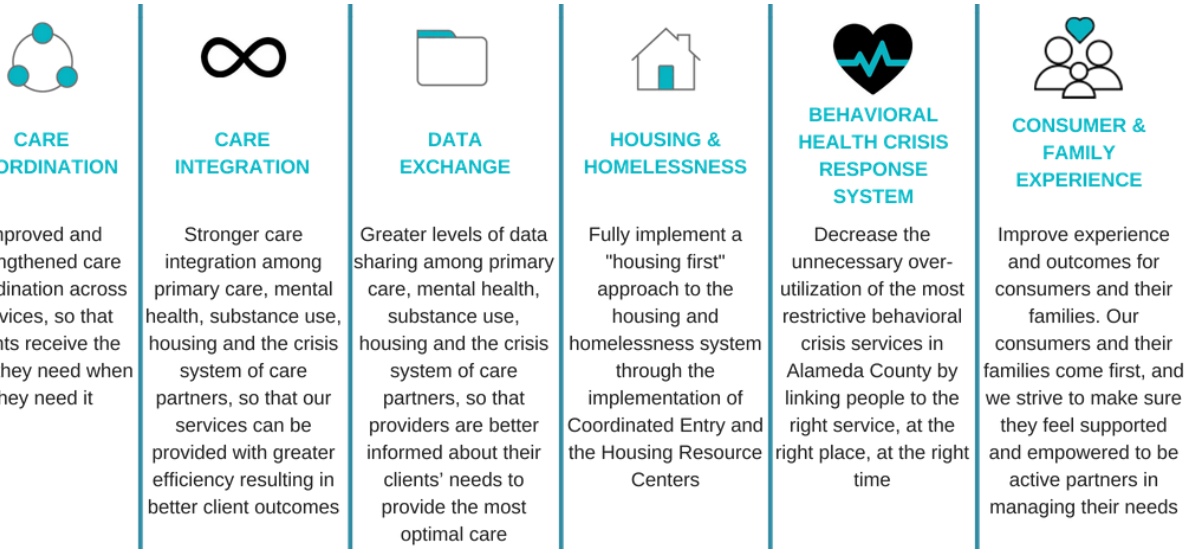
AC Care Connect Director's Report

May 18, 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

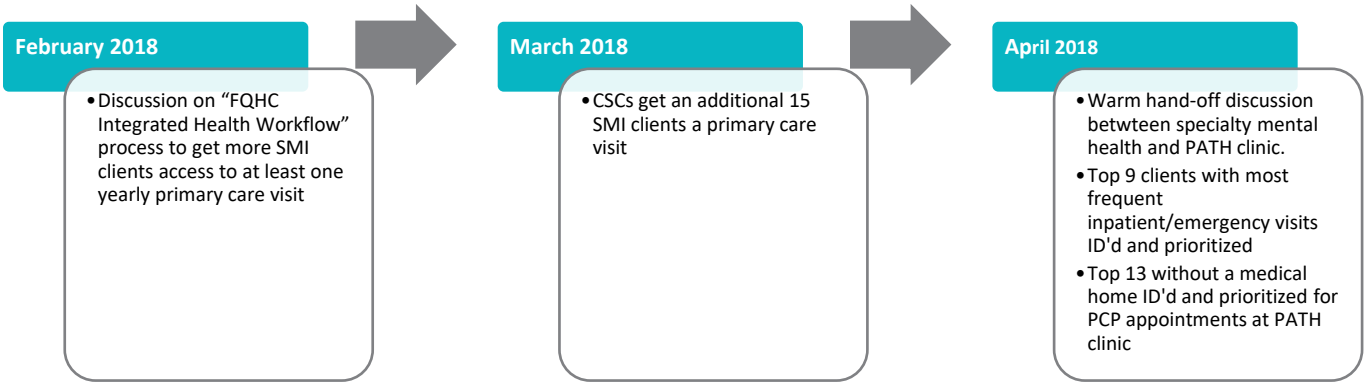
A particularly exciting part of the upcoming Drug Medi-Cal Organized Delivery System (DMC-ODS) rollout is the inclusion of care coordination and care management services for consumers receiving substance use treatment. Members of the AC Care Connect Backbone Organization are pleased to be working closely with Behavioral Health Care Services (BHCS) staff in a working group focused on coordination with primary care and mental health. With the help of Care Connect Subject Matter Experts, the group shaped and stretched Care Coordination Procedure Guidelines for submission to the State to include coordination with housing, medical, and mental health providers not as an exception, but a part of routine and expected care. There is much work ahead to make these processes a reality, but having the expectation in place is a critical first step. The consent management structure of the coming Social Health Information Exchange will provide more traction to collaborating with the substance use treatment system, tracking changeable consumer consent to share protected information with various providers working with that individual. In the meantime, significant groundwork needs to be laid through training the substance use treatment providers in care management methods, and developing relationships and knowledge about the broader system to enable such coordination.

Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care.

CARE INTEGRATION

The Care Integration Team and Quality Improvement Unit (QIU) Consultants continued to monitor their PDCA's progress in getting more SMI adult clients enrolled in Community Support Centers (CSC) a yearly primary care visit.



COMPLIANCE AND DATA EXCHANGE

The Data Exchange Unit (DEU) continues to work with the Behavioral Health Care Services (BHCS) Data Services Team for the annual state report. Most notably, a four-time submission involved coding development, data analysis for 5 state metrics, and dashboard reporting functionality to support Housing Discrete Services were generated and improved upon. To improve the next cycle, a collaborative learning session is scheduled for May 10th. Expected outcomes of that session include: 1) a reliable, consistent, less resource intensive, sustainable, sellable process, 2) clarity on roles & responsibilities and a vision for effective collaboration and 3) clear asks of partners providing data.

The DEU has continued to work with BHCS and with County Counsel to refine the current data request process by refining a new compliance tool to be used by the BHCS Data Manager, Privacy Officer and County Counsel. Additionally, DEU and AC Care Connect personnel have been addressing County Counsel's questions about data sharing with current partners/participants in the pCHR. The questioning led to breaks in file exchange until their questions were addressed by BHCS leadership and Counsel.

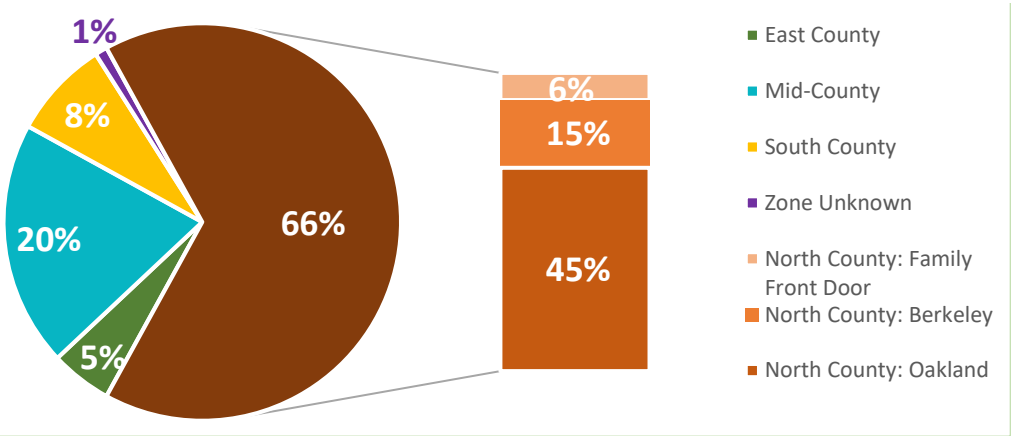
HOUSING AND HOMELESSNESS

HOMELESS MANAGEMENT INFORMATION SYSTEMS (HMIS)

We have finally reached the end of an extensive implementation and system redesign planning period. The old HMIS went dark on May 7, 2018 and the new tool is expected to **go-live on Monday, May 21, 2018.** The launch of the new system was a result of the collaboration between three partner agencies: Care Connect, Housing & Community Development, and EveryOne Home. Analysis, design, training, and implementation strategies have been configured and deployed to ensure all partners and staff are best equipped to successfully handle the demands of the workload. Migration and validation of the existing data will occur after the successful roll-out of the new system to ensure the data loop is closed for all existing clients.

As of April 30, **2,257 unique persons have been assessed** and entered into HMIS. A breakdown of percent of assessments completed by Alameda County area as shown in figure 1, reflecting that the majority of the

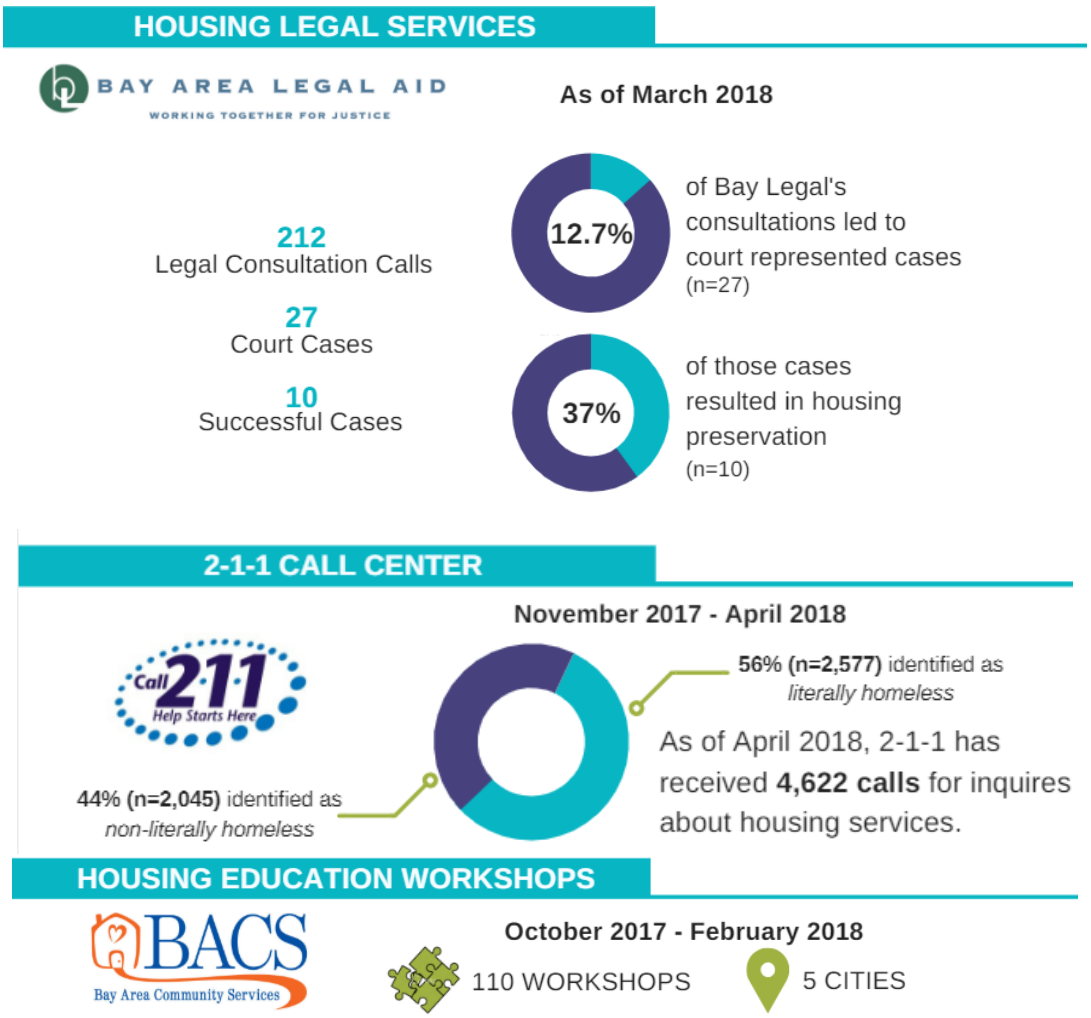
assessments are completed in North County. With the migration into the new HMIS, please expect a delay in data reporting for this area as we work to integrate the new data with the existing.



Two-thirds of all callers are calling from North County, more specifically, Oakland and Berkeley.

FIGURE 1. HMIS Assessments Completed in Alameda County

HOUSING DISCRETE SERVICES



HOUSING BUNDLE ENROLLMENT

Below are our most updated housing bundle enrollments; additional data for 2018 Quarter 1 housing bundle enrollments are not yet finalized.

Housing Navigation Bundle

- From the HRC contracts with Abode Services, City of Oakland, and City of Berkeley, at least **177 unique clients have been provided with Housing Navigation** services in this bundle.
- Of those enrolled in Housing Navigation Services in 2017, **47 reported** moving to various forms of permanent living situations by the end of December 2017 as a part of their housing situation.

Tenancy Sustaining Bundle

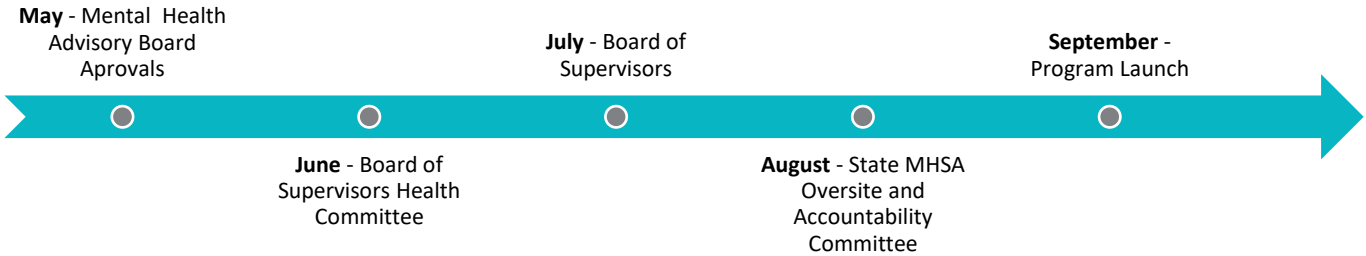
- There are **19 unique clients now enrolled in Tenancy Sustaining Services** across all lead operators, with additional enrollments forthcoming.
- Tenancy Sustaining referral process continues to be streamlined and improved to shorten processing time.

Skilled Nursing Facility Transitions Bundle

- East Bay Innovations has enrolled **18 clients in the SNF Transitions bundle** as of the end of March 2018.
- 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

The **Community Assessment and Transport Team (CATT)** is a proposed collaboration between EMS, BHCS, and Care Connect. This unit, which will be staffed by a Mental Health Clinician and an Emergency Medical Technician (EMT), will be dispatched by the 911 system to 5150 calls for an acute evaluation. This team will be responding in an unmarked vehicle, fitted with appropriate safety features, with the hope of directing consumers to the right service at the place at the right time, and redirecting them away from unnecessary acute care and/or incarceration. The proposal has been successfully making its way through the county and state approval processes. In fact, the proposed project was met with such enthusiasm that the state encouraged us to change from a $2.5 million proposal to a **$10 million proposal,** which will pilot the program in 3 cities over 5 years. Once final approval is granted, the team will provide services for 16 hours a day, 7 days a week beginning first in two communities and expanding to a third after 18 months. The remaining steps in this approval process are:



CONSUMER AND FAMILY MEMBER EXPERIENCE

Care Connect Consumer and Family Fellowship Guild was formally announced with a call for nominations on the Care Connect Website as well as the Care Connect Newsletter on May 1st. The Consumer and Family Fellowship will be composed of a group of people who receive Medi-Cal services in Alameda County who can share their expertise as consumers with service providers. The goal is to create a more consumer-informed and appropriately centered care system. Individuals in the Fellowship group will have personal experience as a consumer or family member of a consumer of health care and/or social services. Fellows will meet regularly each month for training and leadership development and commit to 12 months of service. We are looking to establish a group of 10-12 consumers and/or family members. **Nominations are due by Tuesday, May 15th.** The selection process will include a review of each candidate as well as an in-person interview with staff and BRG. Notifications will be sent out on Friday, June 8th. We are looking to formally start the Fellowship in September.

Consumer Focus Groups: We conducted our first solutions-based consumer focus group at Casa Ubuntu in April. The group consisted of 14 members of their wellness programs. Consumer insights were extremely informative, including statements that spoke to housing, behavioral health crisis, and positive and negative provider experiences. Some of the most powerful insights included:

"Not having a home is traumatic,
but the process of getting a home is also traumatic."

"One of the main things that need to happen is [providers] need to listen to what the person is saying. For over 20 years, I kept falling through the cracks because I wasn't what they thought a mental health crisis looks like."

"I came here because I was hungry, but I stayed for the love."

Workforce Pipeline: We are in the process of on-boarding our UC Berkeley summer MPH intern as well as our academic year MSW intern. We are also working to establish partnerships with San Francisco State University as well as USC School of Social Work virtual program.

STATE/FEDERAL NEWS

The Whole Person Care (WPC) In-Person Convening took place on April 30, 2018 in Sacramento, CA. Representatives from each pilot met to learn about each other's successes and challenges. Most notably, AC Care Connect's Program Development Director, Jennifer Martinez, MPH, Alameda Alliance's Medical Director, Michelle Schneidermann, MD, and Alameda County Social Services' Jee Yeoung Witt, presented on a panel about the Health Homes program. The presentation was well received and resulted in further learning and collaboration among WPC pilots.

COMMUNICATIONS

The top five Frequently Asked Questions are listed below to guide communications about AC Care Connect among partners, providers, and consumers. Talking points can be pulled from these FAQs and you can find them on our website at www.accareconnect.org.