DHCS | PATH

Providing Access & Transforming Health

BluePath HEALTH

Alameda CalAIM PATH Collaborative
July 19, 2024

Welcome! Please grab some coffee, find a table, and introduce yourself to someone you haven't met before.

2024 Collaborative Aims and Objectives

BluePath HEALTH

By December 2024, increase eligible members authorized for ECM by 15% & Community Supports by 15%

1 Build resources and relationships to drive community referrals

2 Strengthen ECM and Community Supports provider capacity

3 Facilitate relationship building between providers, plans, and referral partners

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Today's Agenda

Time	Topic
10:05am	***Welcome, agenda, and housekeeping***
10:10am	***Follow-ups from Past Meetings***
10:20am	***Resources & Updates***
10:25am	***Kaiser Permanente Updates -*** *Data Updates*
10:35am	***Alameda Alliance Updates -*** *Intro to Find Help*
10:45am	***5-minute break!***
10:50am	***Referral Partner Presentations*** - Community Health Center Network (CHCN) - Alameda Health System - Alta Bates Summit Medical Center with Journey Health
11:30am	***Identifying next steps: rapid idea generation***
11:35am	***Lunch and Open Office Hours***

3

Housekeeping

Follow-ups from previous meetings

Care Coordination for Foster Youth (*February 2024*)

- Elevated the strategies identified in February to DHCS

ECM and CS for Long Term Care Population of Focus (*April 2024*)

- New DHCS resource demonstrates how to weave ECM and Community Supports for this PoF

Birth Equity (*May 2024*)

- Following up on resources about how to integrate ECM with existing home visiting programs

Follow-ups from previous meetings

Community Referrals *(June 2024)*

- All referral forms are now posted on the collaborative resource center!

Library of CalAIM Informational Materials

➕ Introduction to Medi-Cal and CalAIM

➕ Enhanced Care Management Resources: Policy and Tools

➕ Community Supports Resources: Policy and Toolkits

➕ DHCS Policy and Program Guidance for CalAIM: Data, Billing, and Provider Terms

➕ Recent DHCS Policy Updates

➕ Alameda County's Community Health Record and Social Health Information Exchange

➕ Data Exchange Framework and Other Data Sharing Resources

➕ Medi- Cal Managed Care Plan 2024 Transition Policy: Alameda County

➕ Referral Forms for Alameda Alliance Members to ECM and Community Supports

➕ Referral Information for Kaiser Permanente members to ECM and Community Supports

Omatochi

2024 Wellness Fair

Promoting Senior Well-being

Event Details

Location : San Lorenzo Library - Greenhouse Community Room

Date: August 24th, 2024

Time: 11 am - 1 pm

An enriching and interactive experience tailored to our cherished senior community's diverse interests and needs. During our fair, we will cover the following topics:

- **Social Interaction:** Encouraging seniors to stay socially connected with family, friends, and the community can help reduce feelings of loneliness and isolation.
- **Physical Activity:** Regular exercise and physical activity can improve seniors' physical health, mobility, and mental well-being.
- **Healthcare Access & Resources:** Ensuring seniors have easy access to healthcare services, regular check-ups, and appropriate medical support can enhance their overall health and address any medical concerns promptly. We also will discuss signs of elder abuse.
- **CalAim Education:** Educating seniors and their families on CS and ECM benefits through CalAIM.
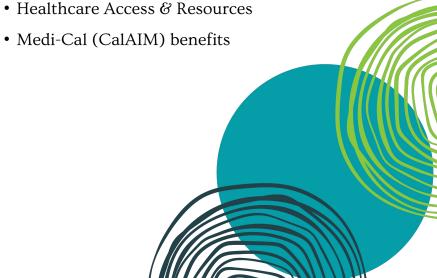
Day-Of-Details

- Wellbeing Tables- Physical Health ex. Senior boxing exercises and activities promoting mindfulness
- Social-Emotional Session- Candidly Speaking: Conversations Across Cultures
- Craft Tables--Stop by and build a craft with new friends.
- Tech Tables- Learn how to use your phone and applicable apps.
- Medi-Cal Education Table- Learn more about YOUR benefits.
- Omatochi Booth- Learn about Omatochi's offerings.
- Live Band- Dance or sit with others while enjoying some music. ???
- TBD: Yoga, Cooking class, Etc.?

Topics

- How to Stay Socially Connected To Your Community
- How to Safely Use Technology
- The Benefits of Physical Activity
- Healthcare Access & Resources
- Medi-Cal (CalAIM) benefits

Why Participate?

The "Senior Wellness Fair," is a 2-hour in-person event dedicated to enhancing the overall well-being of seniors in the community. This collaborative effort brings together local organizations committed to supporting seniors in leading healthy and fulfilling lives.

The fair will feature health screenings, fitness demonstrations, informative workshops, and access to valuable resources, all aimed at empowering seniors to take proactive steps toward their health and happiness. With a focus on inclusivity and engagement, the event aims to foster social connections among seniors while promoting awareness of available support services.

Brought To You By:

Omatochi

URBAN LEAGUE OF GREATER SAN FRANCISCO BAY AREA

Parkinson's Foundation

ALAMEDA Alliance FOR HEALTH

BluePath HEALTH

Candidly Speaking

KAISER PERMANENTE®

Behavioral Health Department
Alameda County Health

SIDE BY SIDE

For Questions Please Email:

Omatochi

kiley.giebel@omatochi.com

BluePath:

ellen.badley@bluepathhealth.com

Please Sign Up

Resource Updates

- ECM and Community Supports Provider Job Aid
- PATHways to Success
- Data Exchange Framework Bootcamp

ECM and CS Provider Job Aid- Redesign now available in Spanish!

Apoyo comunitario (CalAIM) y Gestión Mejorada de la Atención (ECM)

Tipos de apoyo comunitario disponibles en el Condado de Alameda:

Búsqueda de vivienda
Asistencia para encontrar, postular y asegurarse una vivienda en forma permanente.

Cuidados de recuperación (Relevo médico)
Cuidados residenciales de corta duración si le dan de alta en el hospital sin vivienda estable.

Depósitos para la vivienda
Asistencia con gastos de vivienda, incluyendo depósitos de seguridad, configuración y gestión de servicios, como gas y electricidad.

Servicios de cuidadores (Servicios de relevo)
Servicios de relevo de corta duración para asistentes, en el domicilio o en instituciones aprobadas.

Alquiler de vivienda y sostenibilidad
Apoyo para conservar la vivienda, como problemas con el propietario(a), certificaciones anuales y apoyo con recursos locales para prevenir desalojos.

Dietas de apoyo médico/Comidas adaptadas individualmente
Entrega de alimentos nutritivos o de comidas preparadas, con vales para alimentos saludables y/o educación alimentaria.

Cuidados personales y servicios domésticos
Asistencia en actividades diarias, como bañarse, alimentarse, preparar comidas, comprar comestibles y asistir a citas médicas.

Centros de desintoxicación
Ayuda a corto plazo para la desintoxicación ambiente seguro, con acceso a cuidados de alojamiento temporal, alimentación, aseso servicios adicionales.
*Disponible después del

Programas de habilitación para actividades diarias
Guía para desarrollar competencias, tales como usar el transporte público, cocinar, limpiar y ocuparse de su gestión financiera personal.
*Para personas en situación de calle o sin hogar
*Sólo para miembros permanentes de Kaiser

Alojamiento despues de hospitalizacion duración
Alojamiento temporal para pacientes en cu incluyendo tratamientos para adicciones, s establecimientos penitenciarios y otros.
*Sólo para miembros perman

Modificaciones en el domicilio
Actualizaciones y mejoramientos de domicilio que contribuyen a la buena salud, seguridad e independencia, tales como rampas, barras de apoyo, entradas más amplias y elevadores.

Remediación del asma
Actualizaciones en el domicilio para prevenir episodios asmáticos agudos, gracias a filtros al vacío, deshumidificadores, filtros de aire y ventilación mejorada.

De hogares de ancianos a asistencia en la vida diaria
Apoyo para hacer la transición a una vida asistida y recibir servicios diarios de asistencia, vigilancia médica y presencia de personal durante las 24 horas, en lugar de residir en un hogar de ancianos.

Transición de hogar de ancianos a la casa
Asistencia para retornar a casa desde un hogar de ancianos, tales como financiamiento de depósitos de seguridad, gastos en infraestructura de salud, como camas de hospital.

Explicando los servicios de Administración de la Atención Mejorada (ECM) a los miembros:

Su gerente de atención principal especializado coordinará los servicios de salud y atención médica, por teléfono, presencialmente o donde usted vive.

Su gerente de atención principal puede:
- Encontrar el médico y hacer una cita
- Gestionar el transporte gratuitamente hacia y desde las citas
- Verificar las prescripciones y ayudar a renovarlas
- Conectarlo con recursos locales y ayuda alimentaria en la comunidad, alojamiento y otros servicios sociales

Los servicios de ECM no reemplazan:

Sus beneficios: Es un beneficio adicional para miembros de Medi-Cal.

Sus médicos: Mantiene sus actuales médicos y otros proveedores.

Sus opciones: Usted puede cancelar ECM en cualquier momento.

ECM es gratis! Sin costos adicionales para usted.

Ver reverso para detalles sobre los criterios de elegibilidad

bluepathhealth.com/bluepath-health-calaim

NOW LIVE: "PATHways to Success"

Learn about the difference PATH is making for organizations and the Medi-Cal members they serve across California.

PATH is Growing Local Partnerships and Strengthening Services for Members

June 14, 2024

For more than 20 years, Lifespring Home Nutrition has provided Southern Californians with special dietary needs access to nutritious, medically tailored meals (MTM) to heal their bodies and manage their...
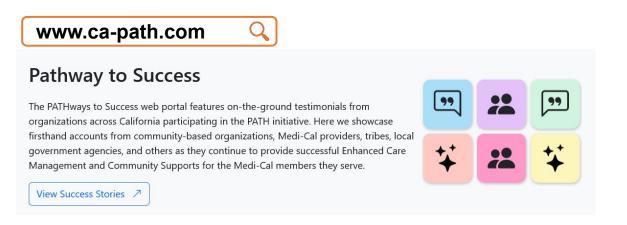
Read More

View All Success Stories

DHCS is featuring PATH success stories from organizations across California

As community-based organizations, Medi-Cal providers, tribes, local government agencies, and others continue to participate in the PATH initiative, DHCS will share their firsthand accounts of providing Enhanced Care Management (ECM) and Community Supports for the members they serve.

"PATHways to Success" showcases how PATH is helping organizations build relationships and make the investments needed to transform Medi-Cal and better serve California's highest need members.

Visit ca-path.com and scroll to "Pathway to Success" to view success stories from organizations participating across PATH.

www.ca-path.com

Pathway to Success

The PATHways to Success web portal features on-the-ground testimonials from organizations across California participating in the PATH initiative. Here we showcase firsthand accounts from community-based organizations, Medi-Cal providers, tribes, local government agencies, and others as they continue to provide successful Enhanced Care Management and Community Supports for the Medi-Cal members they serve.

View Success Stories ↗

Does your organization have a PATH success story to share?

Please send an email to communications@ca-path.com to get started.

Data Exchange Framework Bootcamp

Connecting for Better Health invites you to a Data Exchange Framework (DxF) Bootcamp - Only a few spots remain!

- **Held virtually on August 1, 10am-1pm**
- **Email info@connectingforbetterhealth.com to register**

MCP updates

Kaiser Permanente

Alameda PATH CPI Meeting

July 2024

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Updates

Baseline Q1 ECM & CS Enrollment Data

California Recuperative Care Symposium

Complex Care Certificate

ECM/CS Provider Lists and Information

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Q1 Alameda ECM and CS Enrollment Data

Enrollment by Populations of Focus							
Adult – Individuals Experiencing Homelessness	Adult – Families Experiencing Homelessness	Adult – Avoidable Hospital or ED Utilization	Adult – SMI or SUD	Adult – Transitioning from Incarceration	Adult – at Risk for LTC Institutionalization	Adult – NF Transitioning to Community	Adult – Birth Equity
38	0	43	74	0	7	0	56
Child – Individuals Experiencing Homelessness	Child – Families Experiencing Homelessness	Child – Avoidable Hospital or ED Utilization	Child – SMI or SUD	Child – CCS/CCS WCM with Additional Needs	Child – Child Welfare	Child – Transitioning from Incarceration	Child – Birth Equity
3	0	6	33	3	11	0	1

Community Supports Received (Total: 246)						
Housing Transition/ Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Short-Term Post-Hospitalization Housing	Recuperative Care	Respite Services	Day Habilitation Programs
94	4	14	0	1	5	76
NF Transition to ALF	NF Transition to a Home	Personal Care and Homemaker Services	Environmental Accessibility Adaptations	Medically-Supportive Food	Sobering Centers	Asthma Remediation
0	1	14	1	36	0	0

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2024 California Recuperative Care Symposium

Join us for the first statewide gathering focused on recuperative care

2024 CALIFORNIA Recuperative Care SYMPOSIUM

September 12 and 13, 2024
Hilton Arden West
2200 Harvard Street
Sacramento, CA 95815

Register here:
https://nhchc.org/trainings/regional/2024-california-recuperative-care-symposium/

About the Event

The National Institute for Medical Respite Care (NIMRC), a special program of the National Health Care for the Homeless Council (NHCHC), hosts the inaugural **California Recuperative Care Symposium**, **September 12-13, 2024**, at the Hilton Arden West in Sacramento, California.

NIMRC is excited to showcase promising practices, program models, and examples of leadership at this monumental event celebrating Recuperative Care services in California. The Symposium's schedule and other updates coming soon!

NATIONAL INSTITUTE for MEDICAL RESPITE CARE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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Complex care certificate | A free training resource from Kaiser Permanente

The complex care certificate will provide essential knowledge, skills, and attitudes required to provide complex care. This training program is rooted in Camden Coalition's core competencies for frontline complex care providers.

What is complex care?

- Complex care improves health and social well-being or individuals with complex needs.

- Complex care addresses the multiple drivers of health and social needs through collaboration in communities and across sectors.

What is the complex care certificate?

- Nine self-paced online courses (13 CEUs) that teach frontline complex care staff how to engage with complex health and social needs.

- Learners will be equipped with tools to build relationships and address gaps in care delivery that apply to all target populations, from pediatrics to older adults.

The complex care certificate program provides care teams with shared language and frameworks necessary for collaborative care delivery

❖ KP's California-based community partners

❖ Frontline complex care practitioners

❖ Interdisciplinary care teams including community health workers, nurses, doctors, peers, social workers, care managers

❖ Healthcare and social care workers who want to strengthen their practice of whole person care and team collaboration

The training curriculum is:

Self-paced   **Person-centered**   **Collaborative**   **Accredited**

Registration code: kp2024 |
https://courses.camdenhealth.org/redeem

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Complex care certificate | Courses included in the program

Each self-paced online course includes a set of activities for a team to complete together to apply what they have learned to their work.

Complex care certificate courses:

Introduction to complex health and social needs Interplay and compounding effects of multiple health, behavioral health, and social needs	**Motivational interviewing in complex care** Principles and practices of motivational interviewing in complex care settings
Relationship-building in complex care Building authentic healing relationships, setting boundaries, and establishing self-care practices	**Care planning in complex care** Generating, implementing, and maintaining strengths-based and person-centered care plans
Power and oppression in complex care Power dynamics in complex care, self-reflection on privilege and bias, and responsible use of power	**Complex care delivery** Person-centered language, implementing care plans, and navigating complex systems
Trauma-informed complex care Principles and practices of trauma-informed care in complex care settings	**Collaboration and communication in complex care teams** Building authentic healing relationships, role clarity, collaborative decision-making, and conflict transformation in teams
Harm reduction in complex care Principles and practices of harm reduction in complex care settings	**A systems change project (optional for certificate designation)** Identifying systems issues, collecting data, storytelling, and implementation within your system/community

Courses contain a diverse array of education methods:

Video, audio, and interactive elements

Patient and practitioner stories

Links to research

Reflection and discussion questions

Team activities

ABOUT THE CAMDEN COALITION
The Camden Coalition is a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being.

Camden Coalition

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How to Submit a Referral for ECM or Community Supports

KP has a no-wrong-door approach for referrals
- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
- Use of the KP referral form is recommended; however, KP will accept any referral form created by another Medi-Cal plan. Simply send the completed form to the same KP email address noted below.
- Referrals may be placed via email or via phone.

	Sacramento/Central Valley	Rest of Northern California	Southern California
Cities	Amador, El Dorado, Fresno, Kings, Madera, Mariposa, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare*, Yolo, Yuba	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma,	Kern, Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare*, Ventura,
Phone	1-833-721-6012 (TTY 711) Monday-Friday (closed major holidays) 9:00 a.m. to 4:45 p.m.	1-833-952-1916 (TTY 711) Monday-Friday (closed major holidays) 9:00 a.m. to 4:45 p.m.	1-866-551-9619 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.
Email	Send completed referral form to REGMCDURNs-KPNC@kp.org with the subject line "ECM Referral" or "CS Referral"		Send completed referral form to RegCareCoordCaseMgmt@kp.org with the subject line "ECM Referral" or "CS Referral"

*Tulare Central Valley: 93618, 93631, 93646, 93654, 93666, 93673; Tulare Southern CA: 93238, 93261.

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Enhanced Care Management (ECM) Providers in Alameda County

Organizations listed have executed contracts with KP as of **June 30, 2024.**

Other providers are welcomed to apply to join our provider network via the NLEs.

Provider	Services/Populations of Focus	Phone Number
A Better Way Inc	Children & Youth - Individuals with SMI/SUD Children & Youth - Involved in Child Welfare	510-433-8600
AAT Home Placement Agency	Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community	209-594-5980
Agape Village	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	510-835-2641
Alameda Family Services	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	925-474-2154 (Pleasanton)
Alternative Family Services	Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	530-283-3330
CityServ	TBD	(559) 802-3667
EA Family Services	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals transitioning from incarceration (Adult) Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	(510) 268-3770
East Bay Agency of Children	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration	510-547-7322

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Provider	Services/Populations of Focus	Phone Number
Family Resource Navigators	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	858-444-8827
Fred Finch Youth & Family Services.	Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	530-283-3330
Independent Living Systems	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - Individuals transitioning from incarceration (Adult) Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	844-320-5182
J&M Homecare Services, LLC	Adults - Individuals at-risk for IP and ED Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community	925-552-6500
Koinonia Foster Homes, Inc.	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	209-577-3737

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Providers with blue text are newly added

Provider	Services/Populations of Focus	Phone Number
Lincoln Families	Children & Youth - Involved in Child Welfare	510-273-4700
New Dimensions Foster Family Agency	TBA	209-526-1837
Resolution Care (dba Vynca Care) *[Birth Equity Specialty Provider Type]*	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	888-227-8884
Seneca Family of Agencies *[Birth Equity Specialty Provider Type]*	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	510-654-4004

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Provider	Services/Populations of Focus	Phone Number
Serene Health IPA	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - Individuals transitioning from incarceration (Adult) Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	844-737-3638
Side by Side	Children & Youth - Individuals with SMI/SUD Children & Youth - Involved in Child Welfare	510-727-9401
Star Nursing Inc	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD	877-687-7399

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Provider	Services/Populations of Focus	Phone Number
Stars Behavioral Health Group	Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	510-352-9200
Sterling Hospitalist Medical Group, Inc	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD)	714-897-1071
Unity Care Group, Inc.	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	(408) 971-9822
WestCoast Children's Clinic	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	510-269-9030

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Community Supports (CS) Providers in Alameda County

Organizations listed have executed contracts with KP as of **June 30, 2024.**

Other providers are welcomed to apply to join our provider network via the NLEs.

Provider	Services/Populations of Focus	Phone Number
AAT Home Placement Agency	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Nursing Facility Transition/Diversion to Assisted Living Facilities Community Transition Services/Nursing Facility Transition to a Home	209-594-5980
AccentCare of California	Respite Services Personal Care and Homemaker Services	818-837-3775
Aging Assistant LLC	Respite Services Personal Care and Homemaker Services	916-753-7622
Alegrecare, Inc	Personal Care and Homemaker Services	800-598-4777
ASSURED INDEPENDENCE	Home Modifications	425-516-7400
Breathe California of the Bay Area, Golden Gate and Central Coast	Asthma Remediation	408-998-5865
CityServ	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Short-Term Post-Hospital Housing Recuperative Care Sobering Centers Day Habilitation	(559) 802-3667
Connect America West	Home Modifications	707-200-2138
EA Family Services	TBA	530-283-3330
Eddie's Place "Cardea Health"	Recuperative Care	615-226-2292
Evolve Emod, LLC	Home Modifications Asthma Remediation	844-438-7577
Home Safety Services, Inc	Home Modifications	888-388-3811
Independent Living Systems	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Nursing Facility Transition/Diversion to Assisted Living Facilities Community Transition Services/Nursing Facility Transition to a Home Environmental Accessibility Adaptations (Home Modifications) Asthma Remediation Personal Care (beyond In Home Services and Supports) and Homemaker Services Respite Services Day Habilitation Programs	844-320-5182

Community Supports (CS) Providers in Alameda County

Organizations listed have executed contracts with KP as of **June 30, 2024.**

Other providers are welcomed to apply to join our provider network via the NLEs.

Provider	Services/Populations of Focus	Phone Number
J&M Homecare Services, LLC	Respite Services Personal Care and Homemaker Services	925-552-6500
Lifeline Systems Company	Home Modifications	800-451-0525
Mom's Meals	Meals/Medically Tailored Meals	877-508-6667
Pear Suite, Inc	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Asthma Remediation	628-204-4124
Performance Kitchen	Medically Tailored Meals	512-608-1609
Serene Health IPA	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Short-Term Post-Hospital Housing Community Transition Services/Nursing Facility Transition to a Home Day Habilitation	844-737-3638
Star Nursing Inc	Housing Transition/Navigation Services Nursing Facility Transition/Diversion to Assisted Living Facilities Community Transition Services/Nursing Facility Transition to a Home Respite Services Personal Care and Homemaker Services	877-687-7399
Sterling Hospitalist Medical Group, Inc	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services	714-897-1071
Uncuffed Project Inc	Recuperative Care	415-320-8798
WINETEER INC DBA LIFEWISECHM	Home Modifications	913-653-0766
24 Hour Home Care	Personal Care and Homemaker Services	866-311-6265

KAISER PERMANENTE.

How a community-based organization can serve KP members

KP is working with three Network Lead Entities (NLEs) to develop a network of community-based ECM, CS, and CHW providers.

If your organization wishes to become part of an NLE's network, you may send an email message to:

network@fullcirclehn.org
Phone number: 888-749-8877

Full Circle Health Network meets with prospective providers each week on Thursdays from 12-1pm PST
https://us06web.zoom.us/j/86507421534

ILSCAProviderRelations@ilshealth.com
Phone number: 305-262-1292

Hubinfo@picf.org
* Phone number: 818-837-3775

In your email, please specify the services your organization provides, geography serviced, and population expertise.

*Partners in Care only serves the Southern California region at this time.

KAISER PERMANENTE.

Helpful Links and Contacts

KP Medi-Cal Resource Center: **Resource Center Link**

KP 2024 Medi-Cal Direct Contract: **KP.org/Medi-Cal2024**

KP Designated Medi-Cal Call Center: **1-855-839-7613** Call to speak to a live Medi-Cal trained agent

KP Medi-Cal Programs (ECM, CS, CHW):   For current information, go to our website: **Link**

KP Medi-Cal Continuity of Care: For current information, go to our website: **Link**

KP Self-Service Community Resource Directory: **KP.org/communityresources**
                                                          1-800-443-6328 Toll-free number to speak with a resource specialist (M-F, 8a-5p local time)

KP Community Health Care Program: Available to California residents without access to other health coverage. For current information, go to our website: **Link**

Medi-Cal Redeterminations Toolkit: For current information, go to DHCS website: **Link**

Medi-Cal Rx: **1-800-977-2273**

Medi-Cal Dental: **1-800-322-6384**

Medi-Cal External Engagement   For general Cal AIM and CS/ECM inquiries, medi-cal-externalengagement@kp.org

KAISER PERMANENTE®

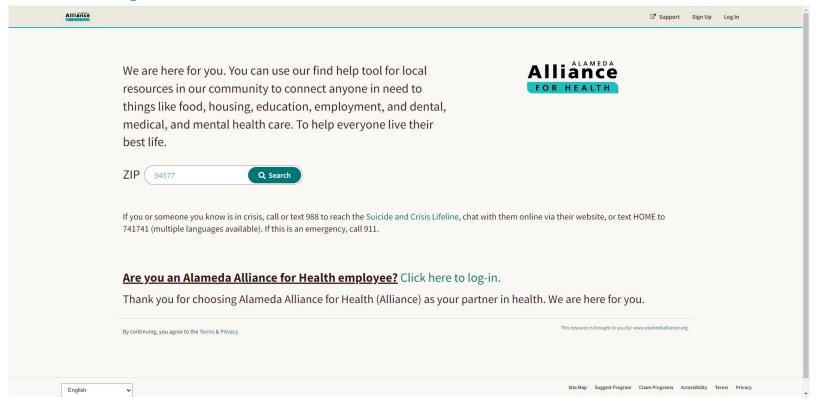# FindHelp

at Alameda Alliance for Health

Closed Loop Referral

- Entity 1 sends referral for member to Entity 2 to receive services.
- Entity 2 receives referral, outreaches to member and coordinates to provide services.
- Entity 2 'closes' the communication loop and replies back to Entity 1 to communicate if member was served (or not).

- The latest DHCS Population Health Management Policy Guide states that further details regarding Closed Loop Referral definition will be shared in future guidance.
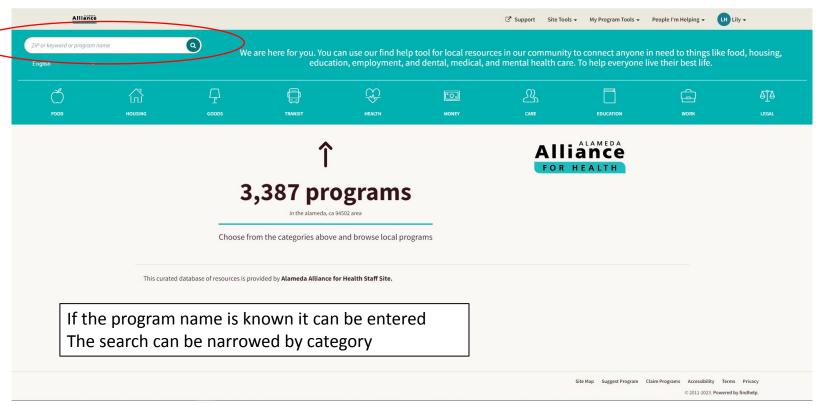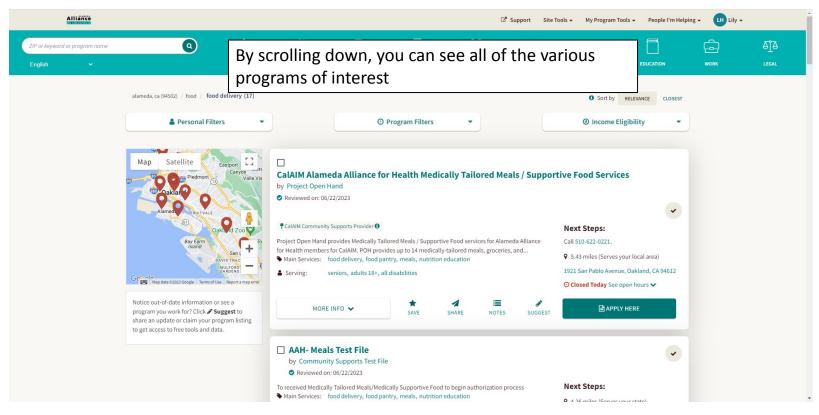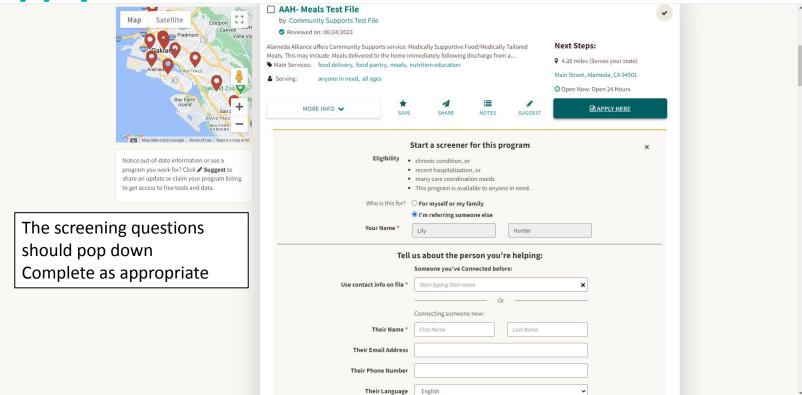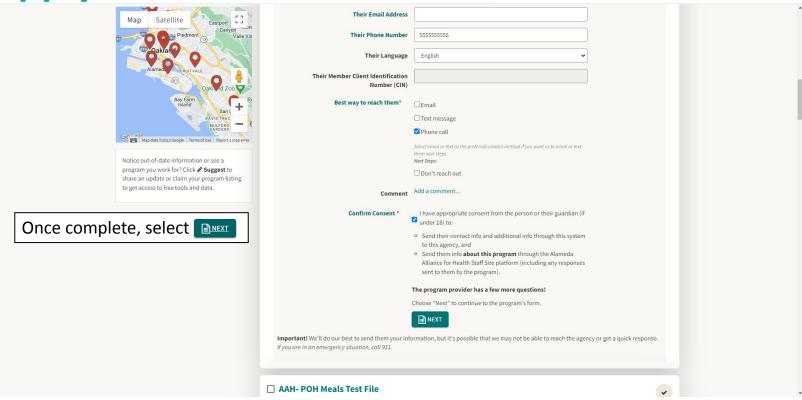
FindHelp

Narrow Your Search

If the program name is known it can be entered
The search can be narrowed by category

Narrow Your Search

By scrolling down, you can see all of the various programs of interest

Apply Here

The screening questions should pop down
Complete as appropriate

Apply Here

Their Email Address

Their Phone Number 5555555555

Their Language English

Their Member Client Identification Number (CIN)

Best way to reach them *
- ☐ Email
- ☐ Text message
- ☑ Phone call

Select email or text as the preferred contact method if you want us to email or text them next steps.

Next Steps:
- ☐ Don't reach out

Comment Add a comment...

Confirm Consent * ☑ I have appropriate consent from the person or their guardian (if under 18) to:
- ○ Send their contact info and additional info through this system to this agency, and
- ○ Send them info **about this program** through the Alameda Alliance for Health Staff Site platform (including any responses sent to them by the program).

The program provider has a few more questions!

Choose "Next" to continue to the program's form.

[📄 NEXT]

Important! We'll do our best to send them your information, but it's possible that we may not be able to reach the agency or get a quick response. *If you are in an emergency situation, call 911.*

☐ **AAH- POH Meals Test File** ✓

Notice out-of-date information or see a program you work for? Click ✏ **Suggest** to share an update or claim your program listing to get access to free tools and data.

Once complete, select [📄 NEXT]

Screening Application

The screening application appears
Complete questions pertaining to member as appropriate

Support   Site Tools ▾   My Program Tools ▾   People I'm Helping ▾   LH Lily ▾

Screening Application for AAH- Meals Test File Program

Select Language ▾   Google Translate

This form must be completed in one sitting, you can not save and return to this form later. Please fill out this form as completely as you can, and make sure you have any reference documents on hand. You may be asked for documentation later to confirm what you've listed here. If you are filling out this form for someone else, answer how they would answer. This form is to help us find out if you might be eligible for services, filling it out does not guarantee services.

Living Situation

Street Address *
123 Main St.

City *

State *
Select an option   ▾

Screening Application

Patient's Qualifying Condition (please select all that apply, must meet at least one (1) to be eligible: *

☑ Has chronic condition(s), such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders

☐ Is being discharged from the hospital or a skilled nursing facility or at high-risk of hospitalization or nursing facility placement

☐ Has intensive care coordination needs

Associated Diagnostic ICD-10 Code: *

write something here

Please upload appropriate supporting documentation here

Drag & drop a file or click to browse

Once complete, select

REVIEW AND SUBMIT

Extension Request

Member's Medical Necessity (please describe) (Medical necessity for an extension would be an acute worsening of the member's condition or the patient is at high-risk for re-developing significant illness.)

REVIEW AND SUBMIT

Screening Application

Initial Request

Patient's Qualifying Condition (please select all that apply, must meet at least one (1) to be eligible:

✓ Has chronic condition(s), such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders

Associated Diagnostic ICD-10 Code:

write something here

Please upload appropriate supporting documentation here

No Response

Extension Request

Member's Medical Necessity (please describe) (Medical necessity for an extension would be an acute worsening of the member's condition or the patient is at high-risk for re-developing significant illness.)

No Response

Please review your responses
If you need to edit, select
EDIT RESPONSES

Otherwise, select
SUBMIT

EDIT RESPONSES   SUBMIT

Screening Application

Once complete, there should be a confirmation of completion
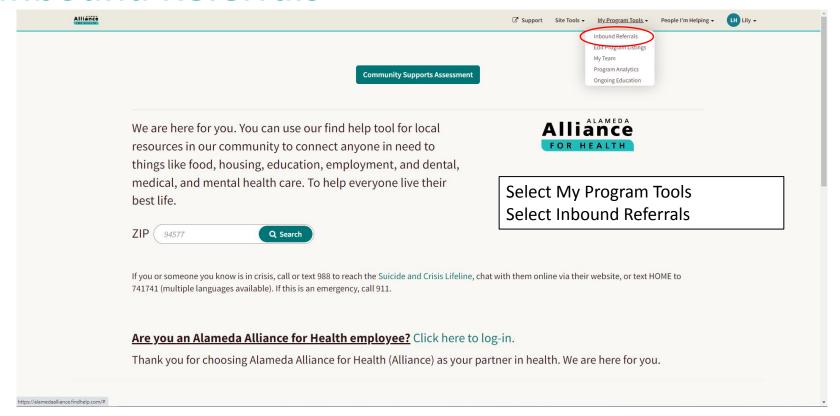
Inbound Referrals

Select My Program Tools
Select Inbound Referrals

Inbound Referrals

When there are new or unaddressed referrals a 🟡3 will appear with the appropriate number of referrals needing attention
Select the folder of choice to follow up

Inbound Referrals

Inbound Referrals

Definitions
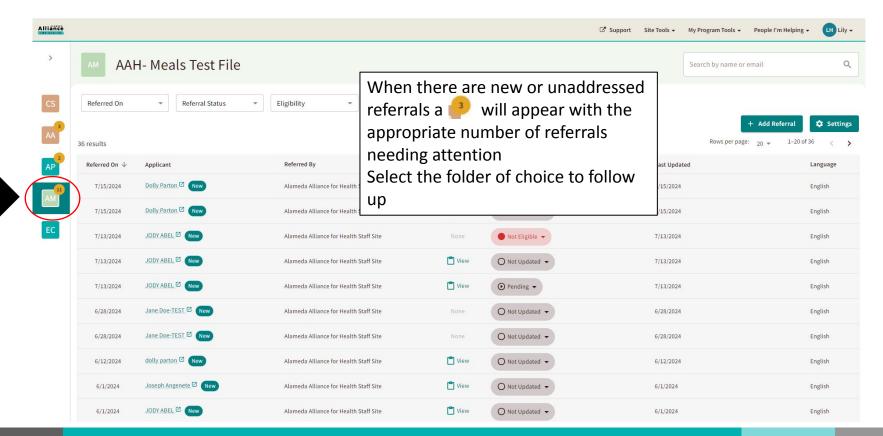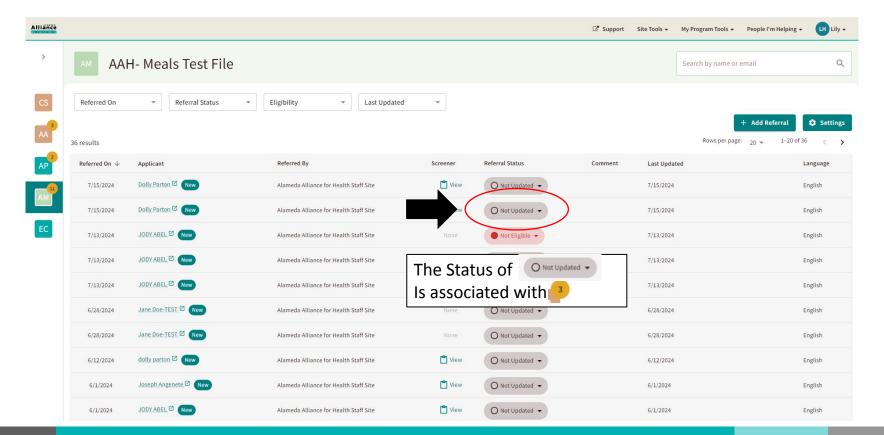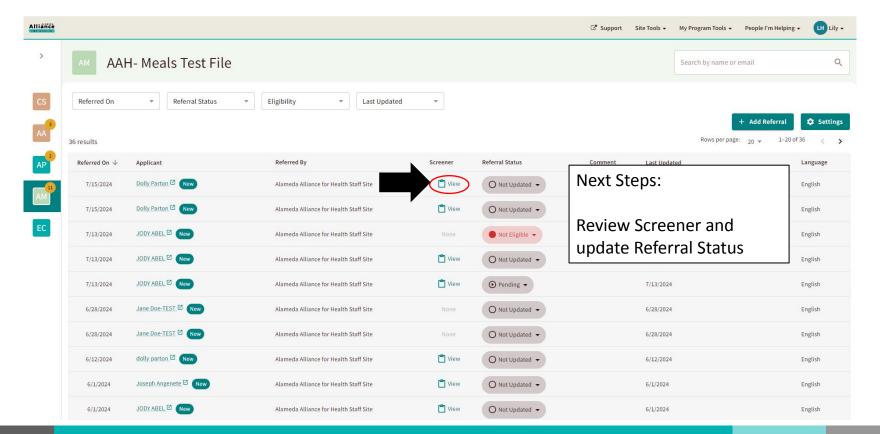
Referral Status	Definitions
○ Not updated	No status selection has been made Referral has not yet been reviewed
⏸ Needs client action	More information is needed to process this referral
▶ Pending	Referral is being processed
➔ Referred elsewhere	Referral could not be fulfilled, member referred to a different program Only to be used in the event that there are other programs/resources that can be offered, otherwise Not Eligible should be selected
➕ Eligible	Member has been authorized for requested service (to be used by AAH only)
✓ Got help	Member has received help and services have started (to be used by external providers only)

Definitions

Referral Status	Definitions
Couldn't contact	Member was unable to be contacted (Internal to AAH: place referral for CM to assist with researching additional contact details)
Not eligible	More information is needed to process this referral
No capacity	Program doesn't have the capacity to help the member. Member should be referred to different program.
Couldn't get help	Member was unable to get help (reason could vary). Refer member to a different program
No longer interested	Member has indicated they no longer need or are interested in this program.

05:00

5-minute break

CHCN ECM
Referral Workflow

Content

CHCN Population of Focus

ECM Referral Process

ECM Referral Review

ECM Referral Approval/Denial

COMMUNITY HEALTH CENTER NETWORK

CHCN Population of Focus

Adults and Children/Youth

Experiencing Homelessness

At Risk for Avoidable Hospital or ED

Serious Mental Health and/or Substance Use Disorder

Transitioning from Incarceration

At Risk for Long-Term Care

Pregnant or Postpartum

COMMUNITY HEALTH CENTER NETWORK

CHW Referral Process

- When CHWs receive a referral, they first check eligibility

- IF the patient meets ECM eligibility, then the CHW will fill out the ECM referral form and send it to the ECM Operation Specialist

COMMUNITY HEALTH CENTER NETWORK

ECM Referral Process

- Community Health Workers (CHWs) sends ECM referral forms to the ECM Operation Specialist
- ECM Operation Specialist reviews all the ECM referral forms before sending them to Alameda Alliance
- ECM referrals are tracked using an Excel sheet

COMMUNITY HEALTH CENTER NETWORK

ECM Referral Review

- Check dates on ECM referral forms
- All boxes must be checked under the Option selected on the ECM referral form

- All ECM referral forms needs to include Supporting Documentation

Example of Supporting Documentation

	05/30/2024	*e*	➕	ED
📎	05/01/2024	*e*	➕	ED
📎	04/14/2024	*e*	➕	ED
📎	04/03/2024	*e*	➕	ED
	04/03/2024	➤	➕	ED
	02/28/2024	➤	➕	ED

Option 2 – Adults at Risk for Avoidable Hospital or ED Utilization (must meet A. OR B.):

☑ **A.** Four (4) or more Emergency Department (ED) visits in a 12-month period which may have been avoided with appropriate outpatient care or improved treatment adherence.

☐ **B.** Two (2) or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

ECM Referral Approval/Denial

Alameda Alliance processes ECM referrals within 5 business days, and informs the referrer of approval or denial via email

Denied ECM referrals can be appealed by filling out Alameda Alliance's appeal/grievance form

COMMUNITY HEALTH CENTER NETWORK

Approved ECM Referrals

- Notify CHW of referral approval
- Ensure Return Transmission Files include all approved ECM referral forms
- The ECM eligibility is based on the approved date, not the ECM referral submission date
- ECM eligibility is valid for 12 months. After 12 months a reauthorization is required

Summary

- Use Correct ECM referral form
- Include Current Date on ECM referral forms
- Make sure to include mental health screeners if Option 3: SMI/SUD is selected
- Be mindful to only submit ECM referrals if you plan to engage with the patient
- Check in with patient to see if they are interested in participating in ECM before submitting a referral

AHS Enhanced Care Management

Complex Care Management at AHS
teams that provide ECM services

Teamlets at Hayward, Eastmont and Highland Wellness

Interdisciplinary teams of Community Health Workers, RN Care Managers and Social Workers

CCM Staffing

The Community Health Worker (CHW) acts as Lead Care Manager

The RN Care Manager support care plan development focused on improving the patient's overall health status; provides patients medication and condition counseling, clinical coordination and symptom triage

The Clinical Social Worker provides mental health assessments, brief therapy as needed and linkage to including psychiatry, counseling and case management.
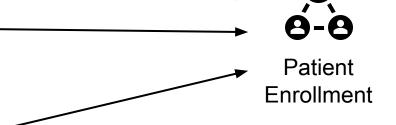
Enhanced Care Management
Low barrier referrals from a variety of sources

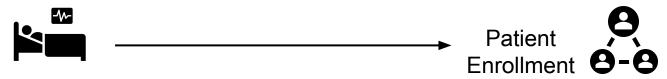Hospital and Emergency Departments

Ambulatory Services

Community Partners

Patient Enrollment

Low barrier referrals from a variety of sources

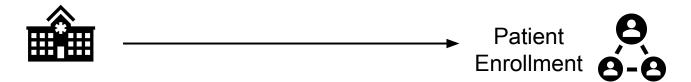Hospital and Emergency Departments

Patient Enrollment

- Hospitalized patients are prioritized, considered "urgent referral" Outreach begins prior to discharge

- Leverage face to face interaction at the bedside for increased engagement

- Epic Report shows all ECM-eligible patients currently hospitalized, daily assignments

- For patients that are eligible and not on MIF, "reverse referral" sent to the Alliance. These account for apx 20% of AHS ECM patients.

- Inpatient CM refers non-AHS assigned patients to Alliance for ECM assignment

ALAMEDA
HEALTH SYSTEM

Low barrier referrals from a variety of sources

Ambulatory Services
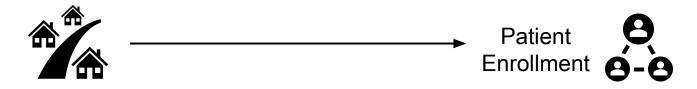
Patient Enrollment

- Primary Care Providers refers to CCM via Epic

- Leverage relationship with provider and medical home for increased engagement

- Specialty Clinics refer AHS-assigned to CCM or non AHS-assigned to Alliance for ECM assignment

ALAMEDA
HEALTH SYSTEM

Low barrier referrals from a variety of sources

Community Partners → Patient Enrollment
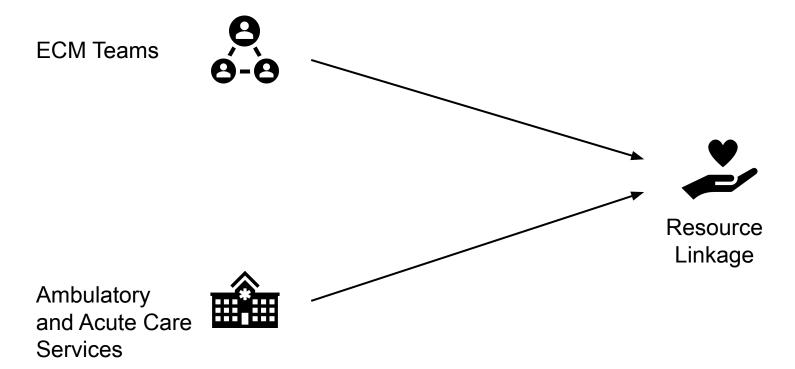
- Refer to AHS CCM via email

- Leverage cross-sector services for increased stability

- For example, recuperative housing, specialty mental health, substance use treatment programs, housing Community Supports
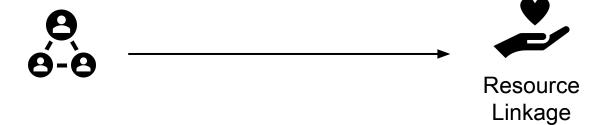
Community Supports

ECM Teams

Ambulatory
and Acute Care
Services

Resource
Linkage

Community Supports

ECM Teams

Resource
Linkage

- Assessments include health-related social needs

- Referrals to CS embedded in care plan

- Most frequently referred – housing and meals

Community Supports

Ambulatory and
Acute Care
Services

Resource
Linkage

- Standard screenings of health-related social needs, positives trigger referral

- Most frequently referred – meals

- Ambulatory partnership with *Recipe for Health*

ALAMEDA
HEALTH SYSTEM

Questions?

For additional program or referral information, please email Lilly MacRae Director of Community Health

lemacrae@alamedahealthsystem.org

Community Network

Air Travel Analogy

Acute Care is like an Airport
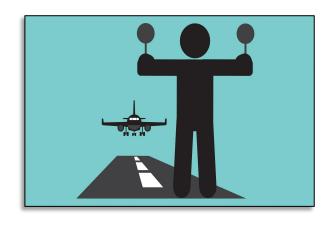
Sutter Health
Sutter Population Health Services

Guiding Patients From Various Populations

4 Key Steps

❏ **Define Target Population**

❏ **Identify At-Risk Individual**
   Within Target Population

❏ **Notify Current Care Team**

❏ **Handoff**

Journey Health

Air Traffic Controller to the community

Comprehensive overhaul of Medi-Cal

California Advancing and Innovating Medi-Cal (CalAIM)

GOAL

Improve the quality of life and health outcomes of Medi-Cal members through broad delivery system, program and payment reform

INITIATED IN

2022

Population Health Management

Enhanced Care Management

Integrated Care for Dual Eligible Members

Community Supports

Behavioral Health Initiative

Supporting Health + Opportunity for Children and Families

JourneyHealth
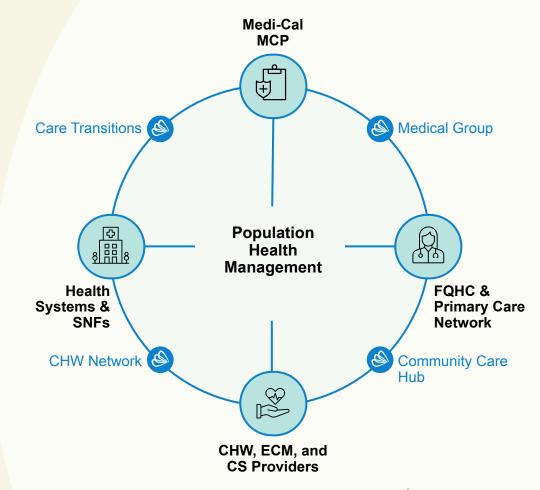
Journey Health offers services and builds capacity where community gaps exist

Core Services

- Population Health Management
  - Transitional Care Services
  - CHW Services
- Social Care Coordination
  - Enhanced Care Management
  - Community Supports
- Medi-Cal Delivery System Optimization
  - Health Plan alignment
  - CBO engagement

Care Team

- Community Health Workers (CHW)
- LCSWs
- RNs
- Providers (Physicians and APPs)

Medi-Cal MCP

Care Transitions

Medical Group

Population Health Management

Health Systems & SNFs

FQHC & Primary Care Network

CHW Network

Community Care Hub

CHW, ECM, and CS Providers

CalAIM:
Community Health Worker Services
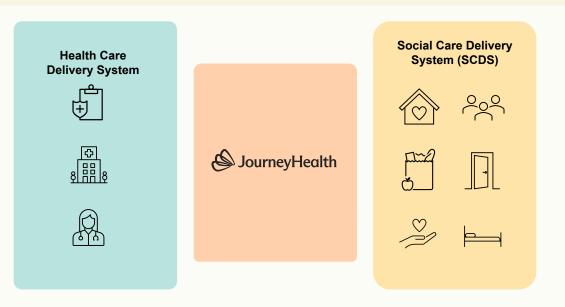
Community Health Workers (CHWs)

CHW services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health

CHW Services

- Health Education
- Health Navigation
- Screening and Assessment
- Individual Support or Advocacy

Building a Social Care Delivery System:
CalAIM Community Care Network

Health Care Delivery System

Social Care Delivery System (SCDS)

Q&A

June Poll Top Themes: Community Referrals

What is going well with referring clients to ECM and Community Supports?

> Timely approvals and responsiveness

What are the gaps related to referrals that we can work together as a collaborative to fill?

> Education and awareness

> Streamlined referral systems

> Enhanced communication

BluePath HEALTH

Rapid Idea Generation

At your table, document 1 idea for a strategy we can take together as a collaborative to address improve referral processes or spread best practices.

Next meeting:
August 16th, 10am - 12pm
On Zoom, Register here:

https://us02web.zoom.us/meeting/register/tZwuf-6trzg
pHtxCQ1uxMMiv2xZiTS8yuLmA#/registration
See you for the 3rd Friday mornings each month in 2024!

Thank you for attending!

Appendix
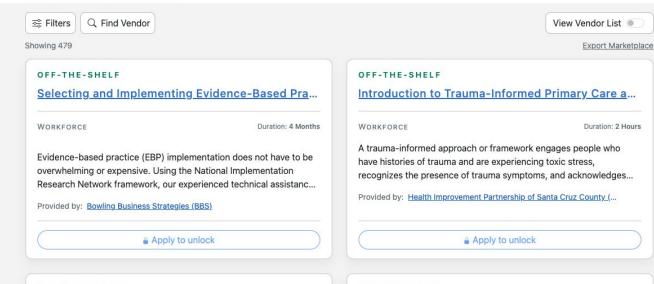
Check out the TA Marketplace!

ⓘ Learn about the Marketplace. Apply to become a TA Recipient and shop the Marketplace. ✕

▶DHCS | PATH   Sign In

⚙ Filters   🔍 Find Vendor   View Vendor List ⬤

Showing 479   Export Marketplace

OFF-THE-SHELF

Selecting and Implementing Evidence-Based Pra...

WORKFORCE   Duration: **4 Months**

Evidence-based practice (EBP) implementation does not have to be overwhelming or expensive. Using the National Implementation Research Network framework, our experienced technical assistanc...

Provided by: Bowling Business Strategies (BBS)

🔒 Apply to unlock

OFF-THE-SHELF

Introduction to Trauma-Informed Primary Care a...

WORKFORCE   Duration: **2 Hours**

A trauma-informed approach or framework engages people who have histories of trauma and are experiencing toxic stress, recognizes the presence of trauma symptoms, and acknowledges...

Provided by: Health Improvement Partnership of Santa Cruz County (...

🔒 Apply to unlock

OFF-THE-SHELF

Health Insurance Portability and Accountability A...

WORKFORCE   Duration: **3 Months**

The goal of this 20-question Risk Assessment is to provide a starting point for healthcare organizations (including hybrid entities) as they begin to evaluate and prioritize their potential liabilities associated...

OFF-THE-SHELF

Evaluation of Care Coordination and Care Manag...

ENHANCED CARE MANAGEMENT (ECM)   Duration: **4 Months**

Our goal is to improve ECM, access, coordination, and integration of care by evaluating structures, processes, and outcomes and by identifying key opportunities to improve care management and care...

2024 Collaborative Aims and Objectives

Alameda Collaborative Aim

By Dec 2024, increase eligible members authorized for ECM by 15% & Community Supports by 15%

Objectives

1 Build resources and relationships to drive community referrals

2 Strengthen ECM and Community Supports provider capacity

3 Facilitate relationship building between providers, plans, and referral partners

Activities
(additional activities in development)

CalAIM 101 trainings

Care Coordination Provider List

PoF-specific post-meeting action items

ECM & CS Member Engagement Job Aid

In-Person Meetings

Alameda Collaborative Resource Hub