Alameda County Care Connect (AC^3)

Whole Person Care Pilot

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Re-Entry Programs and Services Workgroup

October 27, 2016

Agenda for today

1. Alameda County Care Connect Overview
2. How AC Care Connect will work
3. How the Re-entry system can participate

AC Care Connect

OVERVIEW

DHCS: Whole Person Care Pilot Basics

Description

- Competitive grant program
- County is the lead
- 50% funding match
- We were awarded $28M for 2016-2020
- Medi-Cal patients only

Purpose

- Build infrastructure to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Vision

Create a system of whole person care that helps high-need patients achieve optimal independence and health.

Crisis / intensive

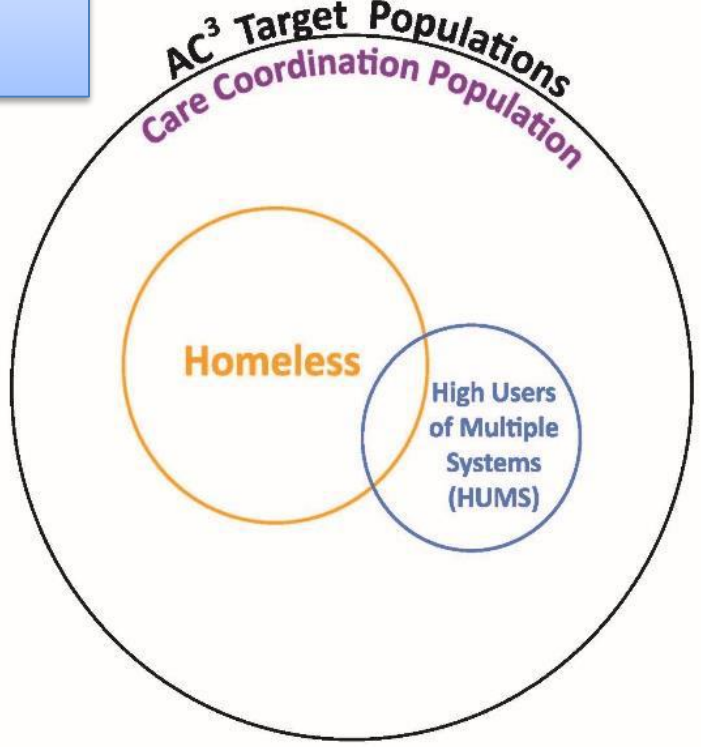
- Emergency Dept
- Psych Emergency
- Homeless Shelters
- Street Homeless
- Jail
- Sobering Centers

Stability & Wellness

- Supportive housing
- Primary Care Medical Home
- Specialty Mental Health Home
- Substance Use Treatment
- Home Health Services

AC Care Connect Target Populations

- People who are **homeless** (~10k)
- People who are **high utilizers of multiple systems (HUMS)** (~6k), and
- **Care Coordination Population**: people with complex conditions who are receiving care management in one system, but require care coordination across multiple systems (>20k, including above)



AC Care Connect Components

- System of Care Coordination
- Housing Solutions for Health
- Community Health Record (Data system)
- Linking clients to PH, BH, SUD treatment and housing resources in real time
- Backbone Organization / Human Infrastructure
  - Skills Development & Quality Improvement
  - Communications and Change Management

Example Outcomes

- Create a countywide **data-sharing and care coordination system**, w/ financing for a $15M technology purchase
- **Reduce admissions to PES/John George** by improving follow up & development of housing alternatives
- Provide **housing navigation services** to approximately 400/year homeless Medi-Cal beneficiaries and ongoing **case management and tenancy supports** for approximately 1,000/year previously homeless Medi-Cal beneficiaries.
- Seed a **housing development fund** by up to $13M over the course of the grant

What will be different for patients & families?

- 1000 more supportive housing slots and infrastructure development for more in the future
- A consistent “front door” experience and standard of care & care coordination for patients and families
- Only have to tell their story once—patient information is available to all providers appropriately & with permissions
- Improved navigation system to help patients get the right service at the right time
- Facilitated transitions and linkages between services such Drug Court, Sobering Center, Integrated Behavioral Health Care at FQHCs, Emergency Departments, and primary care

What will be different for providers?

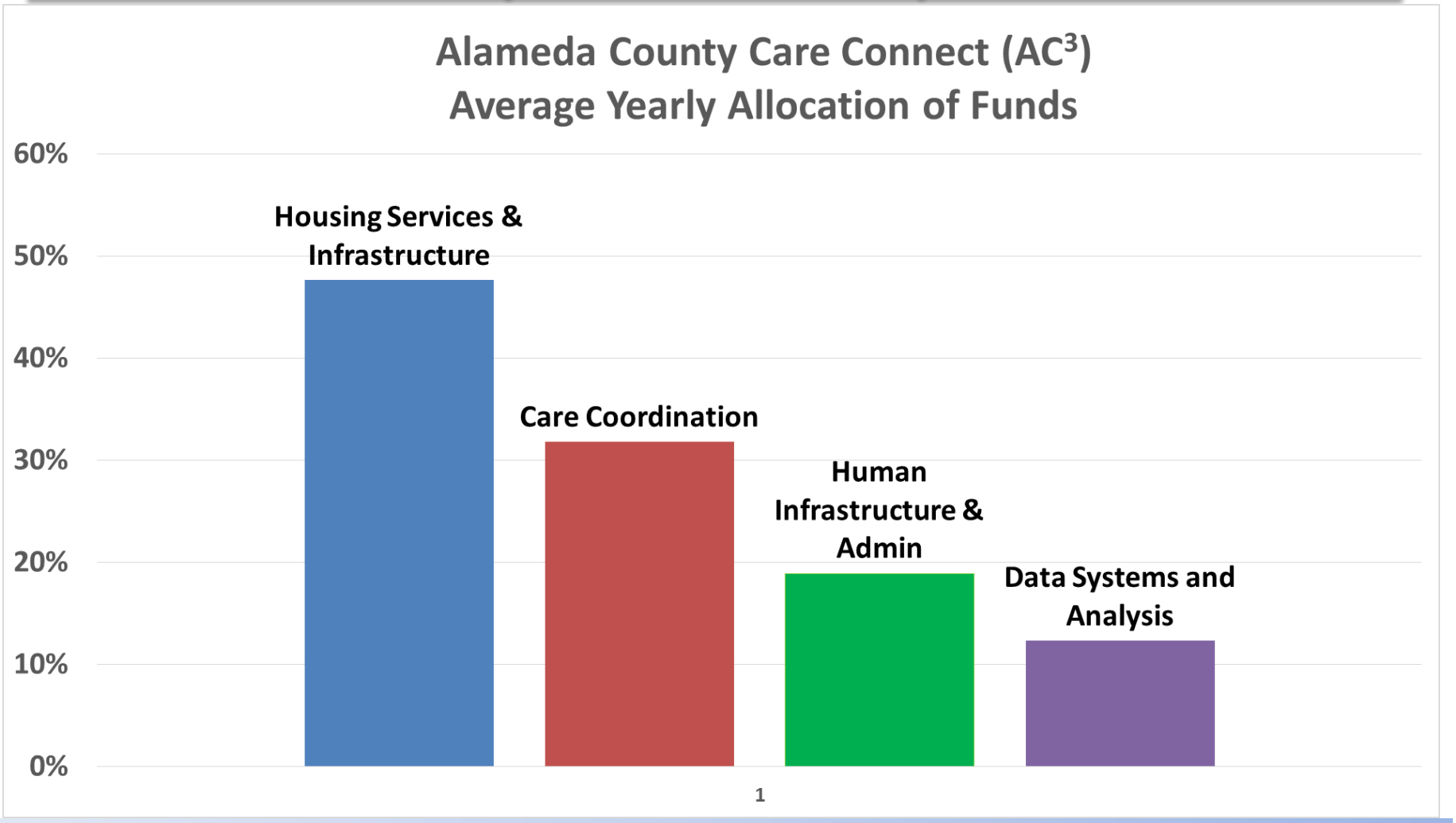
- Option to participate as aspiring CBCME (Community-based Case Management Entity)
- Help design and implement care coordination system
  - Data exchange
  - Standards of care
- Routine and easy communication across systems with others caring for same patients
- Likely to require universal consent system
- Broaden our view of who our colleagues are
- Alternative payment mechanisms

Re-Entry Program Themes

- Reduce recidivism
- High quality comprehensive wrap-around services
- Network of well-coordinated systems of services
- Accountability, transparency, fiscal and performance outcomes

All align perfectly with AC Care Connect goals

Budget Request: $28M x 5 years (new dollars)



AC Care Connect

HOW IT WILL WORK

AC Care Connect Funding Flows: Care Management Services

Administered through Managed Care Plans (MCP)

- Alliance and Anthem Blue Cross
- Service Bundles format
- Mirrors Health Homes Program Design
  - MCP will identify "Community-Based Care Management Entities" (CB-CMEs)
  - CB-CMEs will be paid on a per member per month (PMPM) basis

AC Care Connect Funding Flows: Housing Services

Administered by County

- Housing Service Bundles
  - SNF Transitions
  - Housing Transition Perf incentive: Stable housing at 6 months
  - Tenancy Sustaining Perf incentive: Stable housing at 24 months
- Street Outreach Services
- Community Living Facilities QI program
- Housing education and legal assistance
- Client move-in & Landlord Funds

Performance Incentives for Providers of Services

Administered by County

- Existing and new providers may earn additional funding:
  - **Clinic organizations and other sites**--by participating in the development and implementation of the care coordination system
  - **Organizations providing care management--**by reducing ED utilization and improving follow up after psychiatric hospitalizations

Backbone Organization: Human Infrastructure

primary care

social services

mental health care

substance use tx

housing

re-entry / criminal justice

disability services

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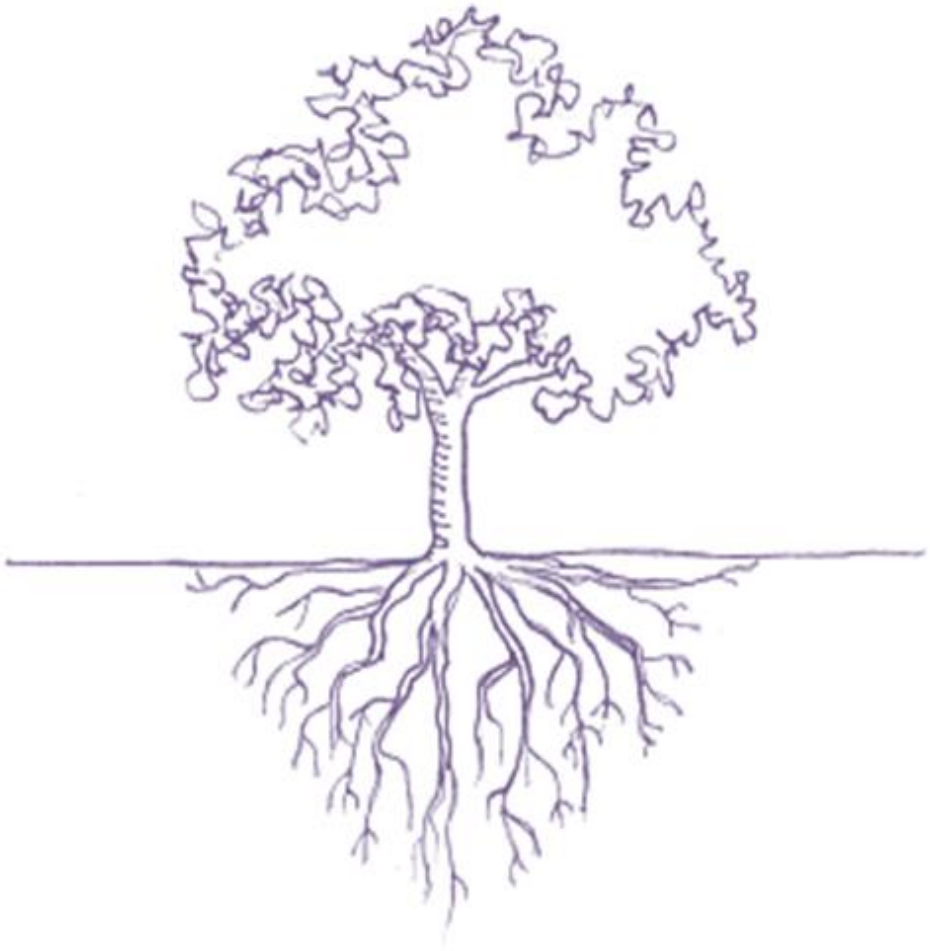
HOW THE RE-ENTRY SYSTEM CAN PARTICIPATE

How the Re-entry system can participate

- Help to design:
  - coordination system
  - the data exchange
- Share data (with permissions)
- Use the system to:
  - enroll clients where appropriate
  - facilitate care coordination being done thru re-entry programs
  - Identify clients' care teams and lead care coordinator

What Else?



The best time to plant a tree is 20 years ago…
the second best time is today

AC Care Connect

OTHER SLIDES FOR REFERENCE

AC Care Connect Components: Care Coordination

- **Develop system of care coordination**
  - Standardize patient facing processes (e.g., consent, assessments and tools)
  - Improve and standardize navigation infrastructure (e.g., triage, eligibility processes)
  - Integrate housing with health care coordination
  - Optimize care team design and practices
  - 24/7 on-call services for AC^3 patients who present in crisis
- **Care Management Service Bundle**
- **Incentives for**
  - timely adoption of care coordination system
  - follow-up after mental health hospitalizations
  - ED visit reduction

AC Care Connect Components: Housing Solutions for Health

- **Transition to Housing**
  - Housing Transition Service Bundle
  - SNF Transitions
  - Homeless outreach
  - Client move-in pool
  - IHSS rapid intake
- **Sustaining Housing:**
  - Housing & Tenancy Sustaining Service Bundles
  - Housing education and legal assistance
- **Increase Supportive Housing Options:**
  - Community Living Facilities QI program
  - Flexible Landlord Pool
  - Housing Development Pool
- **Pay for Outcomes:**
  - Stable housing at 6 & 24 months

AC Care Connect Components: Data Systems & Analysis

- Lead planning & development for data-sharing system for complex care coordination system
- Permissions and consents process
- Partner with the SDQI to deliver trainings for end users
- Reporting standards, data quality assurance processes
- Analysts on-site at participating systems to support quality data reporting
- Analysis of data for tracking outcomes and evaluation of impact

AC Care Connect Components: Backbone Organization

- Leads planning, cross-organizational cooperation and the development of the "human infrastructure"
  - Develop common tools and models
  - Foster communication across systems
- Supports a culture of mutual accountability and collaboration with approximately 50 partner entities or downstream providers
- Overall management of grant: relations with State, Community and Contractors

AC Care Connect Components: Integrated Care

- **Primary Care Capacity**
  - Hep C screening & treatment
  - Access to appointments
  - Population Health
  - Quality measures improvement
- **Substance use treatment**
  - CenterPoint Portals to SUD treatment
  - Sobering Center
  - Drug Court
  - Opioid treatment capacity in primary care
- **Integrated Behavioral Health**
  - Psychiatric consultation
  - BH care coordinators
  - BH medical homes
  - Training and workforce development