8/19/24 CPAG Meeting Q&A

Q: How do the Community Health Improvement Plan (CHIP) workgroups work? What are the outcomes? How will this process connect with future processes? Will there be joint planning?

Workgroups are planned in collaboration with Alameda County Health Public Health Department and community-based organizations. The workgroups are divided by CHIP priority areas: (1) access to care, (2) economic security and opportunities, and (3) peaceful families and communities. The workgroups provide different ways of opening conversations with partners with which we don't usually work.

Q: Who should participate in the Community Health Improvement Project (CHIP) workgroups?

Direct service providers (managers and staff), clients, and community members. Sign up here.

Q: Will the focus groups with hospitals (as part of Community Health Needs Assessment) be jointly planned?

Both the CHNA and CHIP processes are exciting ways to do collective impact in our community. The Public Health Department works with community members, community-based organizations, providers, hospitals, and our Managed Care Plans to identify priorities, communities for workgroups, and key data. Additionally, Hospitals and Managed Care Plans have their own required needs assessments, and we attempt to align our assessments as much as possible.

Q: What is challenging when working with the community groups for the CHNA and CHIP?

The biggest challenge is building and maintaining trust with the communities that we work with. It takes time for people to trust the Public Health Department and provide transparent feedback. This was especially true during the pandemic, when communities that we hadn't spent time with were not open to hearing information from us regarding COVID-19.

Regarding trust, we know that many of our communities are surveyed multiple times, usually not by the same entities. And change can take many years to happen. These factors make maintaining trust even more difficult. It is our responsibility to be responsive and authentic to overcome these challenges.

Q: How is information from the focus groups used in conjunction with other data?

We use secondary data to identify priority issues and the highest disparities. Some data that we use are poverty rates, sexually transmitted infections rates, homelessness rates, and many other data elements. The focus group data will add context and nuance to the secondary data.

Q: What is a big takeaway or something that you're grappling with that you would want this group to help with?

We would appreciate hosts for focus groups, so if your organization is able to host us, please reach out to Carolina.Guzman@acgov.org.

Q: Do you have a model where a distressed community got better? How did the system work together? What are other factors that impact the system for the better?

Elements of a successful model include authentic partnerships, guided by reliable data, and community partnerships are supported and invested in by funders. The more pragmatic the model is—the more it is based on what the community needs, the more successful it is.

Q: For the behavioral health clients who live in residential care facilities, does the Public Health Department conducting the CHIP have jurisdiction over these communities?

The Behavioral Health Department, Public Health Department, and Housing & Homelessness Services partner to gather data that each team keeps regarding their clients.

Q: From the community-based providers, what are the challenges in completing the CHNA and CHIP?

We find that capacity to set aside time and resources is the biggest challenge for providers. Many of our provider groups are asked to participate in multiple assessments, so it can be a big ask. Other challenges include not having reliable or commonly-collected data (e.g. gun violence) and population movement.

Regarding gun violence, we appreciate Supervisor Carson in declaring gun violence as a public health issue, because that means we are more able to track information and data. This will help us create priorities and establish actions plans to reduce this public health issue.

Q: If we assess someone who may be eligible for care management, should we go directly to the community provider or to the Managed Care Plan (MCP)?

Either way will get your client connected to services.

Q: What was the main cause of the decline of HealthPAC enrollees?

The Affordable Care Act and recent Medi-Cal expansions, expanding access to Medi-Cal regardless of immigration status, have made Medi-Cal more accessible to more people. HealthPAC staff help a client enroll in Covered CA or Medi-Cal when they are eligible.

Q: Is there a remaining indigent population that are not eligible for Medi-Cal?

Yes, approximately 8,000 Alameda County residents are enrolled in HealthPAC, as they are not eligible for Medi-Cal.