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

November 2020

Partner Update

Dear Partner,

Welcome to our November *Update*.

This issue includes highlights from our November Steering Committee meeting and updates on recent activities that support the delivery of whole person care across Alameda County.

If you are new to our mailing list and would like to review prior issues, you can find them here. You can also sign up to receive future issues of the *Partner Update* using the link at the bottom of this newsletter.

AC Care Connect Website

Highlights of the November Steering Committee Meeting

The November meeting included a look forward to 2021 and a brief review of Alameda County Care Connect's (AC Care Connect's) 2020 accomplishments. We will share these milestones during the December meeting.

Impact of Whole Person Care: Consumer Stories
We share a consumer story at every Steering Committee meeting to illustrate how our whole person care partner organizations and programs are coordinating services and resources to serve our most vulnerable community members. Josh Levine, Safer Ground Program Coordinator with Berkeley Food & Housing Project, shared consumer stories that

highlight the value of having housing, medical, and behavioral health services accessible to consumers in one location.

Tony, a 56 year-old man who is blind and has been homeless since the 1990s, became a guest at Safer Ground in August. The shelter-in-place order was challenging for him as he was used to being outdoors on his own and had a long history of refusing support services. Tony gradually developed a strong relationship with one of Berkeley Food and Housing Project's Housing Navigators and gradually adjusted to staying in place at the Safer Ground site. He has since been approved for permanent supportive housing and in-home supportive services (IHSS). Soon Tony and the home health aide assigned to him will move into a 2-bedroom Shelter Plus Care apartment in Berkeley. *(See article below about the Housing Assistance Fund that helps cover move-in expenses for consumers.)*

Update on Extension of Section 1115 Waiver
Last September, the California Department of Health Care Services (DHCS) submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) for a 12-month extension of the Section 1115 waiver which funds whole person care pilots like AC Care Connect. The outlook is promising for approval of the extension although we may not receive formal notification until early 2021. This month DHCS asked AC Care Connect to submit a budget proposal for Program Year (PY) 6 (2021) by mid-December. We are currently reaching out to partners to discuss the 2021 plans. The budget may be less than in 2020 but it will include unused funds from this year.

Focus for 2021: Community Impacts
Early on in the pilot, we focused on six areas of change: Care Coordination; Care Integration; Housing and Homelessness; Data Sharing; Behavioral Health Crisis Response; and Consumer and Family Experience. Over time, we have shifted our focus to the long-term *impacts* or outcomes of whole person care to:

- Create a system of care for people without a home
- Ensure that sick and disabled people stay in their homes or return home in a timely manner
- Reduce health outcome disparities among people living with severe mental illness
- Implement early interventions to reduce occurrences of emergency behavioral health crises
- Provide coordinated care through information-sharing that is stable, secure, supported, and well-utilized
- Collaboratively create a new culture and infrastructure in Alameda County to ensure cross-sector, culturally-affirmative, integrated care

Possible New Deliverables and Incentives
Over the next several weeks, we will work with partners to review the status of existing deliverables and consider PY 2021 priorities and the evolving plans for CalAIM (*see below*). In addition to sustainability incentives related to CalAIM planning and preparation, some possible new deliverables / incentives under discussion include:

- Efforts to enroll the reentry population in Medi-Cal, which will be a requirement under CalAIM
- Strengthening and expanding the consumer peer-to-peer program
- Expanding respite care, which has emerged as an important benefit of Project RoomKey where the impact of the respite care provided at the hotels has had a major positive impact on guests' health and well-being

During the Steering Committee meeting, attendees discussed the future of CalAIM.

Overview of California Advancing and Innovating Medi-Cal (CalAIM)
Beau Hennemann, Director Special Projects with Anthem, Inc., provided an overview of CalAIM, which overlaps with whole person care in sharing three key areas of focus: population health management, enhanced care management, and in lieu of services (ILOS) that will provide continuity beyond the AC Care Connect pilot. Health plans will be required

to establish a population health management program characterized by enhanced care management services and to offer ILOS, which are flexible wrap-around supports that haven't traditionally been funded by Medicaid. For further details click here to download the presentation slides.

How AC Care Connect is Planning for CalAIM
Jennifer Martinez, Program Development Director with AC Care Connect, gave an overview of AC Care Connect deliverables that are tied to incentive payments. These fall into four categories:

- System Readiness
- Information System Readiness
- Operational Readiness
- Providers and Consumer Readiness

These deliverables have been completed to varying degrees due to COVID-19, which diverted attention and resources in 2020. Deliverables that are not yet completed will be a focus for the work in 2021. (For more information, see the Steering Committee presentation.) AC Care Connect will work closely with partners to inform and complete these deliverables.

The Future of AC Care Connect's Steering Committee
Attendees broke into groups to reflect on the value of the Steering Committee, where it has been most effective, others that should be at the table in 2021, and how the Committee might be involved in planning for CalAIM. Members commented on the diversity of the expertise and perspectives on the Committee and its value in creating a safe space for representatives from diverse sectors to share knowledge and collaborate on solutions to improve the health of Alameda County's most vulnerable residents. Looking to the future, some commented on the need to focus on integration of behavioral health care and also to not lose sight of the importance of connecting housing and health care, which has been one of the most valuable aspects of the pilot. Members also noted that the Committee will need to focus on building a foundation to provide in-lieu-of services, which are central to realizing the vision of whole person care.

Updates on Efforts to Reduce Homelessness and Support the Transition to Housing

Efforts Continue to Support Guests of the Safer Ground Hotels in Securing Permanent Housing
The hotels have provided an opportunity for guests to have a safe place to stay to prevent COVID-19 infection and to obtain access to needed medical care. At the hotels, under the guidance of co-medical directors Alexis Chettiar and Katie Hayes, UCSF nurse practitioner students are helping guests address a variety of medical needs. This includes helping those who are eligible for Medi-Cal get enrolled, connect with a medical home, and schedule appointments for primary care and needed vaccinations. They are using the CHR to support this work. The co-medical directors recently oversaw a project to get the necessary medical paperwork in place for all guests who are disabled so they are "document ready" when housing opportunities arise. An important learning that has come out of the work to connect hotel guests with medical services is how valuable it is for those experiencing homelessness to be able to stay even for a short time in a safe, welcoming place where they can receive both medical services and help in obtaining permanent supportive housing. This is evidence of the positive impact that respite care can have and is the

rationale underlying AC Care Connect's goal to expand respite care in 2021.

California's Project Roomkey initiative has successfully sheltered individuals around the state. Their stories are impactful as shared in this video produced by the California Department of Social Services, which includes a segment featuring Vince Russo, Senior Program Manager with Abode Services.

Home Stretch Housing Assistance Fund Helps Households Exit Homelessness and Maintain Housing

As of early November the Fund, which is managed by Colleen Budenholzer, MSW, Home Stretch Program Manager with Alameda County's Health Care Services Agency (HCSA), had supported 368 households including those exiting Project RoomKey hotels to obtain and maintain safe and stable housing. Since October 2019 the Fund, which was initially piloted by AC Care Connect, provided approximately $440,000 in rental assistance to help households without savings but with the ability to maintain rent to exit homelessness. Recognizing that rent alone does not create a home, the Fund provided $514,000 to help households obtain household items, furnishings, and moving costs; and $37,000 for households with disabilities to get needed equipment or modifications to make their new homes safe and accessible.

The Fund has a tremendous impact as revealed in the following stories:

"He is no longer living on the streets or in his car. That obviously has improved and lent safety to him physically as he now has a way to control COVID-19. He has a bed that is bringing relief to his back pain. His mental health is improving because he doesn't fear living outside any longer, he has a place to rest. Also, he is now able to cook his meals giving him the ability to eat healthier which of course improves his mental and physical health. He's grateful!"

"The items received were crucial in her recovery, as she moved into her new unit straight from long-term post-op rehab for spinal surgery. The program helped make her new home accessible in a way she couldn't otherwise have achieved."

"Timely help with his move-in funding made the difference between homelessness and housing."

Colleen Budenholzer, MSW, Home Stretch Program Manager shared stories of the impact of the Housing Assistance Fund

For more information, visit the Home Stretch website **or contact program staff at 510-567-8030 or** homestretchfund@acgov.org

Total Number of Consumers Reached by Crisis Connect Increased by 30% in October

The Crisis Connect project, a partnership between Alameda County Behavioral Health (ACBH) and AC Care Connect, strives to help prevent another crisis by offering non-high utilizing consumers a phone call within 24-48 hours after discharge from John George Psychiatric Hospital's (JGPH's) emergency services unit, a Crisis Stabilization Unit, or the mobile crisis team. The project has been ramping up since launching in January 2020. In October, the team served 27 individuals, an increase of 30% over the total served (89) in the nine-month period January - September. The project aims to connect consumers with needed services before they experience another crisis. Some examples of successful linkages facilitated by the Crisis Connect team in October include the following:

- A 20 year old Latino male with depressed mood due to relationship issues was connected to La Clinica de la Raza's mental health services
- A 31 year old Black male who was homeless and experiencing psychosis was reconnected to Abode Services for mental health services after having been discontinued due to inactive Medi-Cal status.

The Social Health Information Exchange (SHIE) and its Role in Promoting Population Health

While many are familiar with AC Care Connect's Community Health Record (CHR), they may not know about the Social Health Information Exchange (SHIE), which is the engine that powers the CHR and has the most impact in promoting population health. In contrast to Health Information Exchanges (HIEs), which hold mostly medical and related information (lab results, medication lists, etc.), the SHIE holds data from both medical and non-medical sectors. It is enabled by a network of partner organizations across sectors—medical, mental health, substance abuse, housing, social care, legal, and crisis response—that securely and appropriately share information over the internet using a standardized approach in compliance with federal and state legal standards. (*The SHIE is depicted in the diagram at the top of this newsletter*.)

The SHIE receives large amounts of data from core partner systems (electronic health record, case management, claims, etc.) and can be used to provide a "big picture" view of health-related issues/challenges across the entire community and identify solutions to these. In contrast, the CHR is a tool that is used by providers in working directly with consumers/clients. CHR-trained users can access a curated record for consumers that have an established relationship with the user's organization. The record pulls critical information from different sectors into one place so that care team members can more effectively coordinate care.

The SHIE's Important Role in Helping Reduce Spread of COVID-19 in the Mam Speaking Community

In last month's newsletter we shared the story of AC Care Connect's Mam Community Outreach Team and their work to address the high rates of COVID-19 infections, morbidity, and mortality in Alameda County's Mam speaking community. To support the Team, AC Care Connect turned to its Data Exchange Unit (DEU) to create an algorithm based on work already started at Alameda Health System to conduct outreach to the Mam community. This was largely based on common Mam last names plus information on race/ethnicity and language (where available). This information was applied to all individuals in the SHIE including the expanded population. The work also helped to identify the primary zip codes where the county's Mam speaking population resides and the top 2-3 clinics the Mam community uses. The Mam Community Outreach Team is using this information to work with the clinics and community organizations in the neighborhoods that correspond to

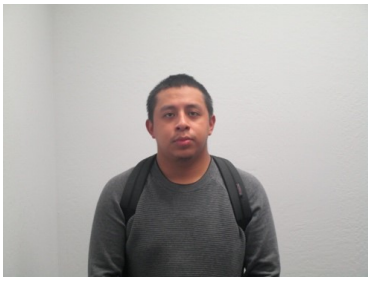
those zip codes to support the Mam speaking community in designing and implementing strategies to prevent the spread of COVID.

A component of this work is ensuring that the community has access to testing. The success of the outreach effort is summarized by Jake Kersey, Northern California Area Manager - COVID Response; CORE (Community Organized Relief Effort): *"As we've seen at all our Alameda County sites this week, demand for testing is surging amid rising case numbers as the holidays approach. We tested 157 patients on Tuesday. I don't have a detailed demographic breakdown of those tested, but anecdotal reports from our staff indicate that 40-50% of patients appeared to be from the local community, which represents a hugely successful outreach effort at a first-time pop-up testing location like this. We could not have reached those most in need without the vital support of the Mam Community Outreach Team."*

AC Care Connect's Mam Community Outreach Team

Ricardo Ortiz Ramirez

Martha Calmo Ramirez



Anibal Pablo Ramos

For more information on the Mam Community Outreach Team please contact Rebecca Alvarado, Team Lead, at Rebecca.Alvarado@acgov.org

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Thank you for your ongoing dedication and support of Care Connect, Alameda County's Whole Person Care initiative. Please feel free to share this newsletter by forwarding to friends and colleagues.

Your partner in connecting consumers for better health,

Kathleen A. Clanon, MD
Director, Alameda County Care Connect and Medical Director
Alameda County Health Care Services Agency

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