Alameda County Community Provider Advisory Group

Meeting 2: Improving Community Health through Collaboration and Connection

August 19, 2024

Alameda County Health

Agenda Overview

- Welcome & Introductions
- Meeting 1 recap & Meeting 2 objectives
- Community Health Collaborations
  - County Community Health Improvement Plan
  - Medi-Cal Population Health Management
  - Health Program of Alameda County & Partner Highlights
- Discussion/breakouts
- Close

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Community Provider Advisory Group Objectives & Deliverables

- **Objectives**
  - Develop shared understanding of evolving safety net policies and landscape
  - Align cross-sector priorities to support health and wellbeing of our communities
  - Identify system strengths and opportunities

Deliverables

Guiding principles for CPAG meetings

System priorities to support planning and future investments

CPAG will not discuss program-specific funding to avoid future conflict of interest

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Draft CPAG Guiding Principles

- Keep a systemwide perspective
- Focus on advancing people's ability to get care equitably
- Focus on coordination, common goals, and shared priorities
- Considerations for discussions and planning
  - Where are connections/opportunities to align across community health, behavioral health, homelessness?
  - How can we collectively strengthen the safety net system in Alameda County to support those who need it most?
  - What should be prioritized over the next three to five years?
  - What do data and trends highlight? Where are there gaps?

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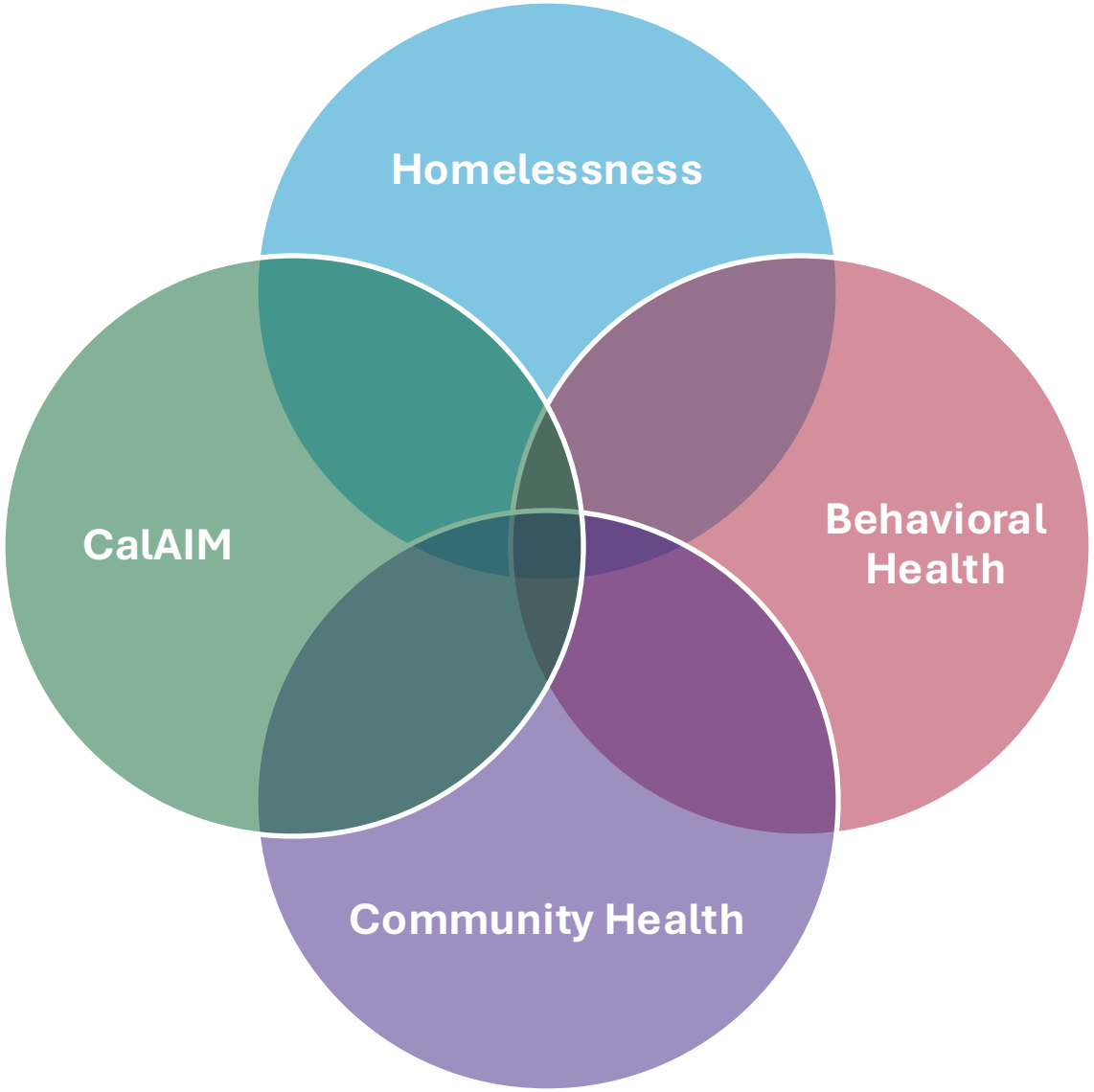
Why are we here?



Cross-cutting priorities

- Equitable access to care and services
- Addressing physical, behavioral, and social health care needs
- Preventing and reducing homelessness
- Preventing and reducing justice involvement
- Integrated service delivery
- Supporting resilient communities
- Cross-systems coordination and data infrastructure

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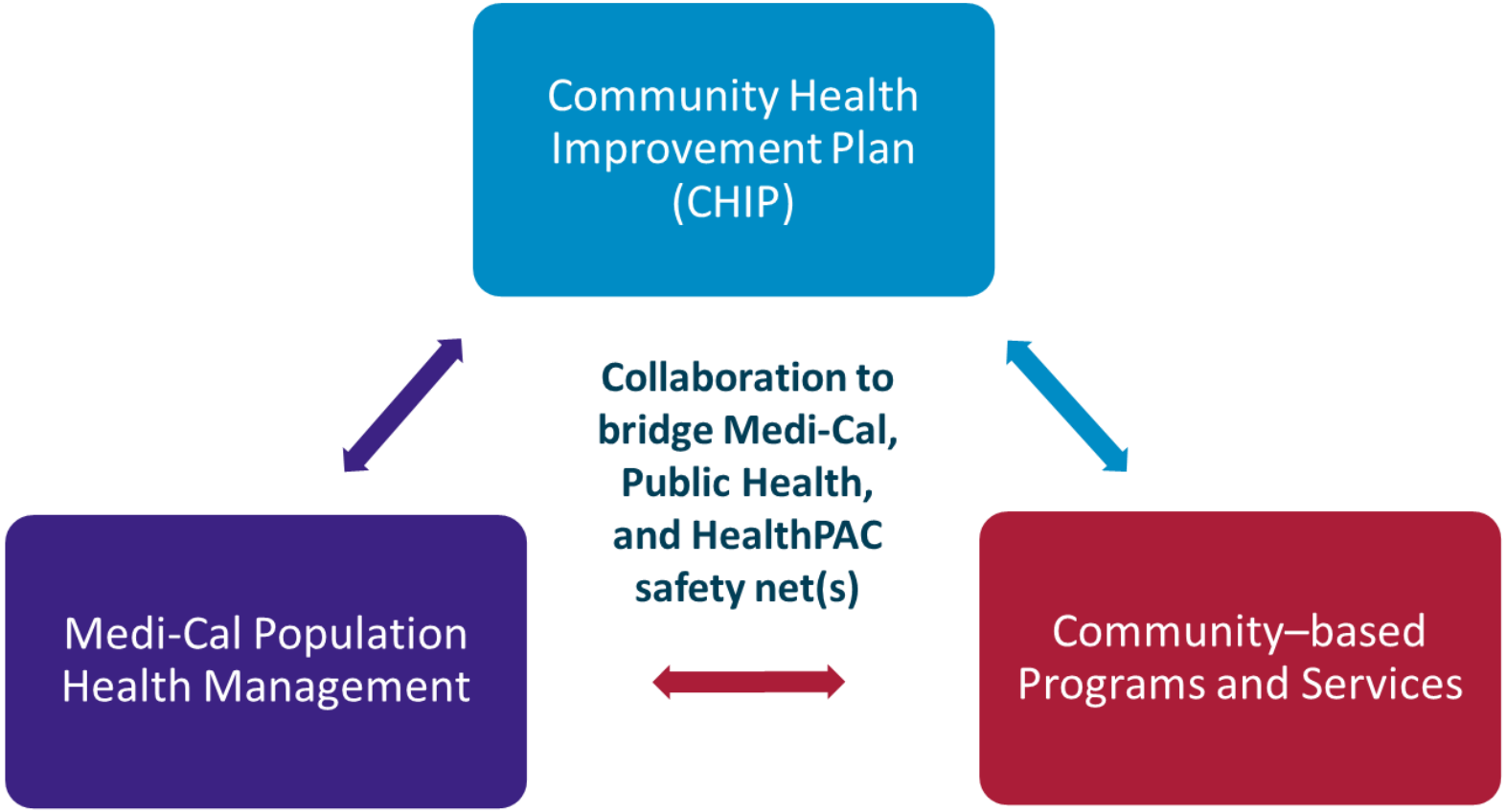
Today's Objectives

- Highlight key concepts in County and community provider approaches to supporting community health, with focus on public health and indigent health
- Discuss impacts of key systems changes on community health
- Identify and explore opportunities to advance community health priorities



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Public Health Department as Community Health Strategist

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

George Ayala, Public Health Deputy Director, ACPHD

Carolina Guzman, QI Manager, ACPHD Quality Improvement and Accreditation

Evette Brandon, Director, ACPHD Quality Improvement and Accreditation

Presentation Overview

I. Community Health Definition

- Public Health 3.0 and Health Strategist Role
- Community Partnership Approaches
- Cross-sector collaboration case samples

II. Community Health Needs Assessment and Community Health Improvement Plan

- Definitions
- Partnerships
- Results and Strategies

III. Next Steps

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Community Health Defined

PUBLIC HEALTH 3.0

Economic Opportunity

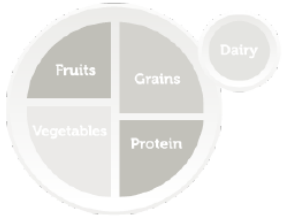
Housing

Environment

Education

Social Determinants of Health

are the conditions in which people are born, live, work and age.



Food

Safe Neighborhoods

Transportation

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The Community Chief Health Strategist will...

PRACTICE #1

adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.

PRACTICE #2

develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.

PRACTICE #3

identify, analyze and distribute information from new, big, and real time data sources.

PRACTICE #4

build a more integrated, effective health system through collaboration between clinical care and public health.

PRACTICE #5

collaborate with a broad array of allies, including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.

PRACTICE #6

replace outdated organizational practices with state-of-the-art business, accountability, and financing systems.

PRACTICE #7

work with corresponding federal partners – ideally, a federal Community Chief Health Strategist – to effectively meet the needs of their communities.

Public Health as Community Chief Health Strategist

- Works with partners to drive initiatives that explicitly address “upstream” social determinants of health and advance equity
- Embedded at every level of the Public Health Department
- The Public Health Department is a convener, collaborator, connector funding source, and asset for other organizations

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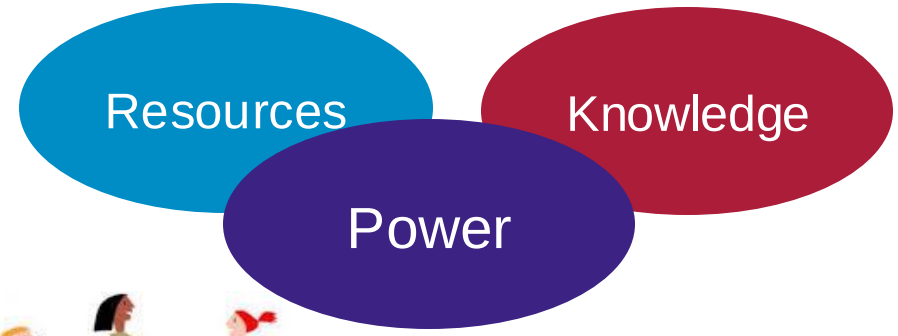
Strategic Community Partnerships

- Includes social and ecological systems
- Counties or cities can contain many communities



The Strategy: What resources, knowledge, and power does each type of stakeholder bring?

Impacted residents: Formal voting power, 'vote with their feet'

Public policy implementers: Enact/enforce legal framework

Policy-makers and advocates: Change legal framework

Service providers: Create new resources or change their distribution

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

2022-2025

CHNA/CHIP Before Mandates

Partnerships

- Local non-profit hospitals meeting IRS requirement to maintain nonprofit status
- Other local health jurisdictions (i.e., Contra Costa and Berkeley)

Assessments

- Community focus groups led by the public health department
- Hospitals provided limited funds for participant incentives

Data Prioritization and CHIP

- Population data provided by the public health department
- Health prioritization and implementation strategies included few stakeholders

Public Health Accreditation Foundational Plans

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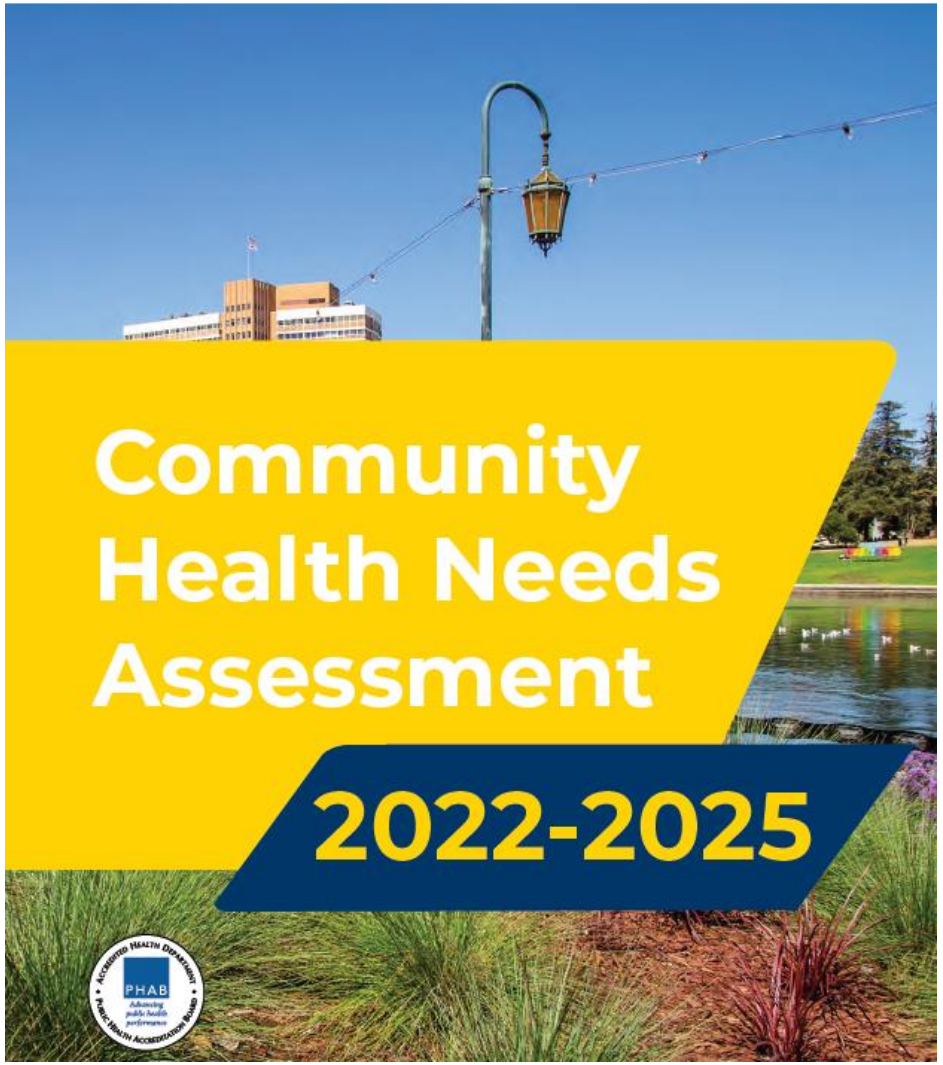

The CHNA takes a comprehensive look at the health of Alameda County residents by studying a combination of the social determinants of health and specific health outcomes of individuals, neighborhoods, and populations.

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

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Ongoing CHNA & CHIP Partners 2024-2027

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What is a Community Health Improvement Plan?

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

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

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

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2023 – 2025 CHIP Priority Areas

ACCESS TO CARE

- Early screening for chronic conditions: diabetes, heart diseases, STIs, immunization
- Preventative services for pregnant and parenting individuals
- Early childhood screening services and health promotion

PROMOTE ECONOMIC SECURITY & OPPORTUNITIES

- Combat hunger and food insecurity
- Promote guaranteed basic income among pregnant and parenting individuals
- Connect people to safety net services and programs

PEACEFUL COMMUNITIES AND FAMILIES

- Data collection: Define the nature and scope of the violence problem.
- Narrative change: Understand and convey why violence occurs, who it affects, define risk and protective factors
- Scaling up best and promising practices: researching prevention and intervention strategies.
- Policy Advocacy: Promote and support community power and leadership efforts

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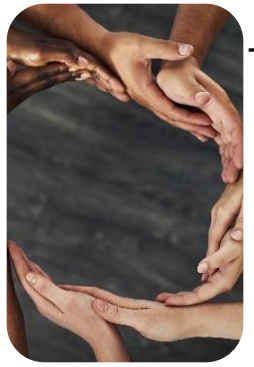
CHIP Alignment with Managed Care Plans via CalAIM



Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Plans (MCPs) to align with local health departments in conducting population needs assessment

Starting on January 1, 2024, MCPs are required to work with LHJs to determine what combination of *funding and/or in-kind staffing* the MCP will contribute to the LHJ CHA/CHIP process.

MCPs are required to direct funding for contracts with community-based organizations/consultants to support data collection and analysis, meeting facilitation, community outreach

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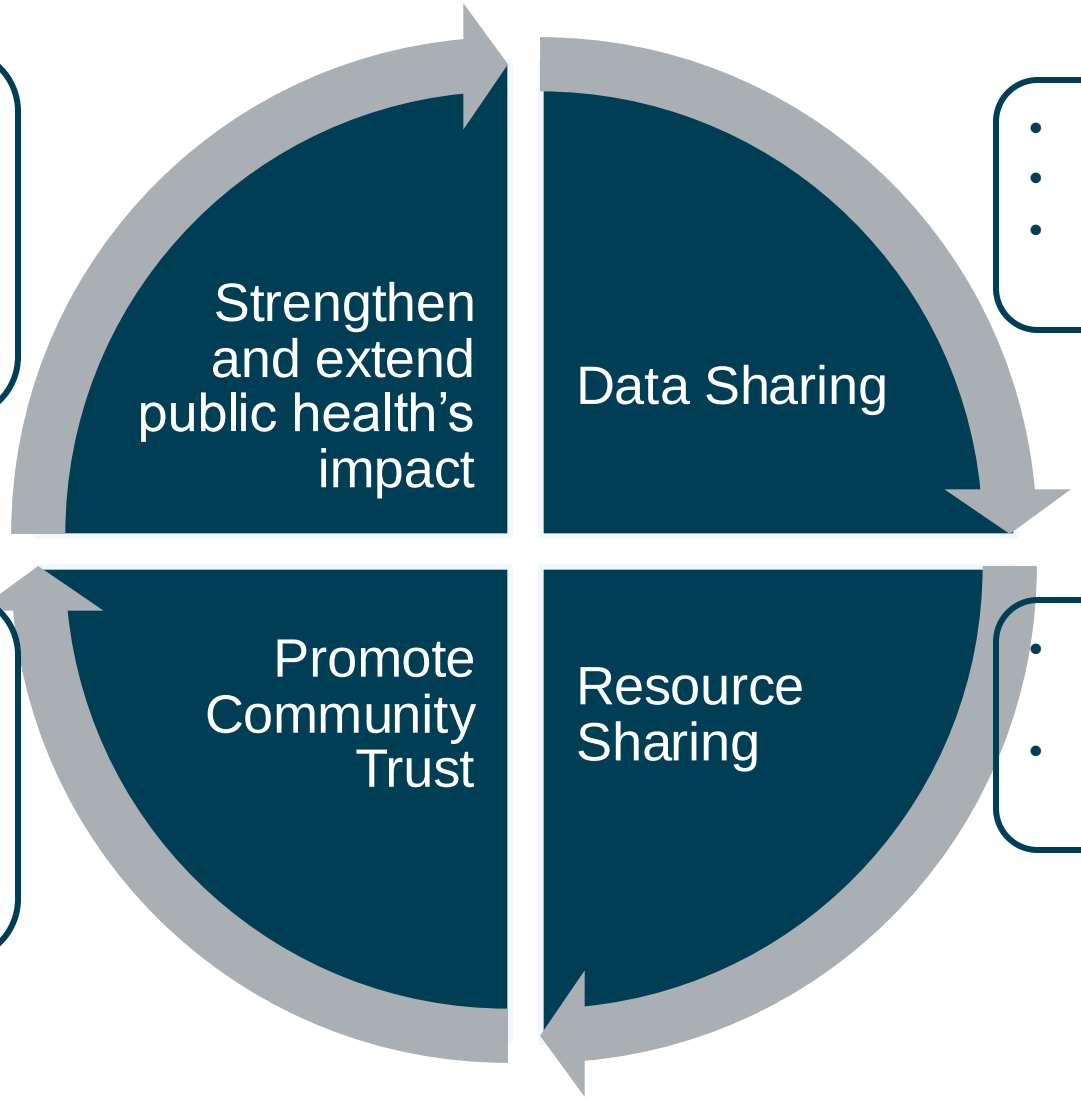
CHIP Alignment with Alameda Alliance & Kaiser

- Promote collaboration amongst sectors with a shared vision
- Scale-up interventions and programs
- Expand geographical reach



- Share data across systems
- Identify inequities
- Identify opportunities for improvement

- Share opportunities for genuine community participation
- Promote community's voices and experiences in program development

- Support integration of strategies across systems
- Identify new sectors and partners to sustain efforts

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Expanding Partnership:
SB 326, Behavioral Health Services Act (BHSA)*

Integrated Plan
Requirements Related to Local Planning Processes

Under SB 326[1], county behavioral health programs (BHPs) must consider both Managed Care Plan (MCP) and Local Health Jurisdiction (LHJ) local planning processes throughout the development of their IPs. Specifically, each county BHP must:

Work with its LHJ on the development of its **Community Health Improvement Plan** (CHIP) (5963.01.(b))

Work with each MCP that covers residents of the county **on the development of the MCP's Population Needs Assessment (PNA)*** (5963.01.(a))

Consider the CHIP of each LHJ that covers residents of the county in preparing their IP and annual update (5963.02.(b)(4))

Consider the PNA* of each MCP that covers residents of the county in preparing their IP and annual update (5963.02.(b)(3))

*SB 326 was written prior to the 2024 DHCS redesign of PNA requirements. MCPs no longer develop and submit a PNA to DHCS.

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[1]Bill Text - SB-326 The Behavioral Health Services Act. (ca.gov)

*There are additional stakeholder engagement requirements for local behavioral health departments that ACBHD will manage

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CHNA & CHIP Timeline for 2024-2027 Cycle

All CHNA Focus Groups must be complete by September 27, 2024

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CHIP Implementation Workgroup Trajectory

June 2024

Working Group Launch

- Identify the focus areas of the working group
- Determine the sufficiency of the data needed
- Commit to data analysis for next meeting

Meeting 2 September 2024

Analysis & Meaning-Making

- Clarify areas of strength and areas needing improvement
- Consider contextual and environmental opportunities and threats

Meeting 3 January 2025

Further Analysis & Generating Possibilities

- Assess the programmatic capacities for desirability, feasibility, and viability
- Develop recommendations for starting, stopping, modifying, or maintaining programmatic efforts
- Articulate priority recommendations

Meeting 4 May 2025

Develop Recommendations & Promises

- Develop recommendations for starting, stopping, modifying, or maintaining programmatic efforts
- Prioritize the recommendations with regards to importance and urgency (short & long-term goals)

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MCPs & CHIP Implementation: Birth Equity Project

Goal: Between July 2024 and December 2025, at least 5% of (approximately 60) Black (African American) Medi-Cal members will receive doula services.

- EmbraceHer Program
- Related DHCS Bold Goal: Close maternity care disparity for Black and Native American persons by 50%

Activities:

1. Forums to educate doulas about Medi-Cal benefits that support maternity care and orient them to Managed Care Plans (MCP) contracting to ensure an adequate, culturally affirming doula network.
2. CHNA Focus groups with doulas and Black members with recent birthing experiences
3. Investigate and share with MCP contracted doulas best practices for HIPAA-compliant record keeping.
4. Meet with birthing hospitals to communicate about the doula benefit and ways to improve doula access.
5. Outreach to providers about the benefits and increase patient referrals to doula services and support engagement in the Abundant Birth Project

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CHIP Community Advisory Board

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

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Advancing the Work

Community-led Health Improvement in Action

CHNA Focus Group Participant Nominations

Identify groups/orgs to recruit participants

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

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CHIP Workgroup Participation

Sign up for one or more CHIP Workgroup:

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

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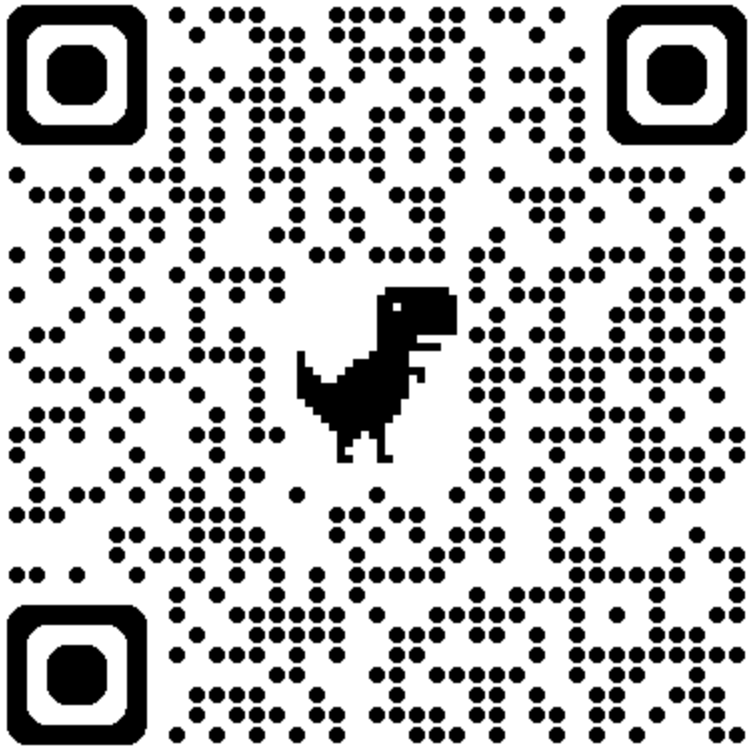

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Questions

Carolina Guzmán, Quality Improvement Manager
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Evette Brandon, Director, Quality Improvement and Accreditation Division
Evette.brandon@acgov.org

Medi-Cal Population Health Management (PHM)

Dr. Donna Carey, CMO, Alameda Alliance for Health

Population Health Management (PHM) Program

Our Aim

Optimal health and wellbeing for all members.

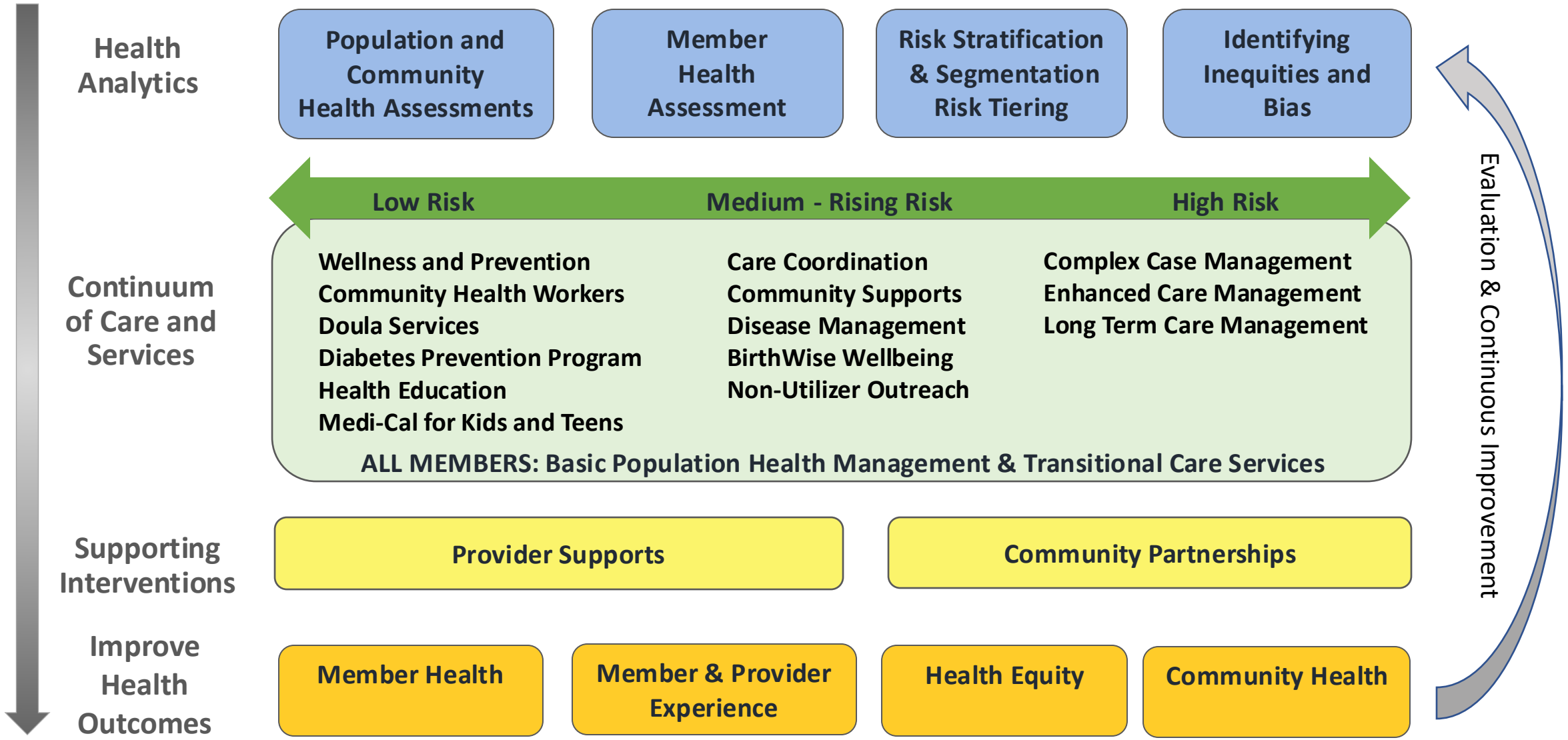
The Need

Not all members need the same care, or receive the care they need, when they need it.

The PHM Solution

- Understanding Alliance members through assessments and identifying groups of members at risk.
- Providing targeted, equitable access to necessary wellness and prevention services, care coordination, and care management programs.
- Collaborating with provider and community partners.
- Desired outcome: Improving health and equity for Alliance members and our Community.

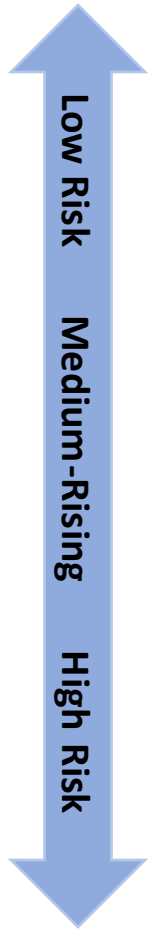
Population Health Management Framework



Addressing social determinants of health to promote health equity.

2024 PHM Strategy

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



ACPHD – Alliance Collaboration

- Monthly meetings between the Alliance and ACPHD
- Community Health Improvement Plan Workgroups Participation
- Creation of a shared goal to connect Alameda County Medi-Cal Members to culturally sensitive doula services (particularly Black birthers)
- Data sharing – will begin by January 2025
- Resource sharing to support CHNA/CHIP initiatives
- Engaging the Alliance Community Advisory Committee in CHNA/CHIP efforts

For more information on the Alliance Population Health Management Program contact:

Linda Ayala

Director, Population Health & Equity

layala@alamedaalliance.org

Advancing Community Health via Health Program of Alameda County (HealthPAC)

Danice Cook, HealthPAC Administrator, HealthPAC, Alameda County Health

Andie Martinez Patterson, CEO, Alameda Health Consortium/Community Health Center Network

Tangerine Brigham, Chief Administration Officer – Population Health, Alameda Health System (AHS)

History of HealthPAC (HPAC)

- All California counties, have an obligation to provide care for the uninsured, referred to as Section 17000 under the Welfare and Institutions Code.

Late 1970s

- County met obligation via longstanding contractual relationships with community clinic providers, constituting the **Alameda County Indigent Care Primary Care Services /Open Access Model Program**

July 2011

- The indigent program renamed the **Health program of Alameda County or HealthPAC**
- Bridge to Reform 1115 Medicaid Waiver leveraged to add program eligibility and registration to support enrollees' future transition to Affordable Care Act's Medicaid expansion.

2014

- **40,000** HealthPAC enrollees automatically transitioned to Medi-Cal!
- **Post-ACA, only FQHCs included in provider network** because of their experience serving the uninsured population, existing infrastructure, and access to federal funding through prospective payment system (PPS) rates.

FY 2015-2016

- HPAC contracts restructured to include **system improvement incentives** using from MediCal 2020 1115 waiver.
- Increased focus on integration between primary care and **behavioral health and coordinated whole person care.**

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HealthPAC Program Overview

- **Services and Eligibility**
  - Comprehensive health care services, mirroring the Medi-Cal scope of services, to low-income adults above 138% FPL to 200% FPL
  - HPAC is not insurance, and does not cover enrollees for medical expenses outside the limited network of primary care providers, specialty care providers, and two hospitals
  - Enrollees must be ineligible for other public programs such as Medi-Cal, Medicare and Covered California
- **Administration: Alameda County Health**
  - Contracts compliance and payment
  - Enrollment assistance to residents
  - Data collection for contract monitoring and outcome measurement

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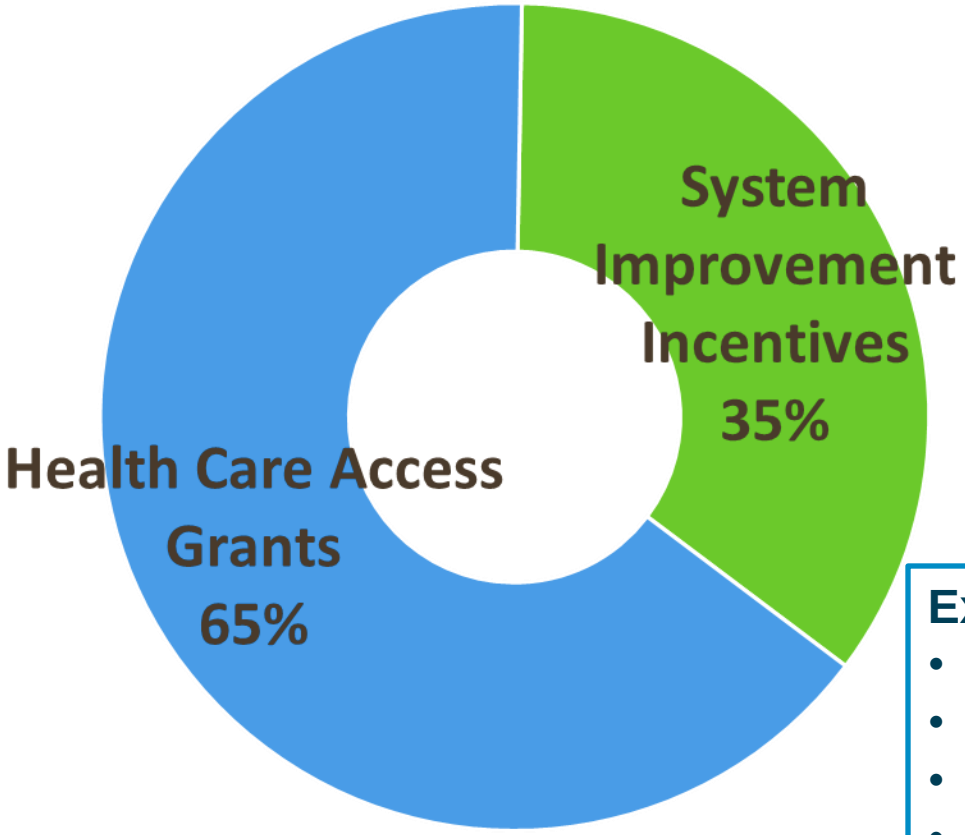
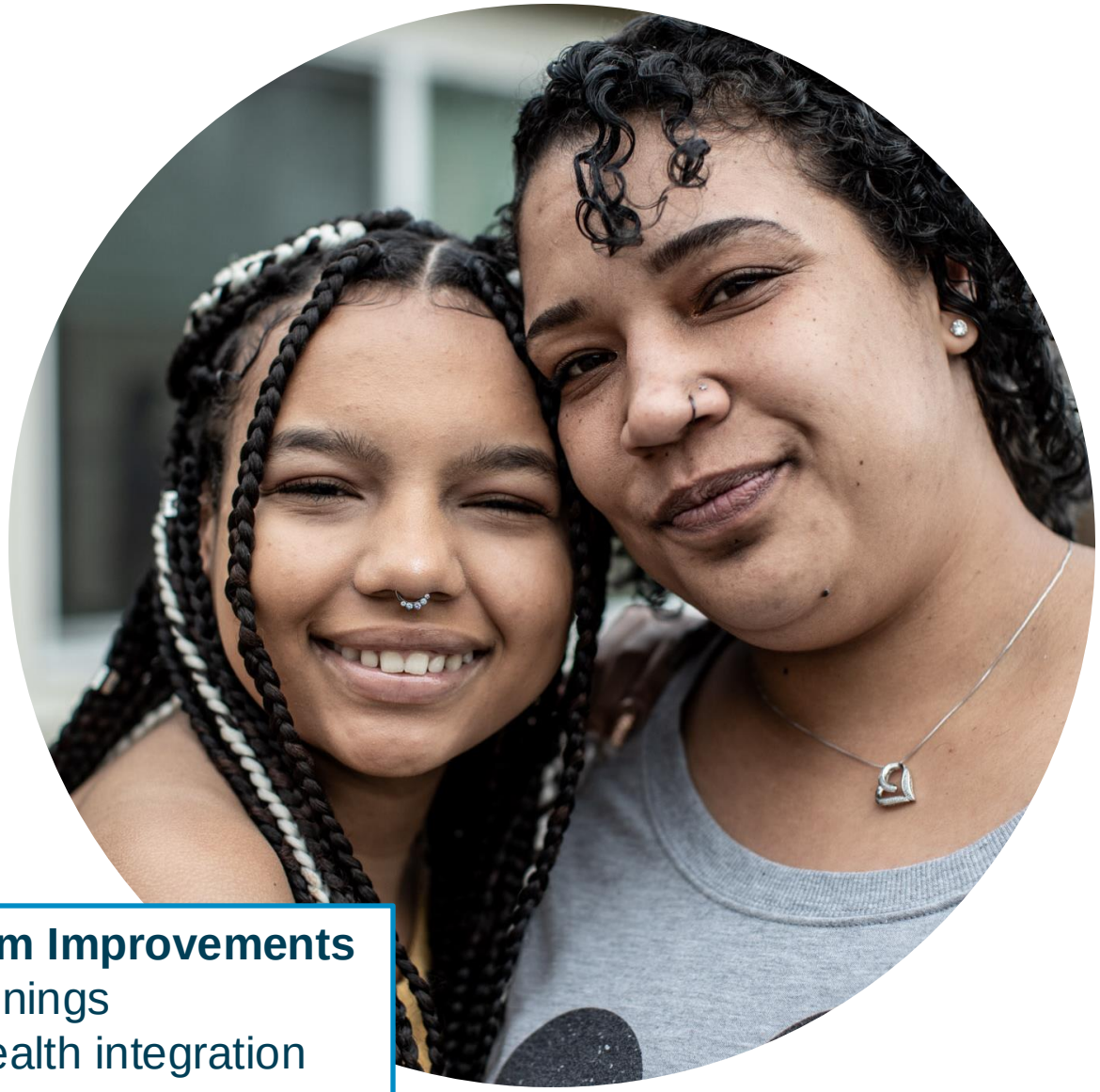
HealthPAC Funding Structure

~$66M annual investment

Over $1B in cumulative investment since 2011





Example System Improvements

- Cancer screenings
- Behavioral health integration
- Fathers Corps
- Recipe4Health

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Current HPAC Landscape

Enrollment and Program Trends

- 66% enrollment decline since FY 14/15 due to increased Medi-Cal enrollment (Affordable Care Act, CA's Adult Expansions)
- Providers rely on HPAC for infrastructure support in addition to care for uninsured people

Major shifts in Medi-Cal

- As HPAC members become eligible for Medi-Cal, provider revenue for patient care shifts from HPAC to Medi-Cal
- CalAIM has significantly changed the Medi-Cal delivery system, moving more responsibility to managed care plans and expanding the scope of services eligible for Medi-Cal reimbursement

Emerging and shifting priorities for County

- COVID-19 response expanded models and providers for serving communities
- Significant new and ongoing investments in local safety net hospitals, CalAIM implementation, data infrastructure (SHIE), behavioral health, and homelessness

HPAC Supports Critical Safety Net Connections

- Care transitions
  - Between hospital and outpatient – for physical and behavioral health
  - Between jail health and clinic/treatment programs
  - Between outpatient clinics and behavioral health
- Collaboration between Health and Homelessness services
  - Documenting medical illness as a part of housing priority
  - Respite care
  - Homelessness prevention
- Connecting to Communities to address health equity
  - Access to health care
  - Reducing disparities

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HealthPAC Partner Highlights

ALAMEDA HEALTH CONSORTIUM

The Alameda FQHC Health Care safety net infrastructure

August 2024

Andie Martinez Patterson, CEO

ASIAN HEALTH SERVICES

axis community health

BAY AREA COMMUNITY HEALTH

La Clínica℠ a california health center

LifeLong Medical Care Health Services For All Ages a california health center

NATIVE AMERICAN HEALTH CENTER Serving the community since 1972

TIBURCIO VASQUEZ Health Center

West Oakland Health

ALAMEDA HEALTH CONSORTIUM

The integral role of the FQHC

FQHC federal requirements

Operational & Clinical Service Requirements	
Governed by patient-majority board of directors	
Serve medically underserved population(s) or service area	
Services available regardless of patients' payment source or ability to pay	
Available (either directly or under a referral arrangement) to patients at all health center service sites	
Comprehensive primary health services, including preventive, diagnostic, treatment, and emergency health services	
Primary health services	Basic health services including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology
Preventive health services	• Well-child care • Prenatal and perinatal care • Immunizations • Voluntary family planning • Preventive dental care
Emergency medical services	Provided through defined arrangements with outside providers for medical emergencies during and after centers' regularly scheduled hours
Enabling services	Required services include, but are not limited to: • Translation services • Health education • Transportation for individuals residing in a center's service area who have difficulty accessing the center
Supplemental Services	Additional services that are not primary health services but are appropriate to meet the health needs of the service population, such as behavioral health and environmental health services

Quality of Care Reporting
❑ Childhood Immunization Status
❑ Cervical Cancer Screening
❑ Breast Cancer Screening
❑ Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
❑ Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
❑ Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
❑ Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
❑ Colorectal Cancer Screening
❑ HIV Screening
❑ Preventive Care and Screening: Screening for Depression and Follow-Up Plan
❑ Depression Remission at Twelve Months
❑ Dental Sealants for Children between 6–9 Years
❑ Controlling High Blood Pressure

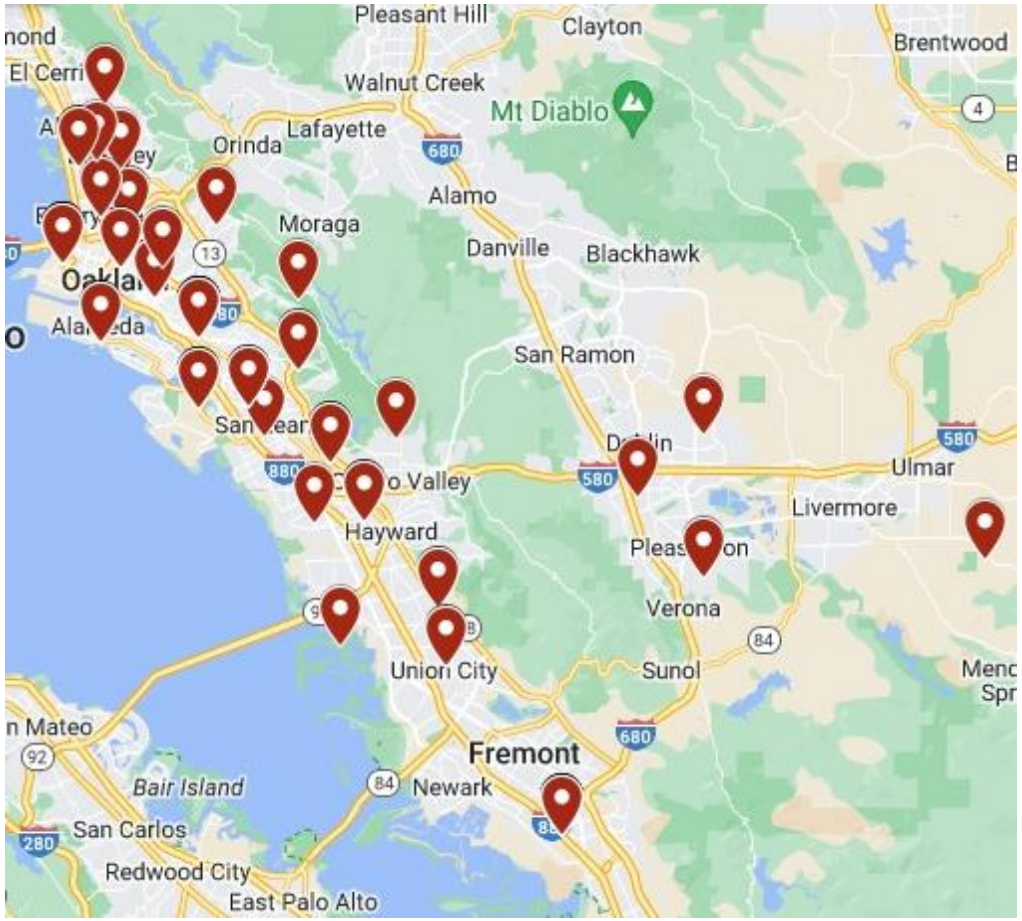
ALAMEDA HEALTH CONSORTIUM

FQHCs as a connector in community health

In Alameda, the FQHCs are the backbone of the Safety Net Primary and Preventive Care Delivery System

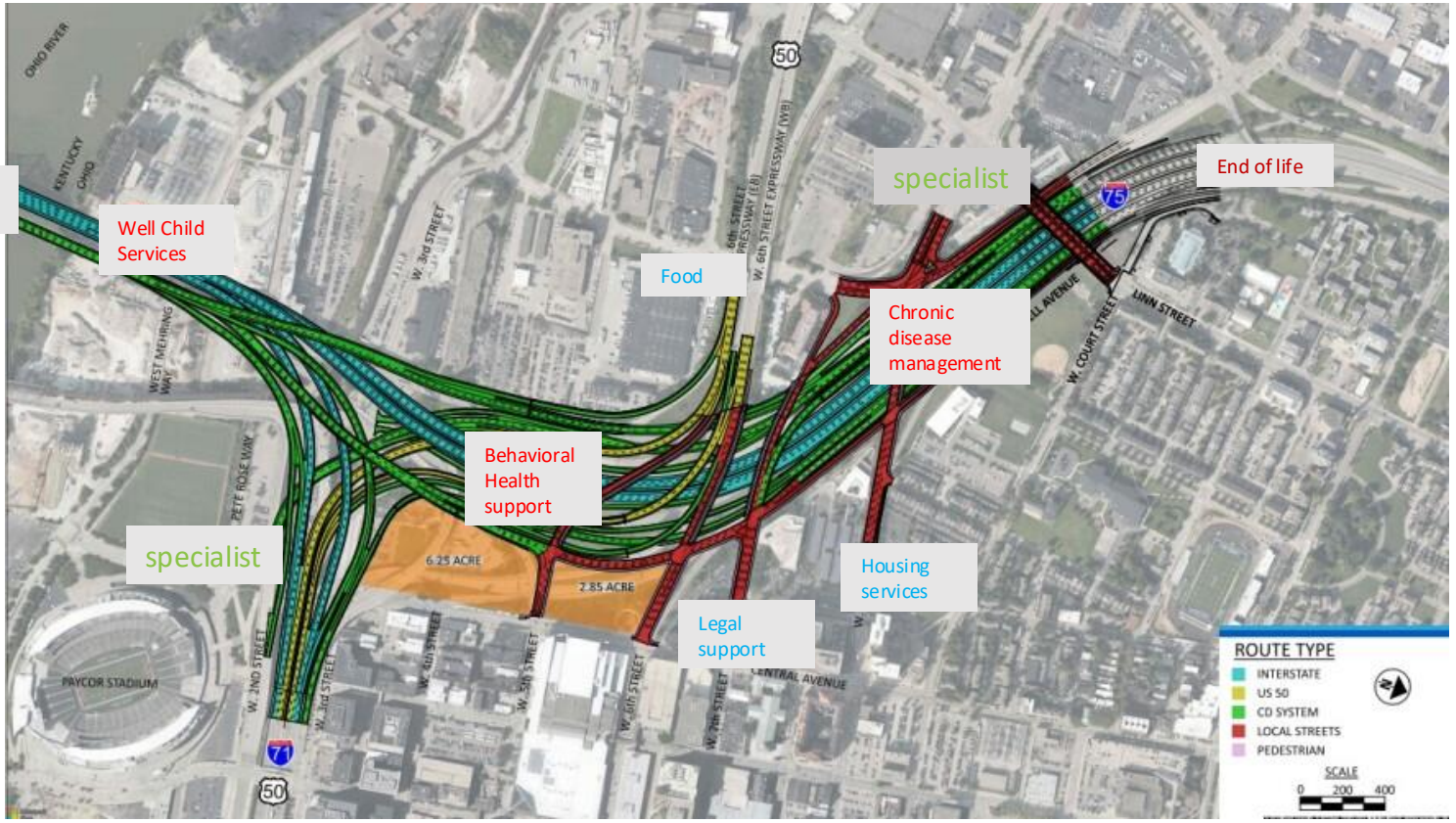
- Medi-Cal members served through 8 community health centers = 45% of Alameda Alliance for Health Medi-Cal population
- Access Points in Alameda: 106
  - 28 of County's 32 school-based health sites
  - 7 WIC sites
  - 21 mobile units
- Primary Care Provider Types
  - Medical: 422
  - Dental: 183
  - Behavioral health: 138

  + acupuncture, vision, chiropractic
- Serving over 200,000 patients in Alameda (90% Medi-Cal, 7% Medicare)



CHCN is both a
Independent Practice Association (IPA)
Management Services Organization (MSO)
on behalf of the 8 FQHCs

The FQHCs in Alameda County serve throughout the lifespan and connect patients to services when they need it



Coordinator for Programs across CHCs

- Medi-Cal & CalFresh outreach & enrollment
- HIV ACCESS
- Workforce development
- Advocacy

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Managed Services Organization & IPA

- Data hub for CQI
- Clinical network coordination
- Claims adjudication

COMMUNITY HEALTH CENTER NETWORK

AHC/ CHCN serve to connect and elevate the work of each FQHC into a connected system

Alameda County FQHCs' Expansive Partnerships

Youth-Based Services

- Our FQHCs partner with 28 of the 32 school-based health and wellness sites in Alameda County (88%)
  - Provide a myriad of health and preventative services
  - *Example: NAHC & TVHC served 4,100 students last year*

Social Determinants of Health

- Our FQHCs partner with other trusted partners (CBOs) to address SDOH conditions:
  - Food insecurities
  - Socioeconomic needs
    - Emergency financial assistance
    - Temporary or permanent housing
  - Domestic violence support
  - *Example: AHS, Axis, & TVHC provided 13,680 households with food last year*

La Clinica: SBS

AHS: Food Distribution

Alameda County FQHCs' Expansive Partnerships

Building Safe Space Networks

- Our FQHCs leverage their reputations as trusted partners to build safe space networks at:
  - Libraries
  - Faith-based organizations
  - Refugee/immigrant organizations
- To provide multilingual/multicultural
  - Health and wellness resources
  - Safety-net guidance/ assistance
  - Connection to community

Senior Care/Socialization Services

- Our FQHCs partner with senior service organizations to continue building and improving the lives of our older community members through:
  - Creating and strengthening community bonds
  - Preventing social isolation
  - Cross-generational relationships
- *Example: AHS partnership with Friends of Lincoln Park = 2,000 attendees/over 5 months*

AHS: Friends of Lincoln Park, Oakland

Alameda County FQHCs' Expansive Partnerships

Building Coalitions and Economic Strength

- **Axis** Community Health has connected approximately 1,200 community members to social and health needs' services through their Livermore Connects Coalition of Tri-Valley nonprofit agencies.
  - The combined services that the community can receive through this collaborative partnership include mental health, healthcare, emergency financial assistance, temporary and permanent housing, food distribution and domestic violence support.
- **Asian Health Services** and the Chinatown Chamber of Commerce of come together to form the Oakland Chinatown Coalition in 2003, this partnership has now grown into a full coalition that includes 15 organizations with the joint mission to ensure that Oakland's Chinatown's future is a secure and healthy one.
- **La Clinica and Native American Health Center**, both members of the neighborhood focused The Resilient Fruitvale Collaborative.
  - This collaborative is joint effort with other neighborhood community organizations to reinforce resiliency through community-led plans designed to prepare the Fruitvale neighborhood in building and executing a collective and compassionate response to natural or man-made disasters.
- **Native American Health Center** works with California Indian Legal Services to assist with expungement services (dismissal of conviction to legally state that you have no convictions) to prevent discrimination against hiring, promotion, or termination.
  - This partnership allows for residents to reenter into the workforce or to remain employed, helping to create an economically healthier county.

Resilient Fruitvale

FQHCs integrate Behavioral Health Services with Primary Care

Teams of primary care providers, mental health professionals and care coordinators work collaboratively to address the expansive behavioral health needs of our patients

In 2022 our health centers had 128,000 Behavioral Health visits

A preliminary analysis showed that on average, with every additional care coordination touch, the total cost of care per patient decreased by $266*

ACBHD Mental health contracts have set up unparalleled Integrated Behavioral Health delivery system

✓ **MHSA contracts**

- **Behavioral Health Care Coordinators** – 23 Integrated BH and Pediatric Care coordinators across 8 health centers that support pts connect to the social, behavioral and medical care they need.
- **Behavioral Health Care Transitions Nurses** – Support patients who are discharged from inpatient care connect to BH and primary care at our health centers
- **Mental Health Urgent Care Services** – Axis' Bridge Program is an innovative mental health urgent care service that provides rapid access to MH treatment to ages 5 and up.
- **Trust Clinic** at LifeLong is a multi-service clinic designed to improve the status of people who are homeless, including providing assistance with housing and income support
- **PATH Clinics** – LIfeLong and BACH provide primary care services co-located withing ACBH operated facilities.
- **ACCESS language line** - Asian Health Services ACCESS operates a designated intake and referral phone line to provide API language speaking/cultural screenings, evaluate medical necessity an determine services levels
- **Culturally Tailored Prevention & Early Intervention –** Programs like Cultura y Bienestar at La Clinica and TVHC, ARISE at BACH and Medicine Wheels at NAHC which provide clinical and non-clinical community based practices

✓ **Specialty MH contracts**

- **West Oakland Health Council**
- **La Clinica de la Raza**
- **Asian Health Services**

Case study: Care Coordinators

A 4-year-old male was referred to the Pediatric Care Coordinator by his pediatrician. Pt lives with his mother, father, and two younger siblings in a hotel. Patient is nonverbal and his mom states he points to things when he wants something or comes and gets her. He also has sensory issues and mom reported he is a picky eater. At the time of referral, mom also stressed to the PCC she had an issue with keeping up with appointments as the family only had one vehicle and dad needed to use it to go to work. The PCC assisted Mom by **referring patient to Help Me Grow** and **supported communication with Alameda Alliance for Health** (AAH) for Autism Testing and Applied Behavioral Analysis (ABA) services. PCC **gave mom AAH transportation contact information** to assist with rides to medical appointments. Additionally, **PCC gave mom contact information for City Serve** to help with housing for the family. PCC followed up and learned the family recently moved into housing.

AHS' IBH Care Coordinator Presenting at a Policy Roundtable

AHC gathers Pediatric Care Coordinators from 8 HCs

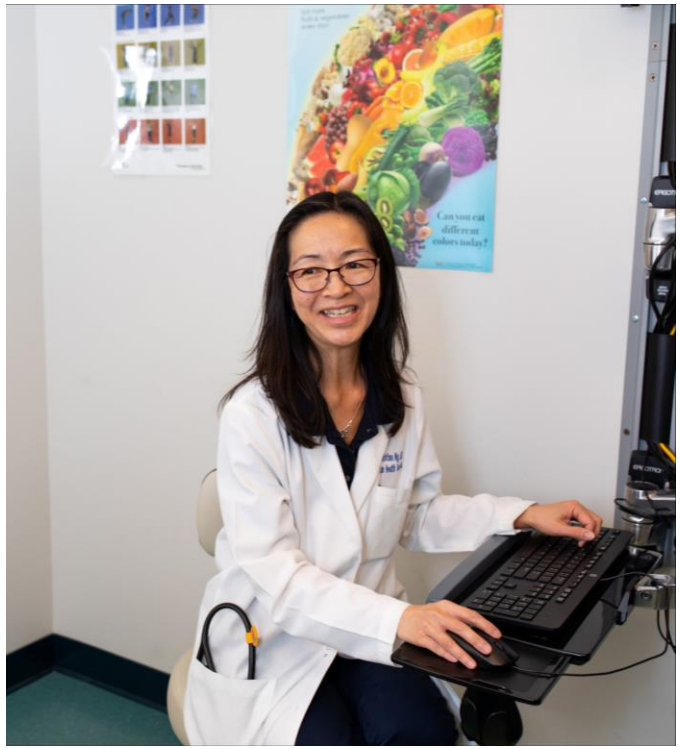
ALAMEDA HEALTH CONSORTIUM

HealthPAC focuses the FQHCs on Alameda County's priorities

HealthPAC has been essential for community health centers' ability to provide quality care and to drive system transformations

Successes include:

- ✓ **Uninsured:** Partially offsetting costs of care
- ✓ **HEP C treatment:** Building capacity to improve clinical outcomes
- ✓ **Opioid dependence:** Increasing the capacity to treat patients
- ✓ **Care after hospital discharge:** Improving performance of the 30-day primary care follow-up
- ✓ **COVID Vaccines:** Supporting elimination of vaccine disparities among Latinx
- ✓ **Recipe4Health:** Promoting food security
- ✓ **Fathers Corps:** Increased utilization of health care services by men

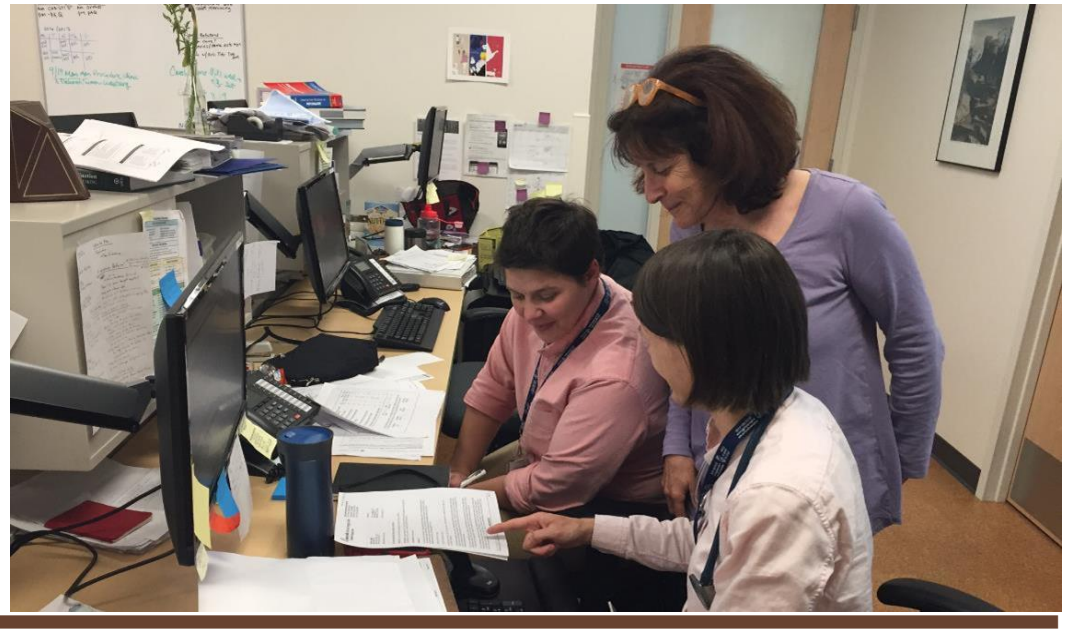


Case study: Multi-year investment led to improved clinical outcomes

A major success supported by HealthPAC funds has been **capacity building efforts to provide onsite Hepatitis C treatment** at all eight AHC/CHCN member health centers.

83% of health center patients with chronic Hepatitis C had been prescribed treatment by the end of FY2021-2022, compared to only 43% in FY2016-2017 (The first FY Hepatitis C was a HealthPAC deliverable).

Consistently, year over year, we've seen an average of **96% of patients treated for Hepatitis C achieved sustained viral response at 12 weeks post–treatment (SVR-12) – considered cured of Hepatitis C.**



Case study: Consistent investment in operations allowed for quick pivot towards COVID vaccinations

COVID-19 Vaccination Equity

As one of the FY2021-2022 system deliverables, health centers increased capacity for delivering vaccinations and using data to increase vaccination rates, with a special focus on reducing disparities.

Between June 2021 and June 2022, health centers increased overall COVID-19 vaccination rates for patients ages 12 and older from 64% to 84% and **eliminated a disparity in vaccine rates for Latinx patients**.

	June 2021	June 2022
All patients ages 12+ with 1 or more COVID-19 vaccine doses	64%	84%
Hispanic/Latinx patients ages 12+ with 1 or more COVID-19 vaccine doses	58%	84%

Data-driven improvement
Health centers worked with CHCN data analysts to develop and validate dynamic reports to allow clinic staff to view performance data and generate lists of patients who were unvaccinated or overdue for a COVID-19 vaccine dose. These lists were then used in outreach efforts, which included phone calls and text messages.

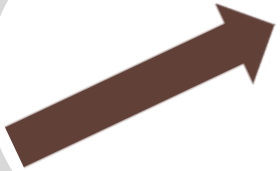
ALAMEDA HEALTH CONSORTIUM

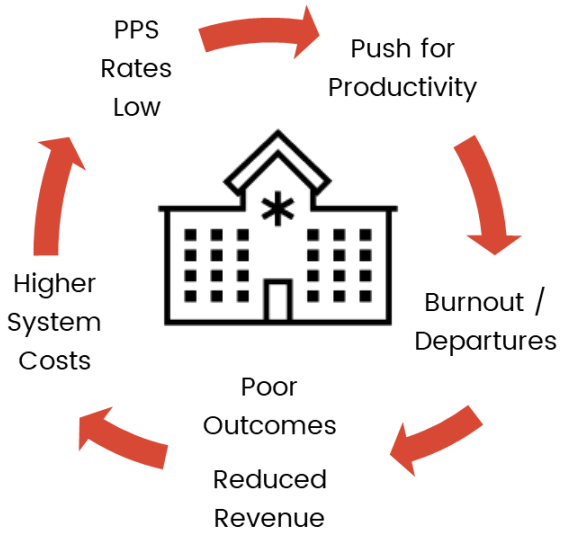
Opportunities

Alameda Health Consortium / Community Health Center Network
2024 – 2028 Strategic Vision and Goals

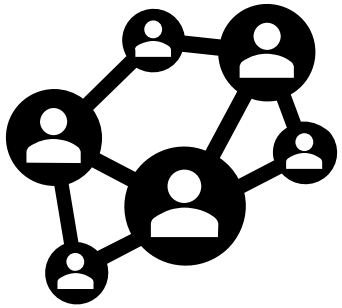
Our vision is for Alameda County to become the healthiest county in California by focusing on the care and outcomes of our most vulnerable residents

- A Comprehensive Safety Net System of Care for ALL
- Elimination of Community Health Disparities
- An Integrated Safety Net Delivery System that Rewards Value





We can make Alameda the healthiest County



Maximizing the power of FQHCs for Alameda

- ✓ **Focus on connection points**
  - ✓ Double down on connection points with CHWs, navigators, coordinators
  - ✓ Prioritize data standardization for data sharing
  - ✓ Reduce bureaucratic reporting quantity and constancy
- ✓ **Align Goals**
  - ✓ FQHCs participation in community health needs assessments to inform the CHIP
  - ✓ Aspire to a countywide goal that all safety net providers are tied to
- ✓ **Align measures**
  - ✓ Focus on a select few HEDIS measures
- ✓ **Provide stable funding for primary care and prevention**
  - ✓ Flexibility to target unique operational & patient population needs
  - ✓ Predictable investment over multiple years for operational sustainability
  - ✓ Time to allow for population-level health improvements

ALAMEDA HEALTH SYSTEM

Health Program of Alameda County and Community Health at AHS

Community Provider Advisory Group

August 19, 2024

James Jackson,
Chief Executive Officer, Alameda Health System

Tangerine Brigham
Chief Administrative Officer, Population Health,
Alameda Health System

AHS: A Public Integrated Health Care Delivery System
Who We Are & Who We Serve

122K
Pts. Served

361K
Outpt Visits

93K
ED Visits

107K
Hospital Days

87%
Pts. Publicly Insured

85%
BIPOC Pts.

50%
Oakland Residents

63%
Adults 25 - 64

* AHS also operates a Mobile Health Center

AHS Role in Community Health

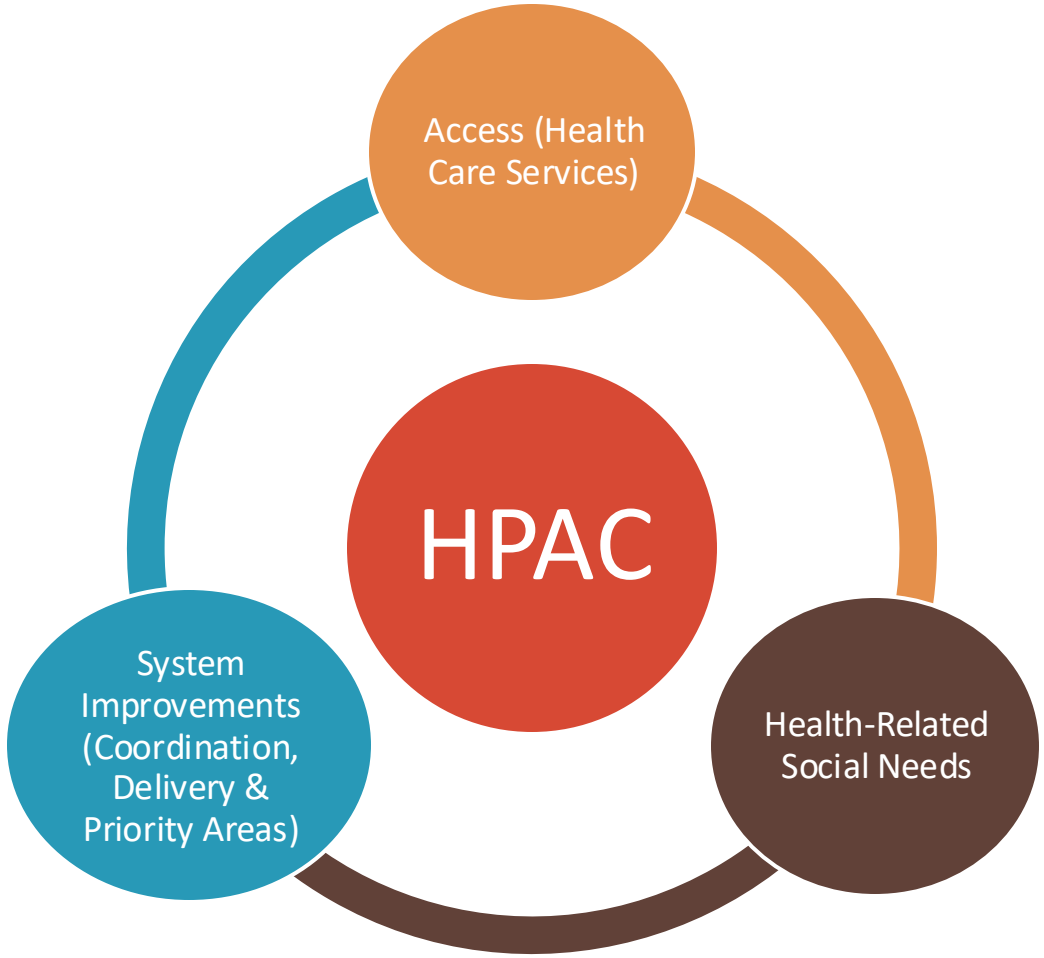
- AHS is part of the larger health care eco-system in Alameda County
- AHS's core role is as a safety net health care provider delivering physical health, dental, mental (inpt. & outpt.) and substance use service – across the health care continuum
- AHS also provides services that enable access to care – patient navigation, interpreters, transportation, health education
- In its safety net role, AHS provides services that are used by or relied upon by other community providers in support of residents who use multiple systems of care
- Imbedded in its core role is care coordination and transitions to other care delivery systems
- Partners with CBOs to address health-related social needs to improve health outcomes and eliminate in health disparities

Health PAC (HPAC) Goes Beyond Health Care Delivery

AHS's HPAC Health Care Delivery Roles:

1. provide preventive and primary care to participants who select an AHS medical home (i.e., Wellness Centers which are Federally Qualified Health Centers)
2. provide or ensure access to specialty, ancillary, inpatient and ED services for entire HPAC population (i.e., irrespective of the medical home the participant selects)

AHS's HPAC Principal for Care Delivery: Care and services provided outside hospitals and clinics support delivery of care within AHS



Access to Health Services is Crucial

- HPAC enables continued access to high-quality, comprehensive, culturally-competent health care

- Sample of results to date (multi-year efforts):
  - ⇑ blood pressure screening rates (from 71% to over 90%)
  - ⇑ HIV screening rates (from 58% to 86%)
  - Opioid treatment – 99% of pts. diagnosed with chronic pain are prescribed a non-opioid pain management strategy
  - Trend of outpatient utilization in HPAC population similar to insured population (appx. 3 visits/year)

Father w/ newborn son at Highland Family Birthing Center
AHS participates in HPAC-funded Fathers Corp

HPAC Contribution:
AHS Movement from Downstream to Upstream Impact

AHS Volunteers at Dig Deep Farms

AHS Backpack and School Supply Drive for Alameda County Schools

AHS Farmers' Market featuring local BIPOC farmers and vendors (for community and staff)

- HPAC has supported AHS's ability to address health-related social needs to close the health disparities gap through such initiatives as:
  - Non-emergency transportation for patients to ensure timely access to care and reduce patient no shows
  - Food insecurity through County's Recipe4Health program
  - Health Advocates program

Addressing Housing Insecurity – an AHS and Community Health Priority

- ❑ Homelessness is an individual, community and public health issue
- ❑ Stable, secure and continuous housing prevents and reduces poor health outcomes

- *AHS activities*
  - *In conjunction with Alameda County Health, AHS operates the Mobile Health Center (meeting patients in the community where they are)*
  - *Partner with Cardea Health for short-term post-hospitalization for those experiencing homelessness*
  - *Partner with East Bay Community Law Center to provide patients assistance on eviction defense, living conditions, public charge, benefits, etc.*
  - *Onboarded an AHS Housing Liaison for referrals, navigation support, care management, standard work for ED, etc.*

AHS Mobile Health Center Van (interior)

AHS Mobile Health Center Van (exterior)

HPAC and System Improvement

- Health care delivery complex and we often have “hand offs” in patient care (internal and external)

- System Improvement Framework: “what does data reveal, what can we do better, how can we do it better, with whom do we partner to make improvement and how do we measure our performance/how we’re doing”

- As a safety net delivery system, HPAC supported system improvements that:
  - benefit all AHS patients and users of AHS services
  - transformed AHS’s delivery of care
  - are identified in the County’s Community Health Improvement Plan (CHIP)
  - are broader County-wide priorities

AHS's System Improvement are Aligned with County-wide Priorities

Mental Health

- Integrated behavioral health services for those with mild to moderate mental health needs in all four AHS wellness centers; part of primary care team
- Almost 26K behavioral health visits across AHS in FY 2023-24 (including Intensive Outpatient Program and partial hospitalization)

COVID-19 Response

- Community testing site to ensure access and reduce disparities

Care Transitions

- Care coordination through our Community Health team (Community Health Workers, Social Workers, etc.)
- Community Health Worker program expansion – including placement in acute care Emergency Department for pilot intervention

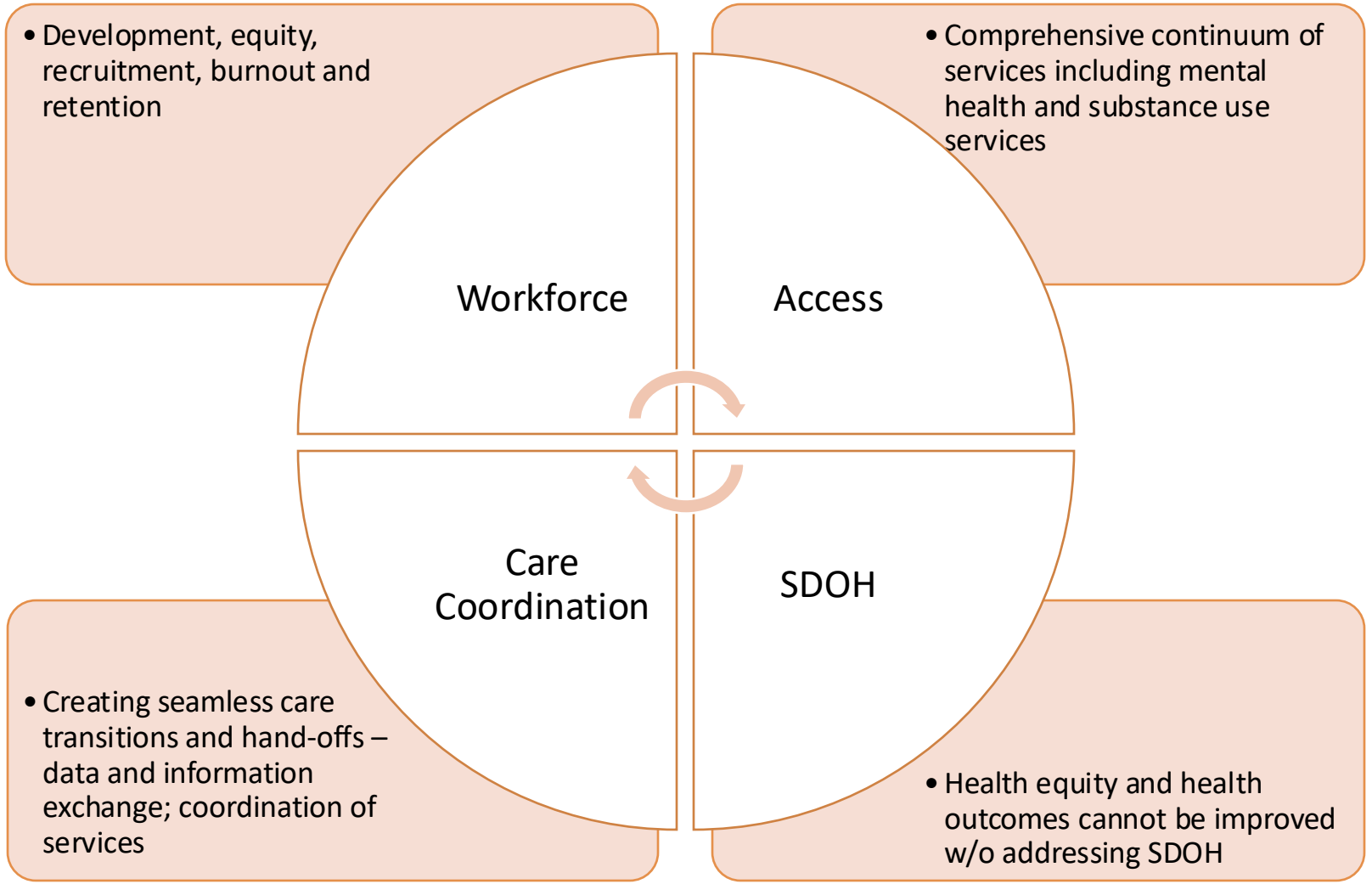
AHS Community Health Team

AHS HealthPATH Students

Key Takeaways

- HPAC improved access, quality and health outcomes
- HPAC contributes to AHS's transformation efforts and supports Alameda County's Community Health Improvement Plan
- HPAC focus on reducing health disparities
- HPAC galvanized the evolution and intertwined roles of physical health, mental health and social health within AHS and its work with other community partners

Collective Opportunities for Partnership to Improve Community Health



Break – 5 minutes

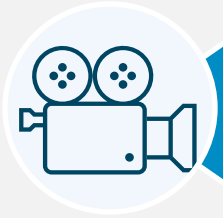
Public Comment

written comments can be sent to cpag@acgov.org

Alameda County Health

Raise your hand via Zoom if you would like to speak.

Your microphone will be unmuted once you are called on.



You are welcome to turn on your camera.

2 min

Please keep your comments under 2 minutes.

Closing Remarks

Preparing for our next meeting

- Slides and notes will be posted on the website: health.alamedacountyca.gov/community-provider-advisory-group/
- **Next meeting – Behavioral Health focus**
  - September 3rd *(Tuesday)*
  - 12:30-3pm
  - same location
- If your organization would like to present at the October 7th meeting (Homelessness focus), **email cpag@acgov.org by September 13th**

Alameda County Health