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

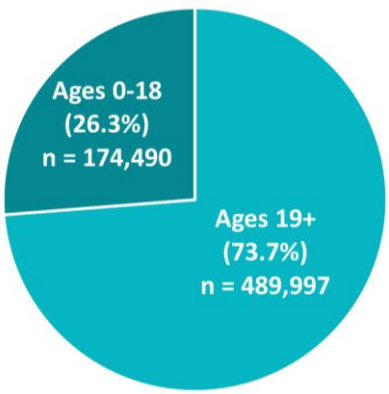
Before starting the COVID-19 pandemic, consumer records in the CHR were limited to those Medi-Cal clients that were AC Care Connect eligible. In conjunction with the emergency order by the County Public Health Officer, the Data Governance Committee voted to approve an Emergency Request to expand CHR/SHIE records to include all Medi-Cal and uninsured consumers in Alameda County to support an effective, county-wide public health response.

This expansion resulted in an increase in CHR records from about 60,000 to more than 700,000 individuals. We expect continued enhanced usability of the CHR for users via access to the broader number of individual records. Our ultimate vision is that all Alameda County residents benefit from improved care coordination supported through SHIE and CHR data integration efforts. Note that users do not automatically see all records; for more information about the privacy and security framework, refer to the SHIE Informational Flyer.

ABOUT THE SHIE/CHR POPULATION

About a quarter of the consumers in the CHR/SHIE are between 0 – 18 years of age. For more information regarding demographics of the total population, contact the Help Desk.

Population Breakdown by Age



Note: Based on a report from January 2021.
Total n = 664,487

COMMUNITY PARTNERSHIP

30+ 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)
- 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
- Pathways to Wellness
- Roots Community Health Center
- Stars Community Services
- Sutter Health
- Telecare Corporation
- Tiburcio Vasquez Health Center
- Titanium Healthcare
- 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.