# Alameda County Care Connect ($AC^3$)

## Whole Person Care Pilot

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*Making a Difference Conference*

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# DHCS: Whole Person Care Pilot Basics

## Description

- Optional 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.**

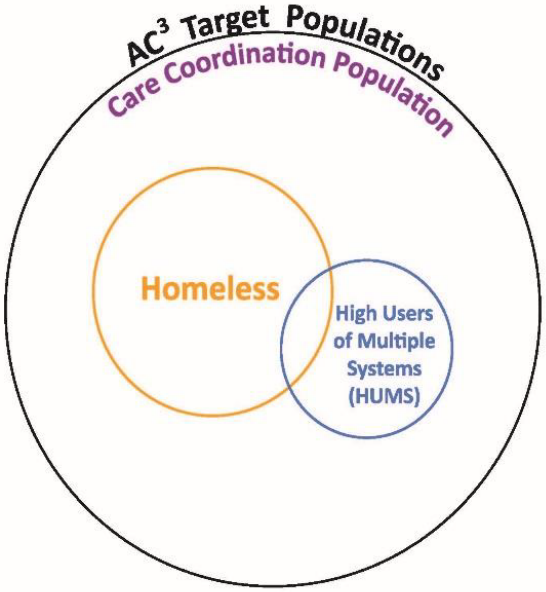
**Crisis / intensive**

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

**Stability & Wellness**

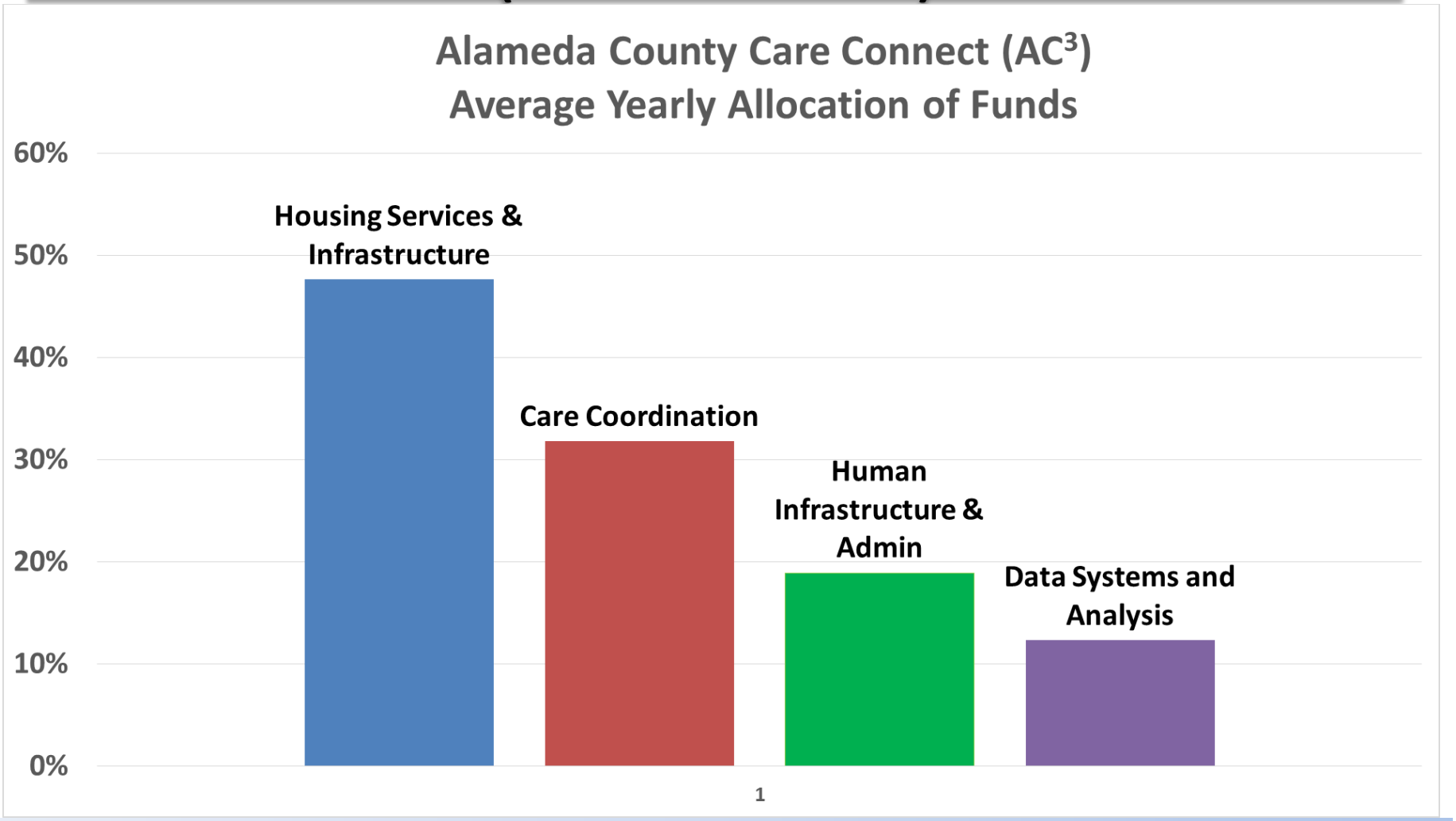
- Supportive housing
- Primary Care Medical Home
- Specialty Mental Health Home
- Substance Use Treatment
- Home Health Services

# AC Care Connect Target Populations




- People who are **homeless** (~10k)
- People who are **high utilizers of multiple systems** (~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)

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



## AC Care Connect Components

- System of Care Coordination
- Community Health Record (Data system)
- Housing Solutions for Health
- Linking clients to treatment and housing resources in real time
- Backbone Organization / Human Infrastructure to make it happen

## What will be different for patients & families?

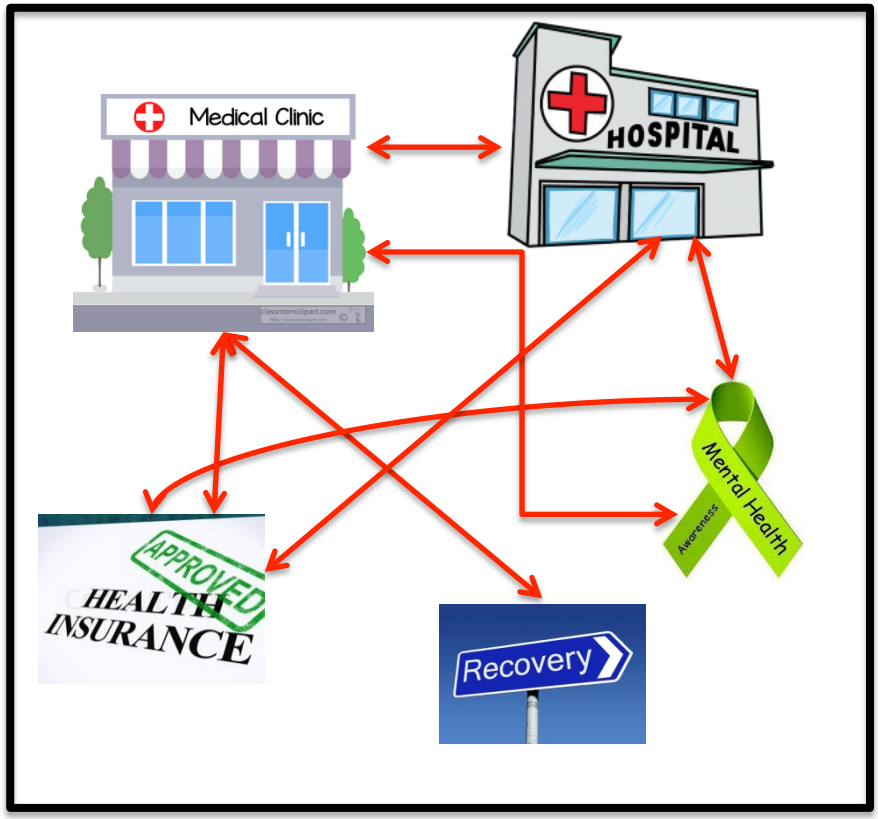
- A consistent "front door" experience and standard of care coordination; only have to tell their story once
- Improved navigation system to help patients get the right service at the right time
- 1000 more supportive housing slots and infrastructure development for more
- Facilitated transitions and 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?

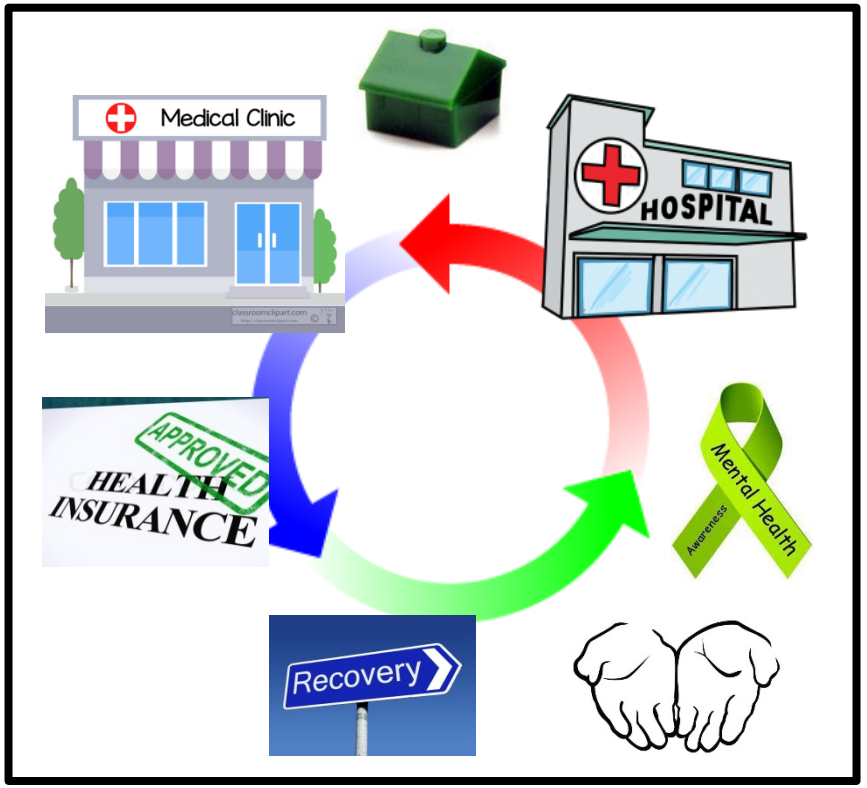
- Option to participate as aspiring CBCME (Community-based Case Management Entity)
- Help design and implement care coordination system
  - Data exchange
  - Standards of care
- Routine and easy communication across systems with others caring for same patients
- Likely to require universal consent system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

# Getting People to the Table

## From Many Conversations to One*




*** Plus housing & supports**

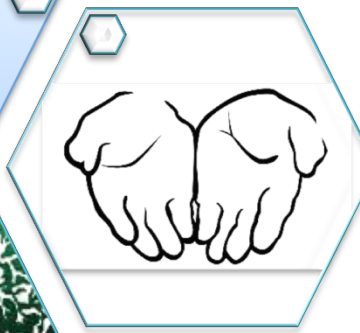


# Human Infrastructure

primary care

social services

mental health care



substance use tx

housing


re-entry / criminal justice

older adults

# Funding Flows

- Like a grant; county is paid for achieving milestones
- Funding flow format:
  - Contracts for specific services (housing programs, IT, cross-training and QI)
  - Care Coordination Service bundles PMPM
- Incentives for service providers for achievement of milestones
- Locally-funded Housing Development Pool

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