**Director's Report**
**November 16, 2018**

**MESSAGE OF THE MONTH**

***Data integration closes gaps*** Providers say unmet social needs - like access to nutritious food, transportation assistance and housing assistance - are leading to worse health for many consumers. Whole person care closes gaps in the safety net by connecting health, behavioral health, and social services in a consumer-centered manner that improves outcomes and manages resources more effectively and efficiently. *The Social Health Information Exchange and Community Health Record integrates select fields from existing electronic health and service records to display a more complete, whole person view that will improve consumer outcomes and provider experience.*

**State Report**

- The AC Care Connect Enrollment Acceleration Plan was submitted to the state on November 1. Two targets were proposed to address enrollment services and ratio by the end of PY 12/31/18.
- *Cumulative enrollment milestone*: 5,300 unduplicated beneficiaries will have been enrolled since the beginning of the project.
    - *Enrollment Acceleration Plan:* enroll ~2,000 clients who are currently in the prototype community health record (pCHR) with a care team member who is using the system.
- *Services ratio milestone*: 17% of dollars claimed for PY 12/31/18 will be in service categories.
    - *Services expansion plan:* we are on track to move from the 11% ratio reported at mid-year, to 17% by the end of this year as a result of work in the following areas:
        - Creation of a health, housing and integrated services bundle with three tiers that will increase billing in this category.
        - The addition of Anthem and Care Neighborhood to Care Management Bundles (CBCME) program.
        - Steady improvement in a number of fee for service deliverables, and improvements in reporting including timelier invoicing.
- AC Care Connect remains optimistic that we will ultimately enroll 20,000 and confident we will enroll at least 17,000 (the cumulative number of all members ever enrolled in the program).

**Data Integration**

- Cherry Hill and Native American committed to participate and are in the process of signing agreements. The team is talking with the City of Oakland/Bay Area Community Services, Social Services Agency, Probation, the Sheriff's Office (to identify potential data elements), and Sutter Health.
- The Universal Authorization Workgroup completed two meetings to focus on questions and obtain feedback. A revised form and responses to questions about the program, prospective system, training and workflow will be shared during the November 27th meeting.
- Universal Authorization form feedback includes debate about "pick list" design (which organizations will be listed for the consumer to select or decline), along with discussions over early versus late inclusion of the Sheriff's Office and Probation.
- The Data Governance Committee held two committee meetings with internal membership to work through policies and procedures and finalize the charter. The next meeting is November 29.
- The team is in startup mode with Thrasys, providing required documents, conducting knowledge transfer, and developing the roadmap for Wave A to occur in Quarter 1 of 2019.

**Care Coordination and Integration**

- Monthly Care Academies focused on Trauma Informed Systems of Care and Mental Health First Aid. Another full-day session on Mental Health First Aid is scheduled on January 29, with priority given to those who expressed interest but did not get a seat in earlier sessions.
- Technical assistance for outreach, engagement, and retention strategies continue this month through the Mini-Collaborative of Community-based Care Management Entities. Outcomes of both rounds will be made available to promote improvement and provide support for other care managers.

**Housing and Homelessness**

- The Housing team is working on contract amendments with the Housing Resource Centers (HRCs) to improve continuity and enhance alignment with the Care Management bundles.
- The consolidation of the two former housing bundles into one health, housing and integrated service bundle with three tiers is based on the intensity of the consumer's needs with reimbursement aligned accordingly.
- This new approach allows the current provider to remain with the consumer for a year after securing housing and places the highest priority at the top tier including partnerships and communications with the primary care provider, visits scheduling, and visit participation.
- The team is also working with the HRCs on improving access including the requirement that all sites have and publish a public phone number and increase drop-in hours to a minimum threshold.

- The new drop-in hour requirements need to be balanced between staff posted to a static location versus going out to encampments; both are important for the consumer.

**Countywide By Name List and Access to Housing Resources**

- The By-Name List is a dynamic record of everyone experiencing homelessness who has been assessed. The list is generated from the Alameda County Homeless Management Information System (HMIS) and is used to match prioritized clients to a variety of services and housing.
- There are currently **4,312** households experiencing homelessness who have been assessed and are on the list.
- If you are working with someone experiencing homelessness who has not been assessed, please call 211 and they will connect them to their nearest HRC. Care Connect staff is compiling direct lines for each HRC that will be made available to partnering agencies. Drop-in hours are also expanding in several regions, including 5 days a week in downtown Oakland.

**Case Conferencing**

- All three Housing Resource Center (HRC) leads (City of Oakland, City of Berkeley, and Abode Services) are now conducting regional case conference meetings with community-based organizations and health care partners that serve those experiencing homelessness. The goal of the regional meetings is to coordinate services for each client discussed.
- Case conference meetings use the dynamic By-Name List and include members of the HRC lead agency, housing CBOs and other subcontracting partners, community clinics, and Home Stretch and Care Connect staff.