Alameda County Care Connect Community Health Record (CHR)

OVERVIEW

In the fall of 2019, Alameda County's Whole Person Care Pilot launched the Community Health Record (CHR) application powered by the Social Health Information Exchange (SHIE).

The application was developed with significant input from providers and consumer focus groups, in partnership with Thrasys, Inc.

This electronic record summarizes data so care team members can see a comprehensive, "whole person" view of a consumer's utilization (clinical, housing, social and community services), enabling more efficient care and a streamlined consumer experience.

More information about the SHIE can be obtained from the Alameda County Care Connect Social Health Information Exchange (SHIE) handout.

KEY DATA & FEATURES

- Client Demographics
- Care Team Members
- Consumer Consent
- Shared Care Plan
- Encounter Information
- Self-Service Reports and Data Visualizations
- Housing Information
- Lists & Panels
- Hospital Alerts (Emergency and In-Patient)
- Secure Messaging

USER ONBOARDING

All programs that wish to get CHR access are required to go through a standard onboarding process once the organization's Data Sharing Agreement is signed. This process includes a readiness assessment, program workflow assessment, and training (3 hours).

CONSUMER RECORDS & ACCESS

At the launch of the CHR, consumer records included those individuals who met Care Connect eligibility criteria – Medi-Cal active in Alameda County and within one of three focus populations (1-experiencing homelessness, 2-experiencing high crisis system utilization, or 3-enrolled in an intensive case management program, such as Health Homes Program (HHP), Full-Service Partnerships (FSPs), Service Team, etc.).
Record count: n ≈ 60,000

In April 2020, due to the COVID-19 pandemic and subsequent emergency health order, the Data Governance Committee expanded the CHR population to include all Medi-Cal active consumers and all uninsured consumers in Alameda County.
Record count: n ≈ 600,000

Users do not receive automatic access to all records in the CHR. A structured data privacy framework, reviewed in a required training, determines which records and data types each user and organization can access.

COMMUNITY PARTNERSHIP

33+ ORGANIZATIONS

600+ ACTIVE USERS

120+ PROGRAMS

1,000+ TRAINED USERS

Users represent county, clinics, hospitals, health plans, mental health, housing, and substance use treatment organizations.

Participating Organizations

- Abode Services
- Alameda Alliance for Health
- Alameda Health System (AHS)
- Alameda County Health Care Services (Behavioral Health, Public Health, Office of Homeless Care and Coordination)
- Anthem Blue Cross
- Asian Health Services
- Axis Community Health
- Bay Area Community Health (formerly Tri-City)
- Bay Area Community Services (BACS)
- Bonita House
- City of Fremont
- Community Health Center Network (CHCN)
- Davis Street Primary Care
- East Bay Innovations
- Family Bridges
- Five Keys
- Fred Finch
- Horizon Services, Inc.
- La Clinica de la Raza
- La Familia Counseling Service
- LifeLong Medical Care
- Native American Health Center
- OCHIN
- Pathways to Wellness
- Roots Community Services
- Stars
- Sutter Health
- Telecare Corporation
- Tiburcio Vasquez Health Center
- Titanium Healthcare
- Washington Hospital
- West Oakland Health

We continue to expand and add new partners.

Participating Programs & Target Users

Target CHR end users are those care team members who play a key role in consumers' care coordination, supporting care transitions, working primarily with consumers in the Care Connect focus population, and/or who address social determinants of health.

Programs include Street Health Teams, Full-Service Partnership and Service Teams, Health Homes Programs, Housing Resource Centers, Crisis Response Providers, *and more*.

End users include staff who are Care Managers, Community Health Workers, Housing Navigators, Social Workers, Nurse Case Managers, Crisis Response Staff, *and more*.

INTEGRATING THE CHR INTO CARE COORDINATION

Benefits of Using the CHR

- Housing navigators can better support clients in accessing health care services and social services benefits
- Users can get Emergency Department/inpatient alerts for their clients so they can coordinate with the consumer and hospital/acute care to support transitions of care
- Primary care teams can coordinate with housing case managers to support consumers getting matched to permanent supportive housing
- Mental health providers can follow up after psychiatric emergency visits to connect clients to outpatient care
- Users can find lost to follow-up consumers and reconnect them to critical services
- Users can identify and coordinate with other care team members to connect consumers with appropriate services

CHR Super Users

The success of the CHR hinges on engagement from community partner organizations. Care Connect asks each participating organization to identify a Super User(s) to participate in a monthly Super User Workgroup. Super Users receive advanced training to provide other users at their organization with technical support and guidance on how to incorporate the CHR into their workflow.

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