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A Whole Person Care Pilot

Alameda County Care Connect Steering Committee

February 19, 2021

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Welcome

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

Nancy Halloran, Deputy Director, AC Care Connect

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Agenda

1. Welcome
2. Consumer Story
3. Director's Report
4. Sustainability Planning
5. Discussion
6. Adjourn

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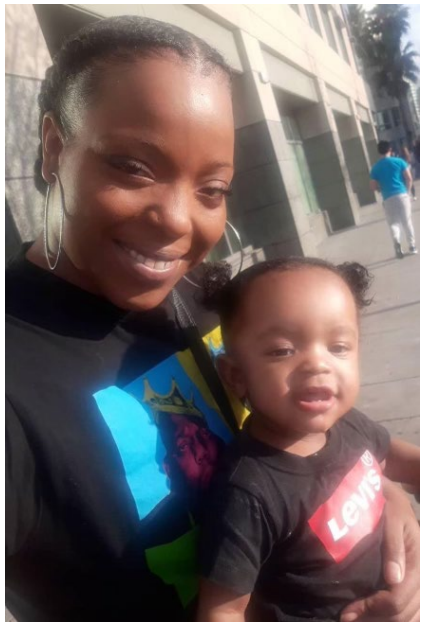

Consumer Story

Gaquayla Lagrone, Peer Advisor, Care Connect
Consumer and Family Engagement Program

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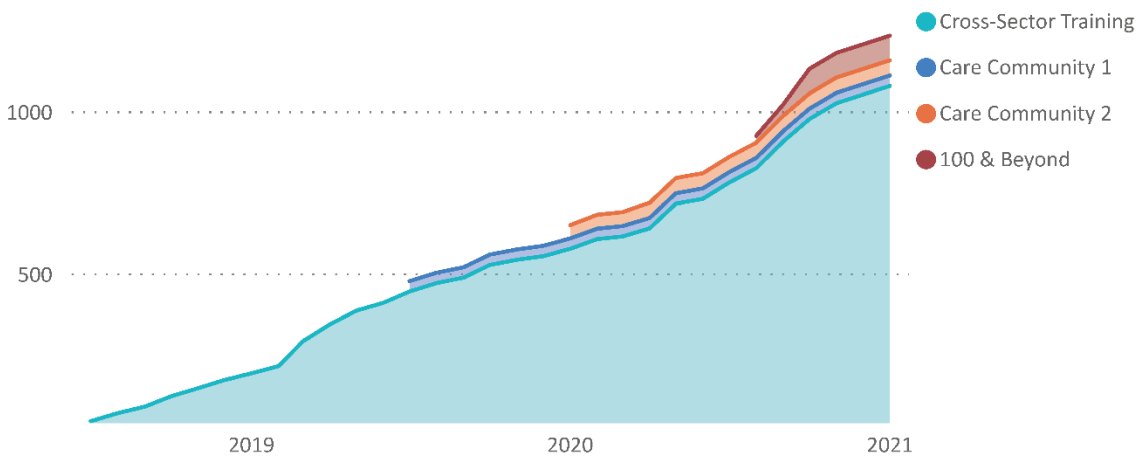
Director's Report

Kathleen Clanon, MD; Director, AC Care Connect

AC Care Connect: Whole Person Care Dashboard

Individuals Trained in Cross-Sector Care Coordination (Jul 2018 - Jan 2021)



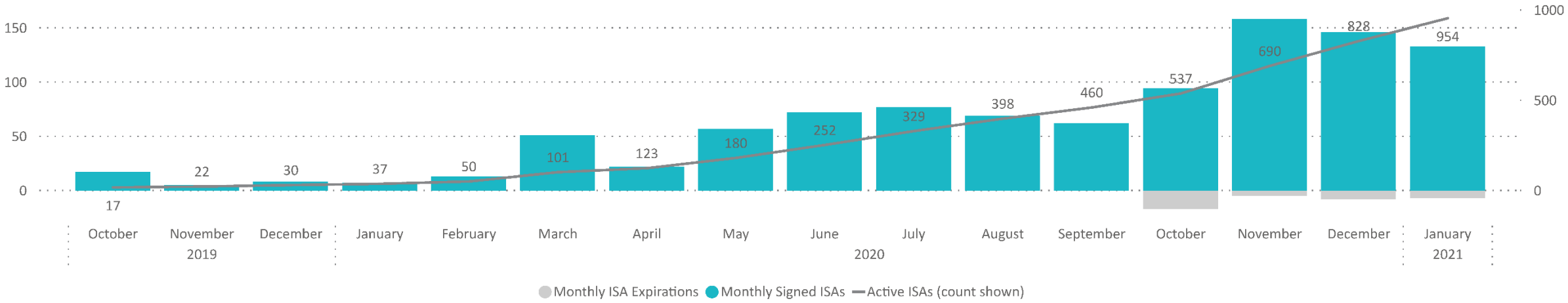
Data source: Care Connect Academy and Care Community team (cumulative count).

CHR and SHIE Utilization (Jan 2021)

Unique Community Health Record End User Logins	**664**
Consumers in SHIE - Currently Eligible	**43,682**
Consumers in SHIE - Ever Eligible	**83,176**
Expanded Population (including Ever Eligible)	**666,843**

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

Signed Information Sharing Authorizations (Oct 2019 - Jan 2021)



Data source: Social Health Information Exchange (excludes 7 revocations of authorization).

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Coordinating care through information sharing that is stable, secure, supported, and well-utilized

- Over 1,000 users completed CHR training (between Sept 2019-Feb 2021)
- Information Sharing Agreements (ISAs): Docusign e-signature integration implemented
- Washington Hospital Data Sharing Authorization (DSA) signed
- Sutter Hospital and St. Rose Hospital: data integration in process
- Ingestion of COVID-19 lab test results from State's CalREDIE system into SHIE
- Implementation of behavioral health appointment scheduling system for Santa Rita Jail (go-live/training complete at end of May)

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Initiatives to integrate behavioral health and primary care services

- Integrating CHR with FQHCs' EHR to improve care coordination between ACBH, Care Connect, and Alameda Health Consortium
- Training ACBH providers to use the CHR to support care coordination across organizations (as part of Final Rule Care Coordination Policies and Procedures)
- Supporting Alameda Health Consortium's pilot project to fund eight Pediatric Care Coordinators to connect pediatric clients to preventive services with focus on those with Adverse Childhood Experiences (ACEs)
- Partnering PATH primary care staff from LifeLong and Bay Area Community Health Centers with SMI clients and ACBH staff (at Oakland, Eden, and Tri-City Adult Community Support Centers) to receive COVID-19 Vaccines

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SUD Continuum of Care Updates

- **Options Recovery Services* resumed limited in-person SUD treatment services at Santa Rita Jail,** on-site services will help launch a new initiative through the Co-Occurring Substance Abuse and Mental Illness (CSAMI) program, a collaboration between Justice Involved Mental Health, Adult Forensic Behavioral Health, and the SUD Continuum of Care.
- **Recovery Residence beds for AB109 clients***: Partnering with the Probation Department to offer recovery residence services (sober living homes) to clients engaged in outpatient treatment, those awaiting placement in a SUD residential treatment program, and those exiting jail or prison in need of immediate access to treatment post-release.
- **Public Information Campaign will be launched in Feb/March 2021** to raise awareness of SUD prevention and treatment services available to Medi-Cal beneficiaries
- **HealthRIGHT360 Asian American Recovery Services** was added to the network to provide outpatient, intensive outpatient, and recovery support services for Medi-Cal beneficiaries

**Funded in part by Care Connect*

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Sustainability Planning

Kathleen Clanon, MD; Director, AC Care Connect

Valerie Edwards, LCSW; Director, Clinical Case Management Methods, AC Care Connect

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Sustainability Planning Activities

- Care Connect Programs and Activities Analyses
  - What has our impact been?
- Funding Assessment
  - What has funding beyond Care Connect?
  - What needs bridge or long-term funding?
- Collaborative planning with partners (health plans, OHCC, etc.):
  - What opportunities are there to transition/sustain this work?
    (e.g., CalAIM, Measure W, others)

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Sustainability Planning 2021 Timeline

Jan-Mar

- CalAIM: ECM-ILOS Model of Care and contract language (DHCS-MCP) released
- Care Connect: Sustainability analyses in process
- County FY21-22 planning

Apr-Jun

- CalAIM: Draft rates for ECM and ILOS pricing guidance released
- Care Connect: Sustainability analyses in process
- County FY21-22 planning

Jul-Dec

- CalAIM: MCPs submit ECM-ILOS model of care for approval by DHCS (July 1)
- CalAIM: Stakeholder process for county inmate pre-release applications
- Care Connect: Collaborate with HCSA and other partners to identify future plans for Care Connect activities
- Care Connect: Stakeholder engagement for transitioning services/programs post-Care Connect

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Highlights of selected Care Connect supported activities and next steps for sustainability

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Creating a whole person system of care for unhoused individuals: Project Roomkey

- Project Roomkey (Operation Comfort & Operation Safer Ground) launched in March 2020
- 9 hotel sites countywide
- Partnerships created/strengthened
  - County/government: ACBH, SUD, EMS, DOC, SSA, Probation, CDCR
  - Shelter operators: Five Keys, Abode, Building Futures, Berkeley Food and Housing Project
  - Transport, security, cleaning, and caregivers
- Purchased two sites (approx. 240 rooms)
- Over **2,700 households** were able to safely isolate/quarantine and/or shelter in place at Roomkey hotels

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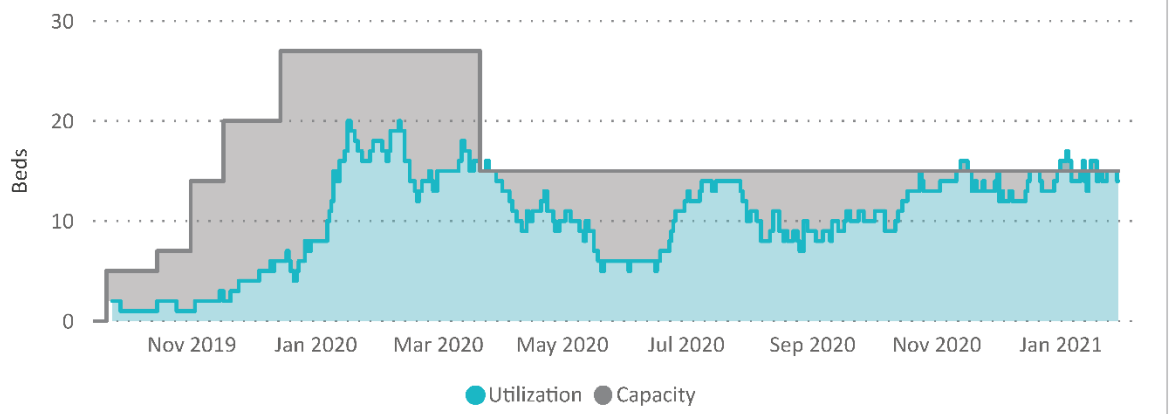
Creating a whole person system of care for unhoused individuals: System Changes

- Coordinated Entry (prioritizes people for access to housing services)
  - Equity-based approach that offers the most intensive resources to those with the most need (vs. first-come, first-served)
  - HCSA is now Management Entity
  - Work will be managed through the Office of Homeless Care and Coordination (OHCC)
- Existing Housing Resource Centers and 2-1-1 are primary access points for services including housing problem-solving; more locations are being added
- Revised assessment protocol will include housing and *crisis* housing
- Changes to HMIS will allow for assessment scores to be more immediate and include housing problem-solving services and outcomes
- New matching procedures for crisis housing and housing navigation

AC Care Connect: Whole Person Care Dashboard

Lifelong Medical Care (Sep 2019 - Jan 2021)

Respite Bed Capacity and Utilization



County Bed Capacity

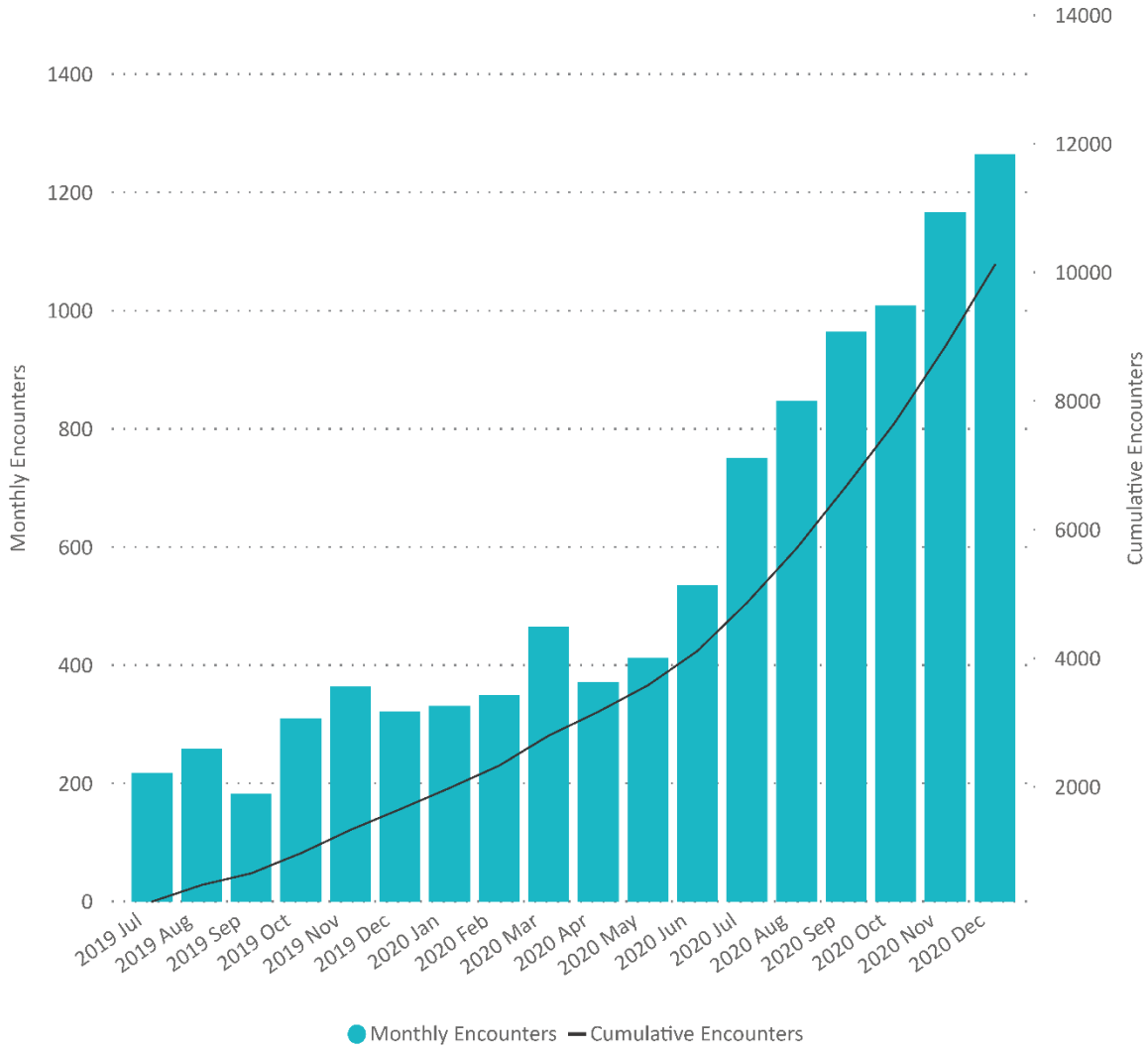
Name	Capacity
Abode	2-5
Bay Area Community Services	42
East Oakland Community Project	15
Lifelong Medical Care (AC3 funded)	15

Housing Status Upon Most Recent Departure

Housing Status	Share
Unknown	48%
Place not meant for human habitation	15%
Shelter	14%
Medical or treatment facility	8%
Permanent housing	5%
Temporary housing	4%
Other	3%
Deceased	2%
Long-term care facility or nursing home	1%

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 - Dec 2020)

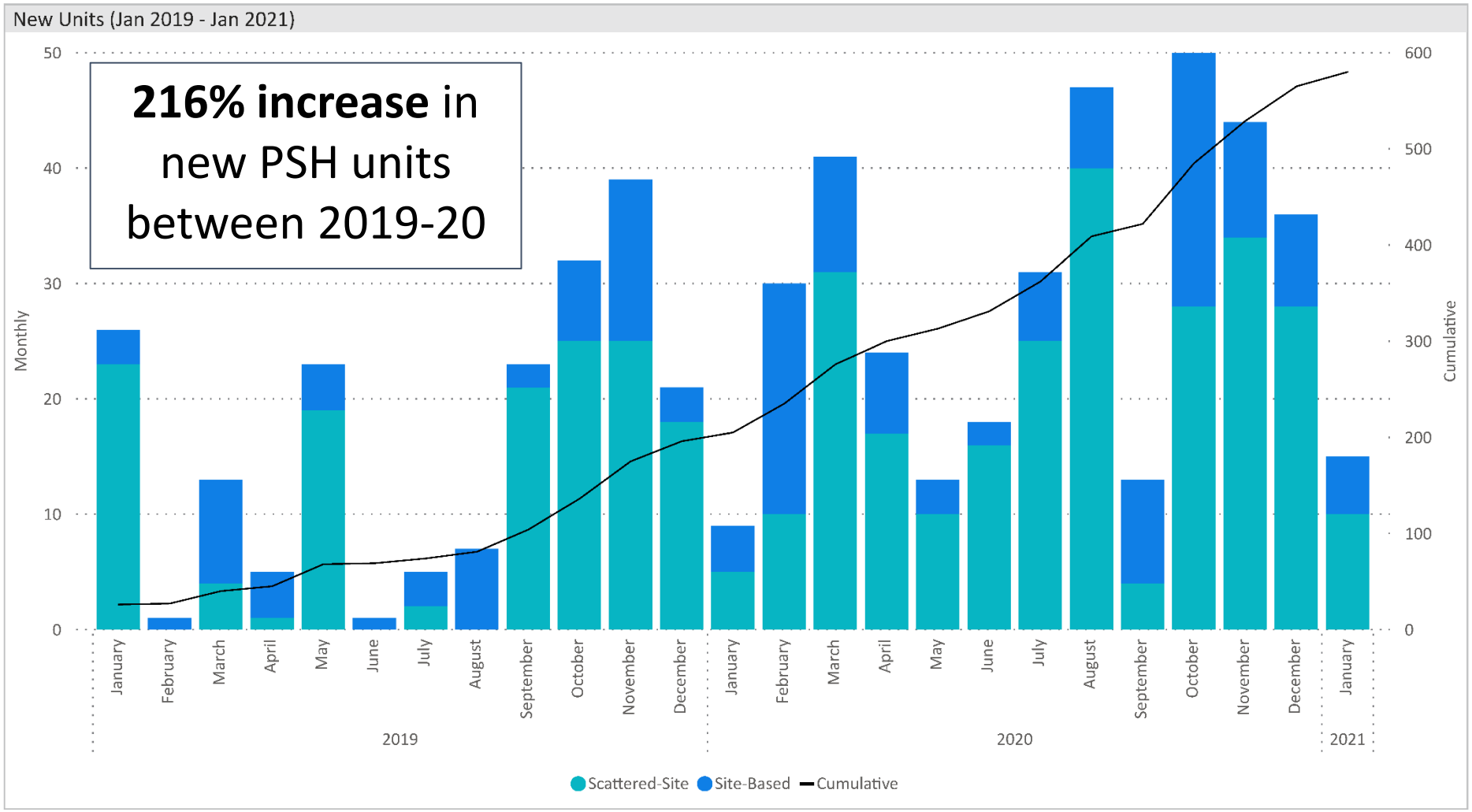


Data source: Alameda County Health Care for the Homeless HRSA uniform data system.

AC Care Connect: Whole Person Care Dashboard

Permanent Supportive Housing (Jan 2019 - Jan 2021)

New Units (Jan 2019 - Jan 2021)



248

Scatter-Site Openings in 2020

138

Scatter-Site Openings in 2020

121

Site-Based Openings in 2019

58

Site-Based Openings in 2019

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.

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Creating a whole person system of care for unhoused individuals: Next Steps

- Planning for Measure W: still TBD
- HCSA, health plans, providers, and Care Connect coordinating on CalAIM planning
  - Care Connect goals:
    1. All current Care Connect and Health Homes clients experience a smooth transition to care management and services that work for them.
    2. Current housing and other providers to be considered as providers under ILOS/ECM.
    3. Current providers to be supported with technical assistance in becoming ILOS/ECM providers if they wish to.
- Ongoing changes with the Coordinated Entry System and HMIS

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Sustaining Cross-sector Skills Development: Interview Findings

- **Cross sector approach** to care coordination helps address the silos
- It's all about the **workforce pipeline**: recruitment, development, and retention
- We need a **coordinated system** for skills development
- Enthusiastic endorsement and support for the **Onboarding New Hire Academy**
- Enthusiasm for participation in a **Skills Development steering group**

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Sustaining Cross-sector Skills Development: Next Steps

- Develop a small workgroup to make recommendations:
  - What does this look like a year from now?
  - Where does it live?
  - How do we make sure it continues to serve the needs of all of our communities/providers?
- **Is anyone interested in participating in this workgroup?**

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Sustaining a culture/infrastructure to ensure cross sector, culturally affirmative integrated care happens

Care Connect Consumer and Family Engagement Program

Vision: *Highest level of wellness, for everyone, through clinical and social care delivery whenever, wherever, and however it is needed.*

- **Aims:**
  - Partner with other Alameda County agencies and programs to cultivate respectful, engaging collaborations.
  - Advocate for meaningful inclusion of the consumers' and their concerned loved ones' perspectives in planning, processes, and programming.
  - Build a peer workforce trained to further health equity, increase flexibility, and circumvent the complexity of our service delivery.
  - Align with system and government priorities and planning (CalAIM and others) to ensure the viability and effectiveness of these efforts.

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Sustaining a culture/infrastructure to ensure cross sector, culturally affirmative integrated care happens: Training Sustainability Goals

- Develop an incubator for Health Equity activities to support system transformation:
  - Create a cadre of community health workers made up of people who share the lived experience of our consumers, including Fellows, Peer Advisors, those on the path of recovery, and youth just entering the work life
  - Advance the county's readiness to tap into new revenue streams (such as SB803, which allows for CHWs to bill Medi-Cal) by expanding the community health worker workforce
  - Strengthen consumer engaged workforce by serving as a source of well trained CHWs for HCSA divisions, county agency partners, contractors and allied systems.
- Build consistency and seamlessness of health equity efforts across the County by:
  - Furthering engagement of family and other networks of support by serving as source of consultation, education and information to the county and partners
  - Coordinating and centralizing the County's health equity and consumer engagement efforts
- Collaborate with County Human Resources to design the job classifications/descriptions to meet CalAIM and other staffing needs that have surfaced from Care Connect's work:
  - Ensure success by crosswalking these efforts by collaborating with County HR in workforce development plan

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Sustaining a culture/infrastructure to ensure cross sector, culturally affirmative integrated care happens: Workforce Development Objectives

- Train this new workforce sector and their potential workplaces in
  - Partnering with consumers to *understand the consumer's context of what s/he cares about, who cares about them, and utilization of the tools needed achieve this*
  - Assessing for the protective elements in their way of life and maximize the benefit of these factors to their health and wellness
  - Identifying and further refining interventions that recognizes that relationship dynamics of consumer's personal and professional circles of care, where they are in the life span, the course of chronic illness and the changing resources in the family and community
  - Training CHWs and line staff supervisors in a model that is rooted in a culturally affirmative, relational-based ethnographic approach with a focus on effective recruitment, development, coaching and staff retention
  - Emphasizing that success runs at the speed of trust
- Conduct analysis of the impact of this work

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Discussion

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

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Discussion Prompts

- What's the best role for the Steering Committee to give input into CalAIM planning and Care Connect wind-down?

- What aspects of the cross-sector work and activities do you want to make sure that we preserve?

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Adjourn

Next Meeting: March 19, 2021

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For more information visit
www.accareconnect.org

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Appendix slides

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Glossary

- **Cultural Proficiency**: a set of congruent behaviors, attitudes and policies that come together in a system, agency or among health professionals that enables work in cross-cultural situations. … values diversity; conducts cultural self-assessments; is conscious of and manages the dynamics of difference; institutionalizes cultural knowledge; and adapts services to fit the cultural diversity of the community served.[1]
- **Ethnographic**: … accessing beliefs and practices, allowing these to be viewed in the context in which they occur and thereby aiding understanding of behaviour surrounding health and illness. … how the effectiveness of therapeutic interventions can be influenced by patients' cultural practices and how ethnocentric assumptions on the part of professionals can impede effective health promotion… [2]

[1] Public Policy Principles for Improving Cultural Proficiency & Care to Minority & Medically Underserved Communities Adopted November 2005 Document Updated May 29, 2007 **Medical Leadership Council on Cultural Proficiency**

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119117/

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Structural Violence

- ….social arrangements that put individuals and populations in harm's way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people (typically, not those responsible for perpetuating such inequalities). With few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease. (Paul E Farmer)

[1] Published online. doi: 10.1371/journal.pmed.0030449**Structural Violence and Clinical Medicine** Paul E Farmer,* Bruce Nizeye, Sara Stulac, and Salmaan Keshavjee 2006 Oct 24

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What We Mean by Culturally Affirmative:

Rather than treating culture as an obstacle to be overcome, it is sought out, welcomed and recognized for its many protective factors.

- *Lean in, choose to engage when racial & other dynamics of difference surface*
- *Focus on what is relevant to the consumers on your panel*
- *Have the tools: for what to do, what to say and above all, how to listen*
- And it necessitates ***actions!***

An example:

- **Care Connect Community COVID Playlist**
  "This document that describes who in our community submitted the song and what it means to them. Our community is over 50 strong and includes staff, consumer fellows and consultants. The music is over 4 hours of our 'go to' for a morale boost, a dance tune to take a break from the computer or the song that seems to express the insanity and tragedy of this moment in time" Kathleen Clanon, MD Ex Director, Care Connect https://open.spotify.com/playlist/5QRvkvbkbcF9pEtWnKcZu2

Consumer and Family Engagement Mam Community Outreach Team

Ricardo Ortiz Ramirez

(510) 631 – 2355

Martha Calmo Ramirez

(510) 631 – 2329

Anibal Pablo Ramos

(510) 631 – 2332

Connecting the community to information and resources to reduce the transmission of COVID-19 and increase healthcare access and linkages.

- COVID-19 information and referral
- Health insurance linkages
- Public Benefits information and navigation
- Consultation education and information

All services provided in Mam

Team Lead:
Rebecca Alvarado, LCSW

Email:
Rebecca.Alvarado@acgov.org

Care Connect, A Project of Health Care Services Agency of Alameda County

CONSUMER & FAMILY ENGAGEMENT
PEER-2-PEER ADVISORS









"When I can make a connection for someone in need I am also healed." --Champ

For more information, contact De'Misha Barker, Project Coordinator at demisha.barker@acgov.org

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