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Providing Access & Transforming Health

BluePath HEALTH

Alameda CalAIM PATH Collaborative

September 20, 2024

Welcome! Please introduce yourself in the chat with your name and organization.

2024 Collaborative Aims and Objectives

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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

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Time	Topic
10:00-10:05	Welcome, agenda, housekeeping
10:05-10:10	Follow-ups from previous meetings
10:10-10:45	Spotlight on the Community Health Needs Assessment and Community Health Improvement Plan
10:45-11:05	Managed Care Plan Updates
11:05-11:15	CalAIM Policy Updates
11:15-11:25	Resources, Training, & Upcoming Events
11:25-11:30	Wrap-up and Survey
11:30-12:00	Optional Office Hours with the Facilitators

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Housekeeping

Follow-ups from previous meetings

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Community Referrals

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

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Community Referrals: Needs and Opportunities

The Need

DHCS expects MCPs to source most ECM & Community Supports referrals from the community. Use of internal data to identify should be balanced with active community-based outreach and engagement. There is a need to increase the proportion of ECM and Community Supports referrals that come from the community.

Current Challenge

Current referral pathways rely on the Member Information File (MIF) and outreach to the member from CBOs, yielding low referral rates.

What We Know

Those with existing member relationships are best positioned to identify eligible members and connect them with services. When members are identified as potentially eligible, current referral processes are not optimized.

Shared Goal

Robust and streamlined community referral pathways to enroll more members who can benefit from ECM and Community Supports.

Collaborative Role

DHCS and the Alameda CalAIM PATH Collaborative can identify promising practices to build community referral pathways.

Strategies to Boost Community Referrals

Strengthen partnerships to foster referral pathways and provide community education on how to make referrals to ECM and Community Supports

Increase community awareness of CalAIM and offer CalAIM 101 presentations to community organizations, including both contracted and non-contracted providers.

Identify and support organizations with existing relationships and touchpoints with eligible members that are well-positioned to become high-volume referral partners.

Support providers and community partners to develop systems to better identify eligible members and refer them to services.

Adopt practices and strategies to remove barriers in referring members to services.

Alameda County Health Community Health Assessment & Health Improvement Plan Intersection with Managed Care Plans

Carolina Guzman, Quality Improvement Manager, AC Public Health Department

Linda Ayala, MA, MPH, Director, Population Health & Equity, Alameda Alliance for Health

September 20, 2024

Agenda Overview

- Welcome & Introductions
- Alameda Co Public Health: Health assessment and health improvement
- Managed Care Plans Population Health Assessment
- Getting Involved

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Public Health Department as Community Health Strategist
Community Health Needs Assessment (CHNA) & Community Health Improvement Plan (CHIP)

Carolina Guzman, QI Manager, ACPHD
Quality Improvement and Accreditation

Presentation Overview

I. **Community Health Needs Assessment and Community Health Improvement Plan**
   - Definitions
   - Results and Strategies

II. **Alameda Alliance for Health: Population Health**

III. **Next Steps**
   - Joining a community health needs assessment focus group
   - Joining a community health improvement workgroup

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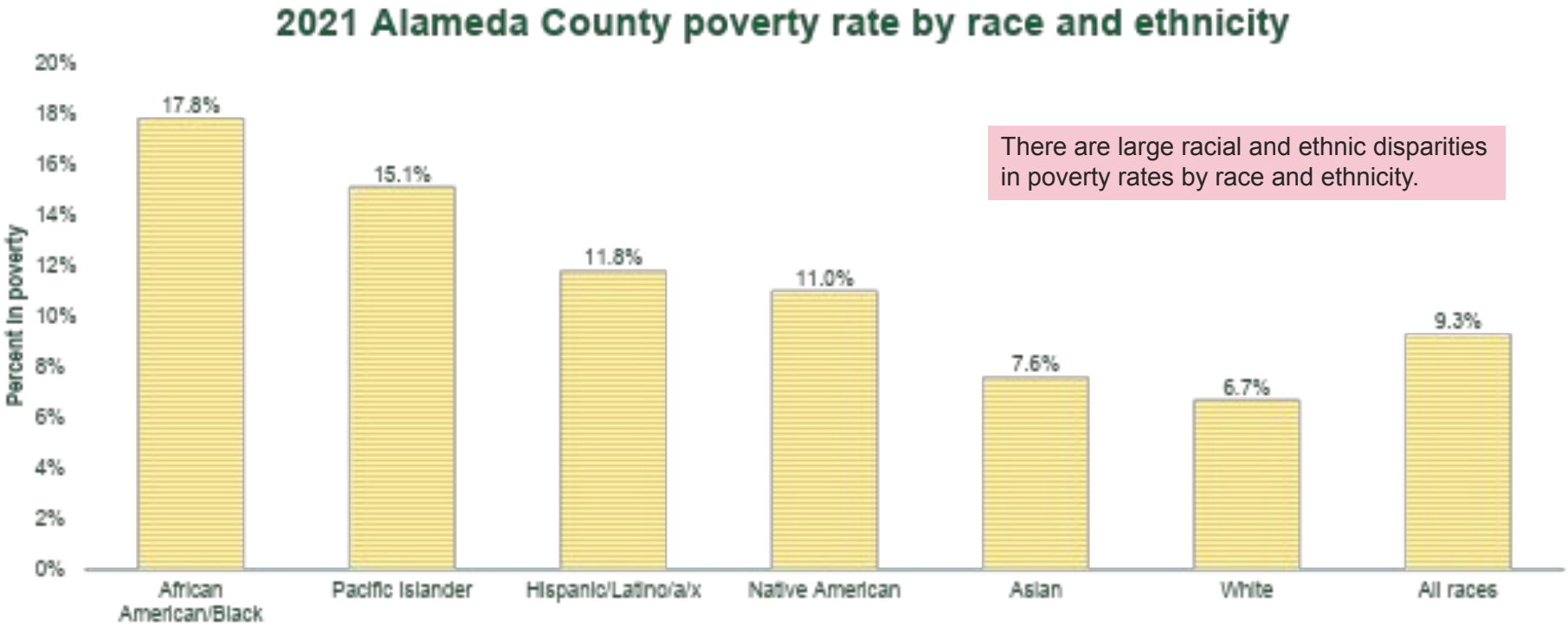
Racial and ethnic inequities in poverty



There are large racial and ethnic disparities in poverty rates by race and ethnicity.

Source: American Community Survey (ACS)
Notes: The ACS does not break out the races mutually exclusive of Hispanic/Latino/a/x except for White.

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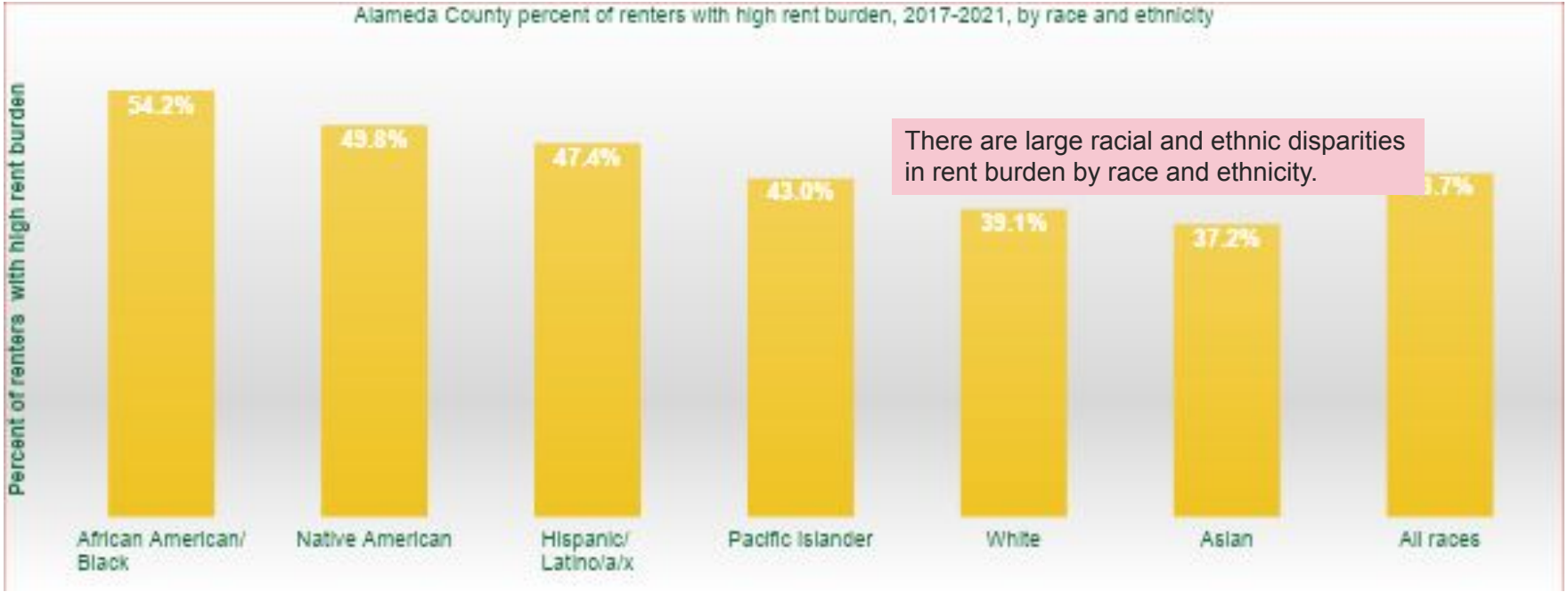
Racial and ethnic inequities in rent burden



There are large racial and ethnic disparities in rent burden by race and ethnicity.

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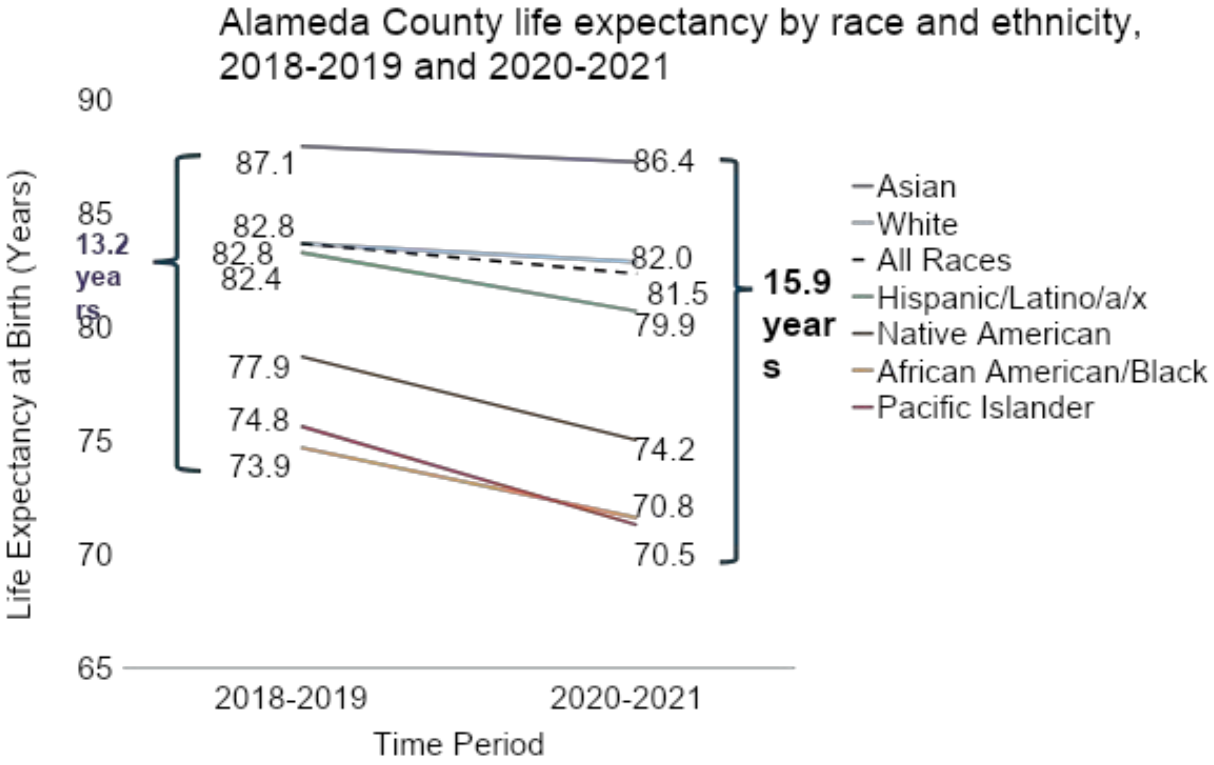
Already large racial and ethnic disparities in life expectancy in Alameda County grew worse in 2020-2021



The already-large gap in life expectancy by race and ethnicity grew from 13.2 years in 2018-2019 to 15.9 years in 2020-2021

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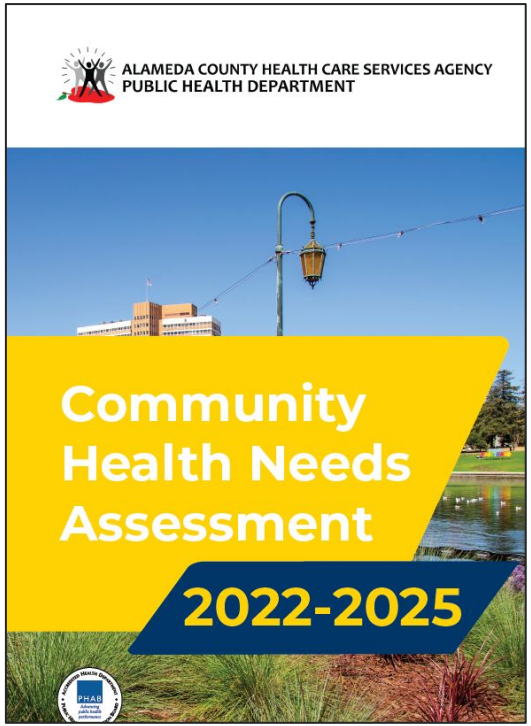
Community Health Needs Assessment (CHNA) & Community Health Improvement Plan (CHIP)

2022-2025

Public Health Accreditation Foundational Plans



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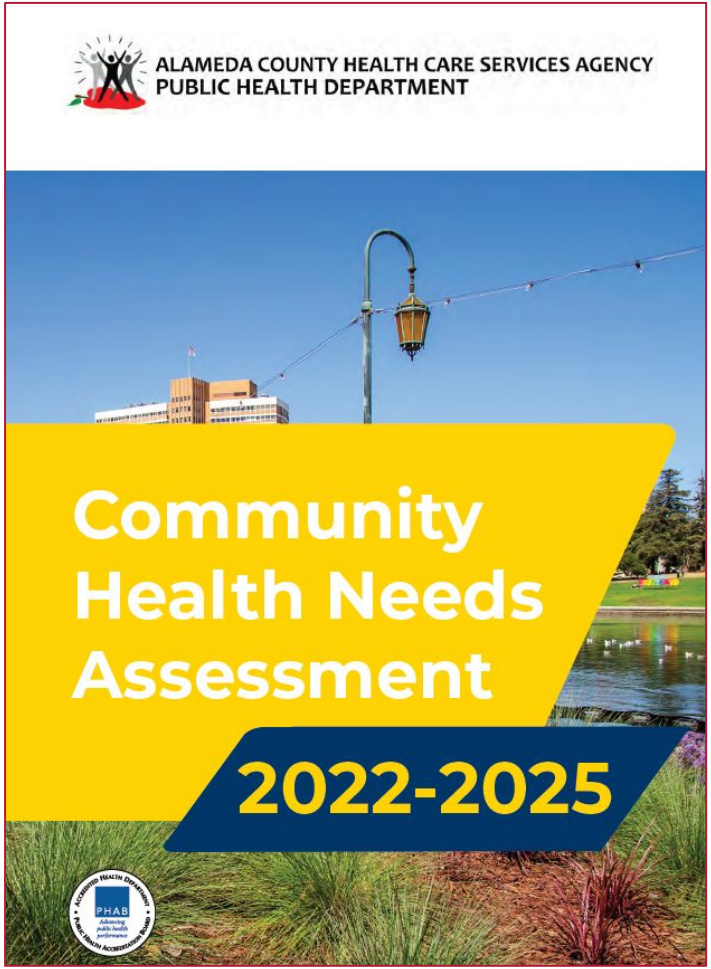

The CHNA takes a comprehensive look at the health of Alameda County residents by studying a combination of the social determinants of health and specific health outcomes of individuals, neighborhoods, and populations.

https://acphd-web-media.s3-us-west-2.amazonaws.com/media/programs-services/chip/docs/chna-2022-25.pdf

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Ongoing CHNA & CHIP Partners 2024-2027

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What is a Community Health Improvement Plan?

"An action-oriented plan for addressing the most significant health issues identified by community partners based on quantitative and qualitative data for a given community*."

The CHIP builds upon the Community Health Needs Assessment (CHNA) by addressing Countywide prioritized health needs.

*Healthy Marin Partnership: A Community Health Improvement Plan. Accessed April 21, 2023 https://acphd-web-media.s3-us-west-2.amazonaws.com/media/programs-services/chip/docs/community-health-improvement-plan-2023-25.pdf

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CHIP SIGNATURE PROGRAMS 2024
WOMEN INFANT AND CHILDREN (WIC)
Results Addressed:
Access to care
Food security
Economic Security
Peaceful families
Premature child death
SEXUAL AND REPRODUCTIVE HEALTH
Results Addressed:
Access to care
Economic security
Premature death
IMMUNIZATION
Results Addressed:
Early Access to Care
Prevention services
Screening
Economic security
Premature death
FRONT DOOR
Results addressed:
Access to care
Economic security
Peaceful families and communities
EMBRACEHER
Results Addressed:
Access to early care
Mental health
Economic security
Peaceful families
OFFICE OF VIOLENCE PREVENTION
Results addressed:
Economic security
Peaceful families and communities

CHIP Community Advisory Board

- The community/resident-led advisory board will inform, provide context, and validate the CHIP strategies
- Unaffiliated residents are prioritized participants
- Advisory Board recruitment begins Fall 2024 with anticipated launch in early 2025

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CHNA & CHIP Timeline for 2024-2027 Cycle

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About Us

Who We Are

- The Alliance is a local, public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to Alameda County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

Mission

- Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

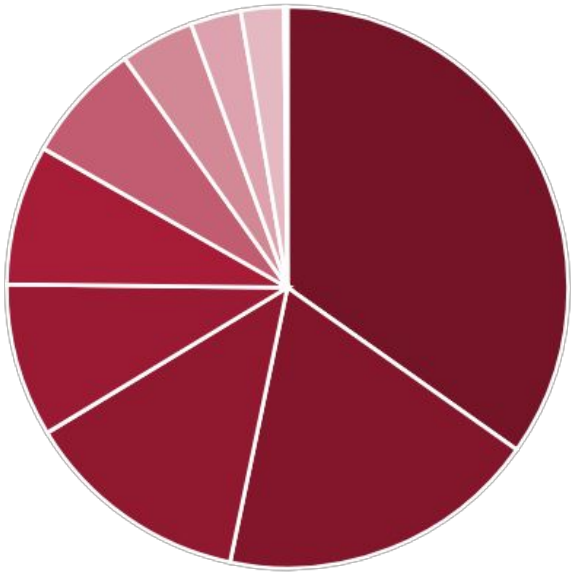
Vision

- All residents of Alameda County will achieve optimal health and well-being at every stage of life.

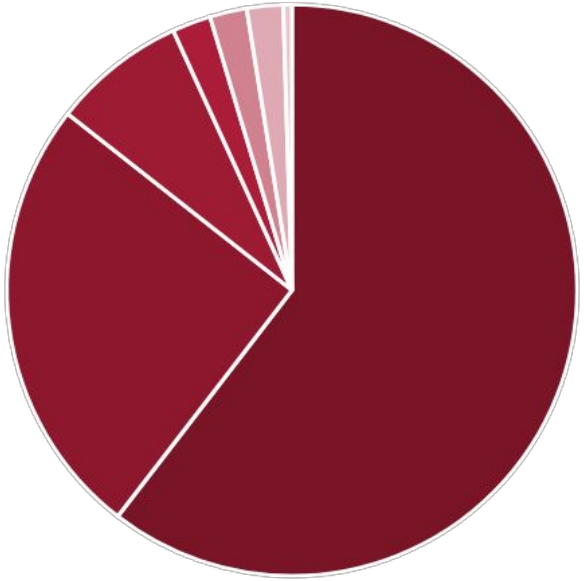
Our Members - August 2024

- Medi-Cal - 400,849
- Group Care (IHSS) - 5,685 Group Care

Members by Ethnic Group



Members by Primary Language



What Is Population Health Management (PHM)?

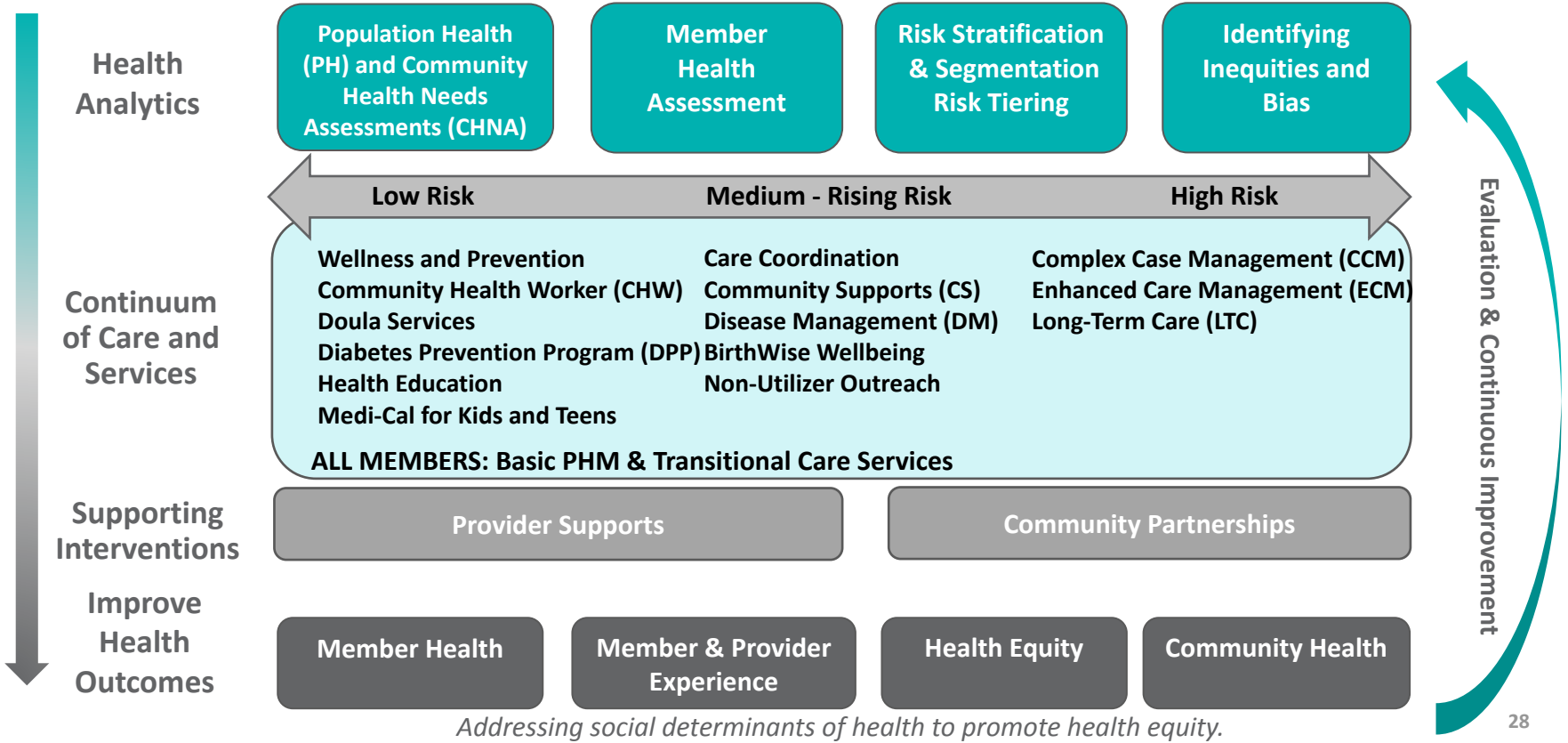
- Population Health Management (PHM) means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized screening, assessment processes, and holistic care/case management interventions.

  - Department of Healthcare Services

The Alliance PHM Program

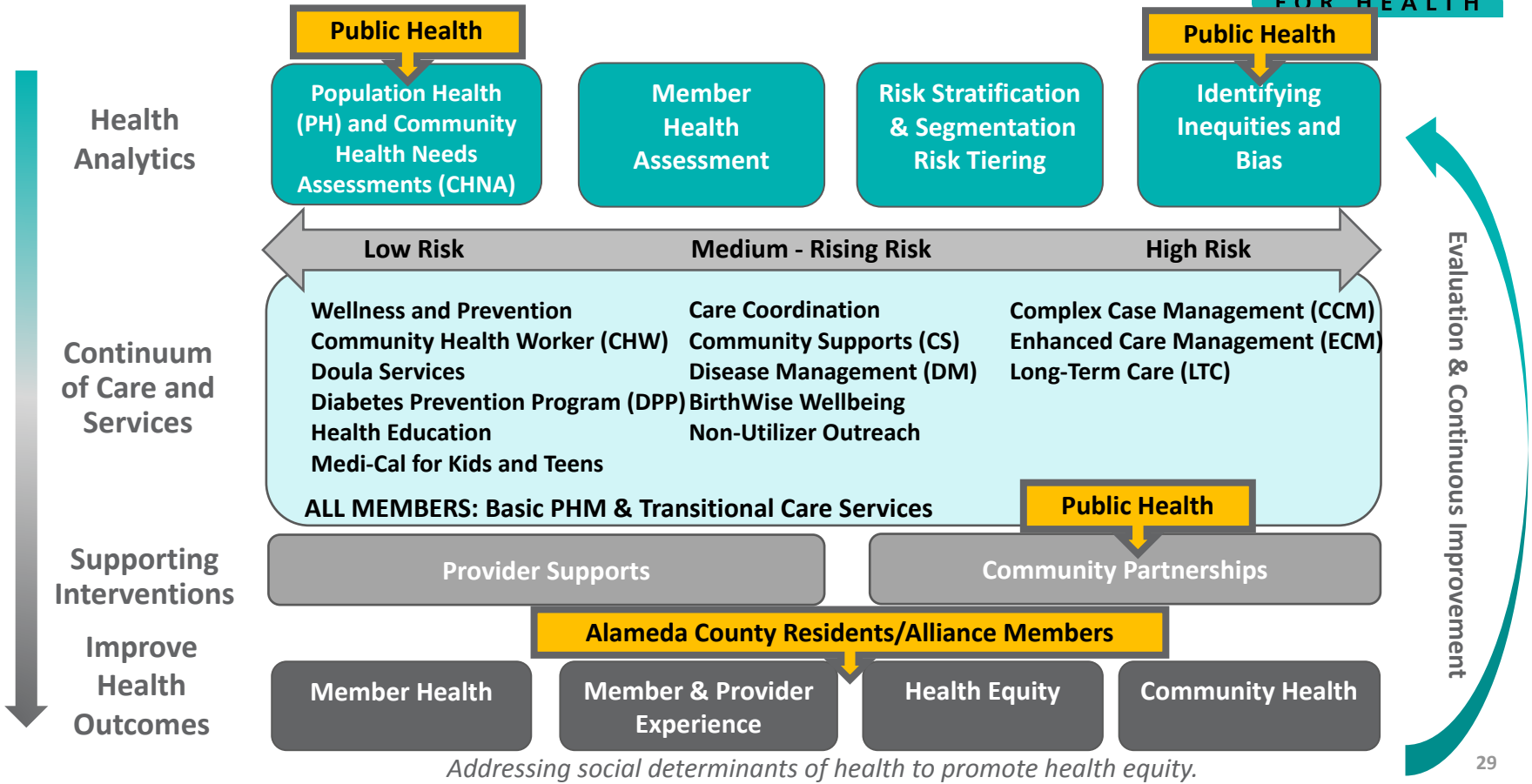
- Our Aim
  - Optimal health and well-being for all members.
- The need
  - Not all members need the same care or receive the care they need when they need it. Health care inequities exist in our current health delivery system that are rooted in historical and systemic racism.
- The PHM solution
  - Understanding Alliance members through assessment and identifying groups of members at risk and those receiving inequitable care.
  - Providing targeted, equitable access to necessary wellness and prevention services, care coordination, and care management programs.
  - Collaborating with providers and community partners.
  - Desired outcome: Improving health and equity for Alliance members and our community.

The Alliance PHM Framework



Addressing social determinants of health to promote health equity.

The Alliance PHM Framework cont.



Addressing social determinants of health to promote health equity.

2024 PHM Strategy

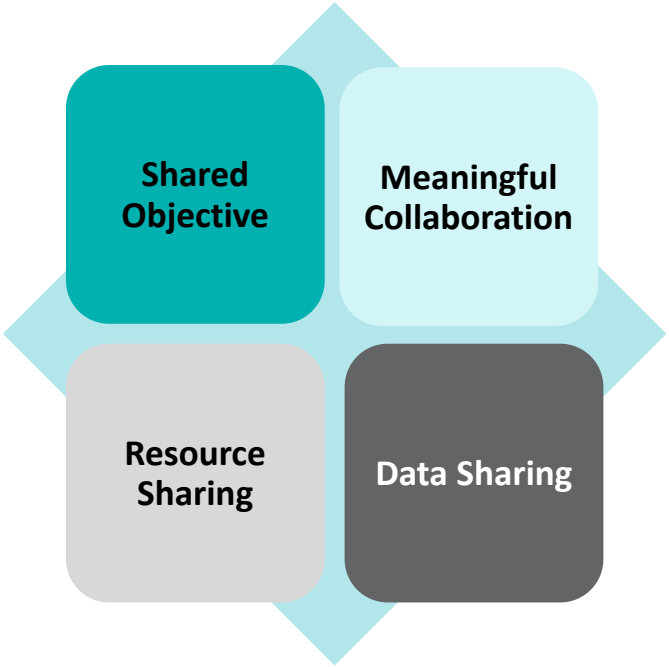
Strategic Pillars	2024 Programs
Address primary care gaps and inequities	• Non-utilizer outreach campaigns • Breast cancer screening – Equity • Under 30 months well-visits – Equity
 **Support members managing health conditions**	• Multiple Chronic Disease Management • Diabetes Prevention Program (DPP) • Post ED Visit for Mental Illness
 **Connect members in need to whole person care**	• **BirthWise Wellbeing – Equity** • Complex Case Management (CCM) • Transitional Care Services (TCS)

Shared Objective

Low Risk → Medium-Rising → High Risk

Alliance – ACPHD Collaboration Meaningful Participation

- Shared objective
  - Increase access and engagement with doula services for Black Medi-Cal members.
- Meaningful collaboration
  - ACPHD CHIP workgroups; CHNA steering committee
  - Alliance Community Advisory Committee (CAC)
- Plan to offer financial and or staffing resources to support ACPHD and/or CHIP
- Bilateral data sharing to support ACPHD CHNA and Plan Population Health Assessment
- Timeline alignment – by Saturday, June 30, 2029



ACPHD – Alliance Collaboration Lessons Learned

- Strong, experienced partners
  - ACPHD – CHNA and CHIP established processes
  - Alliance – PHM
- Regular communication to keep work moving forward
  - Monthly meetings
  - Invite to other's meetings
  - Single point of contact
- Sharing methodologies

For more information on the Alliance PHM Program, please contact:

Linda Ayala, MA, MPH

Director, Population Health & Equity

layala@alamedaalliance.org

Getting Connected

Community-Led Health Improvement in Action

CHNA Focus Group Participant Nominations

Identify groups/orgs to recruit participants

- Alameda County threshold languages
- Youth, Older Adults, LGBTQI, Developmentally Disabled, immigrants, API, and other ethnicities, people experiencing housing insecurity
- Each Supervisorial District
- Service Providers

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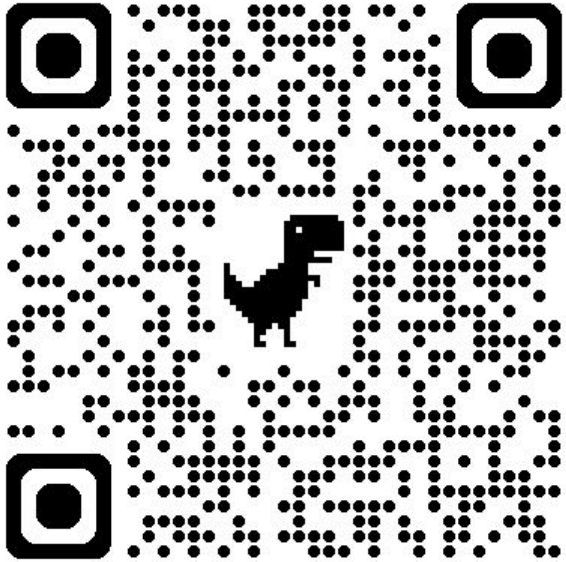
CHIP Workgroup Participation

- Sign up for one or more CHIP Workgroup:

1) Access to Care
2) Economic Security
3) Peaceful Communities and Families

- https://app.smartsheet.com/b/form/990207deb74d4f7086791a0eb8f9357e



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Questions

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Linda Ayala, MA, MPH
Director, Population Health & Equity
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Alameda Alliance Updates

ALAMEDA Alliance FOR HEALTH

Provider Network

- ECM – 9 new potential providers
  - Network Expansion – Go-Live January 1, 2025

- Community Supports – 9 new potential providers
  - New Community Supports – Go-Live January 1, 2025
    - Short-Term Post-Hospitalization Housing
    - Day Habilitation Programs
    - Sobering Centers
  - Network Expansion
    - Asthma Remediation
    - (Caregiver) Respite Services

Provider Network

- Interested in becoming a contracted Provider?
  - Submit Entity Interest Form to: CalAIMinfo@alamedaalliance.org

- Vetting process
  - Review Entity Interest Forms
  - Internal Committee Meeting to finalize list
  - Initial meeting to discuss program alignment

- Preparation to Go-Live
  - Weekly meetings to discuss:
    - Contracting
    - Credentialling, and
    - Provider certification

- Process takes 4-6 months prior to Go-Live
- Continued weekly meetings post-go-live

Thanks!
Questions?

You can contact us at:

For Community Supports:
CSDept@AlamedaAlliance.org

For ECM:
ECM@AlamedaAlliance.org

Enhanced Care Management (ECM) Influencer Pilot

KAISER PERMANENTE®

ECM Outreach Campaign Pilot

To raise community awareness of ECM, and drive ECM referrals, KP is planning a communications approach leveraging a public health communications firm, Public Good Projects, for a trusted messenger campaign.

WHAT?

- Create and leverage a network of local influencers for targeted messaging
- Leverage social media and other methods to communicate about ECM
- Focus messaging on the two of largest populations of focus for ECM, foster youth and birth equity
- Evaluate performance to expand our evidence base

WHY?

- Community-based providers shared feedback via survey and in various external collaborative forums that there is a critical opportunity to drive referrals and enrollments into ECM and CS by fostering community awareness via trusted messengers.
- DHCS expects that the majority of referrals for ECM will come from the community (providers, CBOs, members, etc.)
- Foster Youth and Birth Equity are two of the largest populations of focus

HOW?

- Focus on birth equity statewide
- Target San Bernardino and Sacramento counties for Foster Youth outreach, counties with large numbers of eligible members
- Partner with Public Good Projects and external stakeholders to implement the pilot in Q4 2024- Q1 2025

WHEN?

- September – mid-October: Planning, identifying messengers and message
- November – January: Activate influencers and messaging
- February-March: Evaluation of pilot

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We Want to Hear From You!

Click the link in the chat to join the discussion

1. How do you share information regarding health-related benefits and services with your community members / members?
   - What proves to be the most effective?
   - Have you heard feedback from community members on what they prefer?
2. Who do you see as **local** leaders and organizations working in **birth equity**? Who do you see as **statewide** leaders or voices focused on **birth equity**?
3. How do you currently share information on ECM, CS, CHW?
   - What has worked?
   - What is difficult about the process?

Follow-up: If your organization works with birth equity populations and is interested in engaging more deeply, KP alongside our partners at PGP are offering an opportunity for a 30-minute virtual call to provide guidance for communication materials around ECM/CS/CHW benefits, reach out to KP.

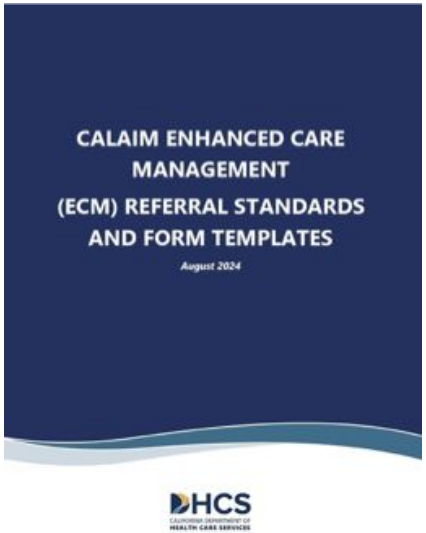
Note: there is not compensation associated with this conversation.

New Statewide Policy Updates

- ECM Referral Standards and Form
- Presumptive Authorization
- Transitional Rent

DHCS Update: Referral Standards and Form

DHCS developed new ECM Referral Standards and Form Template to streamline and standardize ECM Referrals made to Managed Care Plans (MCPs) from providers, community-based organizations, and other entities.



The new ECM Referral Standards define the information that MCPs are expected to collect for Medi-Cal members being referred to an MCP for ECM.

The new **ECM Referral Form Templates** are forms for use by MCPs and referring organizations that prefer a PDF or hard copy form to make a referral.

DHCS Update: Referral Standards and Form

The ECM Referral Standards and Form Templates define the following:

- Medi-Cal Member Information
- Referral Source Information
- Eligibility Criteria for Adults and Children/Youth
- Enrollment In Other Programs
- Referral Transmission Methods – including guidance encouraging batch referrals

***Note: The ECM Referral Standards will not change the existing processes for the MIF and RTF.**

DHCS Update: Referral Standards and Form

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» **Effective January 1, 2025:**

- All ECM Referrals **must** follow the guidelines established in the ECM Referral Standards *regardless* of referral modality (electronic, EMR, hard copy, etc.).
- MCPs choose **which** referral modalities (electronic, EMR, hard copy, etc.) they want to deploy in the community. Electronic referrals are encouraged.
- MCPs **may not** require additional documentation (e.g., ICD-10 codes, supplemental checklists, Treatment Authorization Request (TAR) forms) from referring partners or ECM Providers beyond the information in the ECM referral.
- DHCS expects that many MCPs will embed the referral standards into their existing provider portals but may also offer other electronic referral pathways.

New ECM Presumptive Authorization Requirements

Overview: ECM Presumptive Authorization

Starting on Jan. 1st 2025, select ECM Providers will be able to quickly initiate ECM services *prior to submitting an ECM referral to an MCP* and be reimbursed for services during a 30-day timeframe.

» **What ECM Presumptive Authorization IS:**

- **Select ECM Providers will be able to directly authorize ECM for Medi-Cal Members in select POFs they serve and be paid for ECM services for a 30-day timeframe** until the MCP communicates the authorization or denial of ECM based on a complete assessment of Member eligibility for ECM.
- ECM Providers under presumptive authorization will still check for Member eligibility and submit an ECM referral to the MCP within the 30-day timeframe to receive the full, 12-month ECM authorization.

» **What presumptive authorization is NOT:**

- ECM presumptive authorization is different from *"presumptive eligibility"* policies for Medi-Cal coverage that allow special populations to more rapidly access Medi-Cal insurance (children, pregnant individuals, individuals experiencing homelessness).
- ECM presumptive authorization is different from *"retrospective authorization"* in which MCPs pay for ECM services provided in the past, but only if a Member is ultimately authorized for ECM.

The ECM Presumptive Authorization Policy is included beginning on page 107 in the August 2024 version of the ECM Policy Guide.

Presumptive Authorization: POFs and Providers

Column 1: ECM Population of Focus	Column 2: ECM Providers That Can Serve Members Through Presumptive Authorization
1) Adults & Children Experiencing Homelessness	• Street Medicine Providers • Community Supports Providers of the Housing Trio Services: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services • County-contracted and County-operated Specialty Behavioral Health Providers
2) Adults & Children At Risk for Avoidable Hospital or ED Utilization	• Primary Care Provider practices (including Federally Qualified Health Centers (FQHCs), County-operated primary care, and other primary care)
3) Adults & Children with SMI/SUD Needs	• County-contracted and County-operated Specialty Behavioral Health Providers
4) Adults & Children Transitioning from Incarceration	• Existing DHCS guidance governs authorizations and warm handoffs to support Members receiving pre-release services in the JI POF. See Section 13.3.d of the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative for details.
5) Adults Living in the Community and At Risk for LTC Institutionalization	• California Community Transitions (CCT) Lead Organizations • Community Supports Providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
6) Adult SNF Residents Transitioning to the Community	• California Community Transitions (CCT) Lead Organizations • Community Supports Providers of Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
7) Children & Youth Enrolled in CCS/CCS WCM	• CCS Paneled Providers and Local Health Department CCS Programs
8) Children & Youth Involved in Child Welfare	• County-contracted and County-operated Specialty Behavioral Health Providers • High Fidelity Wraparound Providers • Health Care Program for Children in Foster Care Providers • Department of Social Services (DSS) Offices • Foster Family Agencies • Transitional Housing Programs Current and Former Foster Youth • Children's Crisis Residential Programs
9) Birth Equity Population of Focus	• OB/GYN Practices • Midwifery Practices • Entities that deliver the following services: Entities that deliver the following services: Black Infant Health (BIH) Program, Perinatal Equity Initiative (PEI), Indian Health Program, American Indian Maternal Support Services (AIMSS)

MCP Payment and ECM Presumptive Authorization

ECM Presumptive Authorization Reimbursement

Start of Payment: MCPs must allow network ECM Providers under presumptive authorization to start billing and be reimbursed for ECM services from the date the Member first receives ECM services.

Timeframe for MCP Payment: 30 days or up to the date the MCP communicates the authorization decision to the ECM Provider, whichever is sooner.

Does payment occur if a MCP does not authorize ECM for a Member after the presumptive authorization timeframe because the Member is enrolled in an overlapping program or plan (1915c waiver, D-SNP, etc.)?

Answer: The MCP must still reimburse for services delivered during the presumptive authorization timeframe for Members who are later denied for the full, 12-month ECM authorization due to enrollment in programs that may overlap with ECM.

ECM Payment and Presumptive Authorization

Exceptions to MCP Payment
In the Presumptive Authorization Timeframe

» If the Member has an **existing, open ECM authorization** with another ECM Provider, the MCP is not required to reimburse for services delivered in the presumptive authorization period. DHCS allows for this exception in MCP payment to limit instances of payment for duplicative services.

»If the individual is **not an active Member** of the MCP during the dates of ECM service delivery.

MCP Provider Portal Active ECM Authorizations
Required by January 1, 2025:

To reduce the risk that ECM Providers are not reimbursed for services due to an existing ECM authorization, MCPs must make Members' ECM authorization statuses accessible to ECM Providers via their Plan Portal or similar online system by January 1, 2025.

Upcoming Webinar on ECM Referrals and Presumptive Authorization

Upcoming Meetings/Webinars

All Comer Webinar on ECM Referral Standards and Presumptive Authorization Guidance

» Wed. Oct. 9th from 11AM–12PM PT (*registration forthcoming*)

Recommended audience: Providers, community referral partners, and MCPs

Transitional Rent Concept Paper

DHCS

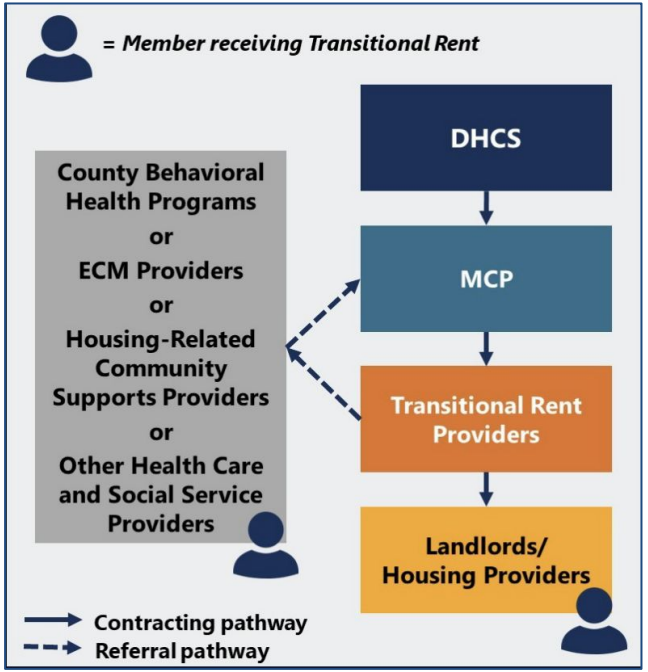
DHCS Vision for Transitional Rent

- DHCS has applied to CMS for waiver approval of up to 6 months of Transitional Rent.
- **Transitional Rent builds on existing initiatives** that help address members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care.
- Transitional Rent is designed to:
  - Help a member **exit homelessness and establish a bridge to permanent housing**.
  - **Prevent and address the adverse health outcomes** that result from homelessness.
  - **Improve overall health outcomes** that have been shown to result from stable housing.

Transitional Rent

- MCP Coverage of Transitional Rent will be:
  - **Optional** beginning **on January 1, 2025**
  - **Mandatory** for all plans to offer **on January 1, 2026**.
- Provides rental payment assistance for **up to 6 months** (can be non continuous)
- Eligibility criteria
  - Clinical risk factors;
  - Experiencing or at risk of homelessness; AND,
  - Transitioning population, unsheltered, or Full Service Partnership (FSP) Eligible

Comment period extended to Tuesday, Sept. 24



Resource Updates

- ECM and Community Supports Provider List
- PATHways to Success
- Upcoming Trainings
- Senior Wellness Fairs

Check out the ECM and CS Provider List!

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CalAIM PATH Care Coordination Provider List
ECM and Community Supports Providers
March 2024

Community Supports Providers: Quick Reference

	Alameda Alliance	Kaiser
Asthma Remediation		
• Alameda County Public Health ASTHMA START	X	
• Breathe California		X
• Evolve Emod		X
• Roots Community Health Center	X	
Community Transition Services/Facility Transition to Home		
• East Bay Innovations	X	
• Independent Living Systems		X
• Omatochi	X	
• Serene Health		X
• Star Nursing		X
Day Habilitation Programs		
• Serene Health		X
Environmental Accessibility Adaptations (Home Modifications)		
• Assured Independence		X
• Connect America West		X
• Lifeline Systems Company		X
• LifewiseCHM		X
• East Bay Innovations	X	

	EAST BAY INNOVATIONS
About	East Bay Innovations (EBI) is a private non-profit organization providing services to people throughout Alameda County. EBI offers a variety of services supporting more than 500 individuals with disabilities to live as independently as possible in their own homes, to be successfully employed, and to feel a sense of membership in their community.
Location	2450 Washington Avenue, Suite 240 San Leandro, CA 94577
Website	https://www.eastbayinnovations.org/
Main Line	510.618.1580
Provider Type	Enhanced Care Management
Population of Focus	Adults At Risk for Hospital or ED Utilization |Adults/Families experiencing Homelessness | Adults At Risk for LTC Institutionalization | Adult SNF Residents Transitioning to the Community

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Available now: Sortable Provider List Spreadsheet

Provider *(See the Provider List on our website for detailed information)*	MCP CONTRACT		ECM		
	Is this provider contracted with Alameda Alliance for Health (AAH)?	Is this provider contracted with Kaiser Permanente (KP)?	Does this provider offer ECM for Children/Youth?	Does this provider offer ECM for Adults?	Does this provider offer CS?
24 Hour Home Care	x				x
AAT Home Placement Agency		x			
A Better Way, Inc.		x	x		
Accentcare of California		x			x
Agape Village		x	x		
Alameda County Behavioral Health Care Services	x			x	
Alameda County Behavioral Health, Eastmont Health Center	x			x	
Alameda County Community Food Bank	x				x
Alameda County Health Care Services	x				x
Alameda County Public Health (Asthma Start)	x		x		x
Alameda County Public Health, California Children's Services (CCS)	x		x		
Alameda County Recipe4Health	x				x
Alameda Family Services	x	x	x		
Alameda Health System	x			x	
Alameda Health System, Eastmont Wellness	x			x	
Alameda Health System, Hayward Wellness	x			x	
Alameda Health System, Highland Wellness	x			x	
Alegrecare		x			x
Alternative Family Services	x		x		
Amity Foundation		x		x	

DHCS | SUCCESS

CA Path Home

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

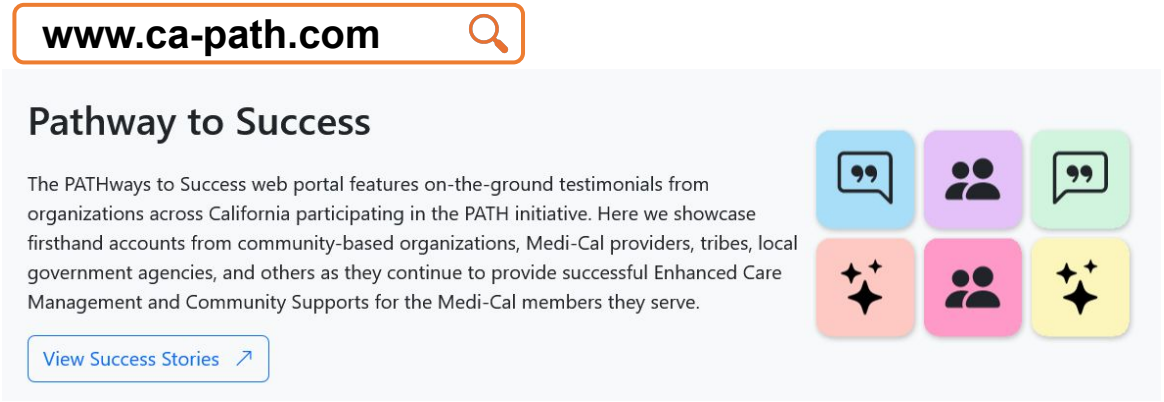
View All Success Stories

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.



Does your organization have a PATH success story to share?

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

Upcoming Trainings from TDU

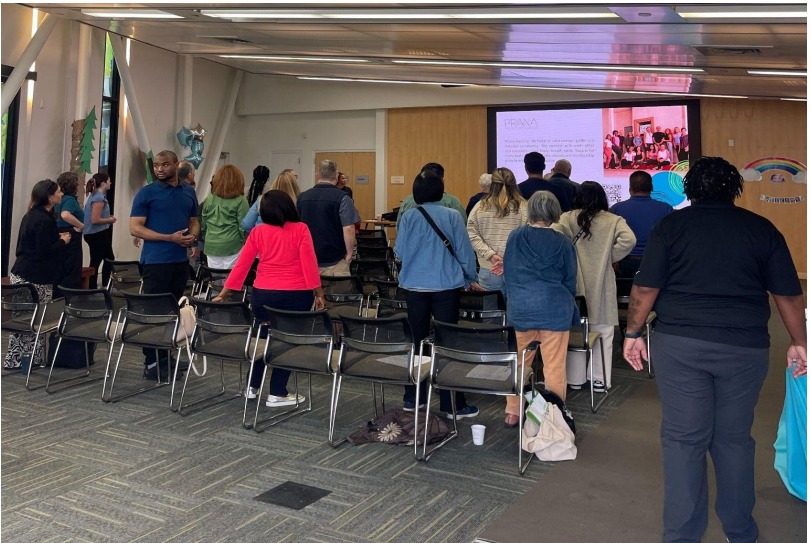
Dates	Location	Topic
10/1	Zoom	Using a Trauma-Informed Approach
10/8 - 10/9	Zoom	Motivational Interviewing
11/12 - 11/13	In-Person	New Hire Academy

Omatochi

Senior Wellness Fair: San Lorenzo

August 24, 2024, 11am - 1pm

BluePath HEALTH



Agenda & Speakers

- Welcome by Omatochi Team and Resource Fair
- LMBe Solutions on Internet Safety for Seniors
- Candidly Speaking
- Prana Yoga presents Movement Activity
- Financial Abuse Awareness
- Parkinson's Foundation
- Medi-Cal and CalAIM presented by Ellen Badley of BluePath Health
- Alameda Alliance
- Resource Fair and Lunch

Event Highlights

- More than 50 attendees
- Excellent support from partners
- The speakers were diverse and representative of the community
- Wide variety of exhibitor tables
- High level of participant engagement
- Great venue with plenty of space, proper seating, AV equipment, free parking, and helpful staff
- Attendees expressed interest in returning.
- Positive feedback from providers collected via follow-up survey
- Improvements for next time:
    - Reduce transition times between activities
    - Incorporate tabling in lunch break

More than 20 partners participated in the event by tabling, presenting, and sponsoring

- 24hr Care
- Alameda Alliance for Health
- Alameda County Community Food Bank
- Anupam: Tech focus group
- BluePath Health
- Balance Financial Empowerment
- California Department of Financial Protection & Innovation
- Candidly Speaking
- Enyi Health
- Institute on Aging
- Journey Health
- Kaiser Permanente
- MomsMeals
- MedZed
- Omatochi
- Parkinson's Foundation
- Safeway
- Sage Surver
- Senior Internet safety
- Urban League
- Yoga practitioner

Senior Wellness Fair

October 19, 2024 | Saturday

San Francisco Bay University | 11 am- 1 pm

Omatochi

BluePath HEALTH

Events Details

Location: San Francisco Bay University
Date: Oct. 19, 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.
- Medi-Cal Education: Educating seniors and their families on their benefits through CalAIM.

Day-Of-Details

Sections

- 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.
- TBD: Yoga, Cooking class, Band, Etc.?

Education

- 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

Senior Wellness Fair

Enhancing the wellness journey for our fabulous seniors!

Why Participate?

The Fair offers your organization the chance to:

- **Support Seniors' Health & Well Being:** Provide essential health services and resources.
- **Boost Community Engagement:** Foster social connections and promote your services.
- **Showcase Your Commitment:** Highlight your dedication to senior well-being.
- **Collaborate:** Network with other organizations and partners.

Join us in making a significant impact on the health and happiness of our senior community!
Your participation can inspire others and contribute to a healthier, happier community.

For Questions Please Contact:

Omatochi
Kiley.giebel@omatochi.com

BluePath Health
lauren.jacobson@bluepathhealth.com

Please Sign Up

Next meeting:

October 18, 10am - 12pm

In-person, Register here:

https://forms.gle/TeKSDXxADMH3hZpL7

See you for the 3rd Friday mornings each month in 2024!

Thank you for attending!

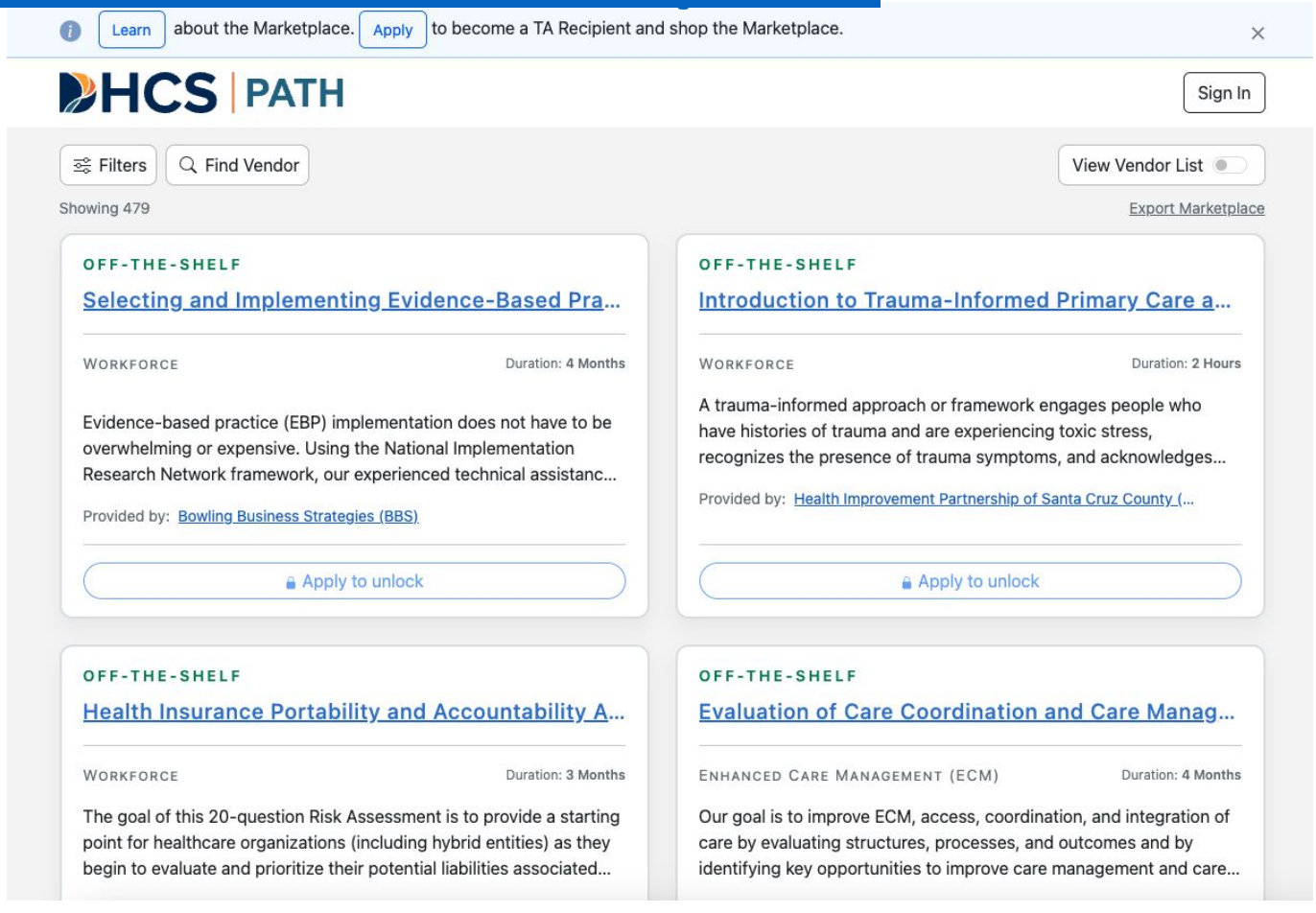
DHCS | PATH

Providing Access & Transforming Health

BluePath HEALTH

Appendix

Check out the TA Marketplace!



2024 Collaborative Aims and Objectives

BluePath HEALTH