PATH Collaborative Planning & Implementation (CPI)

Welcome! The Southwest Collaborative Planning Meeting will be starting shortly.

August 22, 2024

POPULATION HEALTH
INNOVATION LAB
A Program of the PUBLIC HEALTH INSTITUTE

PATH – Collaborative Planning & Implementation (CPI)

Southwest Collaborative Planning Meeting

August 22, 2024

POPULATION HEALTH
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Thank you to our sponsors

Introductions and Housekeeping

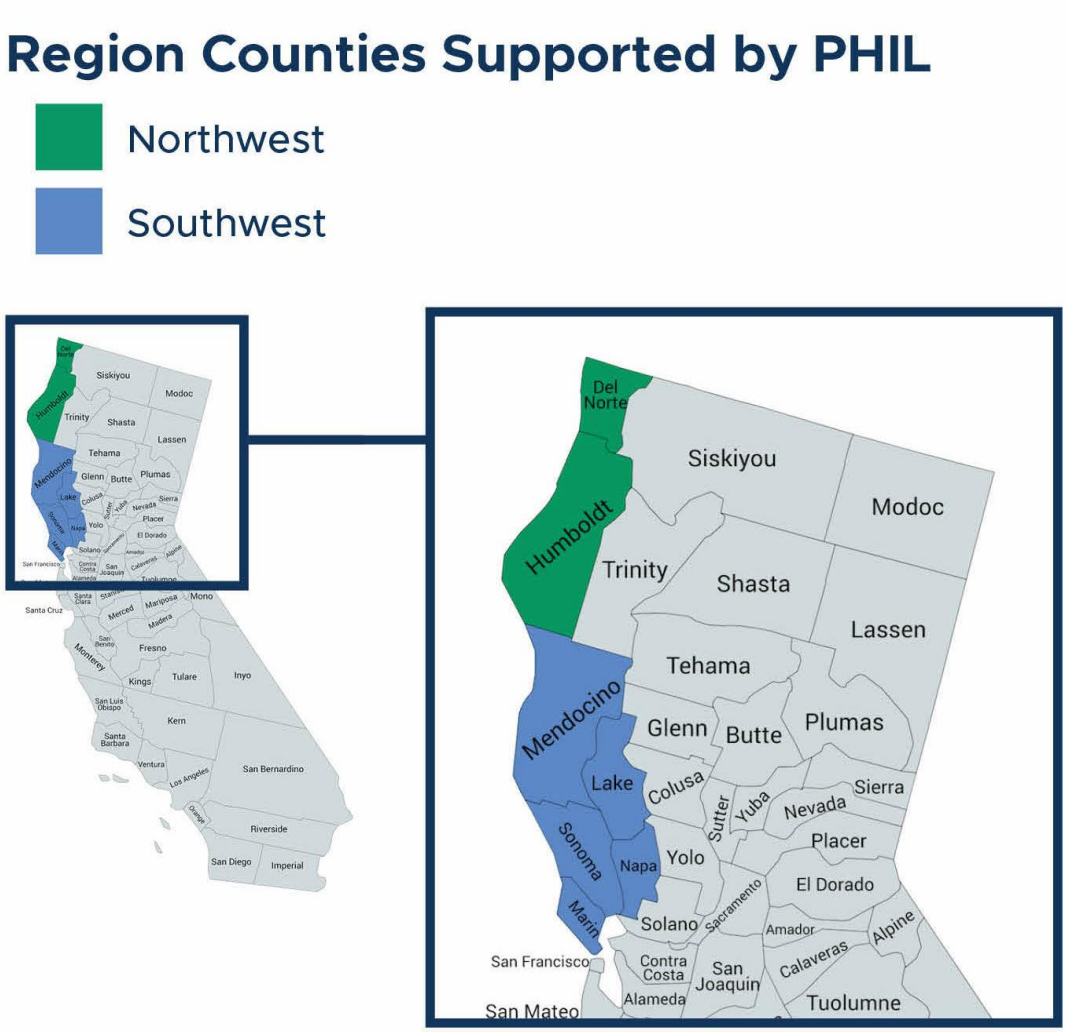
Who is part of the PHIL team?

Where is the restroom?

Where are the exits?

What time is lunch?

Collaborative Planning & Implementation Overview



CPI collaboratives will work together to identify, discuss, and resolve CalAIM implementation issues.

- Learn more about the PATH CPI initiative here.
- Catch up with us! Find meeting minutes, Readiness Roadmap Resources, and registration links on the PHIL website.

Agenda for Today

11:00 – 11:10 am	Arrival and Check-In
11:10 – 11:20 am	Introductions and Framing
11:20 – 11:45 am	Data Sharing Strategies
11:45 – 12:00 pm	Local Organization Spotlight
12:00 – 12:15 pm	Pick up your lunch!
12:15 – 12:30 pm	ECM and Community Supports Quick Reference Guide
12:30 – 12:45 pm	Update from Medi-Cal Managed Care Plans
12:45 – 1:00 pm	Break
1:00 – 2:00 pm	QIP training, Collaborating, Networking, and Open Space
2:00 – 4:00 pm	QIP Training continued

Objectives

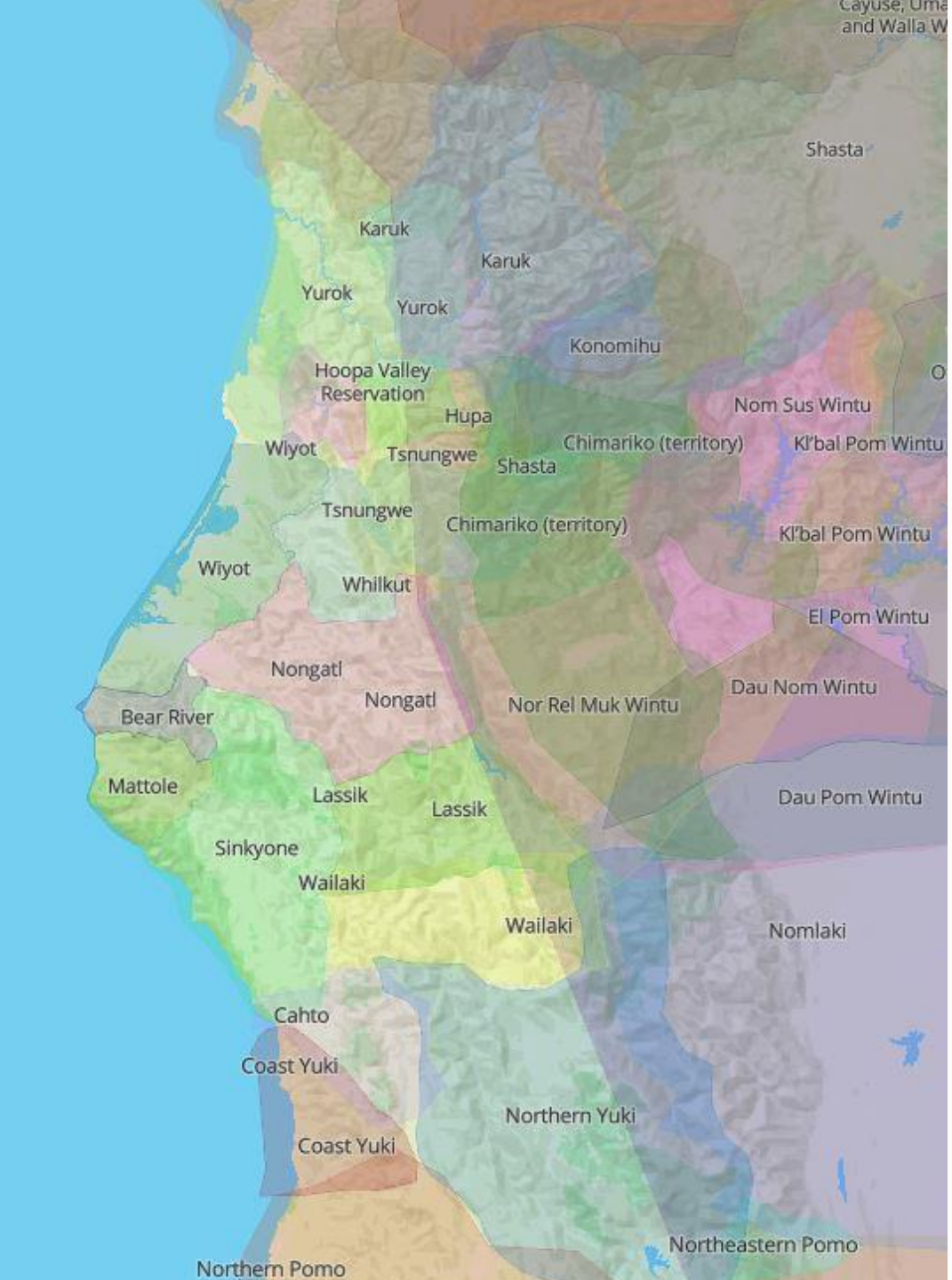
- Network, meet new people, catch up with old friends, and HAVE FUN!
- Gain an understanding of the current CalAIM policy landscape, its implications for service providers, and where to access this information.
- Encourage shared learning and provide a platform for open dialogue with CalAIM providers, local Managed Care Plans, and other local stakeholders to strengthen a culture of collaboration.
- Facilitate an open forum to enhance transparency surrounding challenges, successes, and innovations in CalAIM Enhanced Care Management (ECM) and Community Supports services.

Land Acknowledgment

The Population Health Innovation Lab team respectfully acknowledges that we live and operate on the unceded land of Indigenous peoples throughout the U.S.

We acknowledge the land and country we are on today as the traditional and treaty territory of the Native American, Alaska Native, and Tribal nations who have lived here and cared for the Land since time immemorial. We further acknowledge the role Native American, Alaska Native, and Tribal nations have today in taking care of these lands, as well as the sacrifices they have endured to survive to this day.

Photo by Ralph (Ravi) Kayden on Unsplash



Whose Land Are We On?

Today we are on the land of the Southern Pomo and Coastal Miwok.

Neighboring tribes include the Wappo tribe, Yuki Tribe, and Central and Northern Pomo.

Commitments to Community Inclusivity

Be Present, Brave, and Curious

- Encourage different opinions and respectful disagreement
- Embrace conflict which can deepen our understanding
- Acknowledge the risk speakers take, and value the privilege to learn from one another.
- **Make use of opportunities to connect person-to-person**

Create An Inclusive Space

- Invite the unheard voices
- **Take responsibility for our own voices (make space)**
- Resist the temptation to only witness the dialogue (take space)*

Invite Anti-Racist Dialogue

- Be aware we all have a bias that may impact action; biases are learned and can be unlearned.
- Address racially biased systems and norms.
- Recognize the vast and varied lived experiences participants have with racism.
- **Be intentional about power dynamics and how you exercise your privilege.**
- Avoid defensive responses when people speak from lived experiences with racism

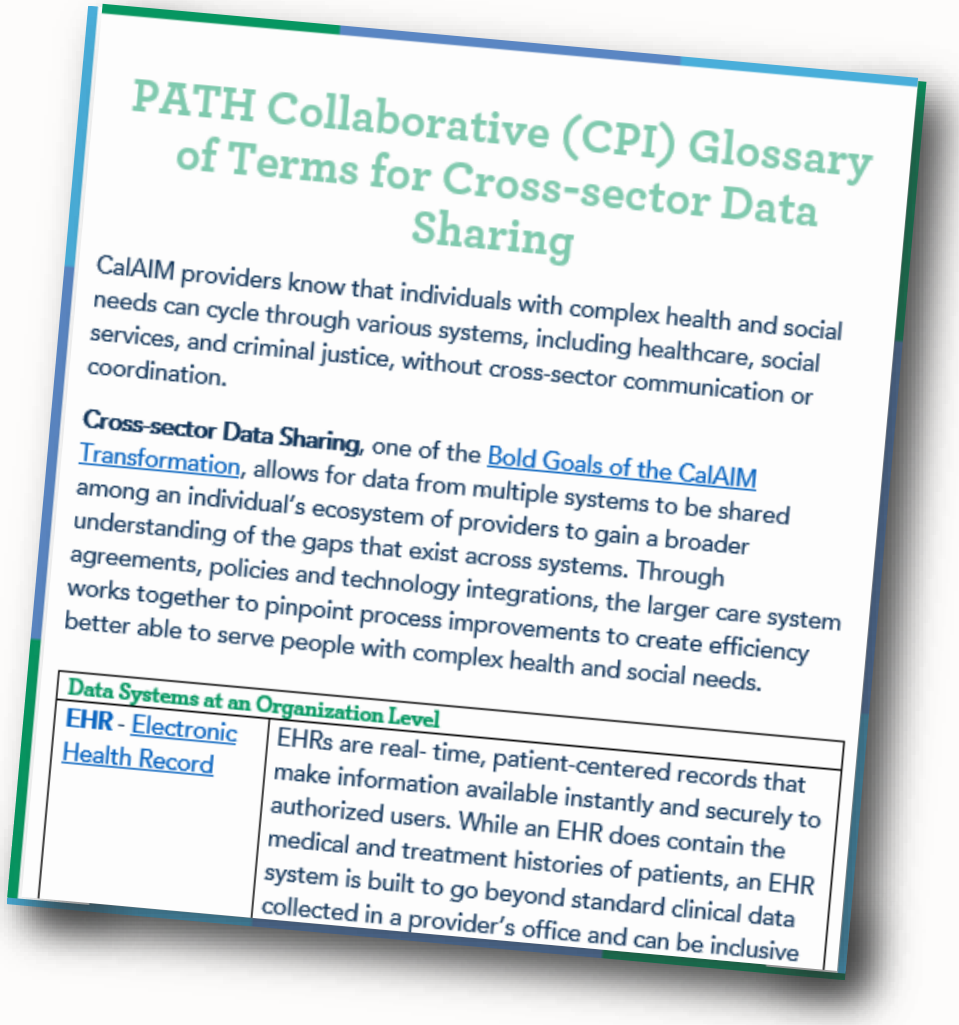
Be Accountable

- **Foster awareness of unrepresented community members not "in the room"**
- Respect each other's time - participate fully and prepare for each activity
- **Commit to actions that move items beyond discussion**
- Practice patience and persistence – we cannot solve everything in a single conversation and will revisit topics that require additional discussion*

Commitments Courtesy of: Community Health Worker & Promotor Workforce Development Resource Library — Health Leads. (2023, June 29). Health Leads. https://healthleadsusa.org/communications-center/resources/community-health-worker-promotor-workforce-development-resource-library/

Sharing data in the CalAIM Ecosystem of Care

- Individuals with complex needs can cycle through various systems -- health care, social services, criminal justice -- without cross-sector coordination.
- Cross-sector data sharing is a bold goal of CalAIM.



PATH Collaborative (CPI) Glossary of Terms for Cross-sector Data Sharing

CalAIM providers know that individuals with complex health and social needs can cycle through various systems, including healthcare, social services, and criminal justice, without cross-sector communication or coordination.

Cross-sector Data Sharing, one of the Bold Goals of the CalAIM Transformation, allows for data from multiple systems to be shared among an individual's ecosystem of providers to gain a broader understanding of the gaps that exist across systems. Through agreements, policies and technology integrations, the larger care system works together to pinpoint process improvements to create efficiency better able to serve people with complex health and social needs.

Data Systems at an Organization Level	
EHR - Electronic Health Record	EHRs are real- time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive

Transformations in the Data Policy Landscape

- **November 2023:** California's Health and Human Services Agency announced the nine state-designated Qualified Health Information Organizations (QHIOs) that will function as the data exchange intermediaries that will facilitate information between DxF participants.
- **January 2024:** Key components of California's Health and Human Services Agency Data Exchange Framework (DxF) went into effect
- **February 2024:** the U.S. Department of Health & Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records
    - 42CFR Part 2 Final Rule Fact Sheet

Connecting Client Data to Enhance Complex Care Coordination

Enter Here

Data Systems at an Organization Level

Identification and Consents

Legal and Regulatory Frameworks

HIE (state)

CIE (local)

QHIO (connector)

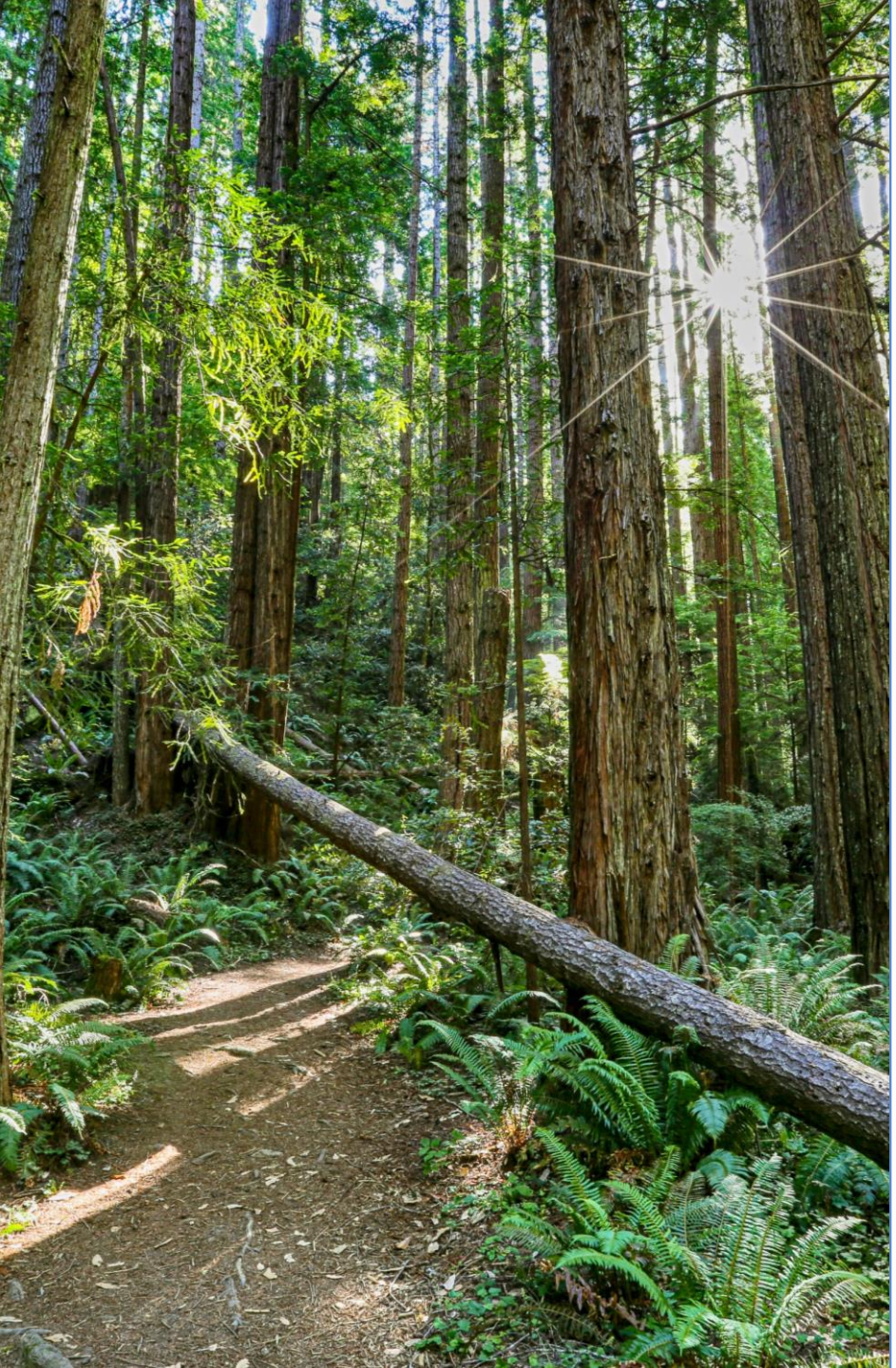
Health Information Sharing

Data Related Challenges and Successes in the CalAIM Ecosystem of Care

1. *What is the most significant data challenge you are facing right now?*

2. *What is your greatest data success so far?*

   Or a data related innovation that is enhancing person-centered complex care management?



Elevating the Expertise of Local Partners

Local approaches to pain points and solutions in the ECM and CS implementation journey.

Welcome:

Sonoma Connect | Somos Unidos

Saskia Garcia

Executive Director

A Community Information Exchange-Model Network

Who We Are

Sonoma Connect | Sonoma Unidos (SC|SU) is a coalition of community leaders and multi-sector partners, working together to prevent and heal Adverse Childhood Experiences (ACEs) and trauma caused by Structural Drivers of Health (SDOH).

Sonoma Connect | Sonoma Unidos leads the development of a local Community Information Exchange Model Network and advances a multi-pronged approach to increasing mental and physical health equity through supporting both direct services and systems changes.

Sonoma Connect | Sonoma Unidos

1. Human Centered
2. Dismantle systems
3. Responsive system and programming
4. SDOH and ACEs
5. Coordination and alignment of systems
6. Measure what needs to be changed

Quick Key Facts

Fiscal Sponsor

Sonoma Community Action Network (Formerly CAP Sonoma)

Funding

Prior seed funding CA Office of the Surgeon General ACEs Aware & current American Rescue Plan Act Funds, PATH CITED R2, DxF, and other grants

Community Network

- 4 FTE Backbone Staff
- 14 Participating Network Organizations using Resource Connection Network
- 124+ Individuals engaged in two Action Teams
- 22 Funded partners

What is a “Community Information Exchange” (CIE)

“A Community Information Exchange (CIE) is a **community-led** ecosystem comprised of **multidisciplinary network partners** using a **shared language**, a **resource database**, and **integrated technology platforms** to deliver enhanced **community care planning**.

Reactive Approach

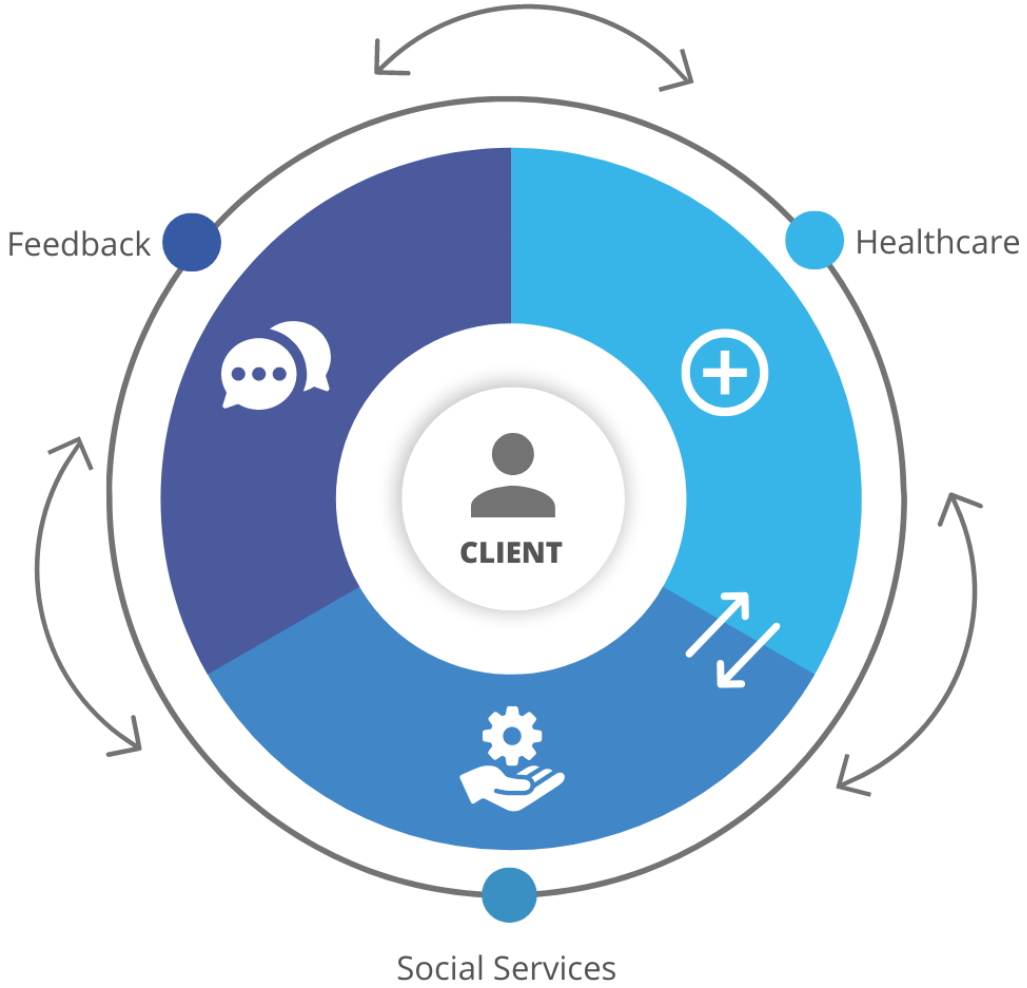
Proactive, holistic, person-centered approach

At its core, CIE centers the community to support anti-racism and health equity.

5 key elements of a Community Information Exchange

	San Diego 211	Sonoma Connect
1 **Network Partners**	San Diego 211 and 34 social service and healthcare providers	Nonprofit, Health Centers, Managed Care Plans, Hospital Systems, Tribal, Education, Government, Behavioral Health, and others
2 **Integrated Technology**	Salesforce	**Resource Connection Network** – leveraging the technology NinePatch & interoperability
3 **Shared Language**	Structural Drivers of Health	Structural Drivers of Health & ACEs
4 **Resource Database**	211 San Diego	211 – Curated by United Way of the Wine Country
5 **Community Care Planning**	• Analysis of shared measures for social determinants of health • Example Impact: Reduced emergency medical services trips and increased stable housing rates	• Forthcoming after 1 year+ Resource Connection Network implementation • Additional forthcoming after integration with Qualified Health Information Organization

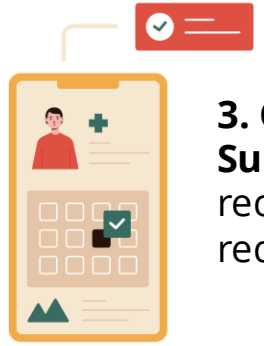
What do we mean by closed-loop?



Closed-loop Referral in a Cross-Sector Setting

1. **Primary Care Physician** orders referral to **Community Supports**

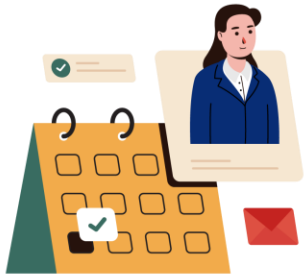
2. **Primary Care Physician staff** complete referral forms & sends to **Community Support's office**



3. Community Support staff receives referral request

6. **Primary Care Physician** receives, and reviews referral report & discusses with patient/family

5. **Community Support** sees patient and completes and sends referral report to **Primary Care Physician**



4. **Community Support staff** schedules appointment with the patient/family

NinePatch Timeline of Selection

Need Identified

Many different data systems in use resulting in duplication of data entry, uncoordinated support to the community.

RCN Action Team

Resource Connection Network Action Team convened with 79 participants from 45 different community organizations to identify desired criteria for the technology selection.

Request for Proposals

RCHC and consultants developed an RFP. The RCN team organized technology vendors demos. Community stakeholders ranked each vendor according to the selection criteria.

NinePatch Selected

Early Adopters

Pilot Group – Petaluma Region

- Petaluma People Services Center
- Petaluma Health Center
- County of Sonoma Comprehensive Perinatal Services Program,
- Sonoma County Office of Education Behavioral Health Department
- County of Sonoma Home Visiting Program

Data Exchange Framework Grant Collaborative Partners

- Family Justice Center
- Child Parent Institute
- La Luz
- Legal Aid of Sonoma County

CalAIM ECM and Community Support

- La Familia Sana
- Community Support Network
- Food for Thought
- Hanna Center
- Community Action Partnership Sonoma County
- Aliados Health (Core Partner)
- United Way of the Wine Country (Core Partner)

0-5 and Child Wellness Partners

- Center for Wellbeing
- Catholic Charities
- First 5 Sonoma County
- Santa Rosa Community Health
- DAAC
- Buckelew
- Women's Recovery Center

…and more coming!

Emerging Use Cases

Use Cases Underway:

- CalAIM Enhanced Care Management Cohort
- CalAIM Community Supports Cohort (Housing Navigation and Support, Medically Tailored Meals)
- Child Abuse Prevention & Child Welfare Cohort
- Birth Equity & Early Childhood Population of Focus Cohort

Possible Use Cases:

- Coordinated Entry Access Point Cohort
- Homeless Services Provider Cohort
- Behavioral Health and Substance Use Disorder Provider Cohort
- Adult and Aging Cohort
- Community Schools/School Wellness Center Cohort
- Family Resource Center Cohort

Upcoming Highlights in 2024

- Connecting with a **Qualified Health Information Organization (QHIO)**
- Enhanced Care Management and Community Support integrated forms and workflows coming by end of 2024
- Working with SC|SU Stakeholders, RCN Participating Network Organizations, with support from Intrepid Ascent on prioritization of data-system integration roadmap (such as Point Click Care, HMIS, Smartcare)
- CITED Round 4 Application coming soon – collaborative application interest?

Why local CIE work is important - CIE Benefits

Individual (Micro) - Individuals benefit from a universal, person-centered record of life events, and system interactions enable providers to proactively tailor services to individual needs. This supports healing-informed care by reducing the need for individuals to repeatedly share their experience and situation to different service providers. The CIE allows for responsive and proactive system that reduces the burden on individuals and families who may be in crisis

Agency (Mezzo) – Agencies can efficiently collaborate with providers across sectors using a shared language and shared outcomes to deliver comprehensive care while generating referrals through the system.

Community (Macro) - Community receives insights into broader trends to more proactively address unmet needs and barriers, as well as disparities in access to services. Data also can be used to inform local planning and funding priorities and to advocate for policy change.

Why local CIE work is important - Increasing Focus on Whole Person Care and Cross-sector Information Sharing

- **California Health and Safety code section 130290**
- Centers for Medicare and Medicaid Services (CMS) **2023 inpatient prospective payment system (IPPS) Final Rule**
- **CalAIM 1115 Demonstration & 1915(b) Waiver**
- **Assembly Bill 133 –** Necessitates the **CA Data Exchange Framework**

Let's Connect!

Saskia Garcia

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Program Manager

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Program Coordinator

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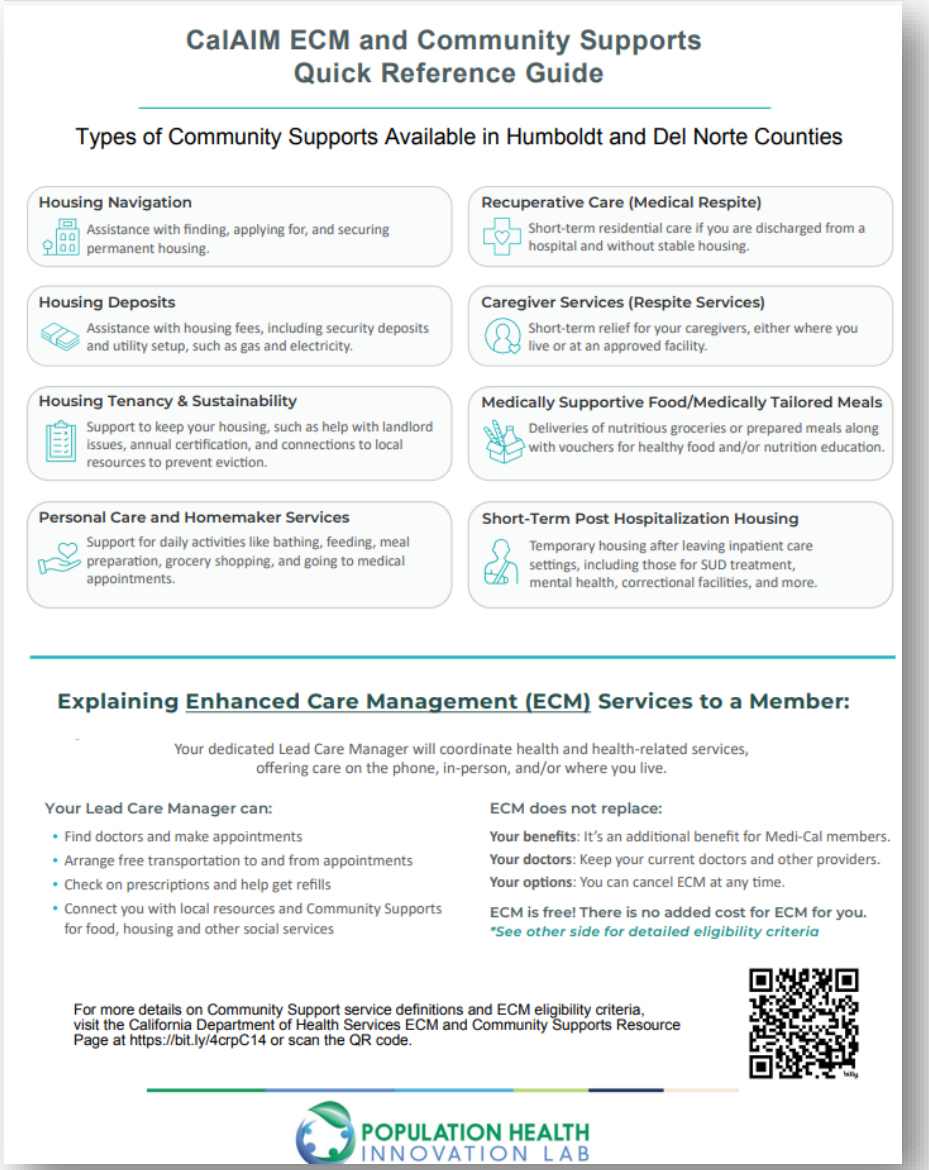
https://www.sonomaconnect.org

Lunch

Quick Reference Guide

- Do you think this tool will be helpful for frontline employees?
- Would you like to pilot test it at your organization?

Please get in touch with Jessica Sanchez, or email us if you are interested!



CalAIM ECM and Community Supports
Quick Reference Guide

Types of Community Supports Available in Humboldt and Del Norte Counties

Housing Navigation
Assistance with finding, applying for, and securing permanent housing.

Recuperative Care (Medical Respite)
Short-term residential care if you are discharged from a hospital and without stable housing.

Housing Deposits
Assistance with housing fees, including security deposits and utility setup, such as gas and electricity.

Caregiver Services (Respite Services)
Short-term relief for your caregivers, either where you live or at an approved facility.

Housing Tenancy & Sustainability
Support to keep your housing, such as help with landlord issues, annual certification, and connections to local resources to prevent eviction.

Medically Supportive Food/Medically Tailored Meals
Deliveries of nutritious groceries or prepared meals along with vouchers for healthy food and/or nutrition education.

Personal Care and Homemaker Services
Support for daily activities like bathing, feeding, meal preparation, grocery shopping, and going to medical appointments.

Short-Term Post Hospitalization Housing
Temporary housing after leaving inpatient care settings, including those for SUD treatment, mental health, correctional facilities, and more.

Explaining Enhanced Care Management (ECM) Services to a Member:

Your dedicated Lead Care Manager will coordinate health and health-related services, offering care on the phone, in-person, and/or where you live.

Your Lead Care Manager can:
- Find doctors and make appointments
- Arrange free transportation to and from appointments
- Check on prescriptions and help get refills
- Connect you with local resources and Community Supports for food, housing and other social services

ECM does not replace:
Your benefits: It's an additional benefit for Medi-Cal members.
Your doctors: Keep your current doctors and other providers.
Your options: You can cancel ECM at any time.

ECM is free! There is no added cost for ECM for you.
See other side for detailed eligibility criteria

For more details on Community Support service definitions and ECM eligibility criteria, visit the California Department of Health Services ECM and Community Supports Resource Page at https://bit.ly/4crpC14 or scan the QR code.

POPULATION HEALTH INNOVATION LAB

Partnership HealthPlan of California (PHC)

Updates on CalAIM

Carolyn Moulton, Program Manager II

Kaiser Permanente

Updates on CalAIM implementation

Kaiser Permanente

Southwest PATH CPI Meeting
Marin, Napa, & Sonoma County

August 2024

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2024 California Recuperative Care Symposium

Join us for the first statewide gathering focused on recuperative care

2024 CALIFORNIA Recuperative Care SYMPOSIUM

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

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

About the Event

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

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

NATIONAL INSTITUTE for MEDICAL RESPITE CARE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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Complex care certificate | A free training resource from Kaiser Permanente

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

What is complex care?

- Complex care improves health and social well-being or individuals with complex needs.
- Complex care addresses the multiple drivers of health and social needs through collaboration in communities and across sectors.

What is the complex care certificate?

- Nine self-paced online courses (13 CEUs) that teach frontline complex care staff how to engage with complex health and social needs.
- Learners will be equipped with tools to build relationships and address gaps in care delivery that apply to all target populations, from pediatrics to older adults.

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

- ❖ KP's California-based community partners
- ❖ Frontline complex care practitioners
- ❖ Interdisciplinary care teams including community health workers, nurses, doctors, peers, social workers, care managers
- ❖ Healthcare and social care workers who want to strengthen their practice of whole person care and team collaboration

The training curriculum is:

Self-paced

Person-centered

Collaborative

Accredited

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

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Complex care certificate | Courses included in the program

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

Complex care certificate courses:

Introduction to complex health and social needs
Interplay and compounding effects of multiple health, behavioral health, and social needs

Relationship-building in complex care
Building authentic healing relationships, setting boundaries, and establishing self-care practices

Power and oppression in complex care
Power dynamics in complex care, self-reflection on privilege and bias, and responsible use of power

Trauma-informed complex care
Principles and practices of trauma-informed care in complex care settings

Harm reduction in complex care
Principles and practices of harm reduction in complex care settings

Motivational interviewing in complex care
Principles and practices of motivational interviewing in complex care settings

Care planning in complex care
Generating, implementing, and maintaining strengths-based and person-centered care plans

Complex care delivery
Person-centered language, implementing care plans, and navigating complex systems

Collaboration and communication in complex care teams
Building authentic healing relationships, role clarity, collaborative decision-making, and conflict transformation in teams

A systems change project (optional for certificate designation)
Identifying systems issues, collecting data, storytelling, and implementation within your system/community

Courses contain a diverse array of education methods:

- Video, audio, and interactive elements
- Links to research
- Patient and practitioner stories
- Reflection and discussion questions
- Team activities

ABOUT THE CAMDEN COALITION

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

How to Submit a Referral for ECM or Community Supports

KP has a no-wrong-door approach for referrals

- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
- Use of the KP referral form is recommended; however, KP will accept any referral form created by another Medi-Cal plan. Simply send the completed form to the same KP email address noted below.
- Referrals may be placed via email or via phone.

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

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

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Enhanced Care Management (ECM) Providers in Marin, Napa, & Sonoma County

Organizations listed have executed contracts with KP as of **August 9, 2024**

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

Provider	Services/Populations of Focus	Phone Number	Counties Served
Aldea, Inc.	Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	707-224-8266	Napa, Sonoma
Alternative Family Services	Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	707-576-7700	Sonoma
CityServ	TBA	661-558-4441	Marin, Napa, Sonoma
Community Support Network, DBA Housing and Wellness Program	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - Individuals transitioning from incarceration (Adult) Adults - living in the community at-risk for LTC Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration	707-757-7892	Marin, Sonoma
Independent Living Systems	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	844-320-5182	Marin, Napa, Sonoma
J&M Homecare Services, LLC	Adults - Individuals at-risk for IP and ED Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community	925-552-6500	Marin, Napa, Sonoma

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Provider	Services/Populations of Focus	Phone Number	Counties Served
Keystone Therapy and Training Services, Inc	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	707-327-0909	Marin, Napa, Sonoma
Resolution Care (dba Vynca Care) **[Birth Equity Specialty Provider Type]**	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	888-227-8884	Marin, Napa, Sonoma
Seneca Family of Agencies	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration	415-482-6182 (Marin) 707-545-2700 (Sonoma)	Marin, Sonoma

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Provider	Services/Populations of Focus	Phone Number	Counties Served
Serene Health IPA **[Birth Equity Specialty Provider Type]**	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - Individuals transitioning from incarceration (Adult) Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	844-737-3638	Napa
Side by Side	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare	415-457-3200	Marin, Napa, Sonoma
St. Vincent Preventative Family Care **[Birth Equity Specialty Provider Type]**	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - Individuals transitioning from incarceration Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Adults -Pregnant and Postpartum Individuals at-risk for Adverse Perinatal Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD) Children & Youth - Pregnant and Postpartum Individuals at-risk for Adverse Perinatal	901-337-3003	Napa

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Enhanced Care Management (ECM) Providers in Marin, Napa, & Sonoma County

Organizations listed have executed contracts with KP as of **August 9, 2024**

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

Providers with blue text are newly added

Provider	Services/Populations of Focus	Phone Number	Counties Served
Stanford Youth Solutions (dba Stanford Sierra Youth & Families)	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration	(530) 656-5080	Napa
Star Nursing Inc	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD	877-687-7399	Marin, Napa, Sonoma
Sterling Hospitalist Medical Group, Inc	Adults - Individuals Experiencing Homelessness Adults - Individuals at-risk for IP and ED Adults - Individuals with SMI/SUD Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community Adults - Individuals with Intellectual or Developmental Disabilities Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals with Intellectual or Developmental Disabilities (I/DD)	714-897-1085	Sonoma
TLC Child & Family Services	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals transitioning from incarceration Children & Youth - Involved in Child Welfare	707-528-3020	Sonoma
Victor Community Support Services Inc	Children & Youth - Individuals Experiencing Homelessness Children & Youth - Individuals at-risk for IP and ED Children & Youth - Individuals with SMI/SUD Children & Youth - Individuals transitioning from incarceration Children & Youth - Enrolled in California Children's Services (CCS) or WCM w/needs Children & Youth - Involved in Child Welfare	(844) 547-1442	Sonoma
Your Home Assistant LLC	Adults - living in the community at-risk for LTC Adults - NF residents transitioning to the community	916-970-9001	Marin, Napa, Sonoma

Community Supports (CS) Providers in Marin, Napa, & Sonoma County

Organizations listed have executed contracts with KP as of **August 9, 2024**

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

Provider	Services/Populations of Focus	Phone Number	County/Counties
Accentcare of California	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Respite Services Personal Care and Homemaker Services	818-837-3775	Marin, Napa, Sonoma
Alegre Care Inc.	Respite Services Personal Care and Homemaker Services	818-837-3775	Marin, Napa, Sonoma
ASSURED INDEPENDENCE	Home Modifications	425-516-7400	Marin, Napa, Sonoma
CityServ	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Short-Term Post-Hospital Housing Recuperative Care Day Habilitation	(559) 802-3667	Marin, Napa, Sonoma
Committee of the Shelterless DBA COTS	Recuperative Care	707-776-4777	Marin, Napa, Sonoma
Community Support Network, DBA Housing and Wellness Program	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Short-Term Post-Hospital Housing	707-757-7892	Marin, Sonoma
Connect America West	Home Modifications	707-200-2138	Marin, Napa, Sonoma
Evolve Emod, LLC	Home Modifications Asthma Remediation	844-438-7577	Marin, Napa, Sonoma

Community Supports (CS) Providers in Marin, Napa, & Sonoma County

Organizations listed have executed contracts with KP as of **August 9, 2024**

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Providers with blue text are newly added

Provider	Services/Populations of Focus	Phone Number	County/Counties
Home Safety Services, Inc	Home Modifications	888-388-3811	Marin, Napa, Sonoma
Independent Living Systems	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Nursing Facility Transition/Diversion to Assisted Living Facilities Community Transition Services/Nursing Facility Transition to a Home	844-320-5182	Marin, Napa, Sonoma
Innovative Health Solutions	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Day Habilitation	707-205-5572	Napa
J&M Homecare Services, LLC	Respite Services Personal Care and Homemaker Services	925-552-6500	Marin, Sonoma,
Lifeline Systems Company	Home Modifications	800-451-0525	Marin, Napa, Sonoma
Maxim Healthcare	Respite Services Personal Care and Homemaker Services	(510) 982-3773	Marin, Napa, Sonoma
Mom's Meals	Meals/Medically Tailored Meals	877-508-6667	Marin, Napa, Sonoma
Serene Health IPA	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Short-Term Post-Hospital Housing Community Transition Services/Nursing Facility Transition to a Home	844-737-3638	Marin, Napa, Sonoma

Community Supports (CS) Providers in Marin, Napa, & Sonoma County

Organizations listed have executed contracts with KP as of **August 9, 2024**

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Providers with blue text are newly added

Provider	Services/Populations of Focus	Phone Number	County/Counties
Solano Women in Medicine	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services Respite Services	707-277-1677	Marin, Napa, Sonoma
St. Vincent Preventative Family Care	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services	901-337-3003	Napa
Star Nursing Inc	Housing Transition/Navigation Services Nursing Facility Transition/Diversion to Assisted Living Facilities Community Transition Services/Nursing Facility Transition to a Home Respite Services Personal Care and Homemaker Services	877-687-7399	Marin, Napa, Sonoma
Sterling Hospitalist Medical Group, Inc	Housing Transition/Navigation Services Housing Deposits Housing Tenancy & Sustaining Services	714-897-1071	Sonoma
Uncuffed Project Inc	Recuperative Care	415-320-8798	Marin, Napa, Sonoma
Victor Community Support Services Inc	Housing Transition/Navigation Services	844-547-1442	Sonoma

How a community-based organization can serve KP members

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

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

Full Circle Health Network

network@fullcirclehn.org

Phone number: 888-749-8877

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

INDEPENDENT Living Systems

ILSCAProviderRelations@ilshealth.com

Phone number: 305-262-1292

Partners in Care FOUNDATION *

Hubinfo@picf.org

Phone number: 818-837-3775

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

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

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Helpful Links and Contacts

KP Medi-Cal Resource Center:	**Resource Center Link**
KP 2024 Medi-Cal Direct Contract:	**KP.org/Medi-Cal2024**
KP Designated Medi-Cal Call Center:	**1-855-839-7613** Call to speak to a live Medi-Cal trained agent
KP Medi-Cal Programs (ECM, CS, CHW):	For current information, go to our website: **Link**
KP Medi-Cal Continuity of Care:	For current information, go to our website: **Link**
KP Self-Service Community Resource Directory:	**KP.org/communityresources** **1-800-443-6328** Toll-free number to speak with a resource specialist (M-F, 8a-5p local time)
KP Community Health Care Program:	Available to California residents without access to other health coverage. For current information, go to our website: **Link**
Medi-Cal Redeterminations Toolkit:	For current information, go to DHCS website: **Link**
Medi-Cal Rx:	**1-800-977-2273**
Medi-Cal Dental:	**1-800-322-6384**
Medi-Cal External Engagement	For general Cal AIM and CS/ECM inquiries, medi-cal-externalengagement@kp.org

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Questions?

Upcoming PATH CPI Events

Our next Southwest CPI regional meeting is virtual:

Wednesday, September 18th from 12:30 – 2:00 PM (Register here)

Upcoming PATH CPI Office Hours/Provider Learning Lounges:

Monday, August 26 from 1:00 – 2:00 pm (Register here)

Monday, September 11 from 12:00 – 1:00 pm (Register here)

Monday, September 23 from 1:00 – 2:00 pm (Register here)

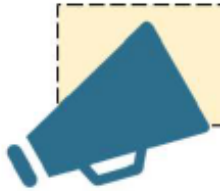
DHCS Policy Guidance Updates

Recently Released or Updated Policy Guidance

- ECM Birth Equity POF FAQs (Updated February 2024)

New Resources

- ECM: POF Spotlight for the ECM Long Term Care POF
- Webinar Slides and Recording for:
  - CalAIM for Individuals and Families Experiencing Homelessness (May 2024)
  - Launching ECM for the Birth Equity POF (Feb 2024)
- Community Supports Elections by MCP (Updated July 2024)



Please continue to share these resources widely with your networks!

Updates on DHCS Guidance for ECM and Community Supports

As of July 2024

2024 Update on ECM and Community Supports Action Plan

- DHCS anticipates releasing the following final guidance in August/September 2024:
  - ✓ Statewide ECM Referral Standards
  - ✓ Updated ECM Policy Guide with presumptive authorization policy for select ECM Providers

- DHCS anticipates releasing the following for **public comment** in August/September 2024:
  - Draft Closed-Loop Referral Implementation Guidance (covers ECM and CS referrals)
  - Draft Clarifications for Community Supports Service Definitions:
    - Housing Deposits
    - Medically Tailored Meals
    - Asthma Remediation
    - NF Transition/Diversion to Assisted Living
    - Community Transition Services/NF Transition

DHCS will share items for public comment with Facilitators for feedback

Comment Period: Closed Loop Referral

- DHCS invites you to provide feedback on their draft **Closed-Loop Referrals (CLR) Implementation Guidance** during the department's open comment period now through **Wednesday, September 4.**

- Feedback should be emailed to **PHMSection@dhcs.ca.gov** by with the subject line "Feedback on CLR Implementation Guidance."

CPI Facilitator Questions & DHCS Answers

Category	Question	DHCS Response
Transitional Rent	When will the Transitional Rent concept paper be released? It was slated for July 2024.	The concept paper has been going through internal review and we now anticipate this to be released in mid-August.
Transitional Rent	Has the requested amendment to the 1115 waiver been approved? Have there been any changes to the timeline presented on 6/5?	DHCS is still undergoing negotiations with CMS for waiver approval. The concept paper is undergoing internal review and acknowledge the delayed released to mid-August. We do not anticipate any material changes to the timeline currently and are actively working on streamlined methods to ensure Transitional Rent has a go-live date of 1/1/25 (at option of MCPs)
Transitional Rent	Will all MCPs have the option to begin this new benefit in October 2024?	MCPs will have the option to cover Transitional Rent no sooner than 1/1/25.
Transitional Rent	Providers are confused about what might count as housing (for example, does a trailer count? Are there certain required elements/conditions?)	More information will be provided through the concept paper. The concept paper will serve as a vehicle for public comment and DHCS will consider that feedback before issuing formal policy guidance.
Transitional Rent	How might cash flow concerns be addressed, particularly for smaller organizations with smaller operating budgets to expeditiously implement for eligible individuals? • Are there discussions at the state level of how the infrastructure to support smaller organizations can be developed locally or in a standardized way statewide (e.g., hub models, flexible funding pools, etc.)?	MCPs covering Transitional Rent will need to properly vet potential Transitional Rent providers to ensure delivery of services to eligible members. DHCS is exploring other innovative delivery models that such as flexible housing subsidy pools, and how MCPs and providers may benefit. No new policies or requirements are anticipated at this time.

Collaborating, Networking and Open Space

Time to talk with peers about…

- What's on your mind?
- How can we work together to overcome barriers and develop solutions together?

Post-Event Evaluation

To continue improving our work as your CPI Facilitator, PHIL kindly asks that you complete the brief survey that pops up in a new tab at the close of the meeting. Your feedback ensures quality improvement and will inform planning and activities through the evolution of the collaborative.

https://bit.ly/3SPxHp6

Thank You!

Feel free to contact our PATH CPI team

Kathryn Stewart
Director of Learning and Action
kastewart@phi.org

Tammy Chandler
PATH CPI Policy & Quality Improvement Manager
tchandler@phi.org

Zachary Ray
Consultant
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Jessica Sanchez
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jsanchez2@phi.org

Megan Kenney
Program Specialist
mkenney@phi.org

Stefani Hartsfield
Consultant
stefani@hartsfieldhealth.com

For general inquiries, please feel free to email path@pophealthinnovationlab.org


Thank you!

COTS
Est. 1988

A little about COTS

COTS' mission is to "assist those experiencing homelessness to ***find and keep housing****,* ***increase self sufficiency*** *and* ***improve well-being****.*

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ECM Populations of Focus we serve

- Adults and children **experiencing homelessness**
- Adults at risk for **avoidable hospital or emergency stays**
- Adults with **Substance Use Disorder** (SUD) or **Serious Mental Illness** (SMI)

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Programs We Offer

Onsite meals for clients and the community

Recuperative Care

ECM

Emergency Shelter for Individuals

Non-Congregate Shelter for Individuals

Family Shelter

Permanent Supportive Housing

Community Housing

Rapid Rehousing

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2023 ECM Stats

Individuals served: 156

Avg per Quarter: 112

ECM Care Managers: 6-8

QIP Incentive earned: 100%

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Key things we learned

- Have a **reliable tool** for keeping track of the data
- Monitoring QIP measures **throughout the quarter** rather than near the end makes a huge difference
- Early and often **communication** between CalAIM Admin and Care Managers keeps things running smoothly

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Data Collection and Monitoring Tools

- We updated our electronic case management system to **capture Blood Pressure and PHQ-9 data** and add Excel export function

- **Monitor PointClickCare** to ensure client records are available and that Care Plans and ROIs have been uploaded

- Modified the ECM QIP Submission Template for **internal analysis**

Track everything in one place

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2024 ECM QIP PHQ-9 Depression Screening and Blood Pressure Screening Submission Template

(Revised 3/25/2024

Measurement Period: **January 1, 2024 - December 31, 2024**

Submission Frequency: **Quarterly**

Submission Deadline: **2nd Friday of month following end of quarterly reporting period**

Submission Method: **sFTP Folder**

Submission Naming Convention: **Facility Name_Dep-BP_Month-Year**

All information must be entered for each member. Incentive dollars will not be awarded for incomplete entries.

** Enter PHQ-2, PHQ-9(OV), or GDS tool in "Score" column*

Provider Site Name	NPI Number	Patient Name	CIN	DOB	PHQ-9 Depression Screening		Blood Pressure Screening	
					Screening Date	* Score	Screening Date	Reading

IP PHQ-9 Depression Screening and Blood Pressure Screening Submission Template

(Revised 3/25/2024)

riod: **April 1, 2024 - June 30, 2024**

uency: **Quarterly** Submission Deadline: **2nd Friday of month following end of quarterly reporting period**

od: **sFTP Folder** Submission Naming Convention: **Facility Name_Dep-BP_Month-Year**

ust be entered for each member. Incentive dollars will not be awarded for incomplete entries.

**Enter PHQ-2, PHQ-9(OV), or GDS tool in "Score" column*

Internal Data Monitoring

Delete these Columns before submitting to Partnership!

					PHQ-9 Depression Screening		Blood Pressure Screening								
e	NPI Number	Patient Name	CIN	DOB	Screening Da	* Score	Screening Da	Reading	Care Manage	TAR Submission Date	Date ICP to PCC	Date ROI to PCC	Discharge Date	Notes
he Shelterless	1497410286													

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Internal Data Monitoring

Delete these Columns before submitting to Partnership!

Care Manager	TAR Submission Date	Date ICP to PCC	Date ROI to PCC	Discharge Date	Notes

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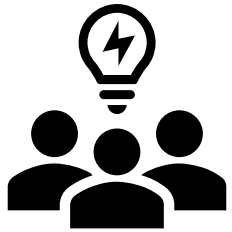
Managing Teams



- Established Workflows and Processes for Care Managers
- Closely monitor PointClickCare
- ECM Agenda Items at Team Meetings

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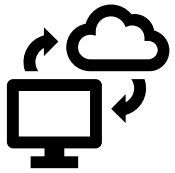
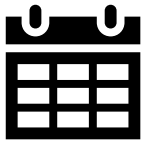
Established Workflow and Processes for Care Managers

Submit TAR and Notify Program Manager and CalAIM Admin that TAR has been submitted



PCC: Upload the ICP and ROI to PointClickCare right away, if the option is available, if not, email CalAIM Admin.

Keep a running list of clients not in PCC, and check again at the end of the month



EOM- Notify CalAIM Admin if client is still not in PCC

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Blood Pressure Readings and PHQ-9 Scores Workflow

Administer BP and PHQ-9 at initial Care Management Meeting

Document in Electronic Case Management system

Repeat monthly for any scores higher than recommended by Partnership

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Monitoring Measure Performance

Designated staff as central point person for ECM data management and communication:

Monitor PointClickCare to ensure that CMs can access their clients in the system, and that documents have been uploaded

Act as the **Point of Contact** to communicate with PHC and PCC when technical issues arise in the portal (missing clients, upload issues, etc.)

Track updates and communicate with Care Managers when:

- Their client was added to PCC
- BP and PHQ-9 scores are missing or out of date
- Documents are missing, incorrectly labeled, etc.

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Communication

- ☑ Make ECM QIP Measures a team meeting agenda item
- ☑ Email reminders ahead of deadlines
- ☑ Make time to discuss strategies for clients who are resistant to getting their blood pressure taken
- ☑ Express appreciation for efforts
- ☑ Celebrate successes big and small

Even partial credit for ECM QIP is worth the effort.

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Contact

www.cots.org

Garrett Crane
Assoc. Director of Shelter Service

Email gcrane@cots.org
Phone 707.789.6410

Shannon Garay
Senior Programs Administrator

Email sgaray@cots.org
Phone 707.765.6530 x134

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