AC Care Connect Director's Report

April 20, 2018

Right Care. Right Time. Right Place.

AC Care Connect is committed to strengthening a system of care that works together to deliver consumer-centered care and supporting high need individuals (the people of Alameda County who face highly complex physical, behavioral, and social challenges) to achieve optimal independence and health.

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

Overall Progress of Pilot

As quarter one of program year three closes out, the Care Connect team and its partners have been laying the foundation for the work being continued from last year while rolling out new initiatives. We are beginning to see the ramp up and scalable pieces coming together: The Care Coordination team continued their Problem-Solving Learning Community sessions and launched their systems-level Executive Case Conferencing series, the Care Integration teams are diligently uncovering improvements for meeting their targets, the Data Exchange Unit (DEU) is troubleshooting on county and state-wide challenges with substance use data sharing, and the Consumer and Family Experience began their Eastmont Collaborative work.

CARE COORDINATION

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

CARE MANAGEMENT

The Care Connect Data Services Team is collaborating with Alameda Alliance for Health (AAH) to redesign the exchange of Care Connect Care Management Service Bundle eligibility and enrollment data to 1) reduce discrepancies, 2) automate the interactions, and 3) quicken the turnaround of payment to the Community-Based Care management Entities (CB-CMEs). This redesign prioritizes upstream information to support strategic outreach by the CB-CMEs to eligible AC Care Connect consumers. In the meantime, Care Connect is engaged in contract renewal with AAH and new contract discussions with Anthem Blue Cross for a July 1 contract start date.

April marked the launch of the **50 Pilot: Executive Case Conferencing**. The purpose is to identify system-level barriers inhibiting 50 consumers from linking to the care they need, including: primary care, mental health services, case management, and housing navigation. The group worked through the first five consumers in early April, and will methodically work through the list to solve both system- and client-level challenges.

This effort will regularly bring leadership and key partners together to unpack the needs and support network of consumers who are:

- Care Connect-eligible
- Frequent users of multiple crisis systems
- Homeless in the prior two years
- High cost to AAH

PROBLEM SOLVING LEARNING COMMUNITY (PSLC)

March 2018 PSLC At-A-Glance

- *Accessing the Coordinated Entry System and Housing Problem Solving Skills for Literally Homeless Consumers*
- Presented by: Lora Ashworth, Home Stretch Program Manager and Alison DeJung, Eden I&R Executive Director
- 40 organizations and 69 participants in attendance

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 March 2018, the Alameda County Care Integration Team started reviewing the discrete service client-level data from the Psychiatric Consultants to Primary Care Providers, PATH Nurse Care Coordinators, PATH Peer Navigators, and Integrated Behavior Health Care Coordinators working in eight Federally Qualified Health Care Centers.

Using the Yellowfin dashboard reports developed for the Integrated Care Discrete Services, we were able to review the number of AC Care Connect clients who received care coordination services as well as identify Discrete Service objectives that are not being met or exceeded each month. The IBH Team now plans to identify the reasons why each of the Discrete Service objectives are not being met. Our next step is to work with each of the key program leaders to identify new strategies that can be implemented soon so that more service objectives will be met before the end of the Alameda Care Connect grant year.

DATA EXCHANGE

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

PHASE II COMMUNITY HEALTH RECORD (CHR) REQUEST FOR PROPOSAL (RFP)

The Phase 2 social health information exchange (SHIE) CHR RFP was released on March 9, 2018 and two Bidder's Conferences followed on March 22 and 23, generating 229 questions from the 36 organizations, including five small and local emerging businesses. **The vendor selection date is expected to be June 5, 2018**. Contract negotiations for the selected vendor will commence shortly thereafter and development work for Phase 2 is slated to start in September 2018.

The Data Exchange Unit (DEU) continues to work with the Behavioral Health Care Services (BHCS) Data Services Team to respond to internal ad hoc reporting needs in addition to preparing for the annual state report. Most notably, coding development, data analysis for 5 state metrics, and dashboard reporting functionality to support Housing Discrete Services were generated and improved upon.

SUBSTANCE USE DISORDER DATA EXHANGE

The DEU has recently been working with both County Counsel and outside Counsel in addressing substance use disorder (SUD) data compliance issues. State reporting of SUD metrics was temporarily halted until the Department of Health Care Services (DHCS) intervened by providing written verification that their use of SUD data is solely for audit and evaluation purposes. This in turn prompted the HCSA Director, Colleen Chawla, to get involved by issuing a memorandum that allows for such sharing to occur for all permissible individuals in support of the issuance from the DHCS.

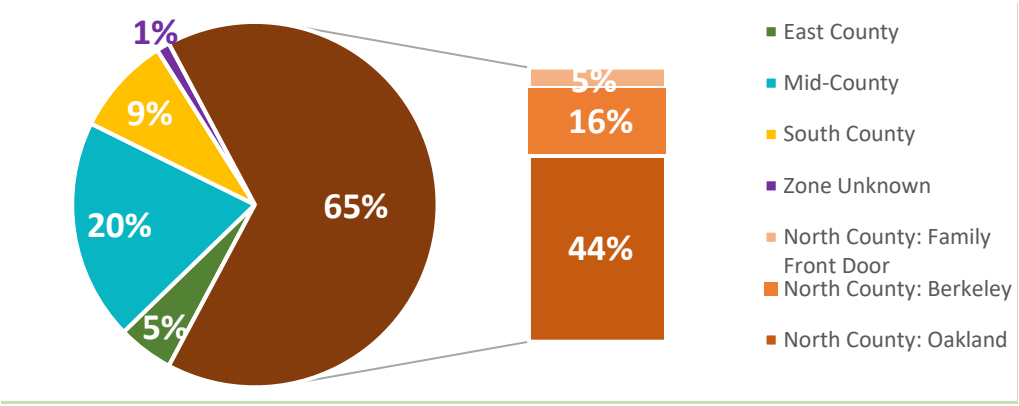
The DEU has been working with BHCS and with County Counsel to refine the current data request process to implement a new compliance tool to be used by the BHCS Data Manager, Privacy Office and County Counsel. Additionally, DEU has been addressing County Counsel's questions about data sharing with current partners/participants in pCHR. In a few cases, the questioning has led to breaks in file exchange until their questions are addressed.

HOUSING AND HOMELESSNESS

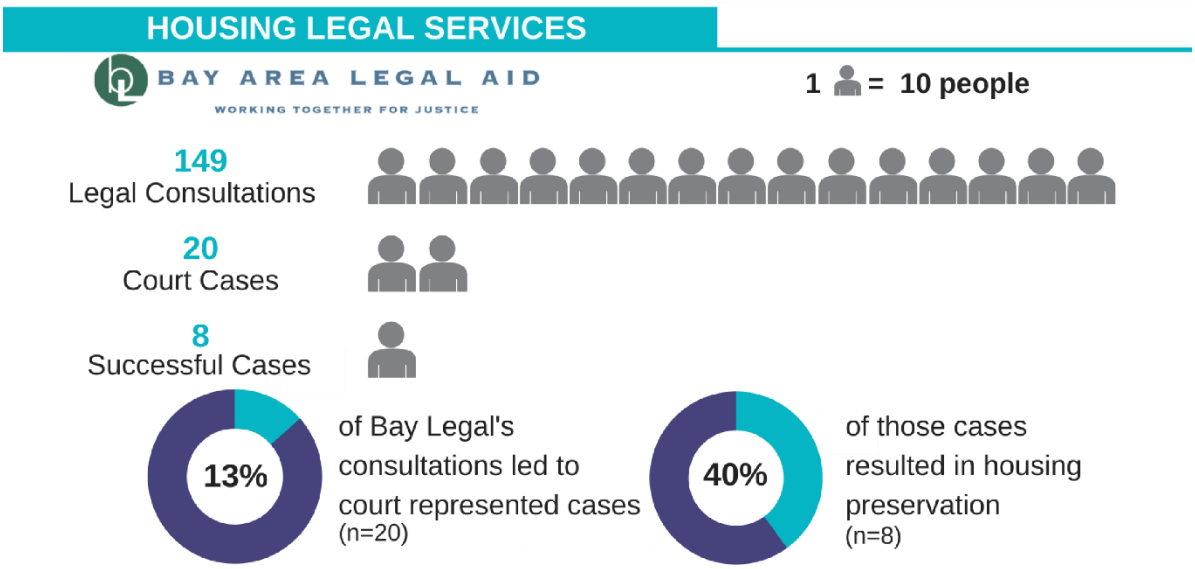
Fully implement a "housing first" approach to the housing and homelessness system through the implementation of Coordinated Entry and the Housing Resource Centers

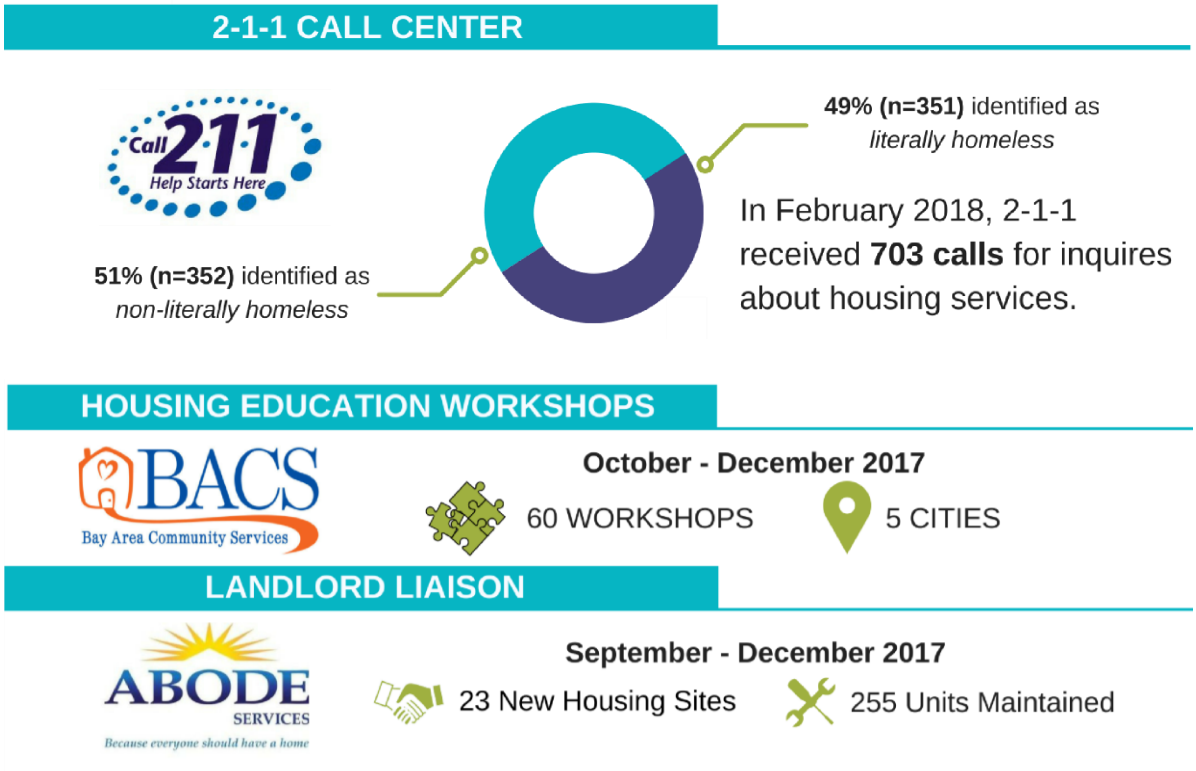
HOMELESS MANAGEMENT INFORMATION SYSTEMS (HMIS)

Care Connect, Housing & Community Development, and EveryOne Home continue to work together on HMIS configuration. Housing Resource Centers (HRC) continue to use the new prioritization assessment tool, while a new, second iteration of the assessment tool is currently being finalized to improve on the original tool. As of the first week of April, **1,986 unique persons have been assessed** and entered into HMIS. The distribution of prioritization scores across those assessed continues to be normally distributed, indicating confidence that the prioritization assessment tool is working as it should. A breakdown of percent of assessments completed by Alameda County area as shown in figure 4, reflecting that majority of the assessments are completed in North County.



CONTRACTED HOUSING SERVICES UPDATES





HOUSING BUNDLE ENROLLMENT

February 2018 data can be found below and additional data for the March 2018 housing bundle enrollment is forthcoming.

Housing Navigation Bundle	Tenancy Sustaining Bundle	Skilled Nursing Facility Transitions Bundle
•From the HRC contracts with Abode Services, City of Oakland, and City of Berkeley, at least **168 clients have been provided with Housing Navigation** services in this bundle.	•Abode and Lifelong Medical have enrolled **14 clients in Tenancy Sustaining Services**. •Tenancy Sustaining referral process continues to be streamlined and improved to shorten processing time.	•East Bay Innovations has enrolled **13 clients in the SNF Transitions bundle**. •East Bay Innovations has **successfully housed 4 individuals** to date, and continues to ramp up numbers of referrals and intakes processed.

BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

Decrease the unnecessary over-utilization of the most restrictive

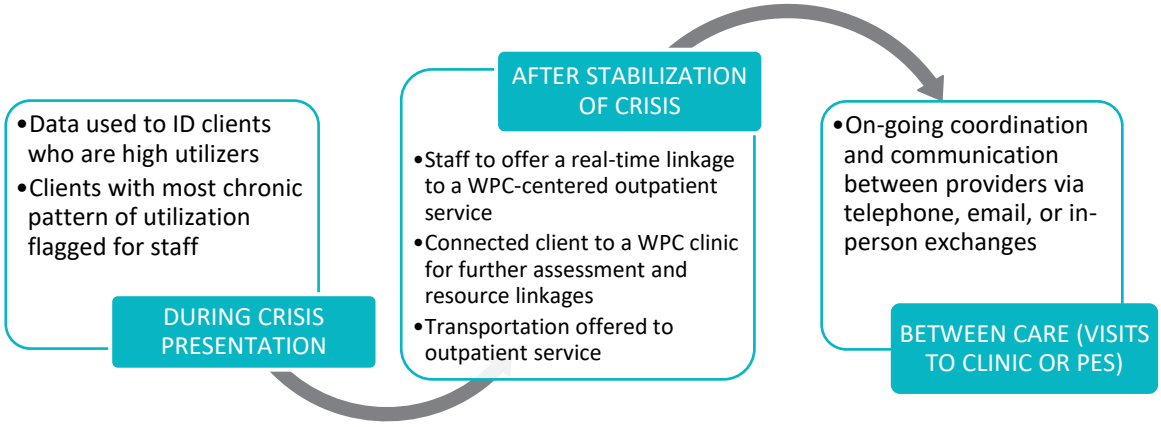
JOHN GEORGE/TRUST/HIP MINI-PILOT

Phase 1 of the John George/Trust/HIP Mini-Pilot concluded on March 5, 2018. The 6-month pilot focused on the highest utilizers of John George's Psychiatric Emergency Services (PES) between January and June 2017.

The goal of the Mini Pilot and Case Conference series was to be a next step in developing a more complete understanding of the needs of the highest crisis system utilizers in order to inform the development of specific interventions with hope that it would bolster care coordination and promote

behavioral crisis services in Alameda County by linking people to the right service, at the right place, at the right time

appropriate crisis system utilization in this population. The pilot had three components, each with key elements.



Case conferencing occurred where patient cases were presented to a group inclusive of providers involved in the patients care, system experts, and consumer experts. This allowed for opportunity to build human infrastructure among providers and evoke collaborative learning to positively impact patient care. The team plans to dive deeper into the outcomes of the pilot in the coming months.

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

CULTURALLY AFFIRMATIVE PRACTICE PROVIDER CHAMPION GROUP (CAPPCG)

The Culturally Affirmative Practice Provider Champion group (CAPPCG) is being further developed and includes representation from key cross-sector partners. The group has designed an ethnographic approach and framework to best serve our clients given all of their unique experiences and social challenges.

EASTMONT COLLABORATIVE

The first Eastmont Collaborative meeting convened on March 28 which brought together over 18 agencies and 30 leaders and providers from the Eastmont Town Center. The purpose of the meeting was to 1) gauge interest in developing a closer collaboration among providers and tenants of the Town Center; 2) connect service providers at Eastmont with Care Connect, District 4 staff, and each other; and 3) make the consumer experience at Eastmont easier and more connected. Supervisor Nate Miley and HCSA Director, Colleen Chawla, opened the meeting by sharing the vision of Eastmont as a place where the community seeks connection to services and resources, in an intentionally safe space, with others on the same path of recovery, health, and wellness.

Public Safety was mentioned as one of top concerns as the attendees felt that the current safety response is fragmented, uncoordinated and often at odds with their vision of creating a welcoming community for the clients and communities they serve. Although participants expressed many concerns, they were eager for the opportunity to collaborate with other tenants and engage in joint problem solving. In order to collaborate, providers need to have information about who is in the mall, time to come together to build relationships and learn about the resources available. An Eastmont Town Center Directory has been developed and distributed with critical information about each agency for easier linkages. Our next steps involve cascading safety concerns to Supervisor Miley's office and Care Coordination and Care Management concerns to our Care Connect teams. The next meeting with the Supervisor is scheduled for September.

State/Federal News

The annual report for program year two was submitted on April 3 due to the tireless efforts of many team members. AC Care Connect claimed $35.8M of the $56.7M for the year. The remainder (~$20.9M) is expected to be approved from the rollover request.

An in-person Whole Person Care Learning Collaborative is convening in Sacramento on April 30th to bring all 24 pilots across the state together. During the two-day session, opportunities for networking, troubleshooting, and learning from one another with be at the forefront.

Sustainability

We are continuing our Sustainability work and are launching a Listening Tour with key executive leaders from multiple sectors to better understand the needs of the individual institutions. Our next charge is to synthesize this information with our panel of subject matter experts that we will be recruiting for our "Sustainability Task Force." This group will help to develop a proposal for a strategic plan to then present to our Steering Committee.