Whole Person Care Pilot Update: Alameda County Care Connect (AC^3)

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Health Committee

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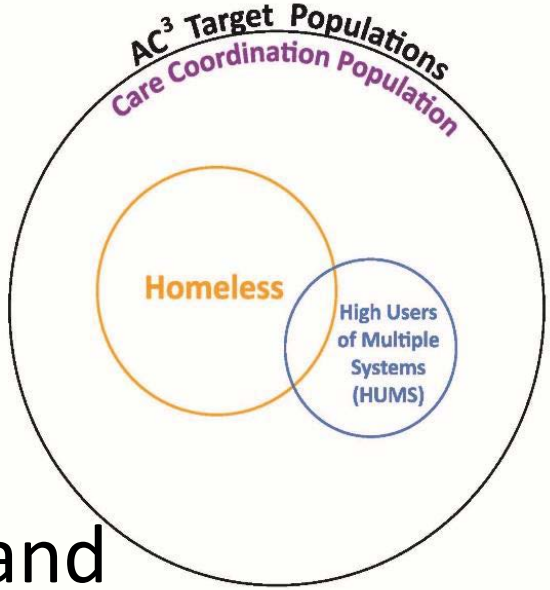
Target Populations



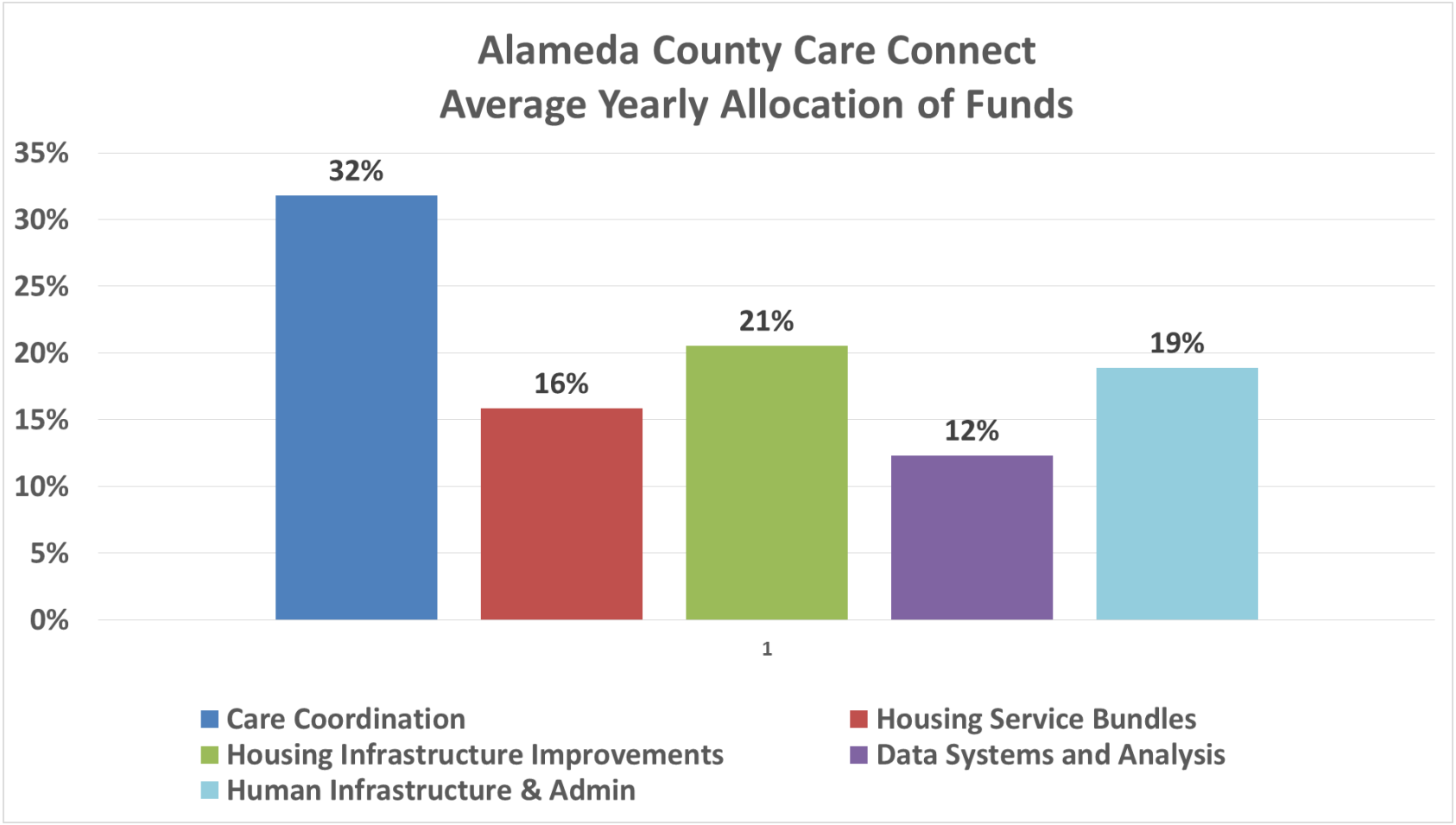
- People who are **homeless** (~10k)
- People who are **high utilizers of multiple systems (HUMS)** (~6k), and
- **Care Coordination Population**: people with complex conditions who are receiving care management in one system, but require care coordination across multiple systems (>20k, included above)

AC^3 Components*

- System of Care Coordination
- Housing Solutions for Health
- Data Systems & Analysis
- Backbone Organization / Human Infrastructure
  - Skills Development & Quality Improvement
  - Communications and Change Management
- County Match
  - Primary Care Capacity
  - Substance use treatment
  - Integrated Behavioral Health

* *Details available on request*

Budget Request: $28,434,278



Sample 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 $14M (local $$) over the course of the grant

What will be different for patients & families?

- 1000 more supportive housing slots immediately 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

Improvement in Crisis Services

Care Coordination

- Organized system of care coordination for homeless & high utilizers
- Facilitated care transitions, continuity of care & post-discharge care
- 24/7 on-call services for AC^3 patients who present in crisis
- Incentives for follow-up after mental health hospitalizations
- Increased capacity for step-down services: Linkage to substance use treatment, primary care, etc.

Housing Solutions for Health

- Prioritized access to supportive housing for high utilizers, and
- Housing transitions and sustainability service bundles
- Increase supportive housing and community living options

Data Sharing System

- Enabling more effective care management and placement in upstream services
- Care teams able to coordinate, with a common care plan

Partner Organizations: Public

AC^3 is built on strong partnership with managed care organizations (Alliance, Anthem, BHCS, DMC-ODS)

Letters of participation from other County partners:

- Behavioral Health
- Housing & Community Development
- Everyone Home
- Information Technology
- Probation
- Social Services
- Housing Authority of the County of Alameda
- City of Berkeley Health, Housing and Community Services
- City of Fremont Human Services
- City of Oakland Human Services

Letters of Participation: Community

- Alameda Health System
- Kaiser Permanente
- Sutter Health
- Alta Bates Summit Medical Center
- Abode Services
- Homeless Consumer/ Community Advisory Board
- East Oakland Community Project
- Satellite Affordable Housing Associates

Partial list of partner agencies

What's Next?

- Review by state completed - Sep 2016
- Notification of Award - Oct 24, 2016
- Formal Acceptance - Nov 3, 2016
- First IGT (75%) - Jan 15, 2017; remainder after baseline data is approved

meanwhile…

- Prepare preliminary approval process
- Prepare to submit baseline data (year 1 deliverable) due by Mar 1, 2017