ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
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ACHCH Commission Clinical Quality Sub-Committee Meeting Agenda

February 22, 2021
9:00am-10:00 am

Via Teams
Join on your computer or mobile app
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+1 415-915-3950,,171824993# United States, San Francisco
(888) 715-8170,,171824993# United States (Toll-free)
Phone Conference ID: 171 824 993#
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1. Welcome and Introductions

2. Review of ACHCH Strategies and Health Services in 2020 – Brief Presentation

3. ACHCH Quality Improvement/Quality Assurance Plan 2021 - Discussion

4. HRSA Operational Site Visit document checklist and protocol – Review and Discuss*

5. Next Steps

*See pages 8-12: https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-cons-docs-checklist-topic-area.pdf

Alameda County
Health Care for the Homeless

ACHCH Commission

Clinical Quality Committee

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Alameda County
Health Care for the Homeless

Vision

We envision a just society where all persons have access to quality health care and housing. We believe the problems of homelessness and health inequities can be solved.

Mission

Our mission is to improve the health of Alameda County residents experiencing homelessness by ensuring access to culturally informed, whole-person health care and housing services.

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Who We Serve, What We Do

- ACHCH: a federally qualified health center program that provides services directly, and in partnership with: AHS, FQHCs and community providers

- ACHCH Health Center services are supported by federal HRSA grant and MHSA
- Who we serve: **people experiencing homelessness Countywide**:

1. **Unsheltered** on streets and encampments
2. **Sheltered** population in shelters, recovery, and transitional programs
3. **Doubled-up/Precariously-Housed/couch surfing**

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Ensuring Access to Comprehensive Care

ACHCH ensures people experiencing homelessness have access to:

1. **Primary care:** medical, mental health, dental homes
2. **Specialty care:** medical, mental health, dental care
3. **SUD services:** Harm reduction to prevent overdoses, Medication Assisted Treatment (buprenorphine for opioid addiction)
4. **Non-clinical enabling services:** housing, benefits, food assistance, case management; addressing basic needs.

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ACHCH Strategies

1. Street Health

a. 1 ACHCH staffed team - RN, CHW, LCSW, MA w/psychiatrist, PharmD (N. Oakland)

b. 9 ACHCH-contracted teams:
   - LifeLong Medical Care (West and Downtown Oakland, Berkeley, Albany)
   - Tiburcio Vasquez Health Center (unincorporated areas, Hayward, Alameda)
   - Bay Area Community Health (BACH) (South County)
   - Abode with BACH (East County/Tri-Valley)

2. **Shelter Health**

a. ACHCH staff (1 RN, 1 LCSW, 2 Social workers) providing direct services with:
   - Alameda Health System mobile van rotating locations
   - Referrals to La Clinica dental clinic in the Fruitvale, Oakland; Onsite Dental Foundation mobile dental van rotates at 4 organizations
   - Referrals to Fruitvale Optometry

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ACHCH Strategies

3. Primary and specialty care brick-and-mortar

1. Alameda Health System (federal grant subrecipient) which includes Highland, Eastmont, Hayward, Newark Wellness Centers
2. LifeLong Trust Clinic in downtown Oakland (MHSA supported)
    - ACHCH-staffed Street Health team and LifeLong teams refer into Trust

4. Weekly calls with shelter and outreach organizations

5. Monthly Street Health learning community sessions

6. Regional Coordination (4 FTE ACHCH regional coordinators)

7. COVID-19 and housing response with Alameda County Office of Homeless Care and Coordination (OHCC) to refer highest risk people into Roomkey hotels and ultimately into housing

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Severity of Health Conditions

- Self-reported health conditions:
  - Disabling Conditions: 42%
  - Psychiatric conditions: 39%
  - Alcohol and drug use: 30%
  - PTSD: 30%

- Mental Health Services Act (MHSA) investments leverages the federal grant to expand ACHCH services to the most vulnerable in the unhoused population.

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ACHCH Health Services

1. Infectious disease prevention and control

- **COVID-19 investigation and testing; Project RoomKey isolation and quarantine - ACHCH staff coordination with AC Public Health Dept; LifeLong Trust Clinic, AHS**
- **Flu vaccines at 38 locations**
- **HIV testing and linkage to primary care**
- **Hep C testing and linkage to primary care**

2. Chronic disease management - through the Trust Clinic and AHS

- Hypertension
- Diabetes

ACHCH Health Services

3. Dental - ACHCH staff referrals to: La Clinica, Onsite Dental Foundation mobile van

4. Mental Health

- **Street Health**
  - Screening (Mental Impairment Questionnaire)
  - Piloting telepsychiatry
- **Shelter Health**
  - LCSW services
- **Integration in primary care - Trust Clinic model**
  - behavioral health screening at initial medical visit
  - psychiatric consults w/PCP
  - Referral and linkage of patients to LifeLong and ACHCH psychiatry
  - Case conferencing in clinic, and w/providers in ACBH network (e.g., BACs)

ACHCH Health Services

5. Substance Use Disorders

- Medication Assisted Treatment
  - Buprenorphine for opioid addiction - Street Health, AHS Bridge Clinic, Trust Clinic
- Referrals to SUD treatment
- Harm reduction - ACHCH overdose prevention trainings, Narcan distribution

6. Non-medical, enabling services

a. Distribution of basic need items - water, food, hygiene kits and supplies
b. Case management
c. Housing and benefits assistance and navigation

ACHCH Health Services

7. Respite/Recuperative Care Services

a. Alameda County contracted-beds
- 15 -27 beds at LifeLong Adeline site for AHS-referred and street health-referred patients

b. Hospital contracted-beds
- AHS contract with East Oakland Community Project (Crossroads shelter)
- Sutter and AHS contracts with Bay Area Community Services (BACS)
- Kaiser contracts with beds

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ACHCH Measures

A. **Access**

- # patients referred and linked to a medical home
- # patients linked to a medical home who completed a visit within 30 days of referral
- # patients receiving a clinic visit or non-medical enabling service
- # of medical, behavioral, dental, optometry visits
- # patients with HIV who complete at least 1 primary or specialty care visit
- # patients with Hep C who complete at least 1 primary or specialty care visit

B. **Clinical measures:**

- Blood pressure control
- HbA1c control
- Patients w/Hep C who were cured
- HIV+ patients with undetectable viral load
- Behavioral health
  - # patients screened for depression, PTSD, trauma, alcohol use disorders
  - # patients receiving care coordination (documented by case conferencing notes)

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ACHCH Measures

C. Housing, Disability Status

- # patients receiving housing assistance
- # Coordinated Entry System (CES) assessments completed
- # patients receiving a disability assessment

D. Patient engagement and patient experience

- Initial engagement as evidenced by at least 3 visits in first six months of program participation
- Engagement in a medical home as evidenced by 3 or more visits in 12 months
- Percent of patients who report on the ACHCH patient experience that they would refer family or friends to their provider

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2021 Quality Priorities

1. Recruit new medical director
2. Review of QI/QA P&Ps to Commission
3. Build out patient record and reporting system:
   - Acquire Epic EHR
   - ACHCH Salesforce app for field-based work
   - Continued uploads of housing docs in HMIS, use of ACBH Clinician's Gateway and CHR
4. Track racial disparities* and patient experience
5. Continue to support learning with staff and partners via convenings and learning communities

*Use applicable federal Uniform Data System (UDS) clinical tables: 6A – Selected diagnoses and services rendered, 6B – Quality of care measures, 7 – Health outcomes and disparities.

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