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

July 2020

Partner Update

Hello Partner!

We're so pleased to restart our updates and hope this email finds you safe and well.

Each month, we bring you highlights of the amazing efforts underway to deliver whole person care: *integrated, respectful, and coordinated care that improves outcomes for Alameda County's most vulnerable Medi-Cal beneficiaries, especially those who are homeless and frequently rely on crisis services.*

Since its launch in 2016, Alameda County Care Connect (AC Care Connect) has achieved great progress in advancing this mission. Fundamental to this work are the Social Health Information Exchange (SHIE) and the Community Health Record (CHR). This system synchronizes clinical data, health and other service visits, and social resources, including housing and family supports, into the consumer's record and is accessible across sectors. Data sharing is essential to coordination of care. With the launch of the SHIE in 2017, followed by the prototype CHR (pCHR) in mid-2019 and the CHR in late 2019, a wealth of data became available to providers to support delivery of coordinated care. This data is also valuable to monitoring the outcomes of AC Care Connect.

This great work would not be possible without the collaboration of our partners. Thank you for your ongoing support.

AC Care Connect Website

SHIE / CHR Dashboard Highlights: Enrollment and Information Sharing Authorizations (ISAs)

This month, Dr. Kathleen Clanon, AC Care Connect Executive Director, presented outcome highlights to the Steering Comittee, having pulled the metrics from AC Care Connect's dashboard. Key findings include:

Consumer records in the SHIE and CHR expanded significantly in 2020:

- **Goal Exceeded!** AC Care Connect exceeded its goal to have 17,000 consumers enrolled as of December 2020. Last month, we reached 18,650.
- Current enrollment grew by 55% in the first six months of 2020, from 10,163 in January to 15,780 at the end of June.
- The SHIE now contains data for more than 70,000 consumers who became eligible for AC Care Connect since the pilot launched.
- Of these, close to 38,000 consumers remain currently eligible.
- Of significant note, the population in the SHIE was temporarily expanded to improve care coordination during the COVID-19 pandemic. Records for more than 632,000 Alameda County residents are now viewable in the CHR. These include those who are enrolled in Medi-Cal, are Medi-Medi (have both Medi-Cal and Medicare), or are uninsured.

The number of CHR users is growing:

- AC Care Connect staff and consultants have been busy onboarding, training, and supporting a growing number of CHR users.
- Close to 600 CHR users were trained by the end of June.

The information viewable in the CHR continues to increase:

- Medication fill information is now included in health plan claims. The pharmacy claims data feed is now live for both Anthem and Alameda Alliance.
- *New:* The FEMA shelter report is available. It shows consumers who are at one of the isolation and quarantine hotels, and supports the hotel operations and the 100 Day Challenge initiative. *See below.*
- Mortality data from Public Health is now in the CHR.

The number of completed and signed Information Sharing Authorizations (ISAs) continues to be low:

- Only a very small portion of AC Care Connect enrollees have completed signed ISAs in the CHR. Consumers must complete and sign the ISA to realize the full value of the CHR and support coordination of care. There are many resources and tools posted on Elemeno. These are updated on an ongoing basis.
- **New to Elemeno**? Elemeno is an online platform containing tip-sheets, guides, videos, and other resources for the CHR, and for services related to Care Management, Health Plans, Housing, Mental Health, Primary Care, and Substance Use Disorder Treatment. Click here to sign up.

Dashboard Highlights: Access to Primary Medical Care

The impact of whole person care is reflected in the outcomes experienced by consumers. AC Care Connect seeks to improve consumers' well-being and health status as a result of increased access to primary medical care services and to safe, stable housing.

The June dashboard revealed positive outcomes in both of these areas. Based on 1,944 persons enrolled in a housing bundle during the period July 2017 - June 2020:

- About one third (36%) received primary medical care in the past six months, and almost half (48%) had received primary medical care in the past year. AC Care Connect's long-term goal is that 100% of persons enrolled in a housing bundle will have had a primary care visit in the past six months.
- The percentages were very similar across race/ethnic groups.
- However, Blacks/African Americans were over-represented among those ever enrolled in a housing bundle in this two-year period. While representing approximately 11% of the population in Alameda County, Blacks/African Americans comprised 52% of those in housing bundles. This is an indication of the underlying systemic inequities and disparities experienced by this population, which has high levels of homelessness and poor health.
- Also noteworthy is that those who had a diagnosis of "severe and persistent mental illness" were more likely to have received primary medical care in the past six months than those who did not have this diagnosis, 50% vs. 22%.
- These statistics were similar for those who had a diagnosis of substance use disorder (SUD), compared with those who did not have SUD: 58% of the former had received primary medical care in the past six months vs. 24% for those without SUD.

KEY FINDING:

Despite all the barriers to access that AC Care Connect enrollees encounter, whole person care appears to be achieving its desired impact as demonstrated by data that shows that those most in need are most likely to receive primary medical care services.

Steering Committee Presentation

AC Care Connect's Long-term Impact: Getting Homeless Consumers Housed

AC Care Connect strives to improve the health status of enrollees by enabling and fostering coordination of care across the many systems that together support the

whole person. Because health status is directly associated with enrollees' ability to access safe and stable housing, a long-term desired outcome is that enrollees have permanent housing.

Additional highlights presented to the Steering Committee this month include:

- Dr. Robert Ratner, Office of Homeless Care and Coordination, Health Care Services Agency, described ongoing efforts to implement coordinated entry and housing crisis system changes to build pathways to permanent housing.
- In June, Alameda County launched a 100-day Challenge with the goal of having viable housing plans in place for at least 400 homeless consumers currently residing in the county's Project Roomkey COVID-19 isolation and quarantine hotels.
- Under Governor Newsom's Project Roomkey initiative, Alameda County is leasing hotel properties representing combined occupancy of 652 rooms. An additional 4 hotels and 100 scattered hotel rooms across the county, representing combined total occupancy of 436 rooms, are in process of being leased, along with trailer sites representing a combined total occupancy of 161 rooms.

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
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