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

January 2021

Partner Update

Dear Partner,

Welcome to our first *Update* of 2021 with our best wishes for a happier new year! In this issue you'll find highlights from our January Steering Committee meeting and updates on activities that support delivery of whole person care in 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 January Steering Committee Meeting

During our January meeting, we reviewed shared accomplishments in 2020 and discussed how to build on this work in 2021 as we prepare for the transition to CalAIM in 2022. The Steering Committee did not meet in December due to the holidays. We were also engaged in the arrival and distribution planning for the COVID vaccine and ongoing pandemic response efforts during the surge.

Impact of Whole Person Care: Consumer Stories

We open each Steering Committee meeting with a consumer story to keep us grounded around whole person care for our most vulnerable community members. Kseniya Povroznik, Housing Navigator with Five Keys, shared a story of a 75-year-old woman whom Kseniya described as "vibrant, sharp, and totally committed to her grandbaby." Kseniya supported her client over several months in the journey to find housing. The story highlights barriers consumers face in finding housing that meets their need for safety and comfort. The experience also underscores the collaborative efforts our partner organizations make to support consumers in achieving this outcome.

This grandmother lost her rental housing due to ongoing rent hikes and was living on the streets. She wasn't eligible to stay at Five Keys because she did not meet the criteria for permanent supportive housing. Kseniya connected her with a shared independent living location through Bay Area Community Services (BACS). The situation was safe and comfortable and the woman agreed to stay. However, she had underlying anxiety about any shared living arrangement as this surfaced trauma from her prior experience on the

streets where her belongings and food were often taken by others. Kseniya persisted in seeking a better option and a house with a nanny unit became available. The grandmother recently moved into the home and her son and his partner live in the nanny unit in back. Close to family and her grandchild, the woman is happy and feels safe.

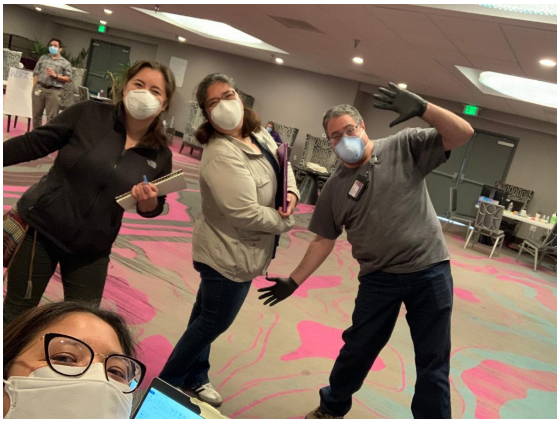
Accomplishments in 2020 and Success Factors

In December AC Care Connect participated in a whole person care appreciation event hosted by the California Department of Health Care Services (DHCS) to celebrate the successes of all whole person care pilots across the state. Each pilot presented their top three accomplishments of 2020. AC Care Connect shared the following successes made possible by the hard work, dedication, and collaboration of our many partners over the course of the pilot including the preceding years when the foundation for whole person care was built. As described at the DHCS event with the support of partner organizations AC Care Connect:

1) Significantly transformed the county's data integration efforts through the development of the Social Health Information Exchange (SHIE), which now contains over 600,000 consumer records. It also includes the launch of the Community Health Record (CHR), which now houses more than 78,000 Care Connect eligible consumers and 22,000 Care Connect enrolled consumers. The CHR has enhanced communication and care coordination across many sectors that work to improve the health status and quality of life of vulnerable consumers. (*See diagram at right*.)

Over the past year the CHR expanded significantly and now connects data from 14 sources and providers from 25 organizations (representing 100+ programs) to give care teams a whole person view of a client's history and priorities. From its launch in October 2019 through December 2020, nearly 800 staff from partner organizations have onboarded and are using the CHR.

2) Invested in and mobilized safety-net organizations across the county to build and strengthen connections between systems that include housing, social services, medical, behavioral health, and legal. Providers and staff of these organizations have participated in multi-sector trainings and capacity development, and engaged in collaboratively problem-solving system challenges in order to improve care coordination between organizations and promote better health and social outcomes for our communities.



AC Care Connect Data Exchange Unit team members conducted CHR user training at the hotels.

3) Leveraged the rapidly-expanding data integration efforts and the strengthened cross-sector partnerships to organize a rapid response to the COVID-19 crisis to prevent spread of infection and COVID-19 related deaths in high-risk populations. This infrastructure has been instrumental in the work to house more than 2,000 guests in isolation and quarantine

hotels where consumers were connected to much-needed resources and services. In total, through the end of December 1,400+ households had isolated/quarantined in Operation Comfort sites and 1,100+ households had sheltered-in-place at Safer Ground sites. The outcomes of this effort are a testament to the strength of the data integration efforts and partnerships. As of the end of December:

- No deaths due to COVID-19 among people experiencing homelessness occurred, and
- 284 households exited the hotels to permanent housing.

Further, **the vision of whole person care was realized at the hotels.** The SHIE's role in population health management was a critical factor in identifying guests who were eligible for Medi-Cal but not enrolled. The partnerships between AC Care Connect, hotel operators, and medical staff—led by hotel co-medical directors Alexis Chettiar and Katie Hayes *(pictured at right)*—and county agencies (including the Social Services Agency), enabled hotel guests to be connected with needed resources and services: Medi-Cal enrollment, health care services, substance use disorder (SUD) treatment, behavioral health care, housing, and more.

AC Care Connect also worked closely with partners to increase services and supports for people experiencing behavioral health crises. This included launching the Community Assessment and Transport Teams (CATT) pilot whose objective is to serve individuals in crisis by assessing behavioral health and substance abuse issues on scene and triaging resource needs rather than transporting the client to an emergency room or John George Psychiatric Hospital's emergency services unit. With CATT all consumers who do not meet 5150 criteria for temporary, involuntary admission for psychiatric emergency care are assessed and transported to more appropriate care. Out of 372 total episodes addressed by CATT in 2020, most (82% or 305 individuals) were diverted from 5150s. Of the remaining 115 consumers who were transported to the hospital, 52% went voluntarily for reasons including detox and medical or psychiatric evaluation. In 2021 the CATT pilot will expand from five (5) to 12 teams.

Focus for 2021

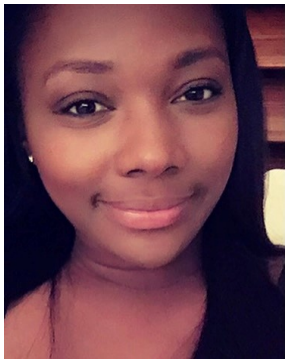
Meeting attendees engaged in small group Zoom break-out sessions to reflect on accomplishments in 2020 and priorities for 2021. There was consensus on the importance of continuing to enhance and expand the data in the SHIE and CHR and the use of these tools for population health management and care coordination with the overall goal of improving health outcomes. Topics raised as priorities for 2021 included sustainability of AC Care Connect-funded programs and services; being more explicit about health equity in planning, data sharing, and evaluating our work; planning for post-pandemic support for our workforce and communities; and increasing engagement with our communities to support our shared work. During 2021 partners will also focus on preparing for the roll-out of CalAIM in 2022. (See the November 2020 *Partner Update* for more information.)

CHR and SHIE updates

Insights from leaders of partner organizations help increase the value of the CHR as a tool for care coordination. Thank you to our partner organizations' leaders for taking time to talk with AC Care Connect leadership to discuss how the CHR is being used by your providers and staff, what is working well, what additional support is needed, and what could be improved in both the tool and the engagement process. These conversations help us maximize the value of the CHR as a tool for care coordination for your staff and the care

they provide. We look forward to upcoming elbow support and focused training sessions spurred by those conversations, as well as increased engagement in the Super User Workgroup. (*See article below.*) Going forward our program leadership will host these discussions quarterly with each CHR user partner organization to provide feedback on the use of the tool among their staff and to continually identify strategies to increase engagement and cross-sector care coordination.

Feedback from CHR end-users helps improve the tool and trainings. We learned so much from the August 2020 survey of CHR end-users that we decided to implement quarterly surveys. Please see the October CHR User newsletter for a summary of the findings and action steps that we implemented to address the feedback and improve and enhance the CHR and end-user trainings. In January we sent a survey to all (n=462) currently active CHR end-users. A summary of the key take-aways will be shared at the February 4th Data Governance Committee meeting and further details will be summarized in our February CHR User newsletter.



Super User Workgroup v.2.0 will be launched in February: Based on the August survey findings and other feedback we decided to upgrade the roles and responsibilities of CHR Super Users. Please see our special December newsletter that celebrated the one-year anniversary of the Super User Workgroup and announced important changes to the role of Super Users including providing more on-site support by serving in a problem-solving role for users at their organizations. For more information contact Carla Justice at cjustice@ pcgus.com.

***New!* The CHR now contains continuity of Care Document Architecture (CCDA) documents from Alameda Health System (AHS).** CCDA documents are electronic encounter-level summaries that contain information critical for effective care coordination such as the reason for a visit, active medication list, encounter details, discharge instructions, plan of treatment, and more. For CHR end-users who are not AHS providers or staff, this information is only visible when a consumer has signed an Information Sharing Authorization (ISA) and consented to full sharing of data types. We will be working closely with Thrasys, our vendor supporting development of the CHR and SHIE, over the coming months to receive CCDA documents from other hospital systems used by AC Care Connect consumers. We will provide updates as more information is available.

***New!* We are now receiving mortality data from Alameda County Department of Public Health.** The data is housed in the SHIE and is not accessible at an individual level in the CHR. In collaboration with key community partners, we will examine this data at an aggregate level and expect the information to become a valuable resource for identifying and addressing disparities in health status and outcomes at a population level.

***New!* EMS data is now in the CHR.** EMS encounter data is now in the CHR and available to all CHR end-users. Special reporting that includes this data can also be accessed via the AC Care Connect data request process**.**

WPC Appreciation Event - Unsung Heroes Award

Rebecca Alvarado, Manager, Clinical Case Management Projects, Recognized as "Unsung Hero"
At the December Appreciation Event for whole person care pilots hosted by the California Department of Health Care Services (*see article above*), Rebecca Alvarado, AC Care Connect's

Manager of Clinical Case Management Projects, was honored for her role in developing and implementing AC Care Connect's Consumer and Family Fellowship Program and its Mam Community Outreach Team. In nominating Rebecca for this award, AC Care Connect provided the following summary of Rebecca's work:

"Rebecca is a licensed clinical social worker. Over the 20 years before the AC Care Connect pilot launched, she served Oakland residents seeking care at Highland Hospital, the County's public hospital, and at Eastmont Wellness, a community clinic. She provided both direct service and served as a manager and trainer of community health workers, social workers, and community-rooted volunteers. Rebecca has a well-earned reputation among her colleagues and her clients and their families for the highest quality of care delivery from each of their perspectives. She carried that ethic into the development and implementation of AC Care Connect's Consumer Fellowship. Her decades of experience working with Oakland's Mayan Mam-speaking community and her proficiency in utilizing culturally affirmative approaches to care led to AC Care Connect endorsing her proposal for a Mam-speaking outreach team. The team was able to quickly gain the trust needed to effectively halt the spread of COVID-19 within the community. It is Rebecca's reputation in the community that made this success possible."

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

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For more information on AC Care Connect clickhere.

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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