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A Whole Person Care Pilot

Alameda County Care Connect Steering Committee

January 15, 2021

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Welcome

Scott Coffin, CEO, Alameda Alliance for Health

Nancy Halloran, Deputy Director, AC Care Connect

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Agenda

1. Welcome
2. Consumer Story
3. Celebration of Shared 2020 Successes
4. Reflections
5. Looking forward to 2021
6. Adjourn

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Consumer Story

Kseniya Povroznik, Housing Navigator, Five Keys

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Celebration of Shared 2020 Successes

Kathleen Clanon, MD; Director, AC Care Connect

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Key Elements of Success in 2020

- Extensive cross-sector partnerships enabled collaboration to support whole person care and coordination
  - AC departments: OHCC, HCH, ACBH, ACPHD, EMS, HCD, SSA, and others
  - CBOs: Abode, Five Keys, Building Futures, Berkeley Food and Housing, Options Recovery Services, and many others
  - Hospitals and clinics: AHS, CHCN, and others
  - City governments and departments
- Data infrastructure enabled data expansion, increased number of partners/ users, and increased access to data
- Partnerships and infrastructure supported quick deployment of resources (e.g., for COVID-19 response)

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A whole person system of care for unhoused individuals

- Collaborated with community partners to prevent COVID-19 morbidity and mortality in high-risk populations and support delivery of whole person care

- **Outcomes**:
  - **NO deaths due to COVID-19** among people experiencing homelessness
  - **1,400+ households isolated/quarantined** in Operation Comfort sites
  - **1,100+ households sheltered**-in-place at Safer Ground sites
  - **284 households exited to permanent housing** as of Dec. 25
  - Created whole person system of care at Roomkey hotels
  - Hotel guests were **connected with resources/services**: Medi-Cal enrollment, health care services/PCPs, SUD treatment, behavioral health care, housing, and more

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Timely interventions to prevent re-occurrences of behavioral health crises

- Increased services and supports for people experiencing behavioral health crises (CATT Program and Crisis Connect)
- CATT Program successes*
  - Of 372 total episodes, **82% (305)** were diverted from 5150s
  - Alternate disposition sites included Woodroe Place, Willow Rock, Amber House, and many others.
  - Of the 115 consumers who were transported to the hospital, 52% went voluntarily for reasons including detox, medical or psychiatric evaluation, etc.

*data between July 21, 2020 – December 14, 2020

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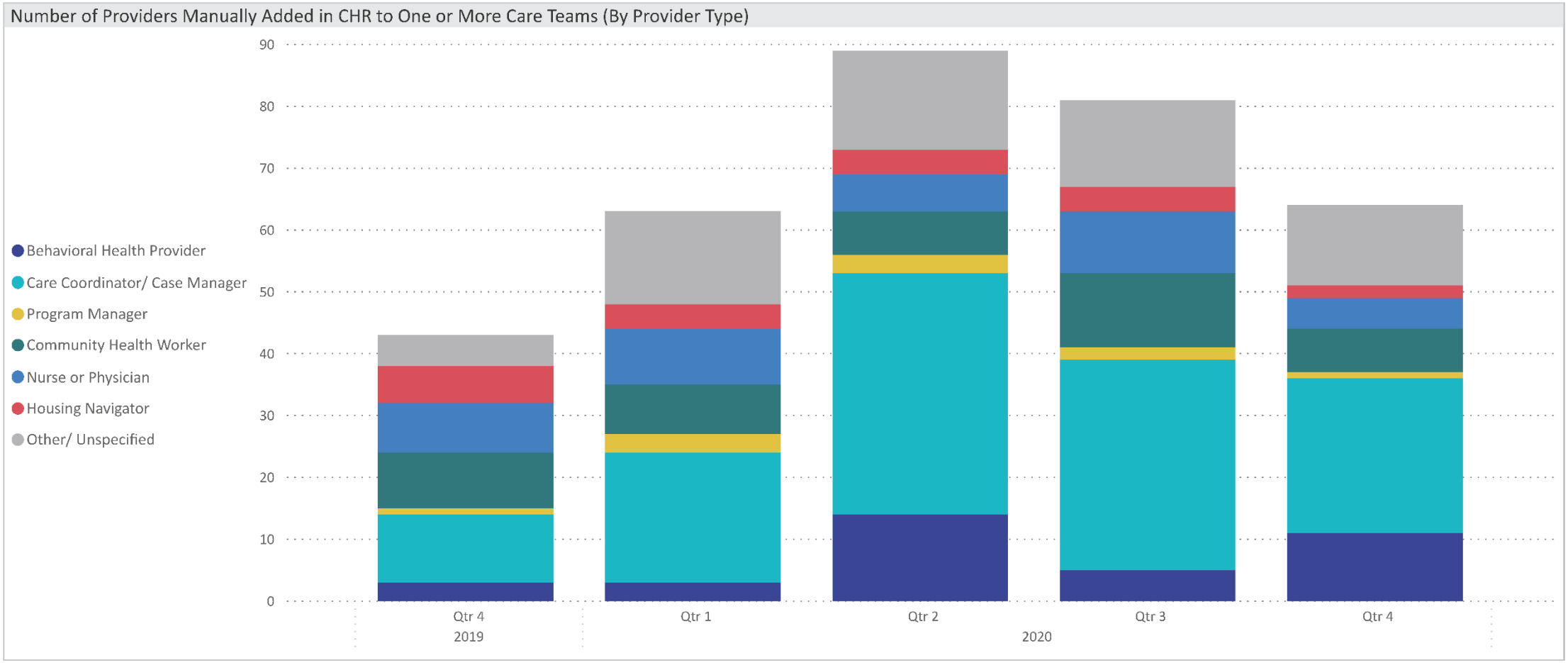
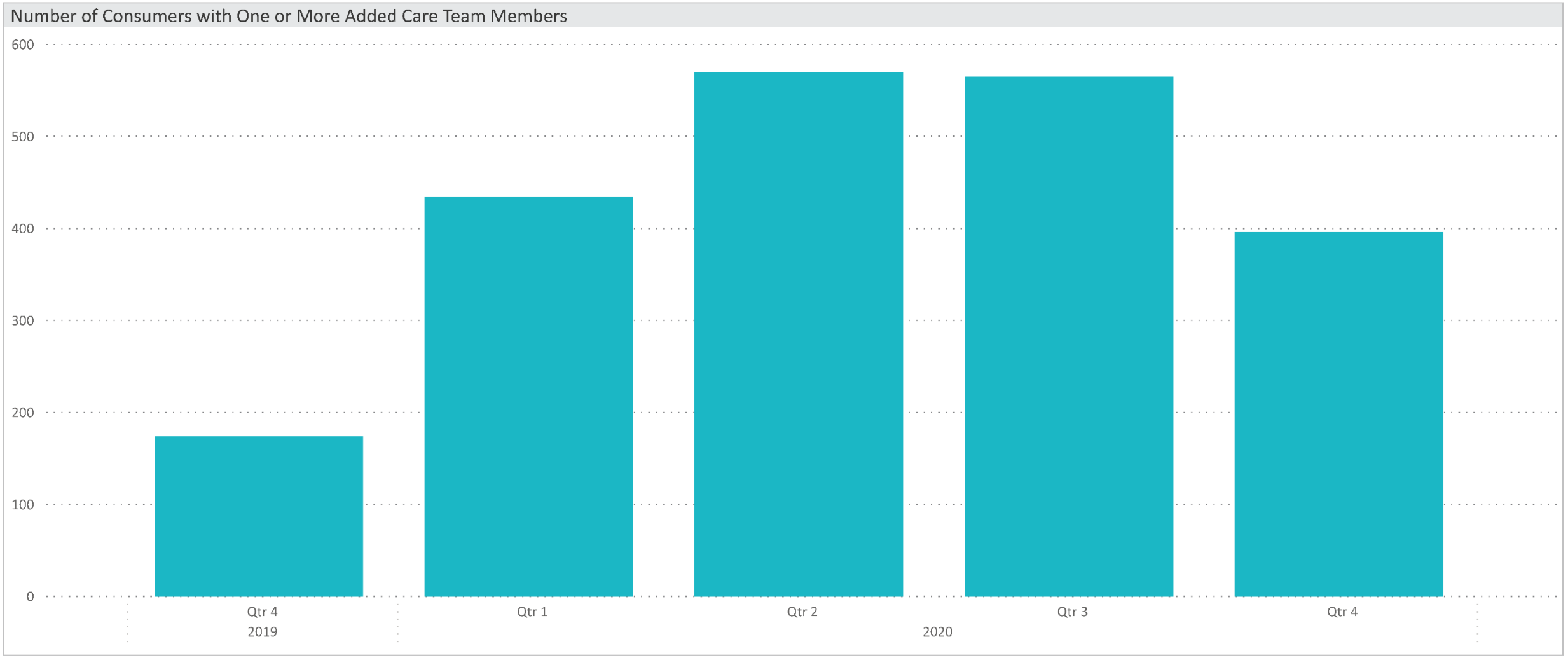
Coordinating care through information sharing that is stable, secure, supported, and well-utilized



Notes: Nurse or Physician includes Attending Physician, Consulting Physician, Primary Care Physician, Physician, Nurse and Nurse Case Manager.
Other includes Crisis Response Provider, Outreach Worker, Peer Specialist, Program Staff, Psychiatrist, Social Worker and Clinical Supervisor.
A single provider type is counted once in a given quarter when added to multiple Care Teams.

Steering Committee

Care Team Additions (2019 - 2020)



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Case Study: Use of the SHIE to enroll guests at Project Roomkey hotels in Medi-Cal

Problem: Inactive or lack of Medi-Cal is a major barrier to accessing care

Situation: Many Project Roomkey hotel guests were eligible for Medi-Cal but were not enrolled or had inactive Medi-Cal

Objective: Enroll/reinstate eligible guests in Medi-Cal

Solution:

- Project Roomkey co-medical directors Alexis Chettiar and Katie Hayes contacted the AC Care Connect Data Exchange Unit (DEU) team.
- The team used the SHIE to generate a list of hotel guests that included their Medi-Cal status and basic identifying information (e.g., DOB).
- Alexis and Katie coordinated with the Social Services Agency (SSA) to identify individuals whose Medi-Cal field in the SHIE was blank or inactive, and who were eligible to enroll.
- Hotel staff and RNs connected the SSA team with these guests to help them complete the Medi-Cal application.

Outcome: In five weeks, half of the 100+ guests who didn't have Medi-Cal were enrolled.

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Case Study: Creating a culture/infrastructure to ensure cross sector, culturally affirmative integrated care happens

- **Situation:** COVID-19 highlighted gaps in care and disparities for many groups—Care Connect's Consumer Engagement Team highlighted major gaps among the local Mam-speaking population
- **Challenge**: Difficulty identifying where population resides and preferred health care providers and the need to establish clear and trusted communication in Mam, and reliable and consistent prevention efforts to community residents most at risk for COVID-19
- **Objectives:**
  - Develop trusting relationships with Mam-speaking families as a foundation for COVID and other public health efforts
  - Provide at minimum, equal access to fact-based info regarding COVID-19 and prevention strategies
  - Reduce new COVID-19 infections among Mam speaking community members and in general
- **Solutions:**
  - AHS algorithm applied to data in SHIE to determine likely Mayan Indigenous ethnicity based on known Mam or Mayan languages, Latino ethnicity, and common last names.
  - Identified, hired and trained Mam speaking community members in Culturally Affirmative Peer-to-Peer model to address community needs around COVID and health care in general.

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Case Study: Creating a culture/infrastructure to ensure cross sector, culturally affirmative integrated care happens cont.

- **Outcomes:**
  - Identified zip codes where Mam-speaking community accesses services and resides
  - The development of the Mam Speaking Community Outreach Team, affirmative community engagement (thus far, has provided referrals to 62 people, connected 25% to health insurance)
  - HealthPAC added “Mam” and “Mayan Language” as options in its One-E-App system
- **Lessons learned**:
  - Standardizing the collection of race, ethnicity and language data across organizations is **critical to provide accurate data to inform decision making regarding equity and disparities**
  - **Investing in a consumer-centered and culturally affirmative team** and consumer partnerships in system delivery is invaluable in bringing attention to local and community needs
  - Importance of **relationships that allow for hiring/training from within a community,** to best partner and address community needs, recognition of community self-sufficiency and self-determination

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From one of their early pop-up testing events:
"…anecdotal reports from our staff indicate that 40-50% of patients appeared to be from the local community, which represents a hugely successful outreach effort at a first-time pop-up testing location like this. We could not have reached those most in need without the vital support of the Mam Community Outreach team."

Jake Kersey, NORCAL Area Manager COVID Response CORE - Community Organized Relief Effort

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Reflections

Scott Coffin, CEO, Alameda Alliance for Health

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Breakout Groups: Instructions

- Participants assigned to small groups of 4-5 people
- Each group will self-facilitate a 10-minute discussion of the prompts

  (*see next slide*)
- Groups will receive a 60-second warning before breakout session ends
- **NOTE: If you're joining the meeting via phone AND web*** please use the chat to tell us

**If so, both your name and phone number will show on the participant list*.

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Discussion Prompts

- Looking back on 2020 and the Steering Committee meetings:
  - What did we move forward successfully?
  - What work do we still need to do?

- Has your work changed over the past 4 years as a result of participating in WPC activities? (approach, partners, resources, etc.)

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DEBRIEF

Looking back on 2020 and the Steering Committee meetings:

- What did we move forward successfully?
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Looking forward to 2021

Kathleen Clanon, MD; Director, AC Care Connect

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Steering Committee 2021: Summary of Feedback (November Meeting)

- What has been valuable/effective?
  - Meeting cadence
  - Problem-solving aspects
  - Openness and safety of space for dialogue
  - Learning about programs and capacity building
  - Space to stay engaged
  - Space to connect across sectors, break down silos, and align planning
  - Diverse technical expertise
  - Consumer stories

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Steering Committee 2021: Feedback, continued

What should change?

- Leverage opportunities to collaborate/plan for services that will need to be sustained or altered after 2021 (CalAIM and Measure W)
- More focus on problem-solving
- Keep the same group or add different parties (community-based organizations, housing, sheriff's office, more consumer presence)
  - **Do you have recommendations on specific people to invite?**

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Opportunities for 2021: Solidifying Whole Person Care Across the System

- Linking housing and medical care (respite, CalAIM ILOS, hotels, others)
- Data sharing/cross sector care coordination
- Sustain & leverage social health information exchange (SHIE)
- Racial justice and racial equity

- Discussion
  - How can we amplify these objectives as a group?
  - What are things your organization is doing that we should connect with?

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Adjourn

Next Meeting: February 19, 2020

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For more information visit www.accareconnect.org