AC Care Connect Director's Report

February 16, 2018

Right Care. Right Time. Right Place.

CARE COORDINATION | CARE INTEGRATION | DATA SHARING | HOUSING AND HOMELESSNESS
BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM | CONSUMER AND FAMILY EXPERIENCE

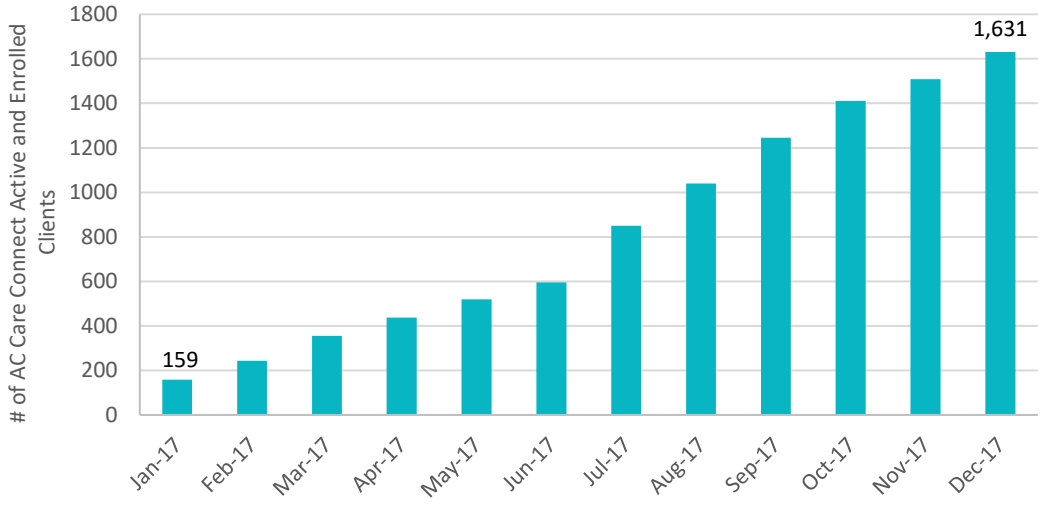
Overall Progress of Pilot

2018 is off to a good start. The RFP for the Community Health Record will be out in a few weeks and initial training modules are debuting in February. The Care Management and Housing bundles have expanded enrollment, while our Care Integration team is bringing about some process improvements for warm hand-offs from behavioral health clinics to primary care providers. Our Consumer and Family Experience unit has made headway with a new initiative called the Eastmont Collaborative, in addition to establishing the beginnings of a Culturally Affirmative Practice movement. This year we are looking to focus more on collaboration and sustainability among the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Housing Bond as we look to scale-up.

CARE COORDINATION

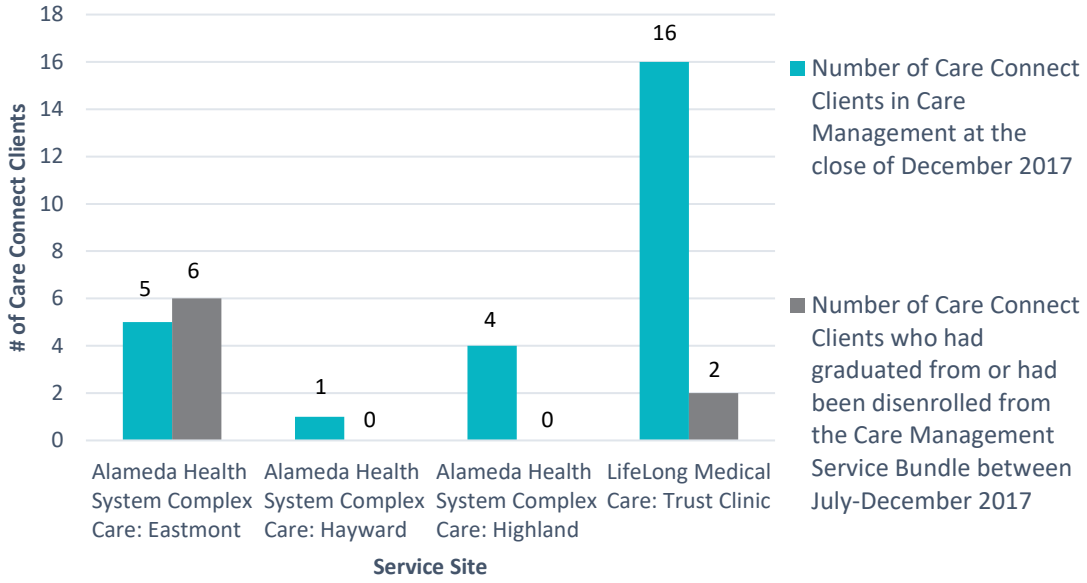
Improved and strengthened care coordination across services, so that clients receive the care they need when they need it

Individuals are eligible for AC Care Connect if they have active Medi-Cal and have 1) experienced literal homelessness in the prior two years, and/or 2) have used crisis services in at least two systems in the one year prior, and/or 3) are currently in comprehensive case management. Eligible individuals are enrolled in the AC Care Connect program when they are put into one of the four service bundles or receive one of the Care Connect discrete services. Those individuals remain enrolled in the program as long as their Medi-Cal stays active (or is renewed) even if they have graduated from that original service bundle or don't receive another discrete service. Care Connect can then continue to track the impact of both services and infrastructure work on the outcomes of this population. **In 2017, 1,790 unduplicated clients were served by AC Care Connect.** The graph below shows the number of individuals actively enrolled by month.



CARE MANAGEMENT SERVICE BUNDLE

The Care Management Service Bundle has been growing in enrollment since July 1, 2017 when the first two clients were put into the available service bundle slots. Between July and December 2017, a total of **118 months of comprehensive care management services were provided to 34 unduplicated clients**. Administered by Alameda Alliance for Health (AAH), these services were provided by a growing network of Community-Base Care Management Entities (CB-CMEs). AAH is building toward a target of at least 15 contracted CB-CMEs by June 2018, which will open up this service bundle to many more clients.



Graph above shows the number of AC Care Connect clients enrolled in the Care Management service bundle by the end of December 2017

These services are provided in parallel with AAH's self-funded pilot of the upcoming Health Homes Program (HHP), which is slated to become an entitled benefit for some complex Medi-Cal beneficiaries in Alameda County in July 2019. The same set of services are provided by the same network of providers with coordinated but distinct funding streams to serve both the Alameda County (AC) Care Connect and future HHP-eligible clients. The numbers above only represent the Care Connect eligible portion of the population served.

PROBLEM SOLVING LEARNING COMMUNITY

The January Problem Solving Learning Community included a **mini-teach session on working effectively within the limits of Health Insurance Portability and Accountability Act (HIPAA)**. The session was given by AC Care Connect's Director of Clinical Case Management Methods, Valerie Edwards, LCSW, speaking from her 30 years of experience as a psychiatric social worker and from her expertise with care coordination between individuals and their families. The group of over **84 cross-sector participants** had stimulating conversations discussing how this information could be spread or put into practice at their respective organizations. Next up: Accessing Substance Abuse Treatment Services.

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CARE INTEGRATION:

Stronger care integration among primary care, mental health, substance use, housing and the crisis system of care partners, so that our services can be provided with greater efficiency resulting in better client outcomes

During the month of January 2018 our Quality Improvement Unit (QIU) Consultants implemented their Plan, Do, Check, Act (PDCA) goals and action steps with regards to connecting Level-1 adults, clients with severe and persistent mental health conditions, to county-operated Community Support Centers (CSC). The goal is to streamline the enrollment into primary care services from these CSC. The PDCA team learned about the process from the Eden and Valley clinical team regarding the need for a warm handoff process to the Federally Qualified Health Centers (FQHC). After the learning sessions and conversations, the PDCA Team developed a FQHC Integrated Health Workflow and resource list for the county behavioral health (BH) clinics to facilitate the warm handoff process from BH clinics to the FQHCs.

DATA SHARING:

Greater levels of data sharing among primary care, mental health, substance use, housing and the crisis system of care partners, so that providers are better informed about their clients' needs to provide the most optimal care

PROTYPE COMMUNITY HEALTH RECORD (pCHR)

The pCHR launched in early October 2017 and since then, we have been working to improve both the user experience and accessibility. In addition to expanding the number of end users for Wave A, AAH went live on February 9th. As a result, we have seen a **120% increase** in the total number of end users having risen from 26 to 57 users across **four organizations**. Implementation for Wave B end users (Tri-City Health Center, Pathways to Wellness, CHCN Care Neighborhood) is currently underway and we anticipate Wave C (Abode) to follow shortly thereafter in mid-March and beginning of April, respectively. Wave B and C go-live dates have been pushed back approximately 2 months due to unanticipated end user organization time constraints for pre-implementation work (e.g., review and execution of Data Sharing Agreements, analysis and set-up of eligibility/encounter files and Care Connect resource focus on Wave A implementation needs). Given the expanded time allocation for bringing up each end user organization and the significant staff resource required to launch each organization, Care Connect leadership agreed to remove City of Fremont and BACS from Wave C, focusing on improving workflows for the other CB-CMEs and on Abode as the pCHR housing partner.

PHASE II CHR RFP

The Request for Proposal (RFP) is in the final stages of being reviewed internally. Next round of reviews will be by Alameda County Information Technology Department (ITD) prior to final release. We are still on track for the target release date of February 22, 2018.

DATA SHARING GOVERNANCE

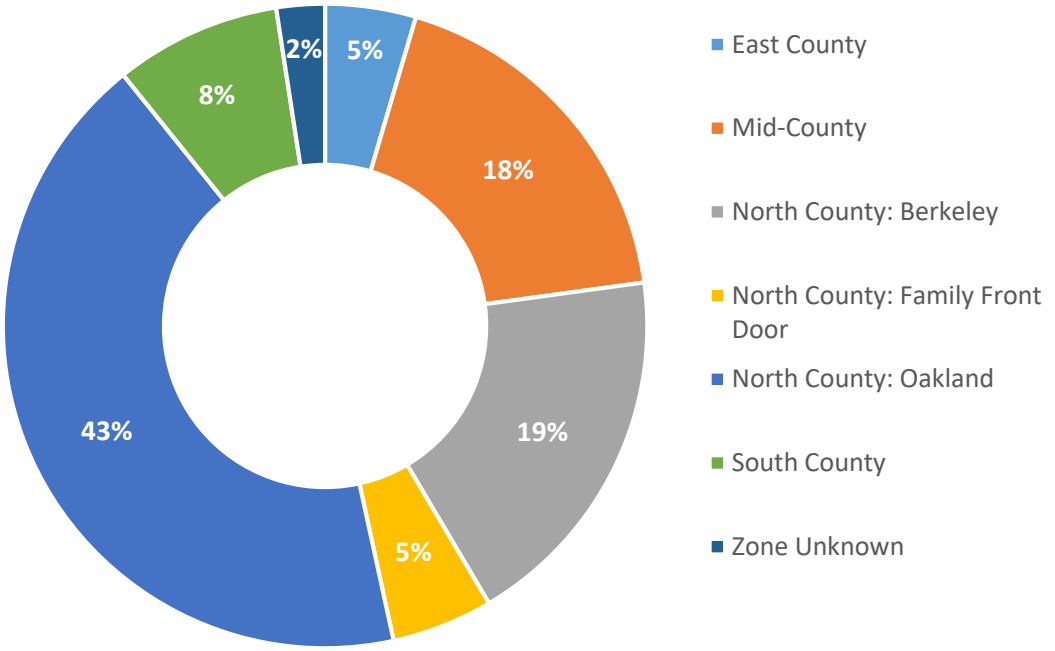
The Data Sharing Sub-Committee reviewed and approved the Data Sharing Agreement and corresponding Policies and Procedures on October 18, 2018. Wave A participants have started executing their respective agreements. Wave B participants, Tri-City Health Center and CHCN Care Neighborhood, are in the process of reviewing the agreements, while Pathways to Wellness executed the agreement in January 2018.

In preparation for Phase II, two workgroups, the Data Transmission and the SUD workgroups, have been established by the Data Sharing Workgroup in order to expand current policies and procedures to better integrate and promote cross-sector collaboration amongst providers and patients.

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

Care Connect is supporting the implementation of a new HMIS, which will support the Housing Resource Centers (HRC) and Coordinated Entry for homeless services by providing key functions such as assessment, prioritization, and matching to resources. In February, Health Care Services Agency (HCSA) of Alameda County, EveryOne Home and the Housing and Community Development Department started project configuration, a key component in the implementation process.

The HRCs began using the new prioritization assessment tools in November. Each region has focused on assessment of clients 1) previously identified as high need individuals, 2) those in existing programs such as shelters and transitional housing, or 3) those on existing prioritized lists. **1,328 assessments have been completed** to-date and entered into HMIS.



The graph above shows the relative number of assessments completed by region

HOUSING AND HOMELESSNESS:

Fully implement a "housing first" approach to the housing and homelessness

STATUS OF CONTRACTED HOUSING RELATED SERVICES

Eden I&R continues to provide 24-hour support for those seeking housing support services. For callers experiencing a housing crisis, the call flow includes a health and safety screening, housing crisis screening, housing problem solving support, and referrals to regional housing education and counseling workshops. In December, **2-1-1 handled a total of 1,223 calls** where callers indicated that they are either currently homeless or experiencing a housing crisis. Of those who completed

system through the implementation of Coordinated Entry and the Housing Resource Centers

a screening and had a housing problem solving conversation**, approximately 58% said they identified clear next steps after the call**.

AC Care Connect is collecting feedback about 211 calls and feeding them to the new E.D. at Eden I and R. Their team has met with several of the frequent referrers. 211's job is difficult – they do not have much housing to offer on the spot at this juncture. Managing expectations of callers and their provider-helpers is important.

Bay Area Community Services (BACS) regional Housing Education and Counseling Workshops continue to be offered daily**,** open to anyone experiencing a housing crisis. A total of **60 workshops were offered in 2017 with 350 total attendees**.

Bay Area Legal Aid joined BACS to offer housing legal education services at 10 of these sessions in December to 102 workshop attendees. They will be offering four more workshops in February.

HOUSING BUNDLE ENROLLMENT:

HOUSING NAVIGATION BUNDLE

- Initial reporting from Housing Resource Center contract with Abode Services indicates **64 clients** have been provided with Housing Navigation services through the Housing Navigation bundle. Final determination of eligibility in our database is being confirmed for **15 additional clients**.
- Initial reporting from 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 bundle in January, data is forthcoming.

TENANCY SUSTAINING BUNDLE

- We anticipate to **enroll 16 clients from Abode and Lifelong Medical** within the next week

SKILLED NURSING FACILITY BUNDLE

- To-date, East Bay Innovations has enrolled 4 clients, with 4 still in the process of eligibility determination.
- They have successfully housed 3 individuals and one additional signed a lease and will be moving in February.

BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM:

Decrease the unnecessary over-utilization of the most restrictive behavioral crisis services in Alameda County by linking people to the right service, at the right place, at the right time

CHILDREN'S SYSTEM OF CARE – BEHAVIORAL HEALTH CRISIS

As more data threads come into our data warehouse, it is becoming clearer to us as to who our eligible population is. **Almost 20% of Care Connect eligible** consumers are between the ages of 0 and 24 with Transitional Age Youth (TAY), ages 16-24, more likely to meet criteria because of the utilization of multiple systems and younger children more likely to meet criteria based on homelessness. In January, the Crisis Team sat down with the Behavioral Health's Transition Age Team (TAT) to understand the system gaps in crisis system delivery to the TAY population. We've also been regularly facilitating conversations between Willow Rock staff and the John George PES, in addition to conversations between Willow Rock staff and the Primary Care Psychiatry Consultation Program. With these groups, we're exploring two critical areas that contribute to the gaps in service. By the end of these discussions, we hope to have a better idea as to how to better bridge the gap between the children and adult psychiatric crisis systems as well as between PES and primary care.

Almost 20% of AC Care Connect eligible consumers are between the ages of 0 – 24, with the TAY population most likely to meet these criteria

TREATMENT OF AGITATION IN THE FIELD

In partnership with Alameda County Emergency Medical Services (EMS), our team has been working to address the timely treatment of acute psychiatric agitation in the field as we believe that these crises should be treated with the same urgency and respect as other distressing physical ailments. EMS Medical Director, Dr. Karl Sporer, and Care Connect Crisis System Liaison, Dr. Melissa Vallas, presented in January to the EMS Quality Council on the topic of the voluntary treatment of agitation with olanzapine by first responders. The presentation was well received and the council is now deciding on next steps.

CONSUMER AND FAMILY EXPERIENCE:

Improve experience and outcomes for consumers and their families. Our consumers and their families come first, and we strive to make sure they feel supported and empowered to be active partners in managing their needs

Since August 2017, we have set our sixth critical change: **Consumer and Family Experience**. We have further articulated what we mean by this goal and set specific aims and action steps.

Care Connect is investing in consumer feedback and input into our care model, to improve the culture of our care, to be more person, family and community-centered, and to create reliable and effective feedback loops between us and the people we serve to improve health outcomes. We have drafted a written discussion of what we mean by consumer, how it differs from patient or client.

This month marked the preliminary steps of the Eastmont Collaborative. The aim is to leverage the co-location of the medical and social services at Eastmont to anchor the connection with the community and the

"Consumers are seeking partnerships with providers that recognize and respect their dignity, treatment strategies that take into account their fierce social barriers, and realize that while they need the skills, expertise and resources offered by our systems, they, and those who care for them, are experts in their own life and its struggles."

-Valerie Edwards, LCSW
Director of Clinical Case Management Methods, AC Care Connect

services and resources they need. Care Connect clients will form the core population of interest, and give us specific goals for information exchange, case conferencing, and other investments. It is also an intentionally secure, trusted space to encounter others on the same path of recovery, health, and wellness for themselves and their families.

Another significant aim is to implement a Continuous Quality Improvement (CQI) process for Alameda safety net providers, which will result in a reliable, effective method of feedback between the consumer, their support network and their providers. Our principal method for this is engagement across the social divides between providers and consumers, particularly those of African descent through and cadre of **Culturally Affirmative Practice (CAP)** Provider Champions. The committee has meet 3 times in the last 2 months and have begun reviewing potential assessment tools.

State/Federal News

The Program Year 3 / 2018 budget revision has been approved by the state. A rollover request of approximately $20M was submitted; it has NOT been approved, and could change a lot over the next two months. The most significant revisions were reductions in substance use and integrated behavioral health units of services, based on more accurate data about the eligible population; and reduction in projections for care management service bundles due to slower expansion in capacity than originally projected. The funds from these reduced services were transferred to increase client move-in funds ($1,144,800) and increase the number of housing transition service bundle slots by 200/month ($776,952).

Enrollment data for the last quarter of 2017 was submitted on January 31st. For several months, Care Connect staff and county counsel have been asking the State to spell out the legal authority that allows us to submit SUD related data specifically to the State. Since this request has not yet been met, we did not submit data on substance use services in this report. The state has assured us that a response will be forthcoming.

Learning From Others

Bright Research Group continues to bring in information from other counties to support Care Connect's work. A recent analysis focused on summarizing key information about how other Whole Person Care counties were planning to spend their money. In particular, we wanted to know what their plans for data systems/tech infrastructure was, and what format their budgets took. The report is attached.

Sustainability

We are developing a work plan for creating a Sustainability Plan for Care Connect. Key informant interviews to identify stakeholders' pain points (among other things) are being conducted by the Skills Development / Quality Improvement unit. The interviews are almost complete, and will be reported out in March. A "plan to plan" session to gather perspectives on a draft workplan will occur on March 7.