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A Whole Person Care Pilot

Alameda County Care Connect Steering Committee

October 16, 2020

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Welcome

Scott Coffin, CEO, Alameda Alliance for Health

Liz Taing, Planning Director, AC Care Connect

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Agenda

1. Welcome
2. Consumer Story
3. Director's Report
4. Community Health Record Demo
5. Adjourn

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Consumer Story

Claudia Hein, Senior CATT Clinician, Bonita House

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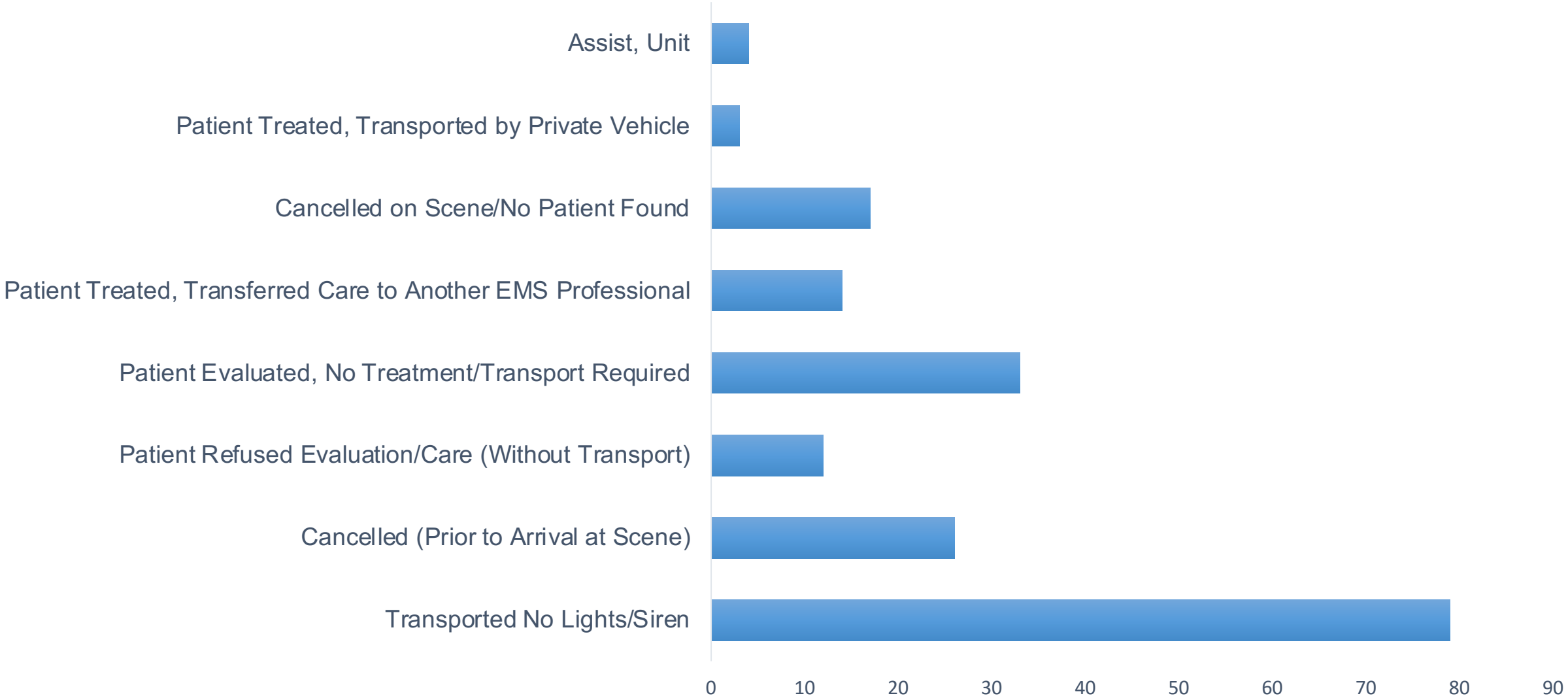
Community Assessment and Transport Teams (CATT)

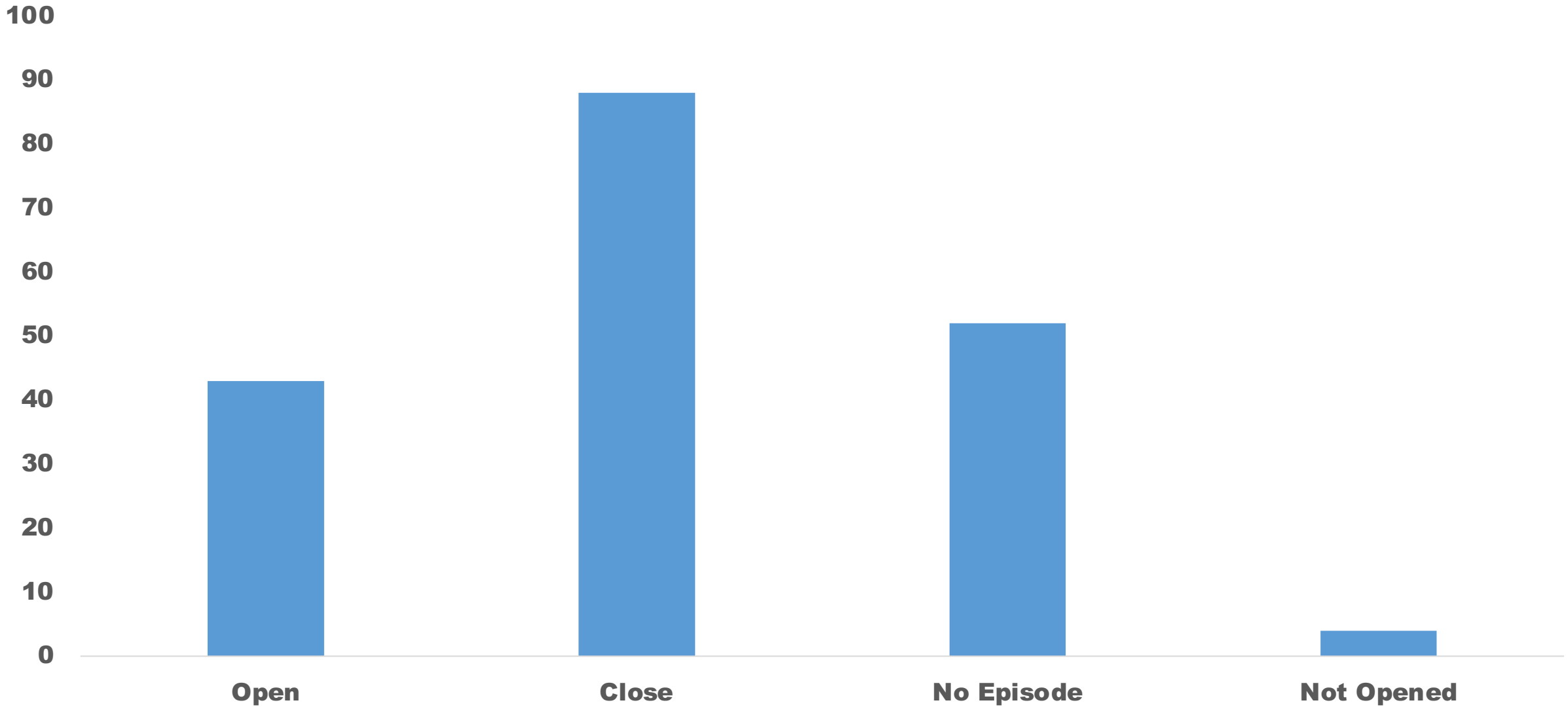
- Objective: Serve individuals in crisis by assessing behavioral health and substance abuse issues on scene and triaging resource needs rather than transporting to an emergency room or the local psychiatric emergency services unit.
- Aim to have 12 teams (of EMT and licensed Behavioral Health Clinician) deployed throughout the County
- Current Status: 5 teams deployed to Oakland, San Leandro, Hayward and Fremont
- In the past, most 911 calls were taken to John George or EDs.

Calls Received

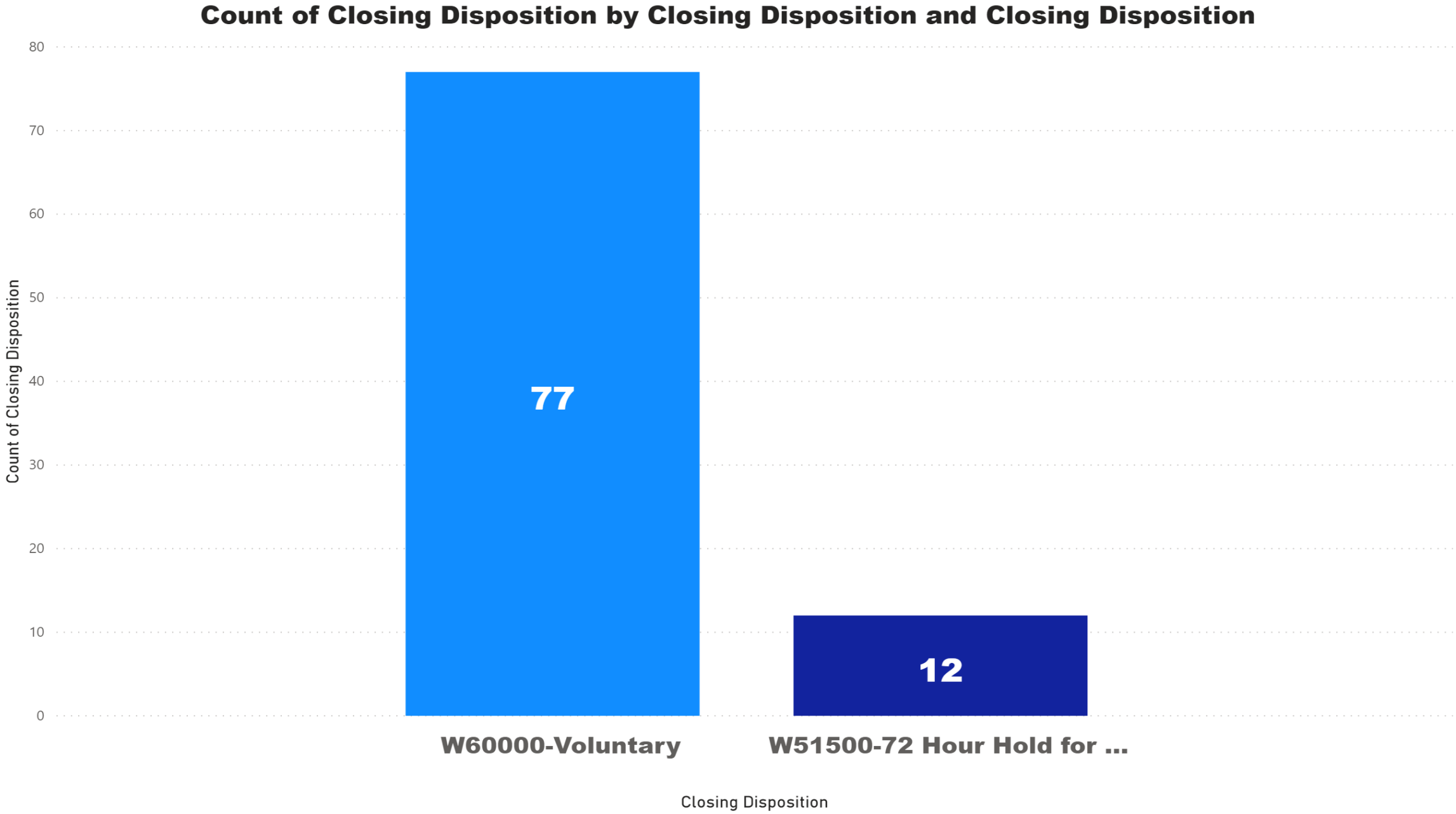


187 Calls received

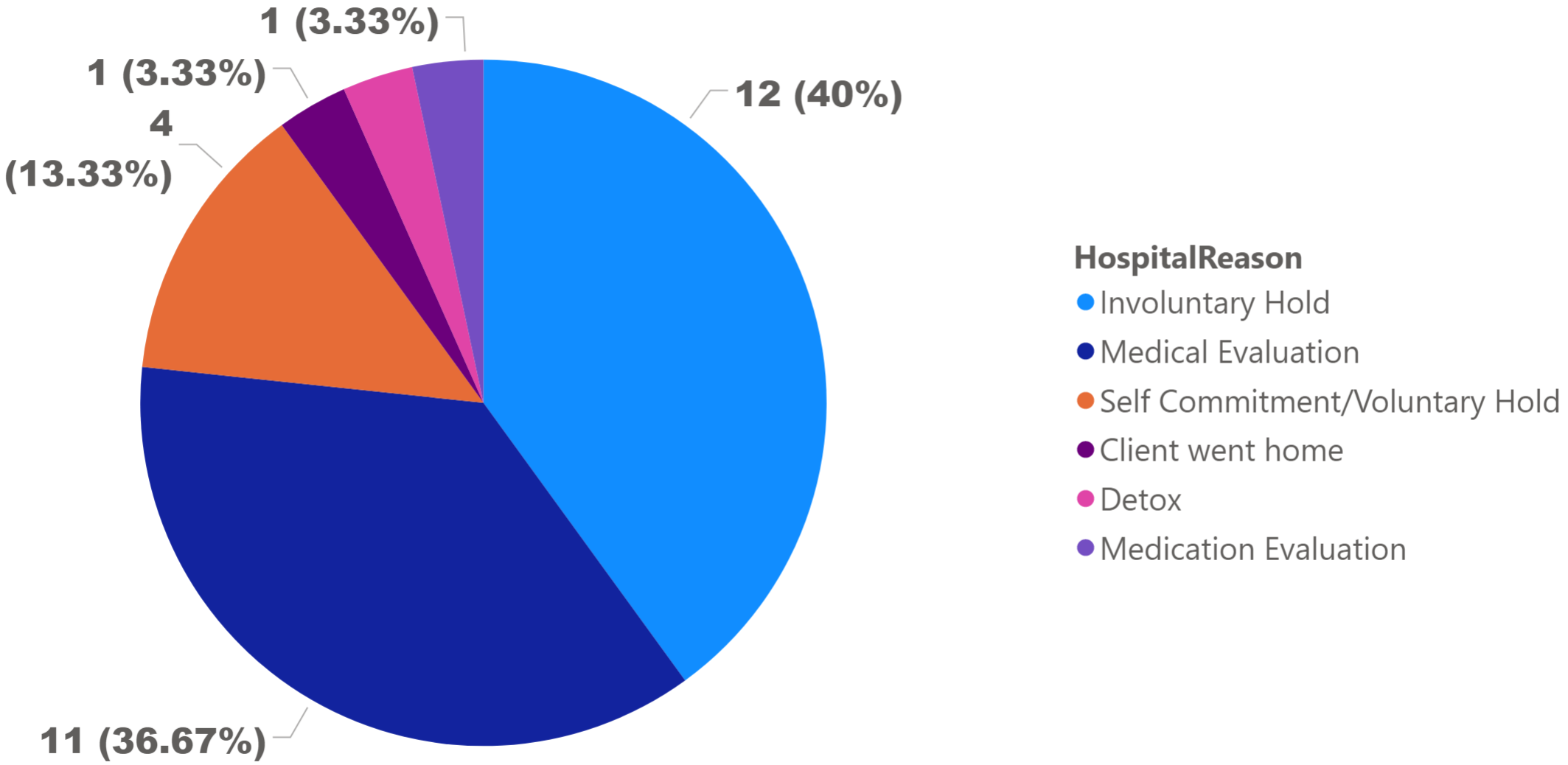
CATT Episodes and Status



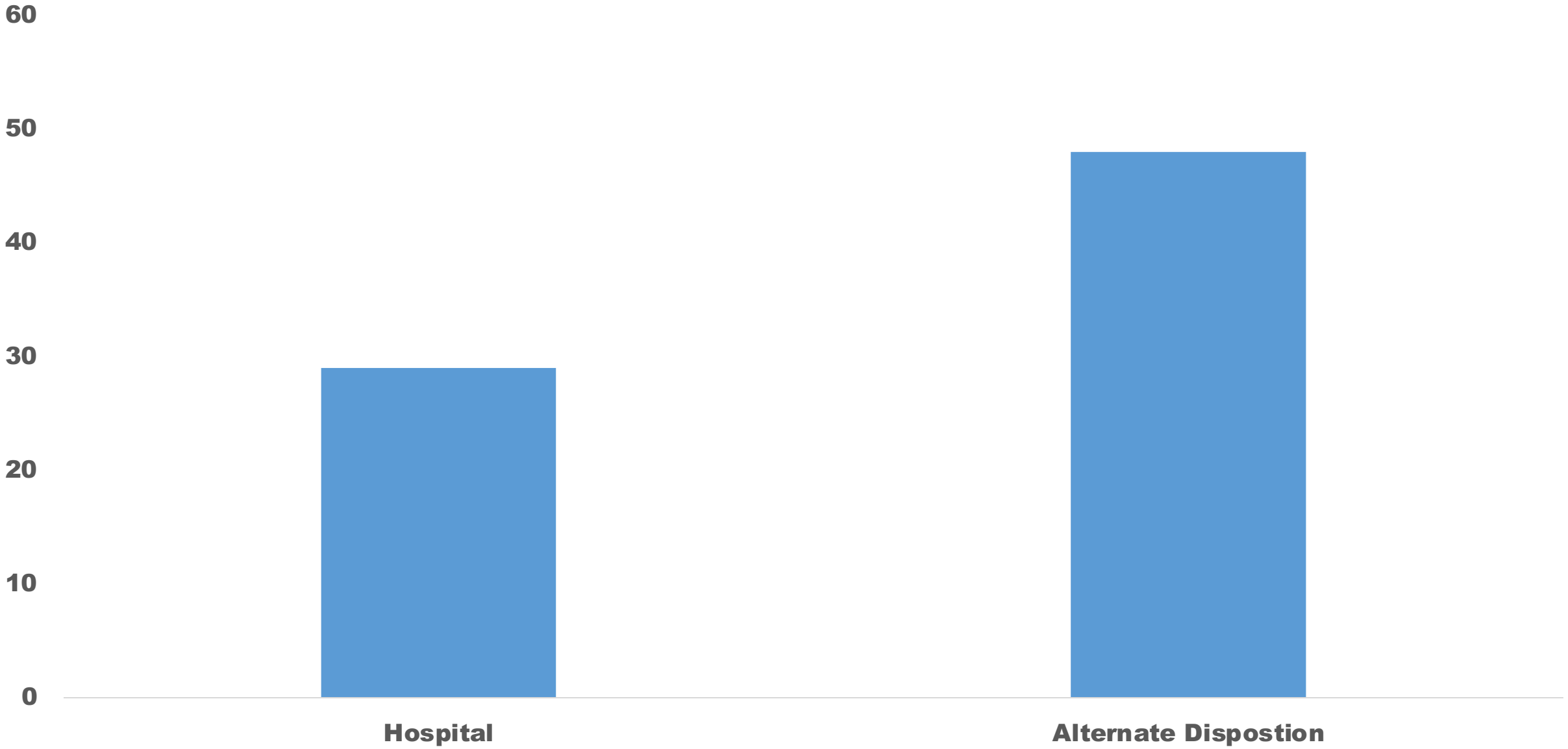
187 Calls received 131 Episodes


Count of Closing Disposition by Closing Disposition and Closing Disposition
80
70
60
50
40
30
20
10
0
Count of Closing Disposition
77
12
W60000-Voluntary
W51500-72 Hour Hold for ...
Closing Disposition

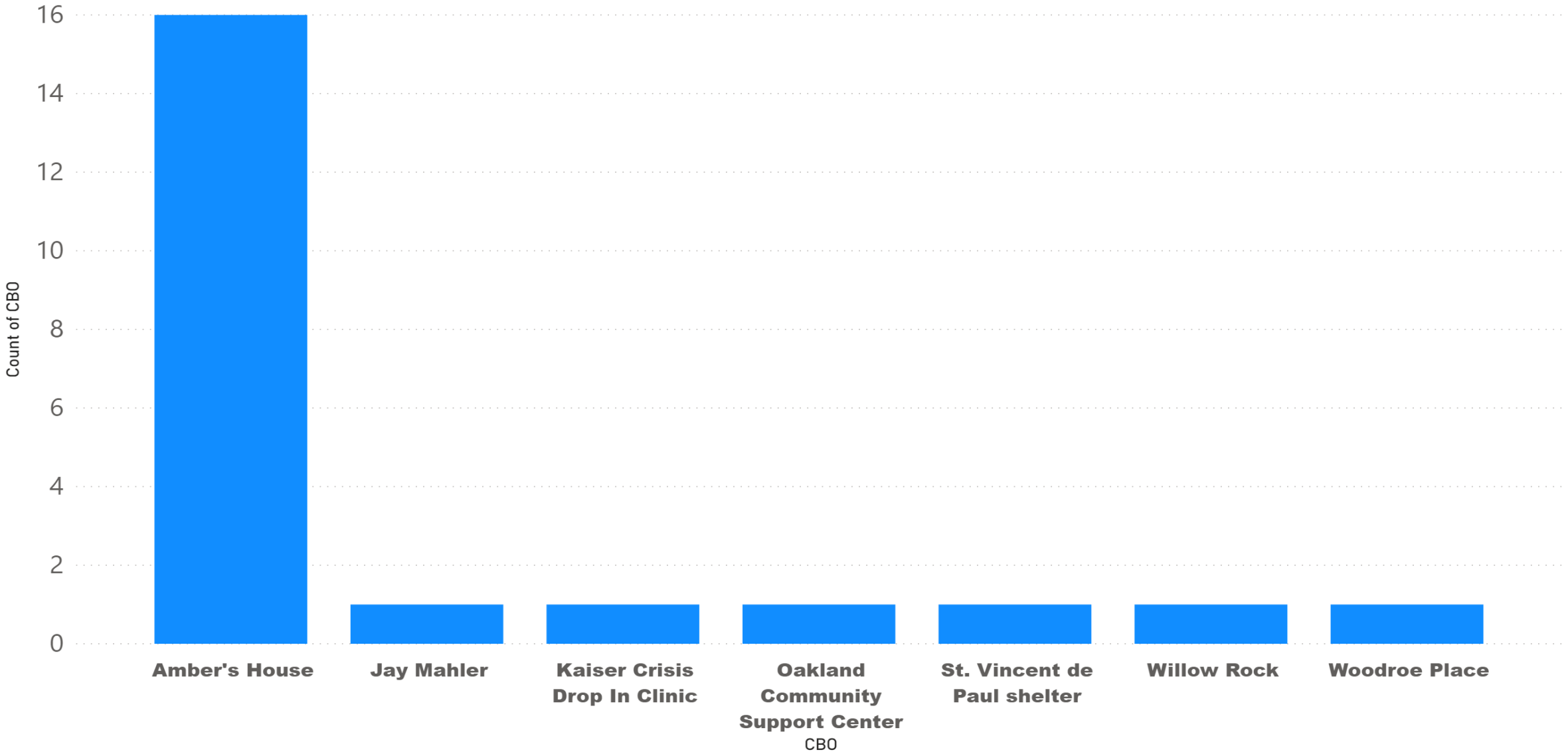
Reasons Clients were transported to Hospital



Hospital & Alternate Disposition Transports

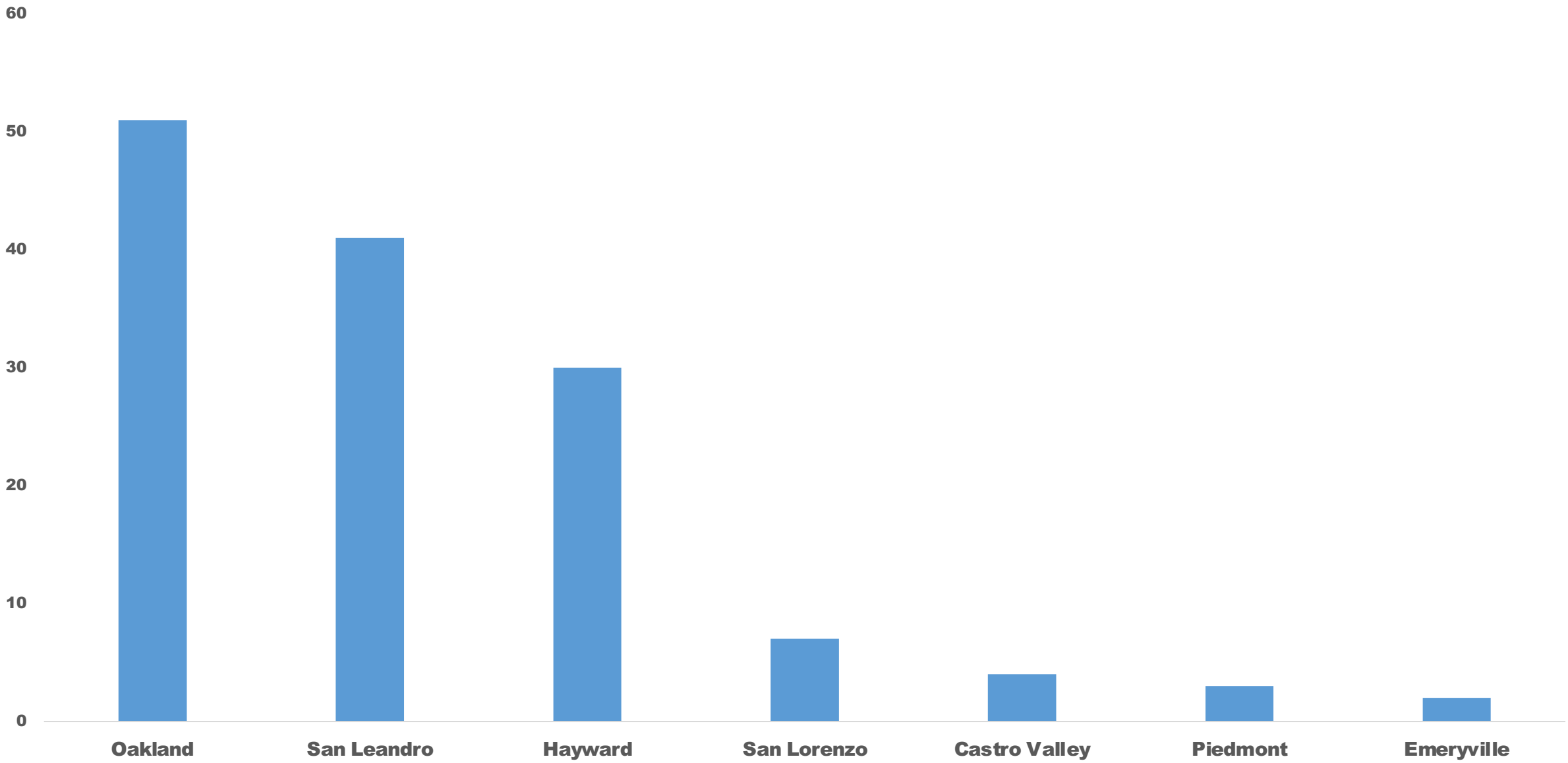


Alternate Disposition Sites

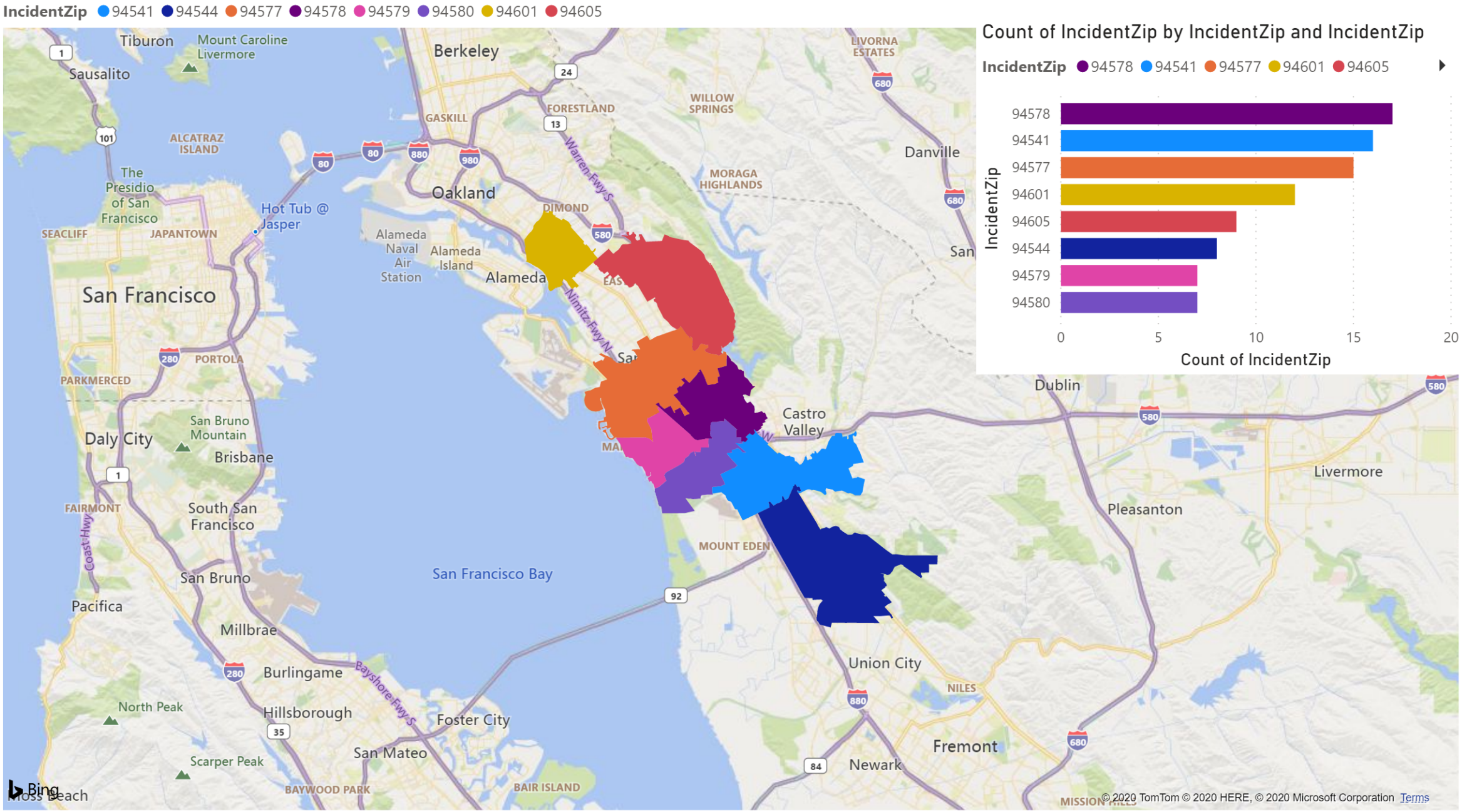


*Closed Episodes

Episodes by City



IncidentZip and IncidentZip



Count of IncidentZip by IncidentZip and IncidentZip

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Director's Report

Kathleen Clanon, MD; Director, AC Care Connect

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Reentry Discussion Follow Up: Next Steps

- Continue to collect/refine data to include in the SHIE and CHR
  (e.g., family/social contacts, service utilization history)
- Identify pathways to obtain and share information on social services, housing, and other needs at release

- Other action steps:
  - Convene cross-sector planning group to discuss improving re-enrollment in Medi-Cal and warm hand-offs to care—need participants
  - Create plan for jail discharge summary to be included in consumer's record and to provide items needed for smooth reentry (phone, transportation, medications, identification/other documents)
  - Determine next steps for data-sharing

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Crisis Connect

- Crisis Connect: Team conducts telephonic post-crisis follow up calls within 24-48 hours to all non-high utilizers
- Total services provided (Jan – Sept): 2,499*
  - Total (unique) number of people reached by phone: 89
- Challenges connecting with consumers directly due to inaccurate phone numbers: new workflow at John George PES (starting 10/15) to address this

*Anita** used to receive services from La Familia but discontinued services for several months due to no active Medi-Cal. She stated that she needed medication support and therapy. After 3 phone calls, Crisis Connect staff successfully linked Anita to Tri-City for urgent med and reconnected her to La Familia.*

*Individuals may receive more than one service
**Names have been changed to protect the privacy of the individual.

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Project Roomkey Updates

Type of Site	Locations	Max Occupancy	% Occupied*	Current Occupancy (households)	Current Occupancy (individuals)	Target Population
Safer Ground (hotels +scattered sites combined)		885	93%	827	1085	Homeless/ high risk
Hotels	Alameda, Berkeley (2), Livermore, Newark, Oakland (2)	785	98%	760	1005	Homeless/ high risk
Scattered Sites	Countywide	100	67%	67	80	Homeless/ high risk
Operation Comfort hotels	Oakland (2)	198	23%	46	46	COVID+/ Person under investigation
Trailers	Alameda, Berkeley, Oakland	150	92%	138	139	Homeless/ high risk
TOTAL ROOMKEY		**1233**	**82%**	**1011**	**1270**	

*Occupancy rate based on household numbers. Occupancy data updated as of 10/12/2020

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Project Roomkey to Project Homekey

- Project Roomkey Status
  - Uncertainty in funding and timing
  - Over 1,200 individuals are currently being housed
  - CARES ACT and Emergency Solutions Grant (ESG) will support exits to permanent housing by providing subsidies for up to one year of rent
  - Office of Homeless Care and Coordination and partners are conducting centralized landlord recruitment to increase housing options

- Project Homekey: In negotiations for up to six Homekey locations (would house 600-700 households!)
  - Will need significant health and housing supports in the next few months to transition hotel guests

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100 & Beyond

- Exits to permanent housing from Roomkey hotels since March
  - **121 (as of October 2)**
- 100 & Beyond effort provides ongoing training to build staff capacity to provide housing support and care coordination within and across hotels.
- Current trainings include:
  - *Motivational Interviewing*
  - *How to Work with Probation*
  - *Housing Pathways Through Realignment Funding*
- Housing Problem Solving will be covered later this month

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Housing Solutions for Health and Office of Homeless Care and Coordination

- Transitions
  - Organizational, program, and staff shifts among ACBH, Care Connect and HCSA
  - Dr. Robert Ratner transitioning to Santa Cruz County

- Alameda County Sales Tax Ballot Measure (Measure W)

  "Shall a County of Alameda ordinance be adopted to establish a half percent sales tax for 10 years, to provide essential County services, including housing and services for those experiencing homelessness, mental health services, job training, social safety net and other general fund services, providing approximately $150M annually, with annual audits and citizen oversight?"

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Policy updates

- DHCS submitted a proposal for a 12-month extension of the 1115 waiver to CMS on 9/16.
- CMS has accepted the application; it is currently in a public comment period.
- Negotiations will likely go through Dec and possibly into 2021.
- DCHS is very optimistic that CMS will approve the 12-month waiver extension.
- If no decision on the waiver is made before Dec 31, 2020, DHCS will grant a "temporary extension," which will allow waiver programs to continue with funding.
- In the unlikely scenario that the waiver extension is not approved, CMS will provide time and funding to "wind down" programs and services.

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CHR/SHIE:
One Year Launch Anniversary

Kathleen Clanon, MD; Director, AC Care Connect

Cristi Iannuzzi, Director of Strategy & Implementation, Data Exchange Unit, AC Care Connect

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Definitions

- ✓ **Social/Health Information Exchange or SHIE**
  - ✓ A community of organizations sharing data under a set of agreements (i.e. according to federal and state regulations), and
  - ✓ A platform to **keep data secure**, **manage who can see what**, and **match identity** when different data streams describe one person.

- ✓ **Community Health Record or CHR**
  - ✓ The first tool drawing from the SHIE rolled out in September 2019**.**
  - ✓ The CHR allows providers to view a thin, timely slice of information on client utilization, diagnosis, and who else is working with them.
  - ✓ 26 organizations, 100+ programs, and 600+ users have been onboarded

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Collaboration on a new level

Individual organizations often have access to one or two data systems.

AC SHIE brings together data feeds from multiple sectors that is shown in the CHR to flesh out a more Whole Person perspective.

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CHR and SHIE: A Year in Review

- The CHR is one year old as of Sept 25!
- 21,619 consumers (ever) enrolled (as of Oct 13)
- 687 users (spanning 26 organizations) have been trained
- Over the past 12 months, in response to CHR users' feedback, we have
  - Developed new reports (FEMA, Health Homes, ISA)
  - Expanded data to include Medi-cal renewal data, census data from Santa Rita Jail, inpatient/outpatient hospital data from several hospitals, medication fill data
  - Enhanced functions including housing tab, user and online status indicators, permanent supportive housing (PSH) alerts, and housing match status
  - Expanded data viewable in the CHR includes expanding the viewable population to the entire Medi-cal population and making housing data viewable without an ISA
- Plans to expand CHR user support include more training videos, tech/user support, quick reference guides, workflow guidance, and case studies.

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CHR/SHIE: New Data Sources Roadmap

Data Source and Description	Expected Timeline
Outpatient visit notification: Patient outpatient visit notification (ADT) from several Bay Area health systems (except Stanford and Kaiser)	Available now!
EMS: Encounter data and various data attributes, including where clients were transported after picking them up from the emergency call location.	Late Oct 2020
AHS facilities (CCDA) Patient clinical record: Patient's inpatient, ED and outpatient clinical record and discharge summaries	Dec 2020
St. Rose (CCDA) Patient clinical record: Patient's inpatient, ED and outpatient clinical record and discharge summaries	Dec 2020
CHCN Clinics (CCDA) Patient clinical record: Clinical record and notification on check-in/check-out (admission, discharge, transfer notification) for Care Connect "ever eligible" population who are patients at CHCN clinics	Dec 2020/ Jan 2021
Sutter Hospitals (CCDA) Patient clinical record: Patient's inpatient, ED and outpatient clinical record and discharge summaries	Jan/Feb 2021
HealthPAC Visit Records/Lab Data: HealthPAC patients' clinical record and lab test data	Mar/Apr 2021

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"In the past, we'd have to dig through backpacks to find scraps of paper that might have information on where an individual had received medical care or on any conditions they might have….Having access to the CHR is like turning on a lightbulb—you can see so much about the person's conditions and use of services and help ensure that they will be connected to healthcare in the community when they leave the hotel…."

-- Alexis Chettiar, PhD, ACNP-BC, Co-Interim Medical Director, Project Roomkey, Alameda County

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A peek into the CHR…..

Cristi Iannuzzi, Director of Strategy & Implementation, Data Exchange Unit, AC Care Connect

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Meeting Debrief and Next Steps

Scott Coffin, CEO, Alameda Alliance for Health

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Debrief and Next Steps

- What is one thing you heard today that you would like to hear more about?
- Review next steps
  - Cross-sector planning group on reentry reenrollment in Medi-cal
  - SHIE/CHR utilization and expansion
  - Other
- November Steering Committee: Focus on sustainability and 2021!

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Adjourn

Next Meeting: November 20, 2020

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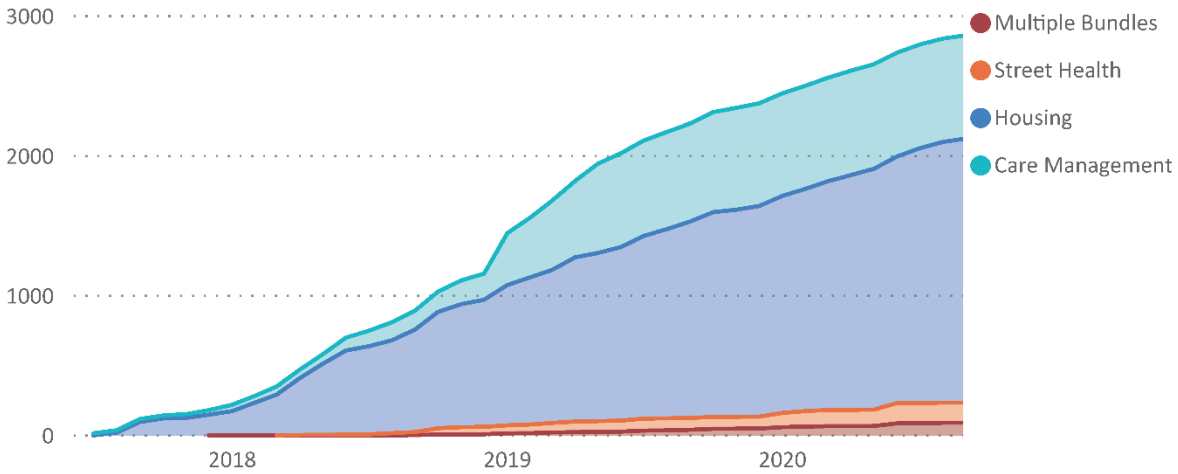
For more information visit
www.accareconnect.org

Appendix slides

AC Care Connect: Whole Person Care Dashboard

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



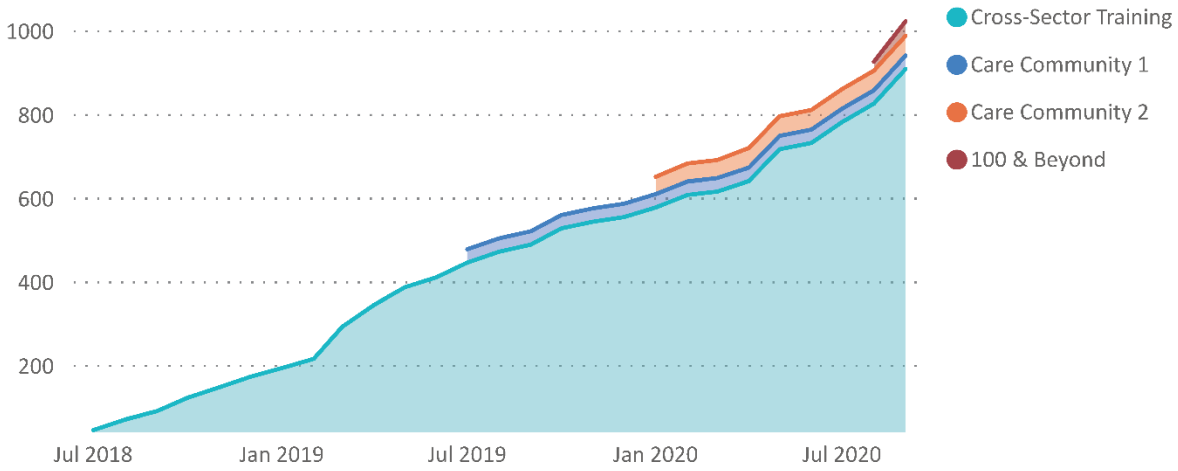
Data source: Enrollment and Utilization report (cumulative count, preliminary data from April).

CHR and SHIE Utilization (Sep 2020)

Unique Community Health Record End User Logins	**511**
Consumers in SHIE - Currently Eligible	**42,400**
Consumers in SHIE - Ever Eligible	**76,887**
Expanded Population (including Ever Eligible)	**644,607**

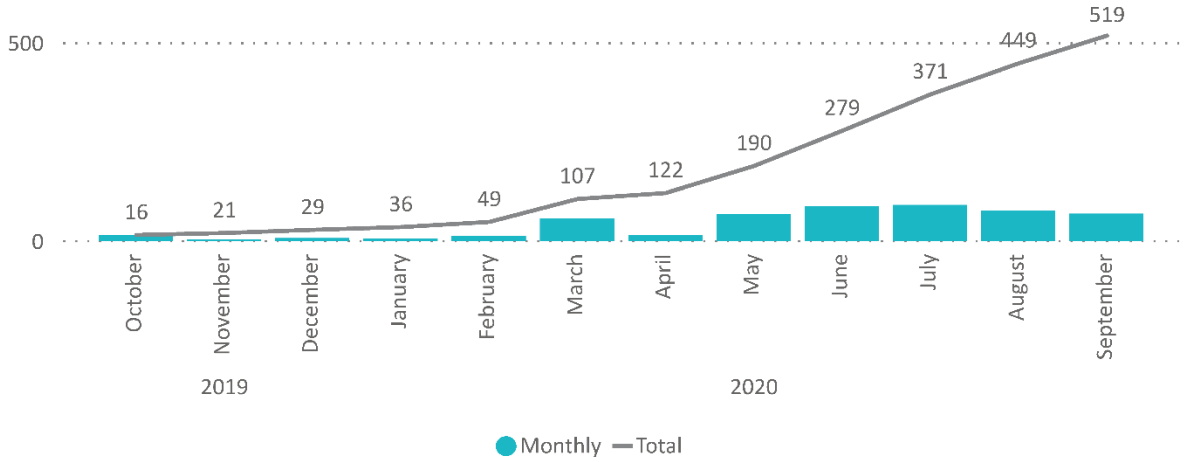
Data source: Social Health Information Exchange (end-of-month data).

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



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

Signed Information Sharing Authorizations (Oct 2019 - Sep 2020)

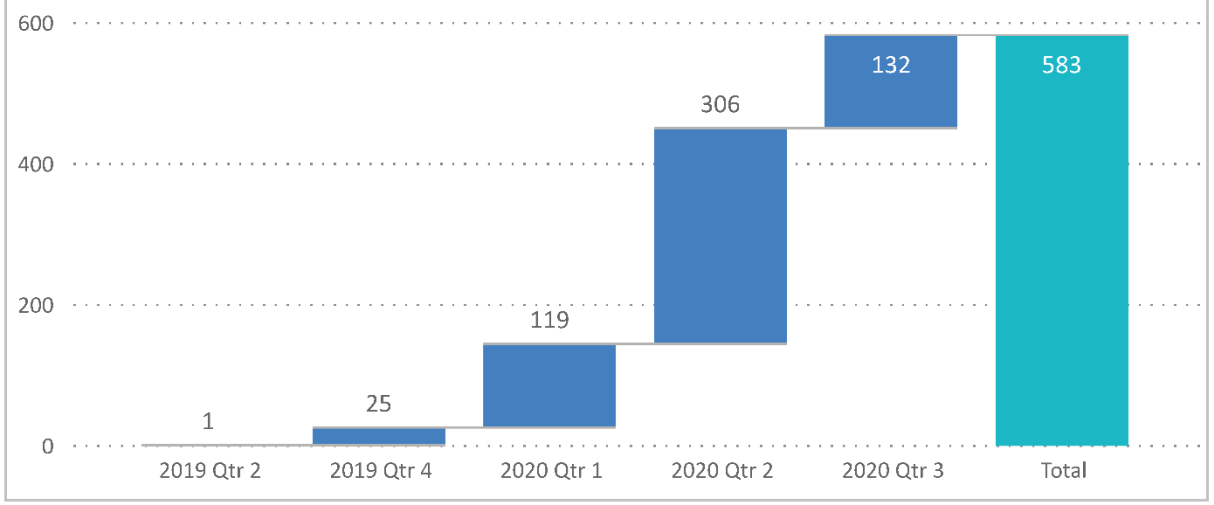


Data source: Social Health Information Exchange (excludes 2 revocations of authorization).

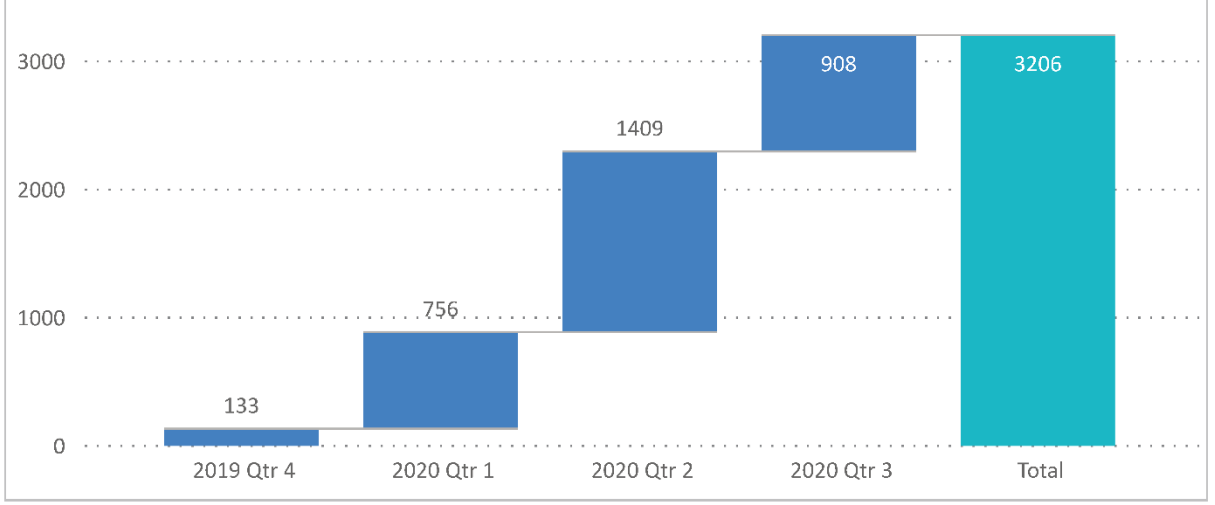
AC Care Connect: Whole Person Care Dashboard

Elemeno (Jan 2019 - Sep 2020)

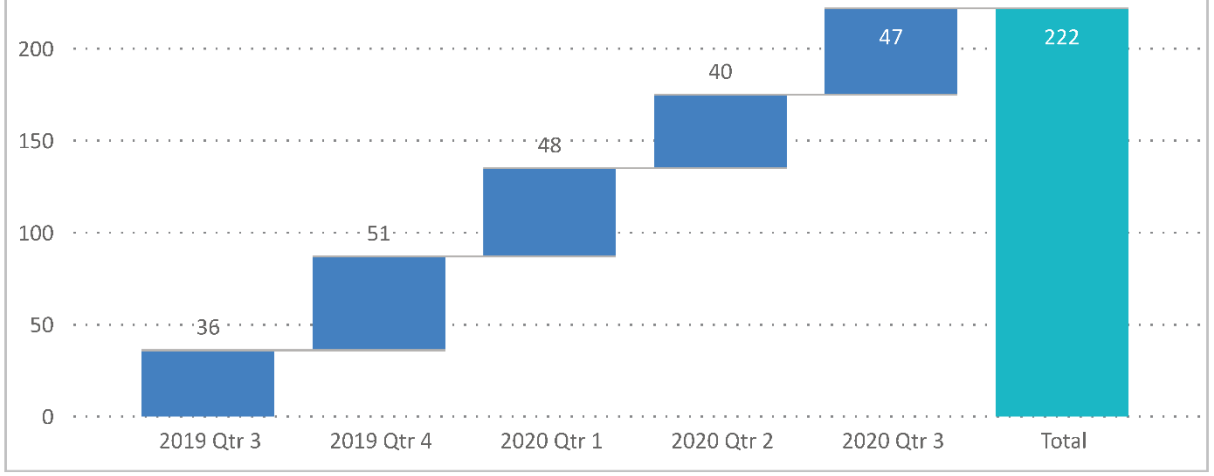
Participants



Views



Resources



Total Views - Top 10

Resource	Views
Housing Resource Guide for Providers	306
Provider Resource Recommendations	177
AC3 Acronyms	170
Benefits: Food	141
Flexible Housing Funds	117
Benefits: Income	102
Housing Resource Centers and Coordinated Entry	99
What To Do If Your Client Is In A Mental Health Crisis	99
CHR: First Time Login Instructions	84
Shower & Laundry Facilities	82

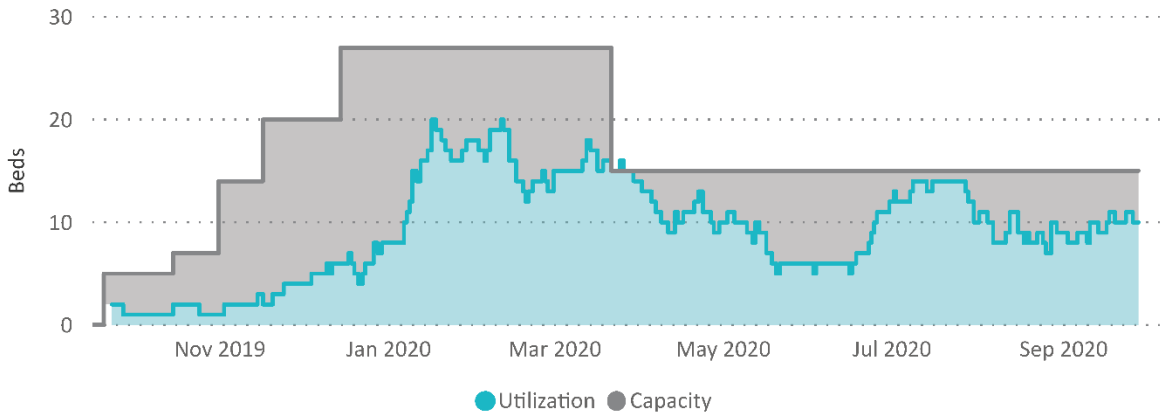
Data source: Elemeno.

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 - Sep 2020)

Respite Bed Capacity and Utilization



County Bed Capacity

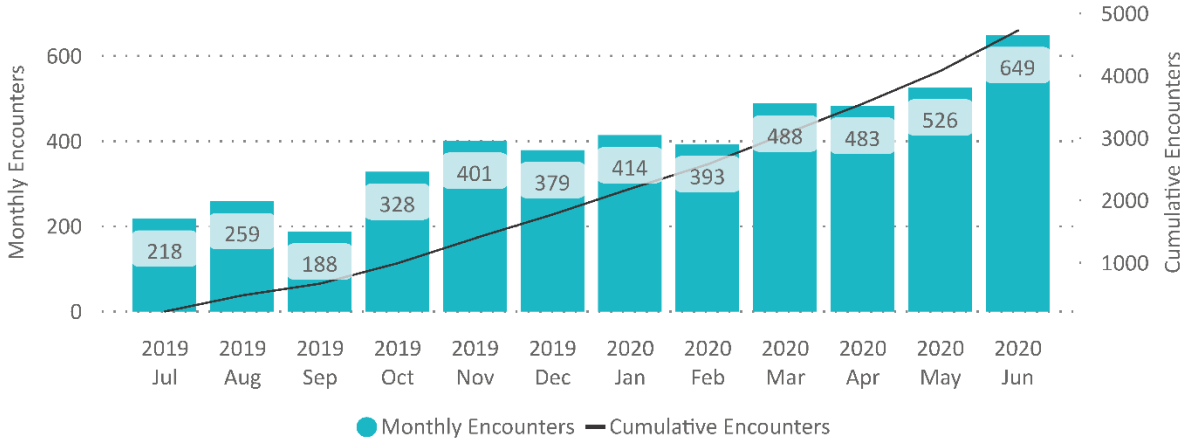
Name	Capacity
Abode	2-5
Bay Area Community Services	42
East Oakland Community Project	15
Lifelong Medical Care (AC3 funded)	15

Housing Status Upon Most Recent Departure

Housing Status	Share
Shelter	23%
Place not meant for human habitation	20%
Unknown	17%
Medical or treatment facility	13%
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 - Encounters (Jul 2019 - Jun 2000)



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

AC Care Connect: Whole Person Care Dashboard

Permanent Supportive Housing (Jan 2019 - Sep 2020)

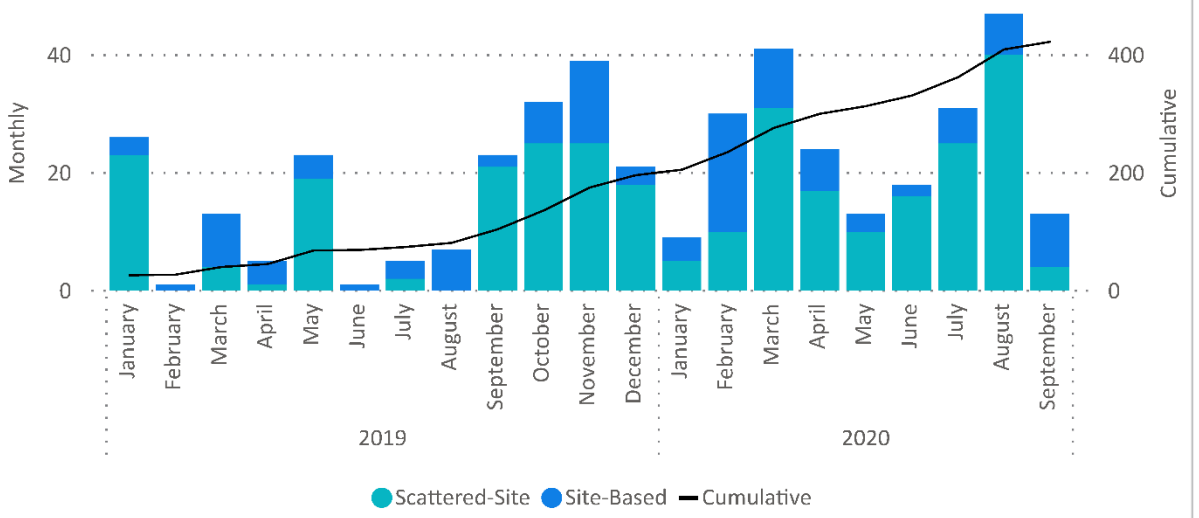
Persons Experiencing Homelessness 2019 (Point-in-Time Count)

Jurisdiction	Total
Oakland	4071
Berkeley	1108
Fremont	608
Hayward	487
San Leandro	418
Unincorporated	349
Livermore	264
Alameda	231

Jurisdiction	Total
Emeryville	178
Union City	106
Newark	89
Pleasanton	70
Albany	35
Dublin	8
Piedmont	0

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

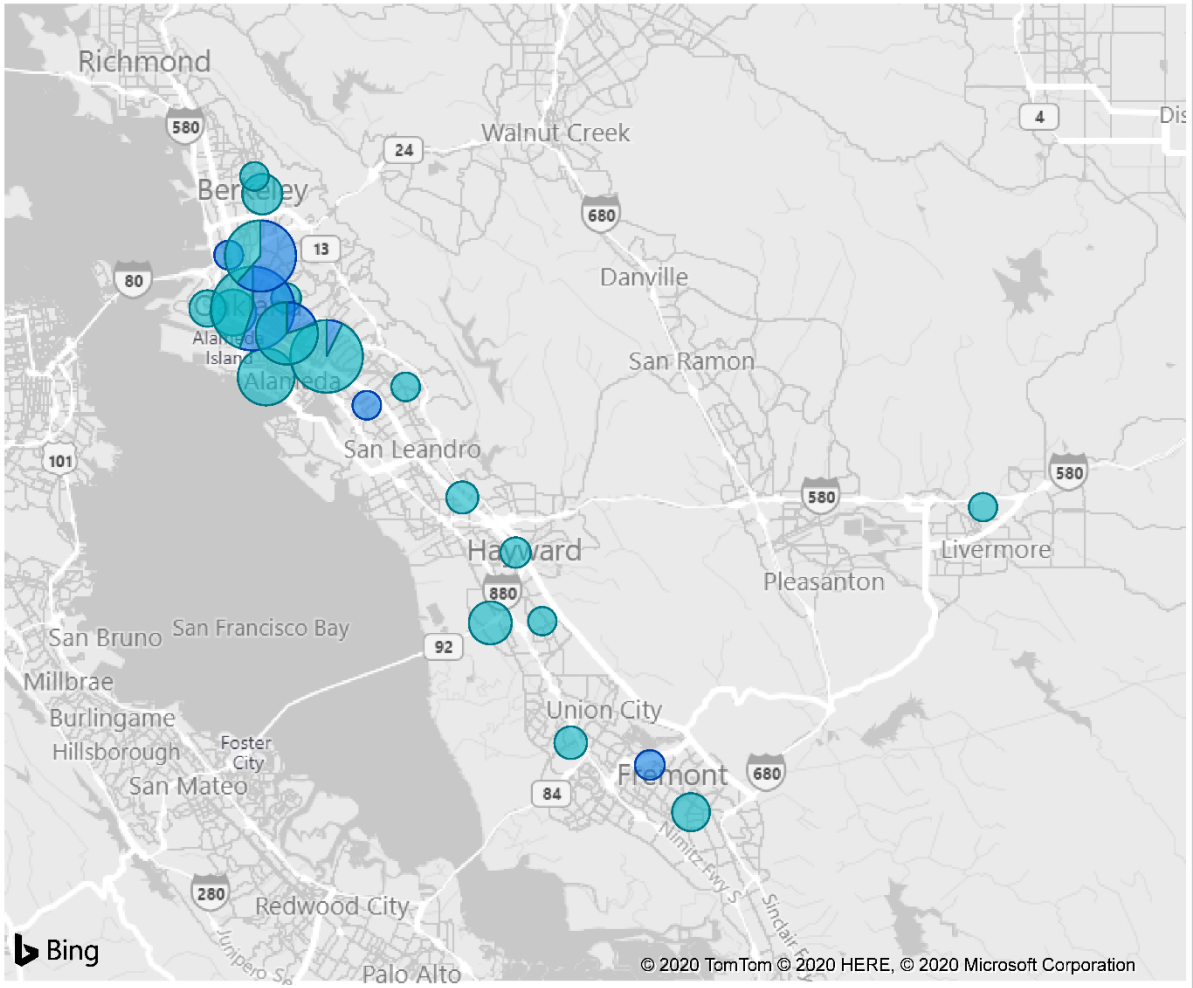
New Units (Jan 2019 - Sep 2020)



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)

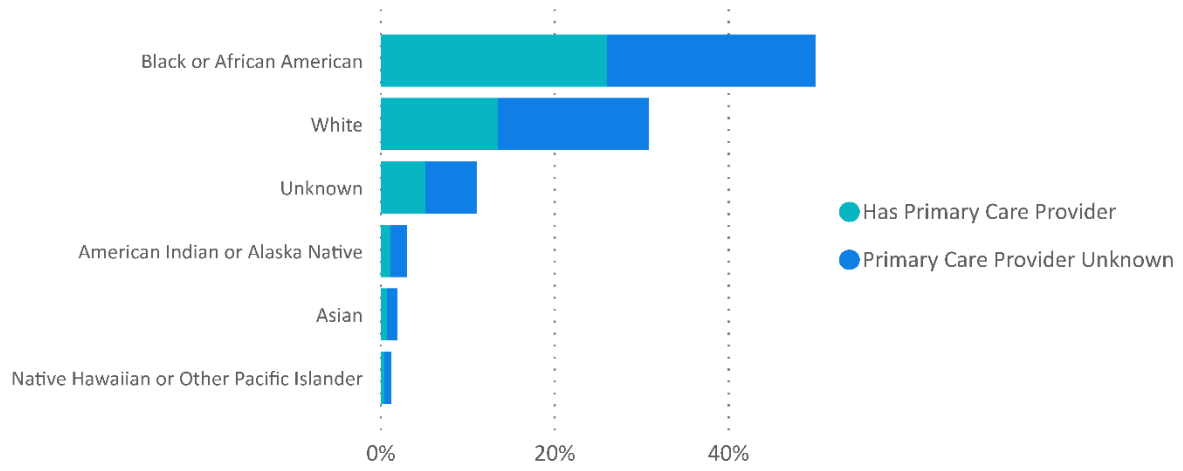


Data source: Permanent Supportive Housing Pipeline Committee (not for public distribution).

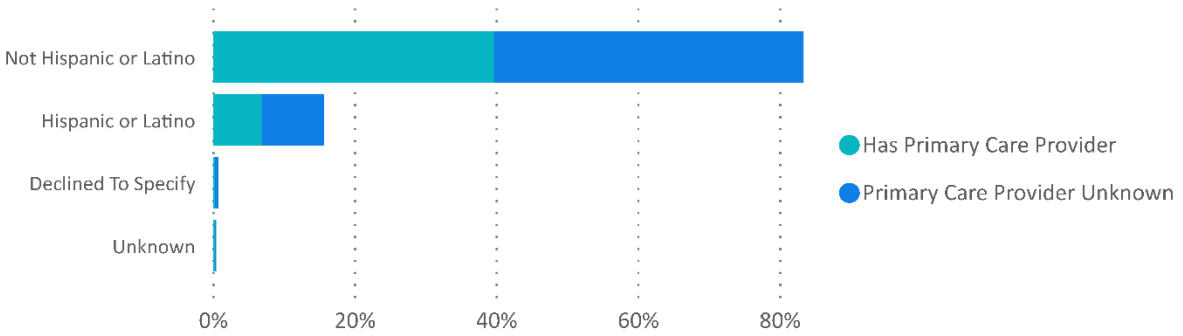
AC Care Connect: Whole Person Care Dashboard

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

In Bundle with Known Primary Care Provider in SHIE: by Race



In Bundle with Known Primary Care Provider in SHIE: by Ethnicity

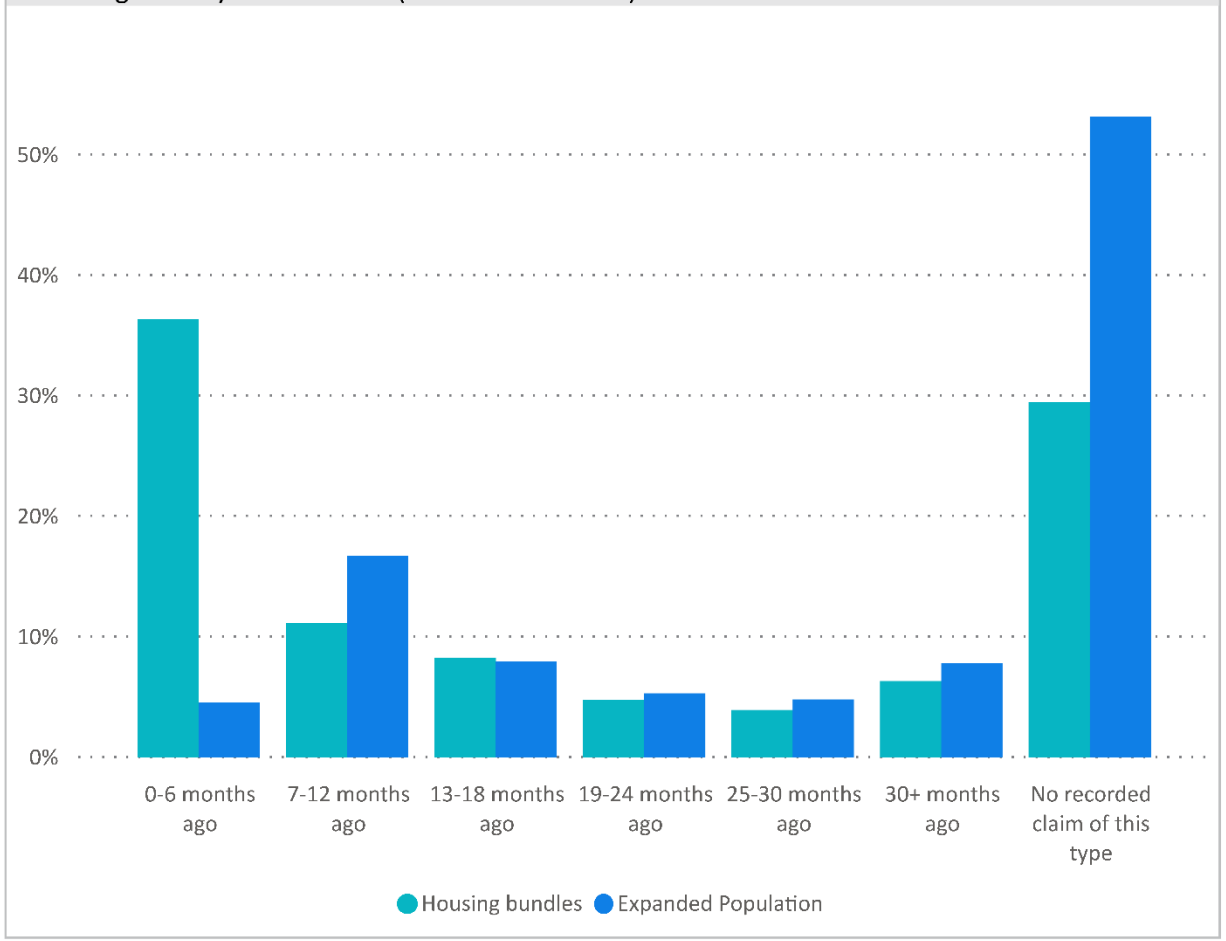


Data source: Social Health Information Exchange.

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.

Receiving Primary Medical Care (Most Recent Claim)



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.