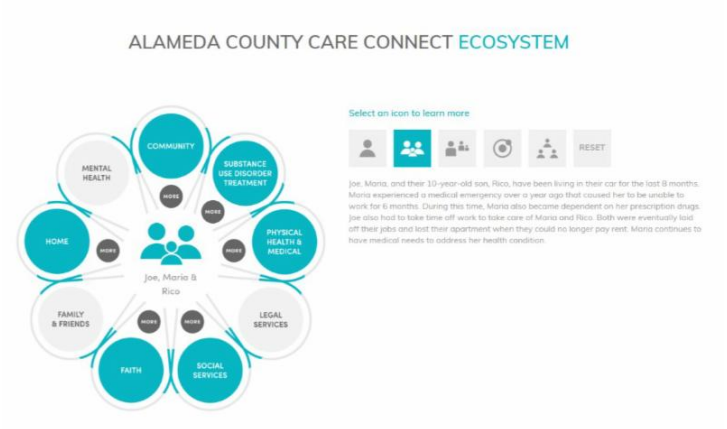
Alameda County Health Care Services Agency | A Whole Person Care Pilot | February 2018

Partner Update

Number of Clients Enrolled: 1,790 **Days Until Grant Ends:** 1,049 (December 31, 2020)

AC Care Connect Launches Website
View Website Here



Alameda County Care Connect (AC Care Connect), a Whole Person Care Pilot launched a new website www.accareconnect.org. The pilot is funded by the California Department of Health Care Services and matching grants from Alameda County. The mission of AC Care Connect is to significantly reorganize how health and social services are provided to the homeless, mentally ill, and other vulnerable and challenged Alameda County residents. AC Care Connect is designed to make major changes by implementing Care Coordination, Care Integration, Data Sharing, Housing Navigation, Behavioral Health Crisis Response, and Consumer and Family Member Experience service programs facilitating a concerted system of communication throughout the consumer's support network. It is estimated that at least 20,000 people will be touched by the Whole Person Care Pilot Program.

"By 2020, we aim to reduce homelessness by building up the supportive housing infrastructure, creating a countywide Community Health Record, and developing an organized care coordination system. Our hope is that consumers will have a single main care coordinator to connect to housing, medical care, mental health, substance use treatment and other critical services," says Dr. Kathleen Clanon, AC Care Connect Medical Director.

The website will support health and social service navigation and collaboration. Behavioral Health Care Services, Alameda Health Consortium, Alameda Social Services, Alameda Alliance for Health and Alameda County Housing and Community Development will use the website. Updates on the Community Health Record will be available on the website. AC Care Connect is preparing hundreds of care providers in Alameda County to use new resources to better serve the consumers. The new website will be instrumental in providing updates on this process.

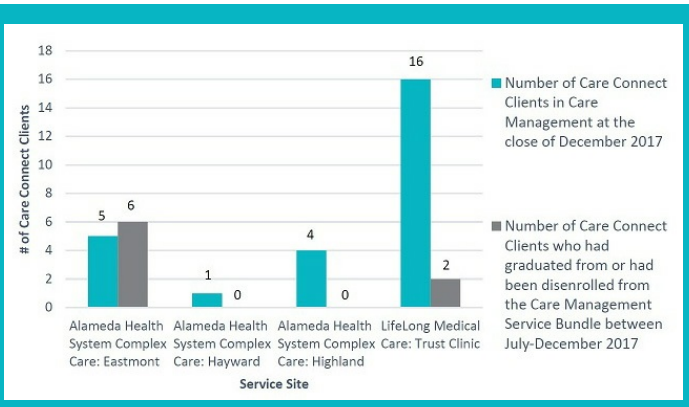
Features of the Website Include:

- Updates on the Community Health Record
- Housing Navigation, Skilled Nursing Facility Transition and Tenancy Sustaining updates
- Care Management: intensive case management support for consumers with complex medical needs who may benefit from addressing social determinants of health updates
- Information on Services such as Housing Education, Housing Legal Services and Care Coordination

- An infographic depicting different scenarios that may lead to homelessness and networks that impact successful health and housing outcomes
- A video that presents critical issues on health and housing challenges
- Patient consumer success stories

Consumer and provider case studies will take place throughout the AC Care Connect initiative and be featured on the website. *For more information, please contact Halimah Anderson, AC Care Connect Communications Manager at halimah.anderson@acgov.org.*

Care Management



The Care Management Service Program has grown in enrollment since July 1, 2017, when the first two clients began to receive services. Care Management is intensive case management support for consumers with complex medical needs who may benefit from addressing social determinants of health. Between July and December 2017, comprehensive care management services were provided to 34 unduplicated clients. Administered by Alameda Alliance for Health, these services were provided by a growing network of Community-Base Care Management Entities (CB-CMEs). The Alliance is building towards a target of at least 15 contracted CB-CMEs by June 2018, which will open up Care Management Services to many more clients.

These services are provided in parallel with Alameda Alliance's self-funded pilot of the upcoming Health Homes Program which is slated to become an entitled benefit for some complex Medi-Cal beneficiaries in Alameda County in July 2019.

The services included represent a new model of care that involves going beyond the typical clinic or provider walls, meeting clients where they are, and providing support for housing needs. The services mirror those of the upcoming Health Homes Program, which are:

- Comprehensive Care Management -- patient engagement, development of a Health Action Plan which includes needs for housing support
- Care Coordination -- implementing that Health Action Plan including assisting the member in navigating health, behavioral health, and social services systems including housing
- Health Promotion -- Encouraging patient self-management
- Comprehensive Transitional Care -- Including admissions, discharges, and planning appropriate care/place to stay post-discharge, including temporary housing or stable housing and social services. Also includes providing transition support to permanent housing
- Consumer and Family Member support
- Referral to Community and Social Support Services

Care Management includes determining the services that meet a client's needs, identifying those services per eligibility, referring, and following up. It also includes identifying resources and eligibility criteria for housing, linkage to housing transition and tenancy sustaining services.

Care Connect partners with Alameda Alliance at the CB-CME network to provide support and technical assistance to connect effectively to housing services and the new Coordinated Entry System, provide or broker training for care coordination and case management, and technological support for the Community Health Record. A few of the first CB-CMEs in the network are partners in the prototype Community Health Record to help test the design of the upcoming long-term solution while also linking them to useful information for their work. We thank Alameda Health System and LifeLong Medical Care for being two of our first prototype users!

Housing Services Enrollment

Housing Navigation Services: Initial reporting from Housing Resource Center contract with Abode Services indicates 64 clients have been provided with Housing Navigation services. Final determination of eligibility in our database is being confirmed for 15 additional clients. Initial reporting from the City of Oakland shows that through their subcontractor, Bay Area Community Services, they have provided at least 40 clients with Housing Navigation services through December. City of Berkeley will began enrolling clients in Housing Navigation in January.

Tenancy Sustaining Services: We anticipate that 16 clients will be enrolled from Abode and Lifelong Medical within the next week.

Skilled Nursing Facility Services: To-date, East Bay Innovations has enrolled 4 clients, with 4 still in the process of eligibility determination. They have successfully housed three individuals and one additional signed a lease and will be moving in February.

AC Care Connect 4-Year Timeline	Start-up: Jan-Jun 2017	Phase 1 Pilot: Jul 2017-Mar 2018	Phase 2 Pilot: Apr 2018-2019	Scale-up & Sustainability Planning 2019-2020	Wrap-up & Sustainability 2021