DHCS | PATH

Providing Access & Transforming Health

BluePath HEALTH

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

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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.

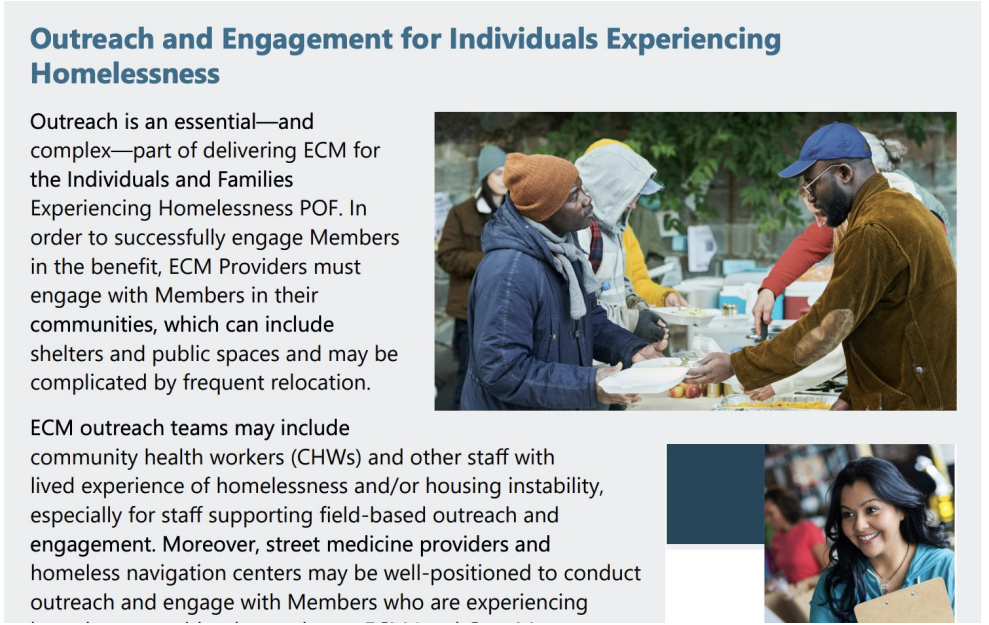
– Community-based service providers are encouraged to identify and refer eligible children and youth to their MCPs for ECM, whether or not referring providers are themselves serving as ECM Providers within the MCP contracted network and/or service area.

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

Alameda County
Health Care for the Homeless

Health Care for the Unhoused: Alameda County Challenges

- 9,747 persons experiencing homelessness on one night[1]
  - **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

Alameda County
Health Care for the Homeless

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

Alameda County
Health Care for the Homeless

Services Provided by Street Health

Outreach and Engagement:
- ✓ Trust and rapport building activities
- ✓ Attending to basic needs

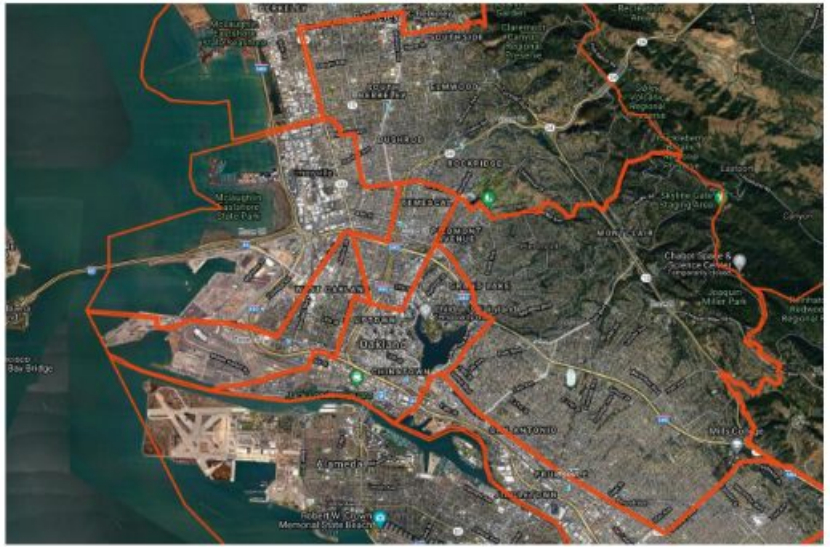
Health:
- ✓ Medical assessments and triage
- ✓ Diagnosis and treatment of conditions commonly associated with being homeless
- ✓ Immunizations and health education
- ✓ Health education and linkage to community resources including Behavioral Health and Substance Use services

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=1vA3PCKMf2uCdzBQO0JQZkc9m8VTOvwYt&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

Alameda County
Health Care for the Homeless

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)

Alameda County
Health Care for the Homeless

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

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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

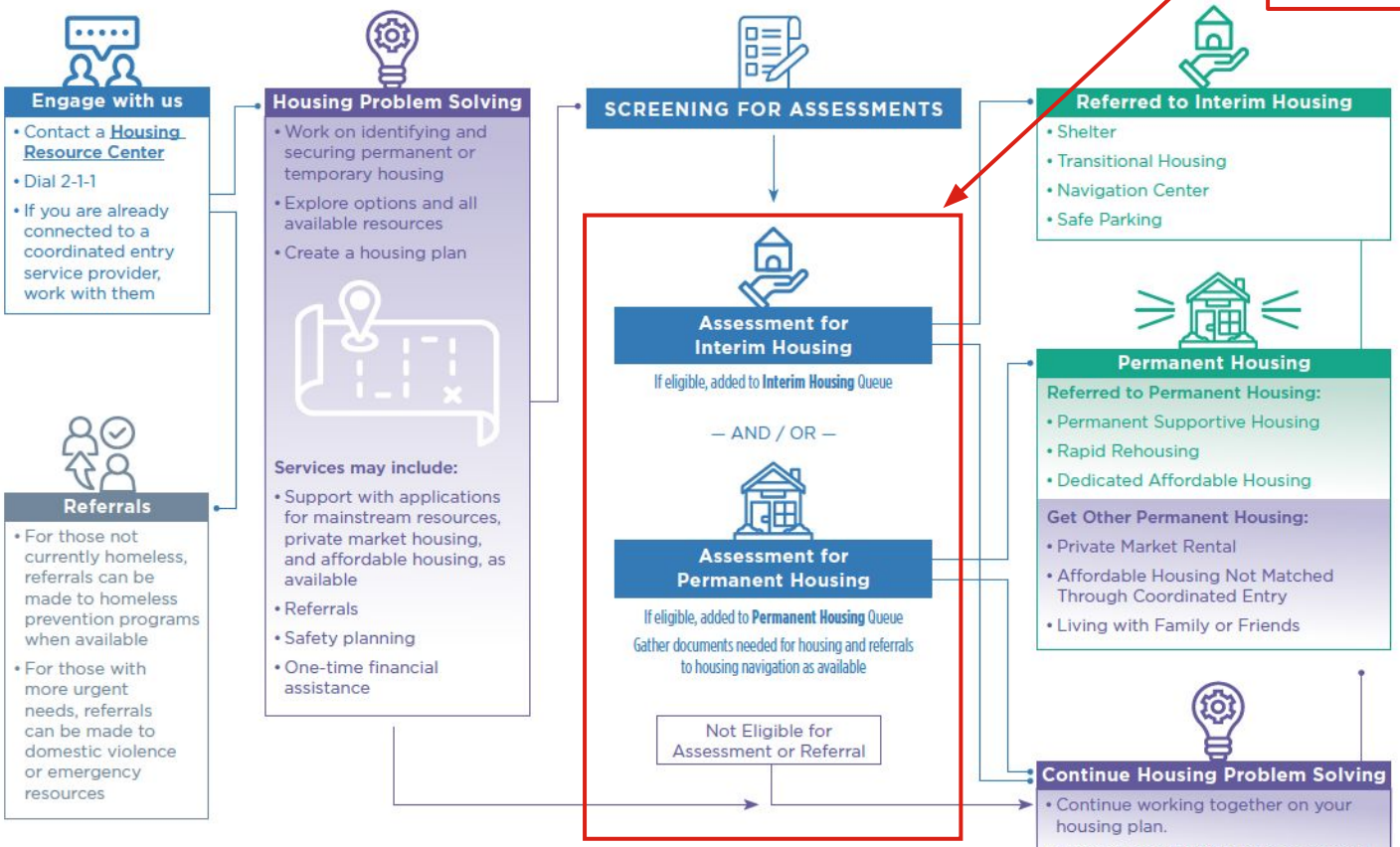
What is the Coordinated Entry System?

- 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

assessment for CalAIM Housing Navigation, Tenancy and Sustaining Services, and Housing Deposits



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	*two more orgs to be added in 2024*

Call 211 Help Starts Here

Eden I&R, Inc.

"linking people and resources" throughout Alameda County

PRESENTATION TO ALAMEDA CAL AIM PATH COLLABORATIVE 3.15.24

Call 211 Help Starts Here

Eden I&R, Inc.

"linking people and resources" throughout Alameda County

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

Call 211 Help Starts Here

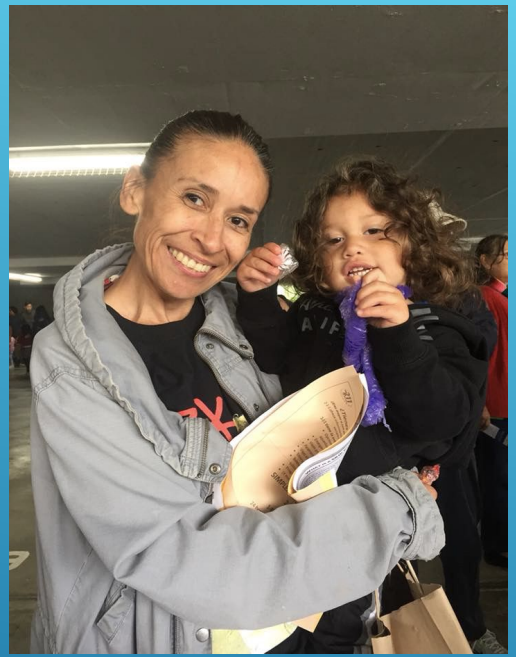
Eden I&R, Inc.

"linking people and resources" throughout Alameda County

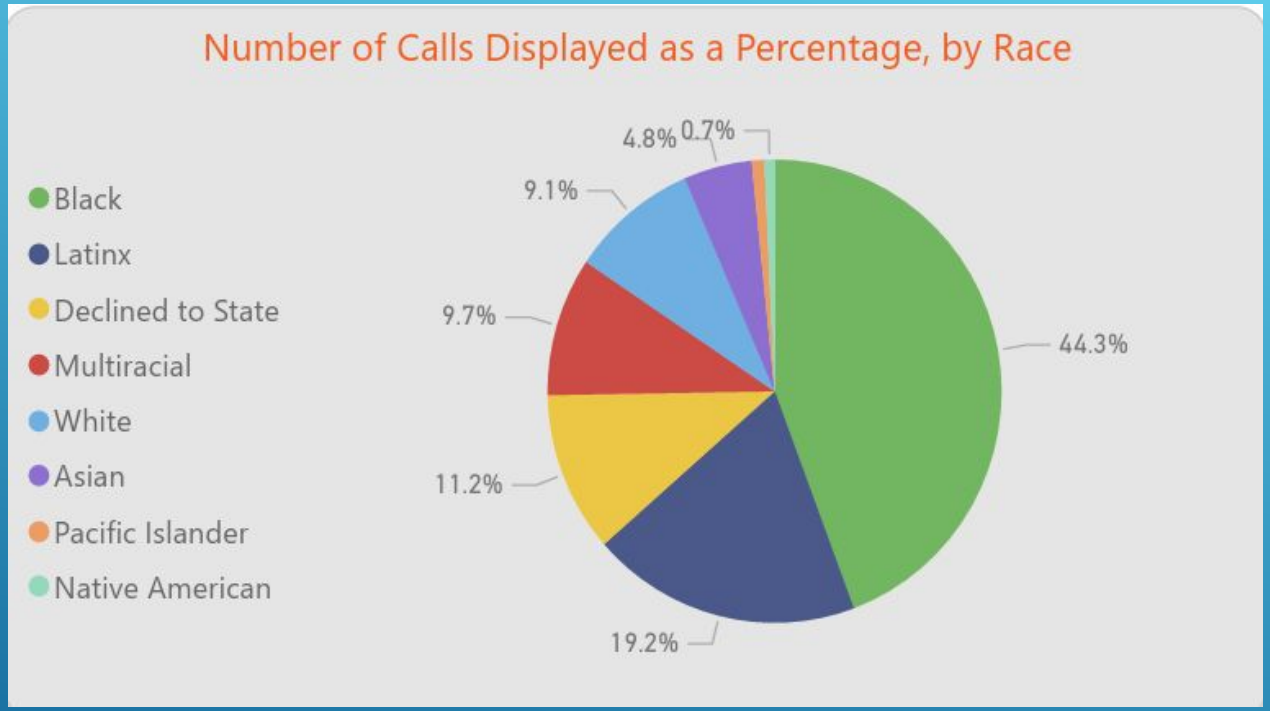
211 STATS

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



Eden I&R, Inc.
Call 211 Help Starts Here
"linking people and resources" throughout Alameda County



211 STATS

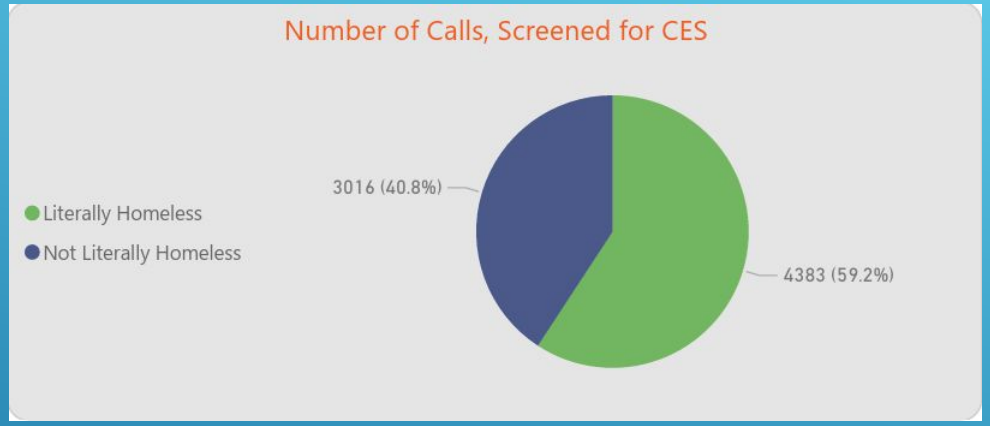
TOP NEEDS

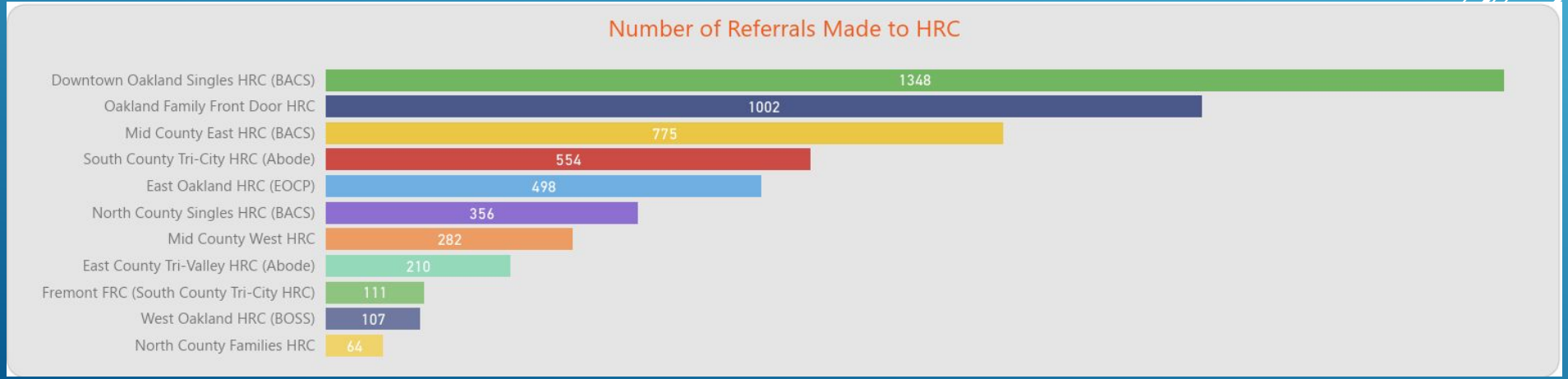
- Housing/Shelter
- Utilities
- Material Goods
- Food
- Legal Services
- Health Supportive Services
- Disaster Services
- Mental Health Assessment & Treatment
- Public Assistance Programs
- Substance Use Disorder Services

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
Literally Homeless
Not Literally Homeless
3016 (40.8%)
4383 (59.2%)

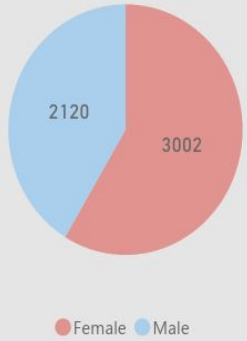

Number of Referrals Made to HRC
Downtown Oakland Singles HRC (BACS) 1348
Oakland Family Front Door HRC 1002
Mid County East HRC (BACS) 775
South County Tri-City HRC (Abode) 554
East Oakland HRC (EOCP) 498
North County Singles HRC (BACS) 356
Mid County West HRC 282
East County Tri-Valley HRC (Abode) 210
Fremont FRC (South County Tri-City HRC) 111
West Oakland HRC (BOSS) 107
North County Families HRC 64

Call 211 Help Starts Here

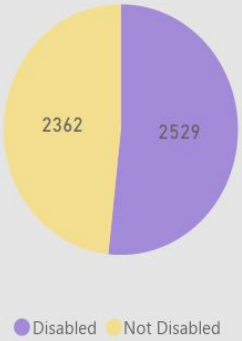
Eden I&R, Inc.

"linking people and resources" throughout Alameda County

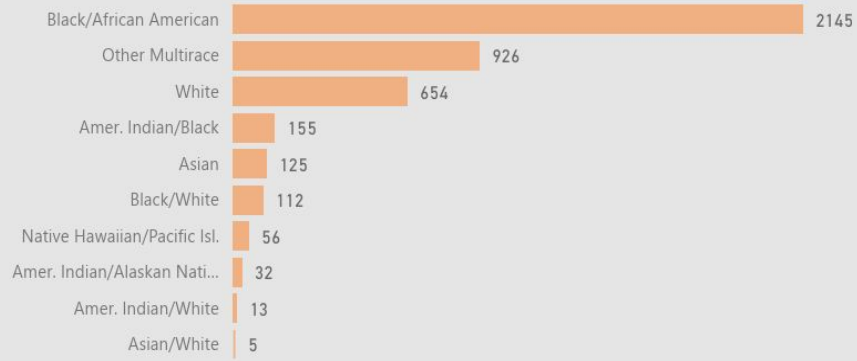
HRC Referrals by Gender



HRC Referrals by Disability



HRC Referrals by Ethnicity



Thank you!

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

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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

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Alameda Alliance

BACS
Bay Area Community Services
Supporting People, Supporting Community

CARDEA HEALTH

LifeLong Medical Care
a californiahealth+center

Kaiser Permanente

THE UNCUFFED PROJECT

CARDEA HEALTH

BACS
Bay Area Community Services

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
-

BACS
Bay Area Community Services

How do you refer a patient to Respite?

BACS
Bay Area Community Services

1
Confirm that patient meets criteria

2
Fax referral form, H&P, PT/OT/psych and wound care notes as applicable to 888-411-4043

3
Receive call back from Respite nurse within 4 business hours

4
If patient is accepted, arrange for Covid test

5
Arrange any home health needs, DME, and 30 days worth of medication and other medical supplies

6
Send patient between 2pm - 8pm

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

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ALAMEDA Alliance FOR HEALTH

KAISER PERMANENTE®

MCP updates

Kaiser Permanente Medi-Cal Direct Contract Transition Overview

Alameda County PATH CPI Meeting

March 15, 2024

KAISER PERMANENTE®

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

KAISER PERMANENTE®

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.

Full Circle Health Network

- **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

Independent Living Systems

- **Current contracted Enhanced Care Management and Community Supports provider with Kaiser**
- Statewide presence in both NCAL and SCAL
- Extensive experience in multiple states by partnering with CBOs
- 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

Partners in Care Foundation

- **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

NLEs serving KP members in Alameda County

KAISER PERMANENTE®

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”

KAISER PERMANENTE®

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:

Full Circle Health Network

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

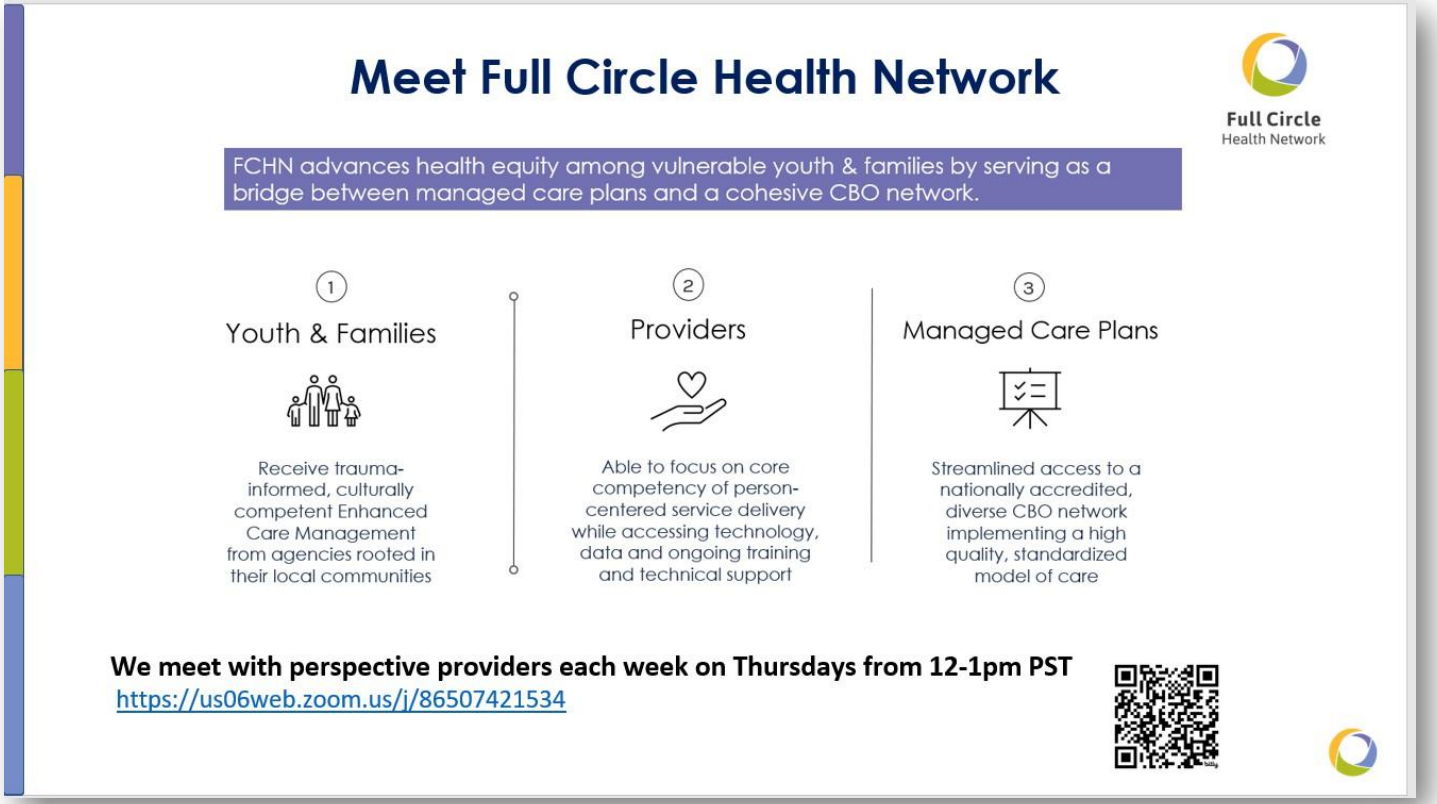
INDEPENDENT Living Systems

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



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Foster Youth Strategy

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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

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

Increase awareness of redetermination process among Medi-Cal beneficiaries

- 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 KPIF/Medicaid

On-the-Ground Enrollment

Help underserved populations to maintain continuous coverage

- 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

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

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MCP updates

Redetermination

ALAMEDA Alliance FOR HEALTH

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

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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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Upcoming TA Marketplace Vendor Fairs

BluePath HEALTH

DHCS | PATH

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

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DHCS | PATH

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

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Providing Access & Transforming Health

BluePath HEALTH

Rapid feedback poll:

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

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Thank you for joining us today!

Next Meeting: Friday, April 19 at 10am

In-Person

Register here

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Office Hours

DHCS | PATH

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Appendix

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**

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”