2018 Milestones and Highlights

December 31, 2018

TOTAL ENROLLMENT: 7,660

Care Connect completed the third year of a five-year pilot to improve care for Medi-Cal eligible residents who face the most difficult combination of physical health, mental health, and housing challenges. Investments in network and capacity development provided the platform for success, and the team remains optimistic about reaching full enrollment of 20,000 consumers in Alameda County.

The Care Connect project roadmap is organized by **6 Critical Changes** necessary to build and sustain whole person care. The following achievements reflect the collaborative efforts of Care Connect staff working with provider partners across Alameda County.

Care Coordination

Workforce development drives consumer care plan synchronization across health services and social service including housing and family supports.

- 15 Community Based Case Management Entities (CBCMEs) are now contracted with Alameda Alliance to provide comprehensive care management and care coordination services with Care Connect. Five of the 15 are also contracted with Anthem.
- Care Coordination Academies were established and 21 trainings delivered last year to over 730 participants representing more than 85 organizations across Alameda County. Topics included Accessing the Coordinated Entry System and Housing Problem Solving Skills for Literally Homeless Consumers, Motivational Interviewing, Trauma Informed Systems of Care, Mental Health First Aid, Drug Medi-Cal Organized Delivery System, Accessing Primary Care, and Cultural Humility.
- Mini-Collaboratives offered peer learning and practical tool development to promote improved outreach, consumer engagement, and retention.

Care Integration

Synergy and alignment across support services system ensures consumers receive the highest quality of care when and where needed.

- Partnership with Alameda County Behavioral Health (ACBH) resulted in care for 100 severely mentally ill (SMI) consumers who had not visited a primary provider in over a year. The integration of primary care and behavioral health data identified the consumers in need and ACBH staff funded by Care Connect supported the delivery of primary care psychiatry in the Federally Qualified Health Centers (FQHCs).
- The Quality Improvement Unit conducted several Plan, Do, Check, Act (PDCA) projects to improve care delivery. PDCA projects included development of an Integrated Health Workflow to connect adult clients between Community Support Centers and primary care.

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Data Exchange

Better prioritization, the ability to locate and engage hard to reach consumers, and accelerate connections to services and supports is made possible by the Community Health Record.

- More than 80 users from eight organizations are now using the prototype Community Health Record (pCHR) and experiencing the value of shared information. Results include planning for transition from acute and post-acute settings to skilled nursing, reporting and outreach to stabilize high utilizers and reduce crisis services, and coordination between community clinics and hospital emergency departments to reduce inappropriate crisis utilization and proactively schedule primary care following hospitalization or ED encounters.
- The contract to build the Social Health Information Exchange was unanimously approved by the Board of Supervisors in October 2018, and the Phase I Data Governance Committee kicked off last fall.
- A Universal Authorization form for consumer consent is under final review by a roundtable of County Counsels with adoption expected in March.

Consumer & Family Experience

Continuous quality improvement occurs through consumer input leading to enhanced partnerships with providers and outcomes for consumers and their families.

- Nine consumers were appointed to a 12-month fellowship offering leadership and professional development. Fellows have direct lived experience in the public health, criminal justice, housing, and child welfare systems that helps inform system change.
- Care Connect formed the Culturally Affirmative Practice Provider Group (CAPPG) to improve the frequency and quality of engagements across social divides between providers and consumers.
- Fellows contributed over 200 hours of input including critical observations and recommendations that foster development of culturally affirmative practices such as language used with the Universal Authorization, housing flexible funding, and the CHR.
- Care Connect welcomed MPH and MSW interns from UC Berkeley to introduce culturally affirmative practice framework into workforce development.

Crisis Response

Organized behavioral health crisis system linking consumers with needed services and preventative care to decrease overutilization of costly, restrictive care.

- ACBH concluded Phase 1 of a pilot to improve care coordination for the highest utilizers of John George's Psychiatric Emergency Services (PES). Phase 2 is focusing on 700+ consumers with four or more visits to PES in the preceding 12 months. Consumers identified as eligible receive a social work consult and option to discharge by taxi to Trust Health Center for follow up and case managers are alerted if their client is in PES.

- Partnership with Alameda County EMS led to development and launch of a county-wide program to treat agitation in the field and bridge the gap of access to timely care. The successful January 1, 2019, go-live included psychiatric crisis training of more than 2,000 EMTs and 800 paramedics.
- A Community Assessment and Transport Team (CATT) will go live this year as a result of extensive planning and collaboration between Alameda County EMS, ACBH, and Care Connect during 2018. Teams will respond to 5150 calls for an acute evaluation to ensure the right care is delivered and avoid unnecessary hospitalization or incarceration.

Health in Housing

Fully implemented Housing Resource Centers and Coordinated Entry System.

- A new Health Housing Subsidy Pool was instrumental in the transition of the first two patients from acute and post-acute care facilities to housing. The Board of Supervisors approved $5M in funding to address the challenges of discharging patients with housing barriers and complex needs. Patients will continue to be identified through case conferencing with HCSA, Alameda Alliance for Health and Alameda Health System.
- Regional care conferences are now routinely convened by the Housing Resource Centers to evaluate nearly 4,000 individuals on the By-Name List generated from the Alameda County Homelessness Management Information System. Cross-sector teams review the list to match the most vulnerable consumers with available services and permanent supportive housing.
- Care Connect launched a document readiness initiative to address the high percentage of consumers who lack basic documents such as identification and social security cards to secure housing. The CHR will accelerate document sharing and completion to ensure consumers are ready when housing becomes available.
- Housing bundles were consolidated into a revised model of Health, Housing, and Integrated Care with three tiers based on the intensity of the consumer's needs. The 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, visit scheduling and participation.
- Care Connect provided funding to support system redesign and implementation of the Homelessness Management Information System (HMIS) that went live in May 2018.
- Care Connect worked with Community Health Improvement Partners and Alameda County's Healthy Homes Department to develop and launch the Independent Living Association to improve the quality and supply of room and board housing and other shared living facilities that are privately owned and do not require licensing to operate.