Alameda County
Health Care Services Agency

Making Change at the Speed of Trust: Whole Person Care in Alameda County

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Health systems are enormously complicated: an intricate mix of human, clinical, infrastructural, and financial relationships. Making change through large-scale transformation projects inevitably depends on understanding and managing intertwined processes and details, and the capacity to be responsive and iterative. Alameda County's whole person care pilot—Alameda County Care Connect, a 6-year, $177 million effort authorized under California's Medi-Cal 2020 Medicaid waiver — sought to improve the way health is delivered in local safety net by investing resources in new services, systems, and critically, in the people who engage in the painstaking work of implementing change. As noted physician and author Atul Gawande stated, "success requires making a hundred small steps go right - one after the other, no slip-ups, no goofs, everyone pitching in." Alameda County Care Connect focused on the small steps with a dedicated backbone structure, and ultimately closed many gaps in the safety net and improved care for the most vulnerable residents who previously endured episodic, fragmented cycles of health care service.

The backbone organization, called the Care Connect team, operated with a very small proportion of the overall initiative budget. This focused and collaborative team was essential to the significant impacts realized: connecting and serving over 1,000 individuals to clinical care management; providing housing navigation and stabilization services to over 3,200 people, and reducing ER and psychiatric emergency services visits among these groups by 5% and 13.5% respectively; launching a comprehensive Social Health Information Exchange (SHIE) and working closely with partners to increase participation and develop data governance policies; and supporting the launch of Alameda County's "Project Roomkey" hotel sites, which, ultimately housed more than 1,400 vulnerable individuals during the COVID-19 pandemic. What follows are reflections on success factors from the leaders, staff, and participants of the Alameda County Care Connect whole person care pilot.

The Power of Working across Sectors on Shared Goals

One of the participants in Care Connect noted that the pilot resulted in systems feeling "a lot less siloed, and there's much more communication than before. Care Connect made it possible to bring all safety net partners together to talk about programs we're doing, and ways we can go forward." Typically, staff working on related issues in separate departments or offices, and with the same populations, don't have the time or capacity to think creatively and problem-solve together. The Care Connect team facilitated strong cross-sector partnerships and built capacity in the system by convening in-person meetings to connect and establish relationships among staff from housing, health care (physical and behavioral), and other sectors serving the focus populations; developing and delivering trainings to learn how to access each other's systems; and ultimately conducting quality improvement work together to solve problems on priority issues.

For example, housing and health care service organizations both operate in extraordinarily complex funding and regulatory environments. Developing a coherent local response requires addressing many issues that cut across sectors. The Care Connect team facilitated collaboration between County health and housing agencies, managed care plans, local cities, and community partners to maximize the impact of a new set of "bundled" whole person care housing services. The group worked through new agreements and systems to develop a shared assessment (known as Care Plans) of individuals for eligibility for services and housing; better alignment and combining of services and resources from multiple sources in response to individual client needs; and intervention at critical moments such as hospital discharge, behavioral health crisis, and eviction. The partners also created an innovative Housing Assistance Fund that helped people furnish their new permanent homes after experiencing homelessness. Care Connect changed people's lives, as noted by a former client, now a peer advisor: "I thank AC Care Connect for advocating for me with the legal system. AC Care Connect gave me enough time to find a new place where I live now." According to County data, over 1,200 individuals enrolled in Care Connect services were connected to permanent and stable affordable housing from 2020 through 2021.

The importance of Response Teams and Flexible Project Management

For a number of years, Alameda County had among the highest rates in California of involuntary 72-hour holds for mental health emergencies (known as 5150s, in reference to the Welfare & Institutions Code Section 5150). When law enforcement encountered someone experiencing a mental health crisis, a 5150 was the primary recourse if they couldn't de-escalate the situation quickly. The volume of 5150s was a widely acknowledged problem, with negative outcomes for individuals and hospital systems. However, with multiple agencies holding different parts of the problem, none had the time or resources to organize stakeholders to develop and implement a comprehensive solution.

A Care Connect project manager joined together with the primary players—Alameda County Behavioral Health Care Services, Emergency Medical Services, the County's contracted 9-1-1 ambulance operator, and Bonita House (community-based behavioral health provider) — and, over the course of two years, developed the Community Assessment Transport Team (CATT) program. This initiative required working through complicated jurisdictional questions, establishing protocols and staffing plans, addressing "wrong pocket" problems to put together the necessary funding, and shifting culture and practices in multiple agencies.

Now, when an emergency call is received that meets CATT criteria, a licensed behavioral health provider and EMT are dispatched in a non-emergency vehicle. The results show dramatic improvements, including increased likelihood of de-escalation in the field, a 62% avoidance of 5150 ambulance transports to ERs, and improved follow-up and reduced recidivism through connection to community-based care rather than the ER. More than 75% of CATT services recipients say they were respected and included in making decisions about their care. Countywide involuntary holds decreased by 30% from 2017 to 2021.

The Significance of Holistic Data Systems

Recognizing the importance of shared data systems, a significant portion of the whole person care pilot resources were dedicated to developing a countywide Social Health Information Exchange (SHIE) and Community Health Record (CHR). The SHIE is an interoperable platform nationally recognized for integrating client data from dozens of sources. The CHR is a holistic data record for individuals that privacy-credentialed care team members can access. The CHR and SHIE have proven to be extremely valuable for closing gaps in the safety net and accelerating care by connecting information across silos to better serve consumers.

"In the past, we'd have to dig through backpacks to find scraps of paper that might have information on where an individual received medical care or any conditions they might have," said a medical director at an emergency shelter. "Having access to the CHR is like turning on a lightbulb in an otherwise dark room —you can see so much about the person's conditions and use of services which helps ensure they will be connected to care in the community."

Significant investment in time and attention by skilled stewards is required to develop, launch and embed social health technology. The data systems alone are just tools; the Care Connect team worked with partners to manage organizational and individual behaviors, processes, and workflows to successfully implement these data systems in the local safety net. Care Connect staff spent countless hours engaging external partners to establish consensus on shared data governance policies that met regulatory requirements and ensured privacy protections (49 data sharing agreements are in place), encouraging data submission and use of the platform (42 organizations, 160+ programs, and nearly 1,600 users trained), and providing hundreds of hours of "elbow support" for organizations learning to use the platform. Care Connect also established a team of data analysts to identify trends, develop reports, and respond quickly to partner queries, directing County resources and dollars toward a system that benefits many organizations including Medicaid managed care plans, hospitals, jails, housing/homelessness providers, and behavioral health service providers.

Continuous Learning, Staff Development, and Incorporation of Lived Experience are Crucial for Promoting Systems Transformation

Care Connect leaders set out from inception to bolster the ability of County employees, providers, and front-line staff to effect change by dedicating capacity development and quality improvement resources specifically to cross-sector learning, problem-solving and change management.

Care Connect formed a Skills Development Unit (SDU) and Quality Improvement Unit (QIU) to train staff and providers working for the County and local community-based organizations to better understand the safety net system and connect providers across sectors—resulting in decreased silos and increased coordination across systems. The SDU's Care Connect Academy trained over 1,300 participants from more than 200 organizations on core skill sets, common

language and protocols, and collective problem solving to support and enhance the implementation of whole person care. Critically, Care Connect also invested in post-training "elbow support" as part of its continuous learning and quality improvement work, which allowed providers to access additional resources to help test, integrate, and/or implement new workflows, processes, and protocols.

Rather than regarding culture as a barrier, Care Connect recognized its many protective factors and aspired to include these benefits in every aspect of care delivery, particularly in alleviating the burden of disease. With a particular focus on anti-Black racism, the Care Connect team created pathways for people with lived experiences to be trained and engage in systems change work through its Consumer Engagement Fellowship. The Fellowship provided critical feedback resulting in improvement of the original design of the previously mentioned SHIE/CHR and CATT program, as well as other aspects of Care Connect development.

In the third year of Care Connect, the team, building on the Fellowship model, established a cohort of community members (Peer-2-Peer Advisors) whose experiences and circumstances mirror the Black and Latinx consumers served. Peer-2-Peer Advisors provided direct community services by offering Medi-Cal beneficiaries and their loved ones emotional support, housing problem solving, and connections to social services, prescription medications, and other medical needs. The Peer-2-Peer Advisor program also provided over 200 hours of crucial strategic input on program development, planning, and interventions for Care Connect, while creating new employment opportunities and career pathways. Over the course of the whole person care pilot, the Care Connect team trained 27 consumers with lived experience who provided over 2,500 services through encounters with over 1,000 individuals in Alameda County.

Conclusion

It is easy to overlook the human, strategic work that is necessary to create more responsive and effective health and wellness systems that are consumer-centric. As Louise Keogh Weed, Program Director of the Leadership Strategies for Evolving Health Care Executives program at the Harvard Medical School Center for Primary Care, stated, "We are great at coming up with the 'next big thing': we have brilliant people who are at the front lines of innovation…Where we fall short is actually implementing it, because it's a different skill set and fewer people want to do it." The complex project and people management skills don't align with existing health care job categories, certifications, and training. And yet, without resources and time dedicated specifically to managing and guiding the process of sustained change, investments in new services and systems are at high risk of failing to fulfill their promise. Investments at the local level require consistent vision; significant, dedicated, long-term financial commitment; and embedding staff and project management structures within systems. The experience of the last few years with the COVID pandemic demonstrated even more that it is critical to have staff with the flexibility, authority, and skills to respond in a fast-changing environment.

Over the course of the whole person care pilot, Care Connect leaders adopted the term "relentless incrementalism" to describe their approach. On a more macro level, policies, evidence, and incentives that encourage and reward systems-change infrastructure are what's needed. In Alameda County, national and state policy shifts facilitated local action that reached over 30,000 people and created shifts in practices and mindset. As the State embarks on a broad and ambitious transformation of the public health care framework, California Advancing and Innovating Medi-Cal (CalAIM), Alameda County is relatively well prepared and many Care Connect innovations are highlighted as examples and models of the infrastructure necessary to facilitate such complex change.

View the impact of Alameda County's whole person care pilot through the voices of consumers chronicled in the Care in the Safety Net video series.

The Health Care Services Agency (HCSA) is the local health jurisdiction (LHJ) for Alameda County, the seventh most diverse county of the more than 3,000 counties in the U.S. With a total area of more than 800 square miles and a population of more than 1.6 million residents, Alameda County encompasses urban, suburban, and rural geographic areas as well as a large urban unincorporated area, for which County agencies have jurisdictional responsibility. HCSA holds responsibility for various state and federal health mandates operated through the Behavioral Health, Environmental Health, Office of the Agency Director, and Public Health departments. HCSA also leads Emergency Medical Services in Alameda County, the Center for Healthy Schools and Communities, the Office of Homeless Care and Coordination, and the Health Program of Alameda County (HealthPAC), providing affordable health care to uninsured people living in Alameda County. HCSA serves as the County's health authority which includes the response to the COVID-19 pandemic under the direction of the County Health Officer. HCSA operates within the largest annual budget in the County of $1.04B and employs more than 1,600 people.

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