

Alameda CalAIM PATH Collaborative

March 15, 2024

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

Today's Agenda

#	Agenda Topic	Approximate Time
1.	<i>Welcome</i>	5 minutes
2.	<i>Follow-ups from February meeting</i>	5 minutes
3.	<i>New Resource: DHCS PoF Spotlight on ECM For Individuals Experiencing Homelessness</i>	5 minutes
4.	<i>ECM and Community Supports for Individuals Experiencing Homelessness in Alameda County</i>	60 minutes
5.	<i>MCP Updates</i>	20 minutes
6.	<i>Update on Resources and Events</i>	10 minutes
7.	<i>Quick Feedback: Ideas for April In-Person</i>	5 minutes
8.	<i>Optional Office Hours</i>	~30 minutes

CPI Initiative Survey Feedback

Which ECM topics would you like covered in future meetings?	Which CS topics would you like covered in future meetings?
“All things referrals”	“Community-based referral strategies”
“Capacity needs for ECM providers to increase enrollment”	“Care coordination between ECM and CS providers”
“Supporting individuals disproportionately at risk for homelessness based on race/ethnicity”	“Keeping homeless members better engaged”

2024 Aim & Priority Objectives



Aim Statement: Between January 1, 2024 and December 31, 2024, the Collaborative aims to increase the number of eligible members who are authorized for ECM by 15% and increase the number of Community Supports authorizations by 15%. The Collaborative will also track this progress by PoF.

Priority Objectives:

Build resources and relationships to drive community referrals to ECM and Community Supports

Strengthen ECM and Community Supports provider capacity through tools, job aids, and education

Facilitate relationship building between providers, plans, and referral partners

2/16 Collaborative Meeting: Foster Youth Population Discussion

Follow-ups in progress:

- Inviting MCP Foster Care Liaisons to Collaborative meetings
- Reviewing processes with MCPs for updating authorized caregiver information for foster parents
- Elevating to DHCS that important parent information is not shared with MCPs
- Sharing resources on how different Medi-Cal services for foster youth can be combined

DHCS Spotlight on Children and Youth

Highlights:

- What does ECM delivery look like for children and youth?
- How does it link with other programs, particularly the CHW benefit and dyadic services?
- Example cases/vignettes

Access the resource [here](#)

How Do Children and Youth Access ECM?

Access to ECM can be created in multiple ways.

- » Eligible Members may be referred to the Medi-Cal MCP by a **provider, case manager, or other professional already serving the child or youth.**
 - DHCS expects MCPs to source most ECM referrals in this way. Since children and youth with complex needs are usually already being served by at least one health care or social service delivery system, DHCS expects almost all children and youth to access ECM this way in the first few years of the program.
 - Community-based service providers are encouraged to identify and refer eligible children and youth to their MCPs for ECM, whether or not referring providers are themselves serving as ECM Providers within the MCP contracted network and/or service area.



DHCS Spotlight on Individuals and Families Experiencing Homelessness

Highlights:

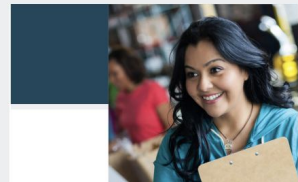
- ECM delivery strategies
- Approaches to outreach and engagement
- Example cases/vignettes

Access the resource [here](#)

Outreach and Engagement for Individuals Experiencing Homelessness

Outreach is an essential—and complex—part of delivering ECM for the Individuals and Families Experiencing Homelessness POF. In order to successfully engage Members in the benefit, ECM Providers must engage with Members in their communities, which can include shelters and public spaces and may be complicated by frequent relocation.

ECM outreach teams may include community health workers (CHWs) and other staff with lived experience of homelessness and/or housing instability, especially for staff supporting field-based outreach and engagement. Moreover, street medicine providers and homeless navigation centers may be well-positioned to conduct outreach and engage with Members who are experiencing



This visual is intended to illustrate how ECM and six housing-focused Community Supports can work in concert to support a Member experiencing homelessness. Members' specific needs will vary, and the availability of specific Community Supports services varies by MCP and county.



ECM Member ...

Begins to receive ECM

Is referred by ECM Provider for recovery-focused, short-term housing

Is referred by ECM Provider to Community Supports Providers who will help them find, secure, and maintain long-term housing

ECM Provider ...

Overall role in supporting Member: Serves as the key point of contact and coordinator across all the Member's clinical and nonclinical support needs, including (but not limited to) the Member's need for secure, safe, stable housing.

To support housing needs specifically: Identifies need and eligibility for services over time, places referrals for Community Supports that provide specialized housing services, and coordinates with Community Supports Providers to ensure seamless delivery of services.

Community Supports Provider ...

Recuperative Care

Provides interim housing, bed, meals, and ongoing monitoring of medical or behavioral health conditions.

Day Habilitation

Provides programmatic support to assist with socialization and adaptive skills.

Short-Term Post Hospitalization Housing

Provides interim housing and ongoing supports needed to support recovery and recuperation.



"Housing Trio"

Housing Transition Navigation Services

Conducts a housing assessment and develops an individualized housing support plan for the Member. Presents housing options to the Member and helps coordinate financial support for security deposits and modifications.

Housing Deposits

Provides funds to establish household and assistance in spending those funds (e.g., deposits, utilities, air conditioner).

Housing Tenancy and Sustaining Services

Provides support with maintaining housing once secured (e.g., identifying and addressing hoarding and other lease violations, education, dispute resolution).



Alameda County **Health Care for the Homeless**

Alameda County Street Health Program Overview

Lucy Kasdin, LCSW, Director Health Care for the Homeless



Alameda County
Health Care Services Agency



Health Care for the Unhoused: Alameda County Challenges

- 9,747 persons experiencing homelessness on one night¹
Unsheltered: 73% (7,135 people)
Sheltered: 27% (2,612 people)
- Large County (740 square miles): both dense urban areas and rural
- Difficult population to engage in health care and building trust takes time





Street Health Program Objectives



Remove barriers to health care services for unhoused Alameda County residents



Prevent deterioration of physical and behavioral health



Appropriate and timely utilization of emergency, inpatient, and crisis health care services



Housing stability through partnership and collaboration with community-based organizations



Increase enrollment in health insurance



Increased income through benefits enrollment and support of disability cases



Services Provided by Street Health



Outreach and Engagement:

- ✓ Trust and rapport building activities
- ✓ Attending to basic needs



Health:

- ✓ Medical assessments and triage
- ✓ Diagnosis and treatment of conditions commonly associated with being homeless
- ✓ Immunizations and health education
- ✓ Health education and linkage to community resources including Behavioral Health and Substance Use services



Housing:

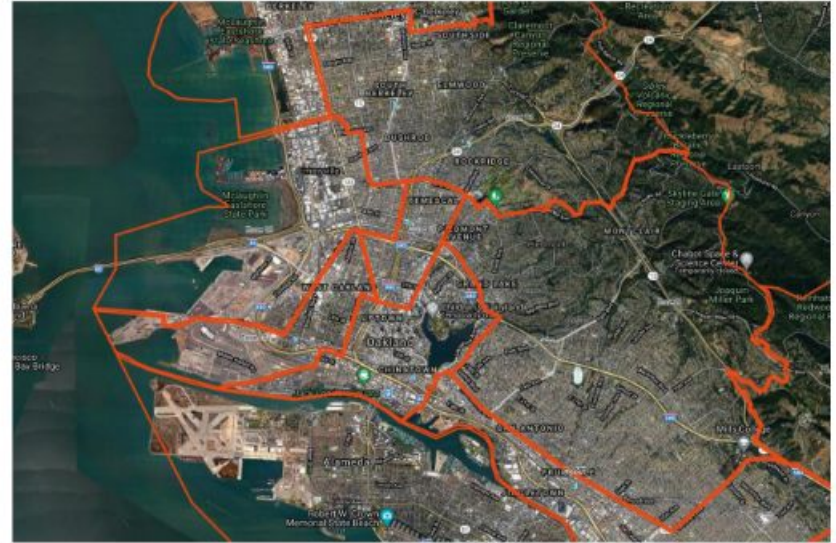
- ✓ Coordinated Entry assessment
- ✓ Housing problem solving
- ✓ Connection to available housing resources: Shelter, Rapid Re-housing, Housing flex funds
- ✓ Housing Navigation, housing focused case management



Alameda County
**Health Care for
the Homeless**

Street Health Team Zones

- Based on best practices for street based medical outreach zones were created, informed by density of unsheltered homeless
- 14 zones were created.
- Each zone has approximately 500 unsheltered individuals.
- Staffing ratio approximately 1:140.
- Geographic model adaptations for urban and rural areas



Interactive map: <https://www.google.com/maps/d/edit?mid=1vA3PCKMf2uCdzBQ00JQZkc9m8VTOvwYt&usp=sharing>

Services	Street Health: Primary Activities Teams of 4: RN, Unlicensed Social Worker, CHW, 0.3 FTE Provider
Street Health Outreach	• Establish relationship (build trust by assisting with needs: hygiene kits, sleeping bags, water, socks) • Provide information on available supports & services • Medi-Cal enrollment and retention • Obtain consent for ECM and/or Health Services
Enhanced Care Management	• Preliminary assessments for program eligibility (housing, Medi-Cal, GA, SSI, CalFresh, etc) • Basic needs screening • Develop care plan • Refer patient to new supports • Provide linkage to new supports and accompany patient to appointment as needed • Support patient with meeting care plan goals
Health Services/Primary Care	• Triage nursing assessment • Preventive care including vaccinations • Wound Care • Chronic disease management • Address communicable disease

*Street Health Teams work as a team; however, this position leads this activity



Clinical Case Study: M.W.

- March 2023: Outreached by ACHCH Street Health team.
 - Enrolled in benefits (health insurance, GA, food stamps)
- April 2023: Referred to Psychiatry. Started on an oral antipsychotic, transitioned to a LAI- provided on the street
 - Referred to Intensive Case Manager
- June 2023: Referred to PCP
 - Treated body lice, coordinated shower, washed clothes
- August 2023: Housed at the Northgate Community Cabins
 - Warm hand-off to an FSP (psychiatry and case management)





2024 Providers

14 Street Health Teams:

More than **25,000 Encounters** annually

Almost **3,000 Patients** seen

Annual cost of approximately \$6 million

Contractor/Provider	Number of Teams	Zone(s) Served*
Bay Area Community Health (BACH)	2	1,2
Tiburcio Vasquez Health Center (TVHC)	3	3,4,5
Roots	2	6,7
LifeLong Medical Care	6	9,10,11,12,13,14

*Zone 8 no current contract



Alameda County
**Health Care for
the Homeless**

Q&A

Questions?



Alameda County
Health Care Services Agency

Housing Community Supports

Housing Navigation

Members who are experiencing homelessness or are at risk of experiencing homelessness can receive help to find, apply for, and secure permanent housing.

Housing Deposits

Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.

Housing Tenancy and Sustaining Services

Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.

Coordinated Entry System and CalAIM

Kimia Pakdaman, Lead CalAIM Coordinator



Continuum of Care (CoC)

- A “Continuum of Care” refers to the planning body in a community that addresses homelessness
 - The CoC Board, known locally as the Leadership Board, makes decisions on behalf of this planning body
- The CoC Board collaborates with the following entities to complete its duties:
 - Homeless Management Information System (HMIS) Administrator
 - Collaborative Applicant
 - Coordinated Entry Management Entity
 - Policy & Planning Entity



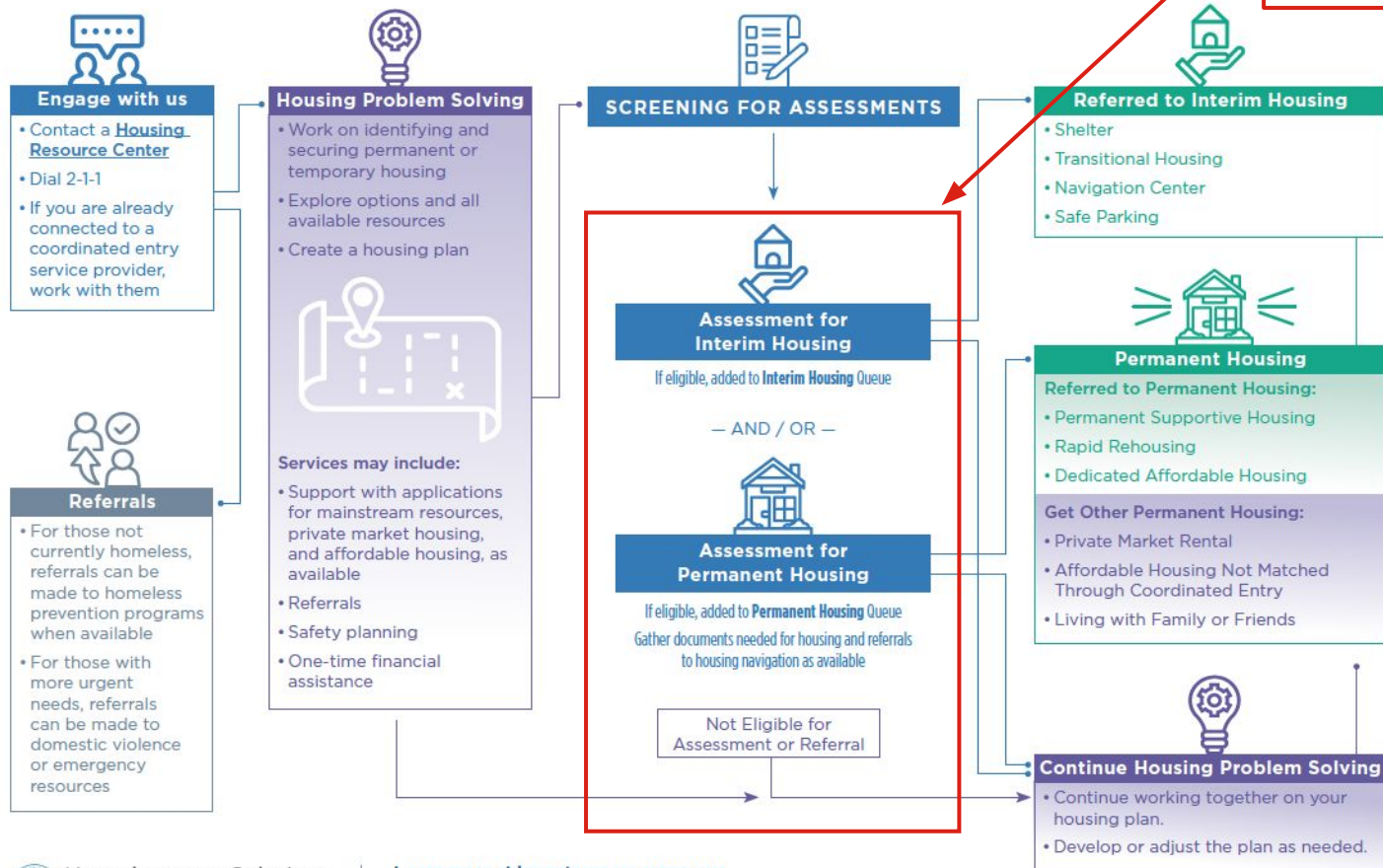
What is the Coordinated Entry System?

- Coordinated Entry – The Coordinated Entry process is an approach to coordination and management of the crisis response system's resources that allows users to make equity consistent decisions from available information to connect people efficiently and effectively to interventions that will end their homelessness.
- The Coordinated Entry System includes:
 - Points of access to resources for people experiencing homelessness
 - Housing Problem Solving
 - Assessment
 - Prioritization for available resources
 - Referral/Matching to Housing/Homelessness Resources
 - Grievance processes



FROM HOMELESSNESS TO HOUSING

Alameda County Coordinated Entry Workflow



Homelessness Solutions
in Alameda County

Learn more at homelessness.acgov.org
If you are looking for housing or services,
please call 2-1-1

Alameda County Coordinated Entry and CalAIM Community Supports

- Alameda County's Office of Homeless Care and Coordination (OHCC) is the hub or administrator of the three CalAIM Housing Community Supports:
 - Housing Navigation
 - Housing Deposits
 - Tenancy and Sustaining Services
- OHCC works with the Managed Care Plans to identify Community Support-eligible individuals and match them with available resources using the Coordinated Entry System



Alameda County Coordinated Entry and CalAIM Community Supports

- OHCC subcontracts with the following organizations/entities to deliver the 3 Housing Community Support services:

Abode	Housing Consortium of the East Bay
Bay Area Community Services	Insight Housing
Building Futures	La Familia
Building Opportunities for Self-Sufficiency	Lifelong
City of Fremont	LifeSTEPS
Covenant House	Roots
East Bay Innovations	St. Mary's Center
East Oakland Community Project	Tiburcio
Five Keys	Women's Daytime Drop-in Center
Fred Finch	<i>two more orgs to be added in 2024</i>





PRESENTATION TO ALAMEDA CAL AIM PATH COLLABORATIVE 3.15.24





Connecting people to hope, 24/7. Multilingual staff assess callers' needs and give referrals from databases of over 2,500 human service programs and 78,000 housing units. Proactive outreach. Critical role in disaster.

Two-way texting 898-211 available
Monday-Friday 9:00am – 4:00 pm

211 ALAMEDA COUNTY

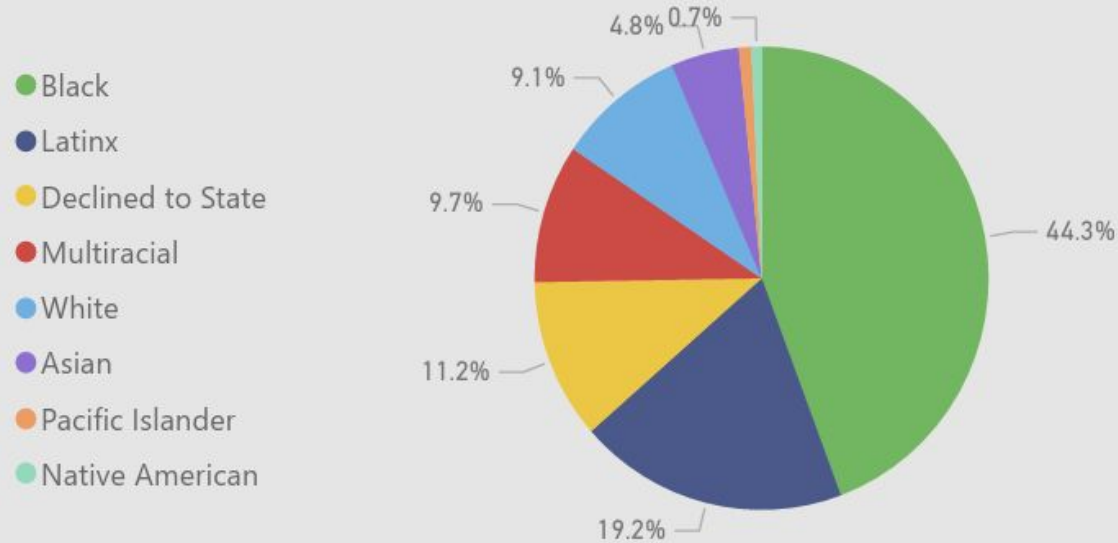
FY 22/23

- 69,660 total contacts
- 113,161 total referrals
- 70% Female
- 51% Living with a Disability
- 26% Single Mothers with Minor Children
- 17% Older Adults
- 99% Low, Very Low, Extremely Low Income



211 STATS

Number of Calls Displayed as a Percentage, by Race



211 STATS

- Housing/Shelter
- Utilities
- Material Goods
- Food
- Legal Services
- Health Supportive Services
- Disaster Services
- Mental Health Assessment & Treatment
- Public Assistance Programs
- Substance Use Disorder Services



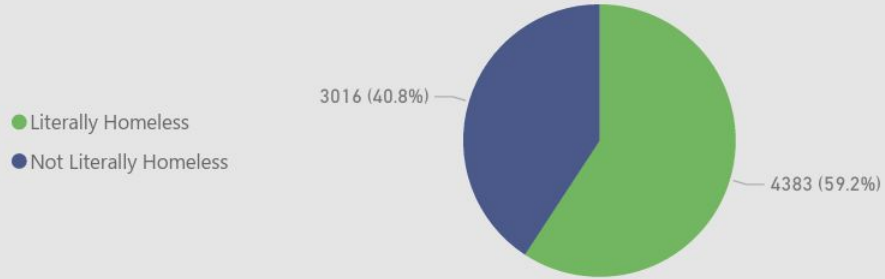
TOP NEEDS

Coordinated Entry System

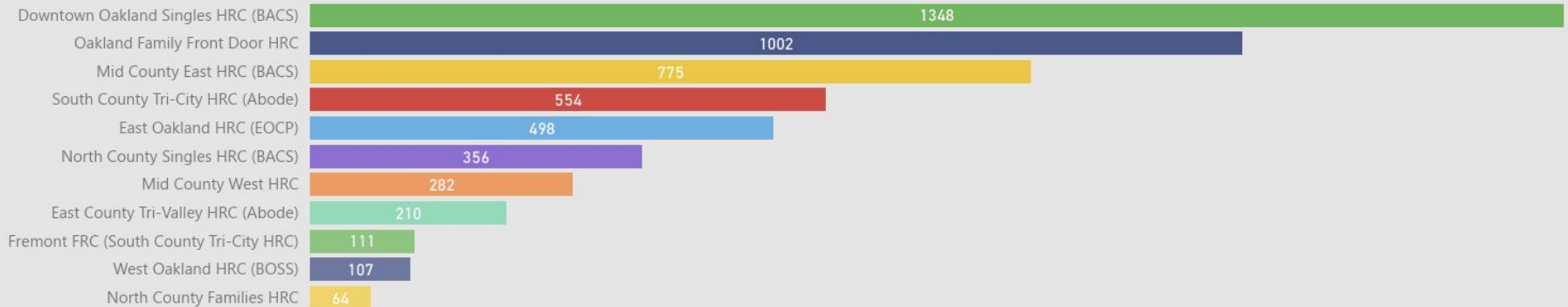
- 211 often the entry point
- Staff determine LH/NLH status
- Transfer LH callers to one of the other access points
- Housing problem solving
- Average length of CES calls: 9 min 34 sec vs. average length of other 211 calls: 6 min 57 seconds

FY 22/23

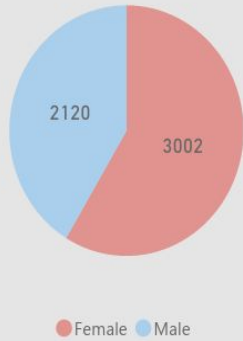
Number of Calls, Screened for CES



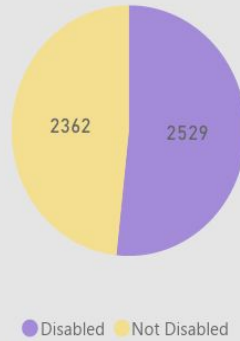
Number of Referrals Made to HRC



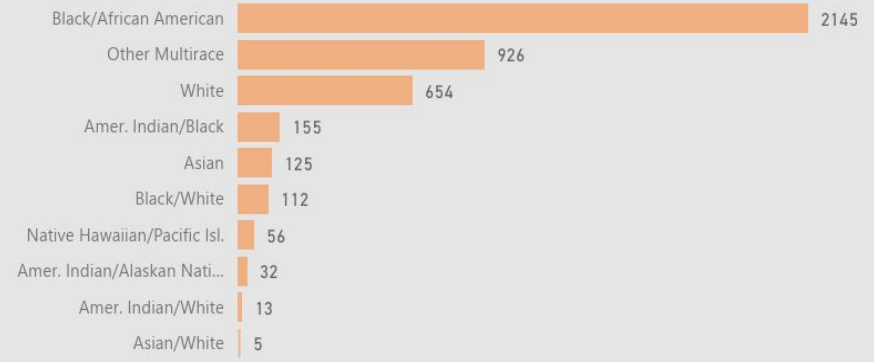
HRC Referrals by Gender



HRC Referrals by Disability



HRC Referrals by Ethnicity



Thank you!

Alison DeJung
Executive Director
adejung@edenir.org
510-537-2710 x 514

Recuperative Care (Medical Respite)

Members with unstable housing who no longer require hospitalization, but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.

Contracted Recuperative Care Providers

Alameda Alliance



CARDEA  HEALTH



Kaiser Permanente



CARDEA  HEALTH



Medical R E S P I T E

23950 Mission Boulevard

Hayward, CA 94544

510-759-4289 Fax: 888-411-4043

Team-Respite @bayareacs.org

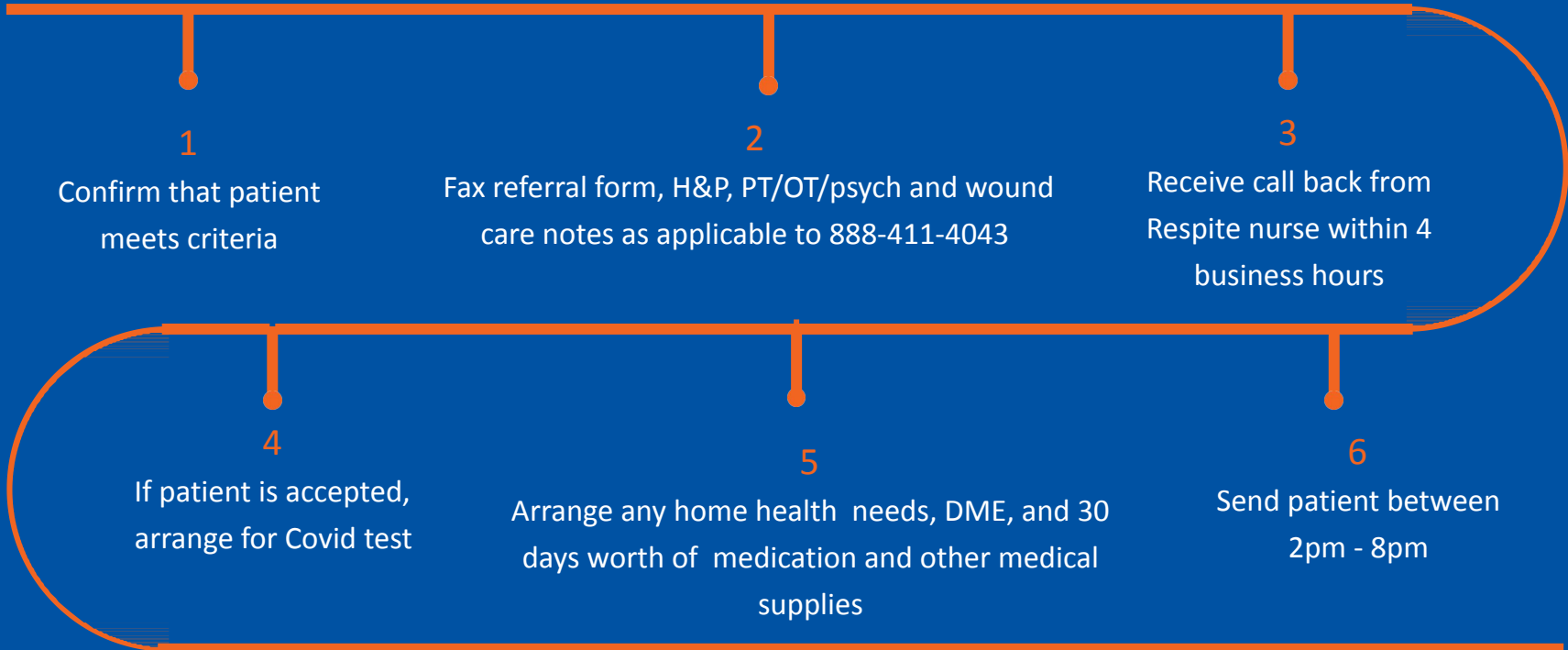
Presented By:
Celina Yee-Izon,
Program Manager

Criteria

*What is the
criteria for
respite?*

- ♥ Must be homeless or lack adequate housing to support recovery
- ♥ Must have a medical condition that can be effectively addressed/recovered from within limited amount of time, </4 weeks
- ♥ Must be >/18 years old
- ♥ Must be willing and able to comply with BACS Respite Program rules and agree to admission to Respite and agree to discharge date
- ♥ Must be able to perform all activities of daily living independently, including taking medications
- ♥ Must be independently mobile and able to self-transfer in and out of bed, in and out of shower, on and off toilet etc. without supervision and/or stand-by assist
- ♥ Must be able to feed self independently with meals provided
- ♥ Must be independent with all wound care or have home health in place with 1st visit scheduled and need up to 3/week
- ♥ Must be a continent of urine and stool
- ♥ Must be alert and oriented x4 Must not have any skilled nursing needs
- ♥ Must weigh less than 300lbs.
- ♥ Must not be in the 2nd or 3rd trimester of pregnancy Must not
- ♥ have any contagious diseases or require isolation
- ♥

How do you refer a patient to Respite?



Cardea Health

Community Supports: Medical Respite Care

Cardea Health Respite Programs

Cardea Health is an Oakland Based non-profit founded to connect marginalized populations to the clinical and supportive services they need to improve their health, become stably housed in the community, and age in place.

Cardea Health operates clinical services at two respite/recuperative care programs in Alameda County

Fairmont Respite: 34 bed respite -> transitional housing program in partnership with Five Keys and Alameda County Health Care for the Homeless

Eddie's Place: 51 bed program (20 contracted AHS beds, 31 respite): Cardea Health program



Respite Program Clinical Services

Robust clinical staffing:

Nursing care:

Eddie's Place: 7 days a week up to 16 hours a day

Fairmont Respite: 5 days a week, business hours

Caregiver support (adjustable)

Eddie's Place: 12 hours a day

Fairmont Respite: as needed

Medical director presence: clinical oversight from medical providers.

Support for clients requiring ADL assistance:

The need for ADL support is qualifying criteria for Cardea Health respite programs.



Unique services at Cardea Health Respite

SUD treatment services:

Eddie's Place maintains a partnership with Addiction Medicine program from Alameda Health System and Kaiser San Leandro.

Can provide on-site access to Medication Assisted Treatment for Substance Use Disorder and harm reduction services.

Hospice Care

Both respite locations accommodate end of life care for PEH enrolled in home hospice services.

Referral pathway for medically frail housing at Project Homekey



MCP updates

Kaiser
Permanente Medi-Cal Direct Contract
Transition Overview
Alameda County PATH CPI Meeting

March 15, 2024

The Kaiser Permanente Mission



Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

ECM, CS, CHW Network

Three Community-Based Providers have been selected to serve as Network Lead Entities

Multiple Network Lead Entities allows Kaiser Permanente to build a comprehensive network to provide Enhanced Care Management (ECM), Community Supports (CS) and Community Health Worker (CHW) benefits for Kaiser Medi-Cal members.



- **Expertise in working with children, youth, young adults, and families**
- Model anchored in existing relationships with trusted community-based organizations with a focus and expertise in children and youth (includes Counties, etc.)
- Provides upstream assistance for capacity building for Community-Based Organizations



- **Current contracted Enhanced Care Management and Community Supports provider with Kaiser**
- Statewide presence in both NCAL and SCAL
- Extensive experience in multiple states by currently prepared to provide CHW services in 21 counties with expansion planned to all 32 counties by 2024
 - Strong existing infrastructure to facilitate business systems with capacity to scale

NLEs serving KP members in Alameda County



- **Significant experience as an NLE**
- Distinct expertise in supporting "high needs members"
- Well established relationships with local community-based organizations
- Demonstrated understanding of how other Medi-Cal services can be accessed outside of ECM to coordinate and support care by work with Multipurpose Senior Services Program/Assisted Living Waiver programs

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.



Cities

Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma,



Phone

1-833-952-1916 (TTY 711)
Monday-Friday (closed major holidays) 9:00 a.m. to 4:45 p.m.



Email

Send completed [referral form](#) to REGMCDURNS-KPNC@kp.org with the subject line “ECM Referral” or “CS Referral”

How a community-based organization can serve KP members

KP is working with three 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



ILSCAProviderRelations@ilshealth.com

Phone number: 305-262-1292

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.

For Prospective Providers: Meeting With Full Circle Health Network

Meet Full Circle Health Network



FCHN advances health equity among vulnerable youth & families by serving as a bridge between managed care plans and a cohesive CBO network.

① Youth & Families



Receive trauma-informed, culturally competent Enhanced Care Management from agencies rooted in their local communities

② Providers



Able to focus on core competency of person-centered service delivery while accessing technology, data and ongoing training and technical support

③ Managed Care Plans



Streamlined access to a nationally accredited, diverse CBO network implementing a high quality, standardized model of care

We meet with perspective providers each week on Thursdays from 12-1pm PST

<https://us06web.zoom.us/j/86507421534>



Foster Youth Strategy

KP Medi-Cal For Foster Youth and Former Foster Youth

- Foster Youth Liaison is onboard and serving as a resource to County Social Workers & Public Health Nurse's (questions, escalation & coordination needs)
- Examples of inquiries:
 - Obtaining KP medical records for Foster Youth
 - Updating contact information in KP system
 - Updating legal documents (letter of adoption or court orders)
 - Accessing care when out of county/in a county without KP offices/facilities
 - General ECM questions & specific ECM enrollment status for Foster Youth
 - Information about KP dental benefits/coverage
 - Foster Youth drop in coverage
 - Rescheduling appointments/looking up existing appointments
- KP is working our Network Lead Entity, Full Circle, to provide our county agencies education related to Full Circle's ECM services & enrollment.



Medi-Cal Redetermination

Strategy

Kaiser Permanente's Medi-Cal Redetermination Strategy is guided by a **data-driven** approach, focuses on communities with **highest needs**, leverages **existing partnerships** with proven community organizations, **addresses gaps** in state and county-funded efforts, and establishes **cross-functional partnerships across KP** to support growth and retention opportunities.

Medi-Cal Beneficiaries (Community and KP Members)	
 Education and Outreach <i>Increase awareness of redetermination process among Medi-Cal beneficiaries</i> • Allocate grants for culturally and linguistically relevant outreach • Leverage COVID-19 Vaccine Equity trusted messengers • Amplify KP/other redetermination resources • Leverage hospital navigators and Thrive Local • Develop an events strategy, including partnerships with	 On-the-Ground Enrollment <i>Help underserved populations to enroll</i> • Allocate grants to expand enrollment navigation support in the community and to support statewide advocacy • Monitor and respond to redetermination enrollment and termination rates • Inform external stakeholders about redetermination response, trends and opportunities

KPIF/Medicaid

Confidential and Proprietary. Internal Use Only. Do Not Distribute.

For More Information About Kaiser Permanente

Vanessa Davis

Director, Medi-Cal External
Engagement

Kaiser Permanente

Medi-Cal Line of Business
(510) 507-2711 (mobile phone)
Vanessa.W.Davis@kp.org



MCP updates



Redetermination

For MediCal or Social Services

- Situation:
 - Member has lost MediCal Eligibility
- Solution:
 - Work with member to either three-way call or share Health Care Options:
 - **1-800-430-4263**

- Situation:
 - Member's MediCal was put on hold while incarcerated
- Solution:
 - Work with member to either three-way call or share Social Services Administration (SSA):
 - **Local: 1-510-263-2420**
 - **Toll-Free: 1-888-999-4772**
 - (They go to the same place)

Resources, Reminders, and Wrap Up

Available now: ECM and CS Provider List



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

Upcoming TA Marketplace Vendor Fairs



Hosted by DHCS, virtual vendor fairs feature approved vendors TA Marketplace domains to learn more about their services

Domain 1: Building Data Capacity – Data Collection, Management, Sharing and Use
March 28, 9 -10:30 a.m.

[Advance registration is required](#)

Domain 2: Community Supports – Strengthening Services that Address the Social Drivers of Health; and
Domain 7: Workforce – Recruiting and Retaining a Well-Prepared, High-Performing Workforce
April 9, 9 -10:30 a.m.

[Advance registration is required](#)

Domain 5: Promoting Health Equity; and
Domain 6: Supporting Cross-Sector Partnerships
April 25, 9 -10:30 a.m.

[Advance registration is required](#)

Upcoming Training

Check out to upcoming trainings from the Alameda County Training and Development Unit (ACTDU)

Dismantling Drug Related Stigma
April 11 | 10am - 12pm

Cultural Humility - From Understanding to Action
April 16 | 9am - 12pm

Motivational Interviewing Pt. 1
May 7 | 10am - 12pm

Motivational Interviewing Pt. 2
May 8 | 10am - 12pm

Conflict Management and De-Escalation
May 9 | 10am - 12pm



Rapid feedback poll:

What activities are you interested in for our April in-person meeting?

Thank you for joining us today!

Next Meeting: Friday, April 19 at 10am

In-Person

[Register here](#)



Office Hours



Appendix

2024 Aim & Priority Objectives



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Priority Objectives:

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Strengthen ECM and Community Supports provider capacity through tools, job aids, and education

Facilitate relationship building between providers, plans, and referral partners

Referring members to ECM and/or Community Supports

Alameda Alliance for Health

Case and Disease Management Department

Monday – Friday, 8 am – 5 pm

Phone Number: 1.510.747.4512

Toll-Free: 1.877.251.9612

People with hearing and speaking impairments
(CRS/TTY): 711/1.800.735.2929

Email (Community Supports):

CSDEPT@alamedaalliance.org

Email (ECM): ECM@alamedaalliance.org

Kaiser Permanente

Monday – Friday (closed major holidays)

9:00 am to 4:45 pm

Phone Number: 1-833-952-1916 (TTY 711)

Email: Send completed [referral form](#) to
REGMCDURNS-KPNC@kp.org with the subject
line “ECM Referral” or “CS Referral”