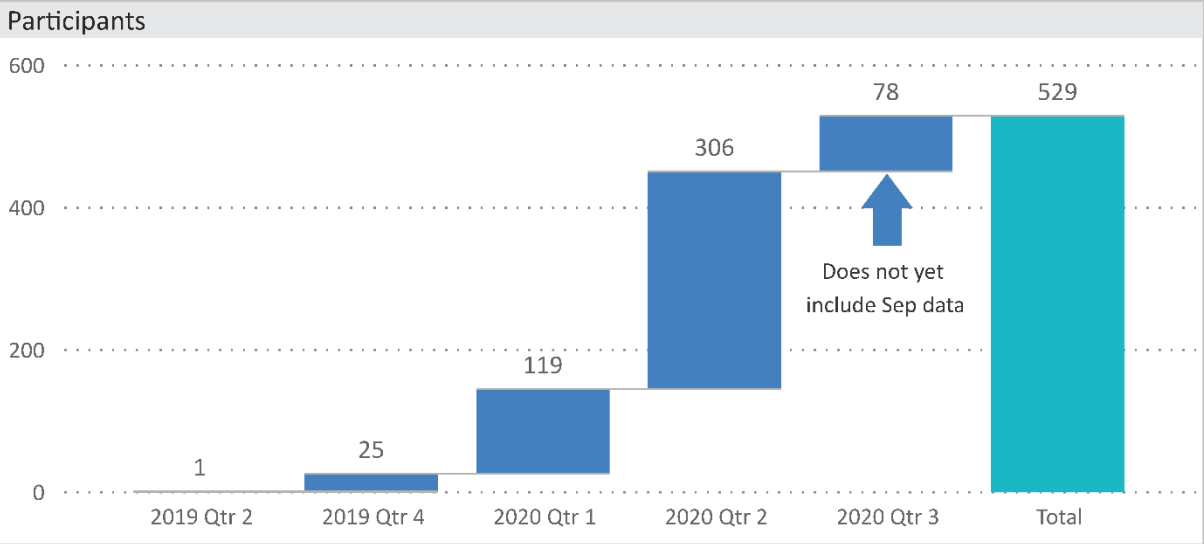
Signed Information Sharing Authorizations (Oct 2019 - Aug 2020)



Data source: Social Health Information Exchange (excludes 2 revocations of authorization).

AC Care Connect: Whole Person Care Dashboard

Elemeno (Jan 2019 - Aug 2020)



Total Views - Top 10

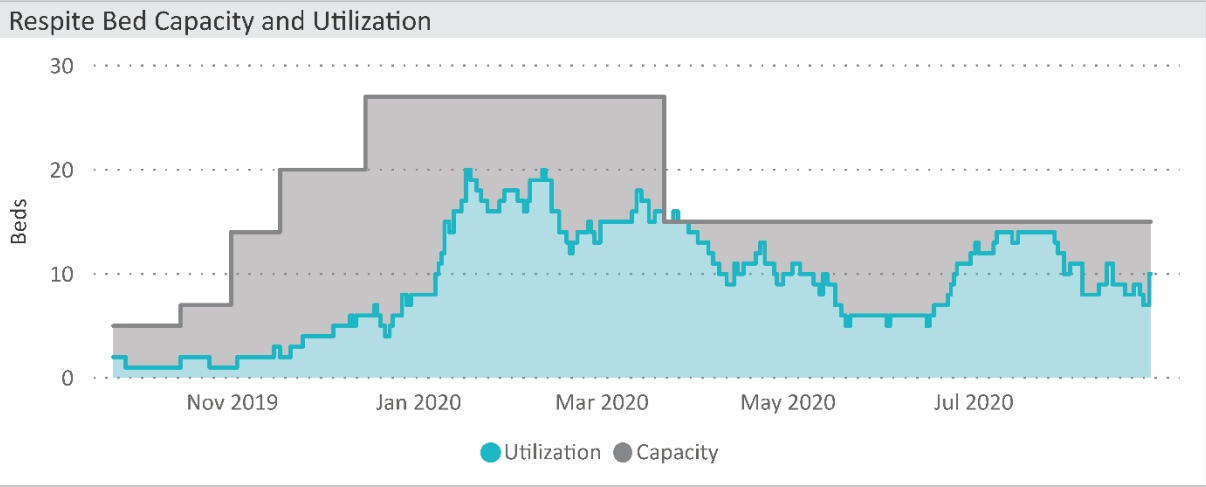
Resource	Views
Housing Resource Guide for Providers	286
Provider Resource Recommendations	167
AC3 Acronyms	158
Benefits: Food	128
Flexible Housing Funds	109
What To Do If Your Client Is In A Mental Health Crisis	97
Benefits: Income	91
Housing Resource Centers and Coordinated Entry	89
Shower & Laundry Facilities	82
CHR: First Time Login Instructions	77

Data source: Elemeno.

Data source: Elemeno (excludes Care Connect Team members and old PDF downloads so conservative count).

AC Care Connect: Whole Person Care Dashboard

Lifelong Medical Care (Sep 2019 - Aug 2020)

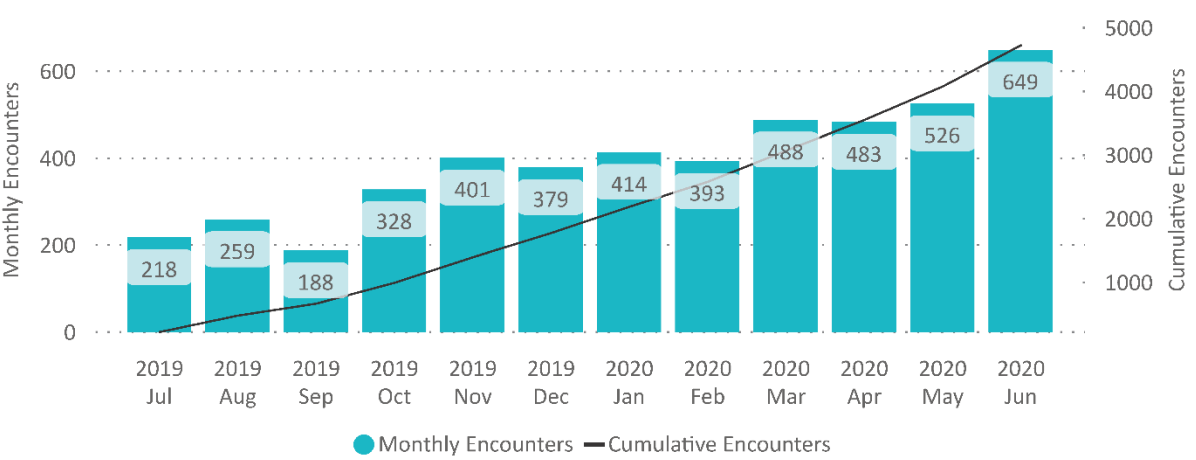


County Bed Capacity	
Name	Capacity
Abode	2-5
Bay Area Community Services	42
East Oakland Community Project	15
Lifelong Medical Care (AC3 funded)	15

Housing Status Upon Most Recent Departure	
Housing Status	Share
Shelter	24%
Place not meant for human habitation	19%
Unknown	17%
Medical or treatment facility	14%
Temporary housing	8%
Other	5%
Permanent housing	5%
Check	3%
Deceased	3%
Long-term care facility or nursing home	2%

Data source: Social Health Information Exchange, Lifelong Medical Care (bed capacity decreased in March to account for social distancing).

Street Health Outreach Teams - Consumers and Encounters (Jul 2019 - Jul 2000)



Data source: Alameda County Health Care for the Homeless HRSA uniform data system (preliminary data from April).

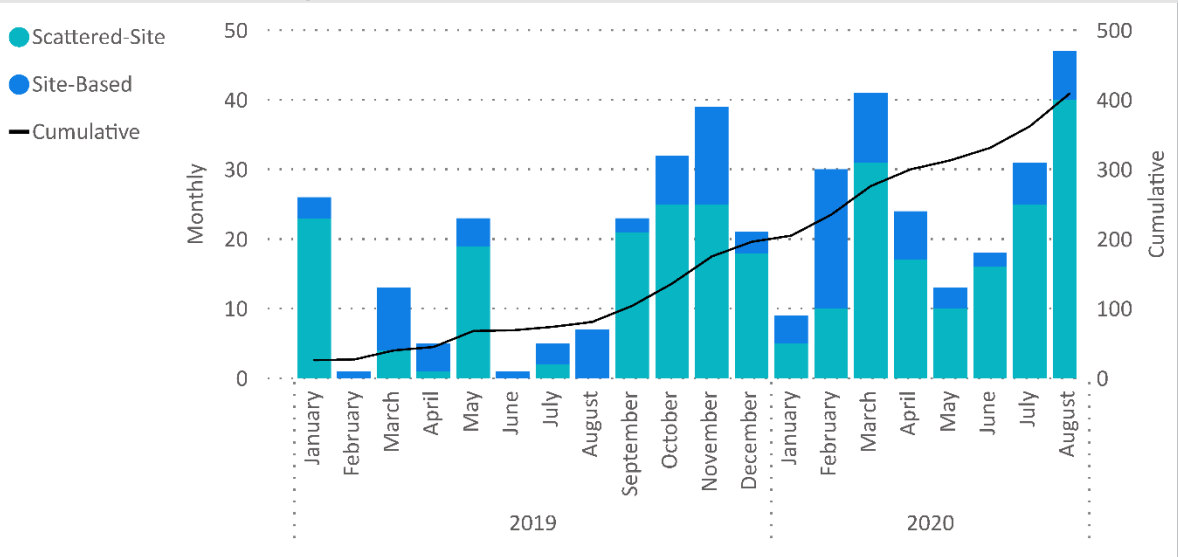
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Permanent Supportive Housing (Jan 2019 - Aug 2020)

Persons Experiencing Homelessness 2019		(Point-in-Time Count)	
Jurisdiction	Total	Jurisdiction	Total
Oakland	4071	Emeryville	178
Berkeley	1108	Union City	106
Fremont	608	Newark	89
Hayward	487	Pleasanton	70
San Leandro	418	Albany	35
Unincorporated	349	Dublin	8
Livermore	264	Piedmont	0
Alameda	231		

Data source: Alameda County Homeless Count & Survey Comprehensive Report 2019.

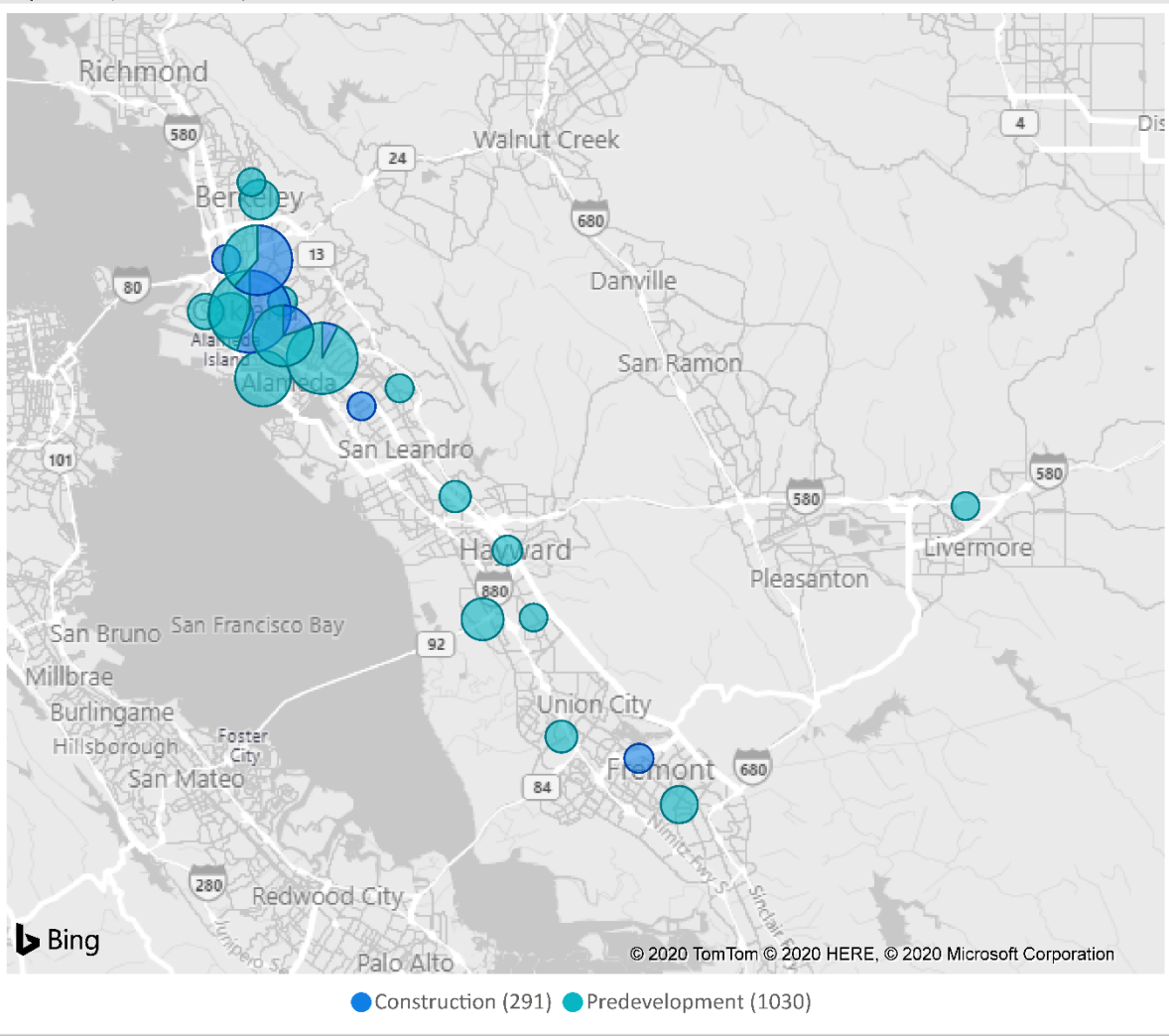
New Units (Jan 2019 - August 2020)



Data source: PSH Matching Log.

Notes: Shown openings required a referral and cover both newly created units and those resulting from attrition.
Units that opened before 2019 or where someone continued to live in at the start of 2019 are excluded.

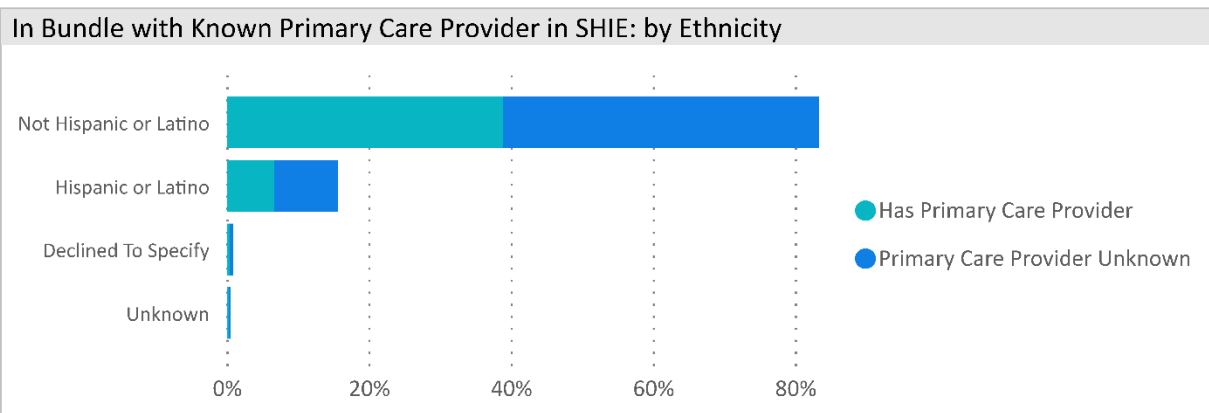
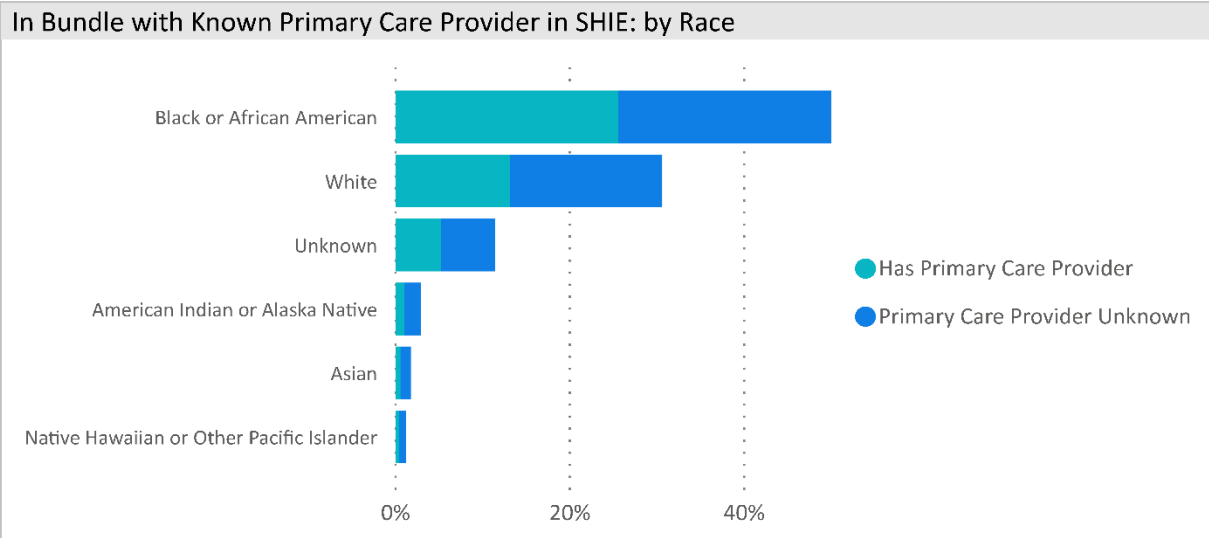
Pipeline (2020-2023)



Data source: Permanent Supportive Housing Pipeline Committee (not for public distribution).

AC Care Connect: Whole Person Care Dashboard

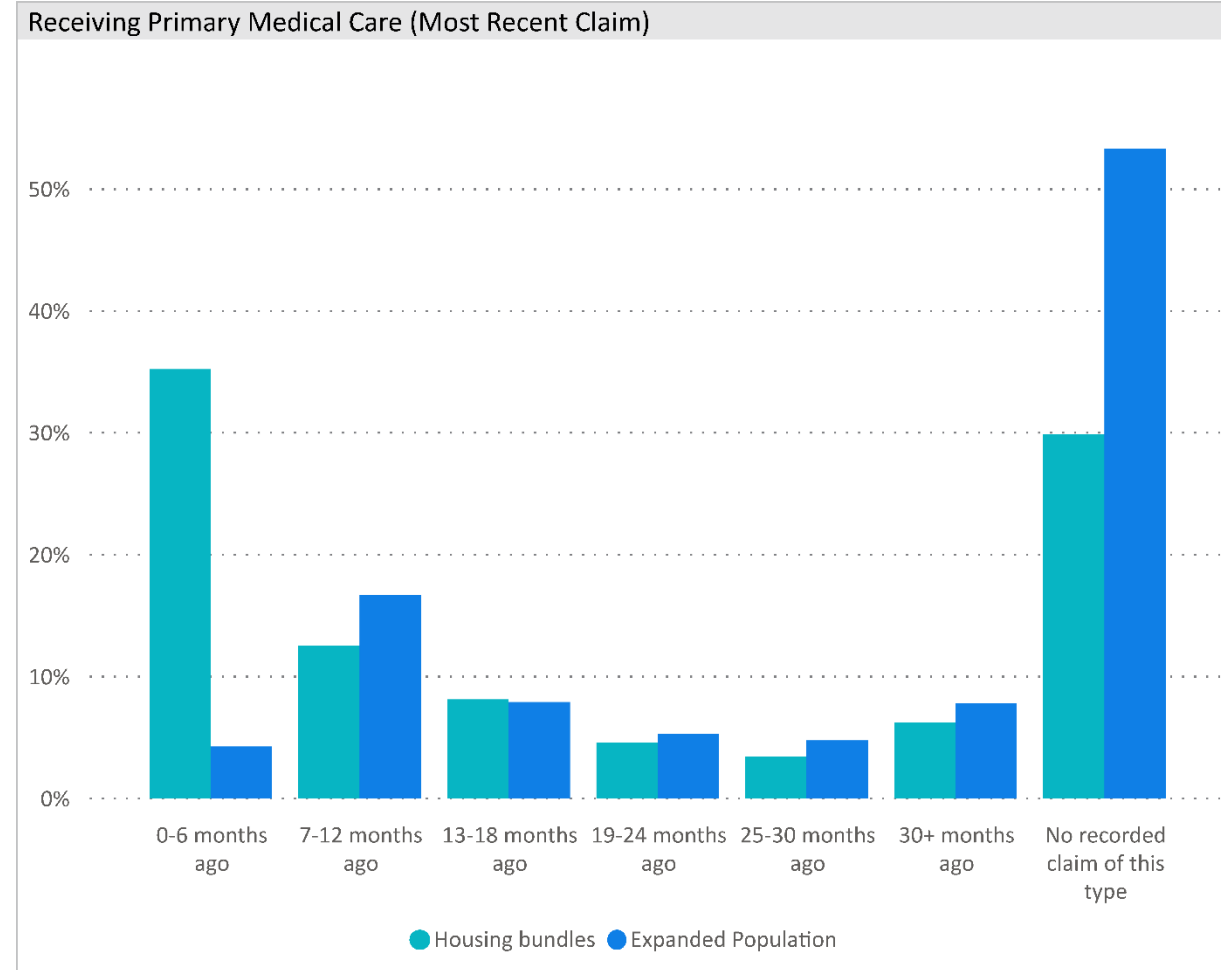
People Enrolled in Housing Bundles (Jul 2017 - Aug 2020)



Data source: Social Health Information Exchange.

Notes: Based on admission, discharge, and transfer (ADT) or Continuity of Care Document (CCD) patient information.

Race and ethnic classification data used from Homeless Management Information System. Reference data from Alameda County Homeless County & Survey Comprehensive Report 2019 on persons experiencing homelessness: Black or African-American (47%), White (31%), Other/Multi-race (14%), American Indian or Alaska Native (4%), Asian (2%), Native Hawaiian or Pacific Islander (2%), Hispanic/ Latinx (17%) and Non-Hispanic/ Latinx (83%). PCP assignment only available for consumers with managed care.



Data source: Social Health Information Exchange.

Notes: Analysis was conducted for people ever enrolled in a housing bundle and the expanded population that is visible in the CHR. Primary Medical Care was assessed based on the following Current Procedural Terminology (CPT) codes corresponding to established patient office visits: CPT 99211, CPT 99212, CPT 99213, CPT 99214 and CPT 99215 as recorded by Alameda Alliance for Health, Anthem Blue Cross and AC Behavioral Health.