

Alameda County Health Community Health Assessment & Health Improvement Plan Intersection with Managed Care Plans

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Alameda County Health

Agenda Overview

- Welcome & Introductions
- Population Health Management (PHM) background
- Alameda County's residents
- Public Health Department's CHNA and CHIP
- Alameda Alliance for Health PHM
- Lessons Learned



Medi-Cal Transformation: CalAIM Initiatives

Whole Person
Care Transition

Behavioral
Health Delivery
System
Transformation

Dental Initiative

Integrated Care
for Dual Eligible
Members

Population
Health
Management

Statewide
Managed Long-
Term Care

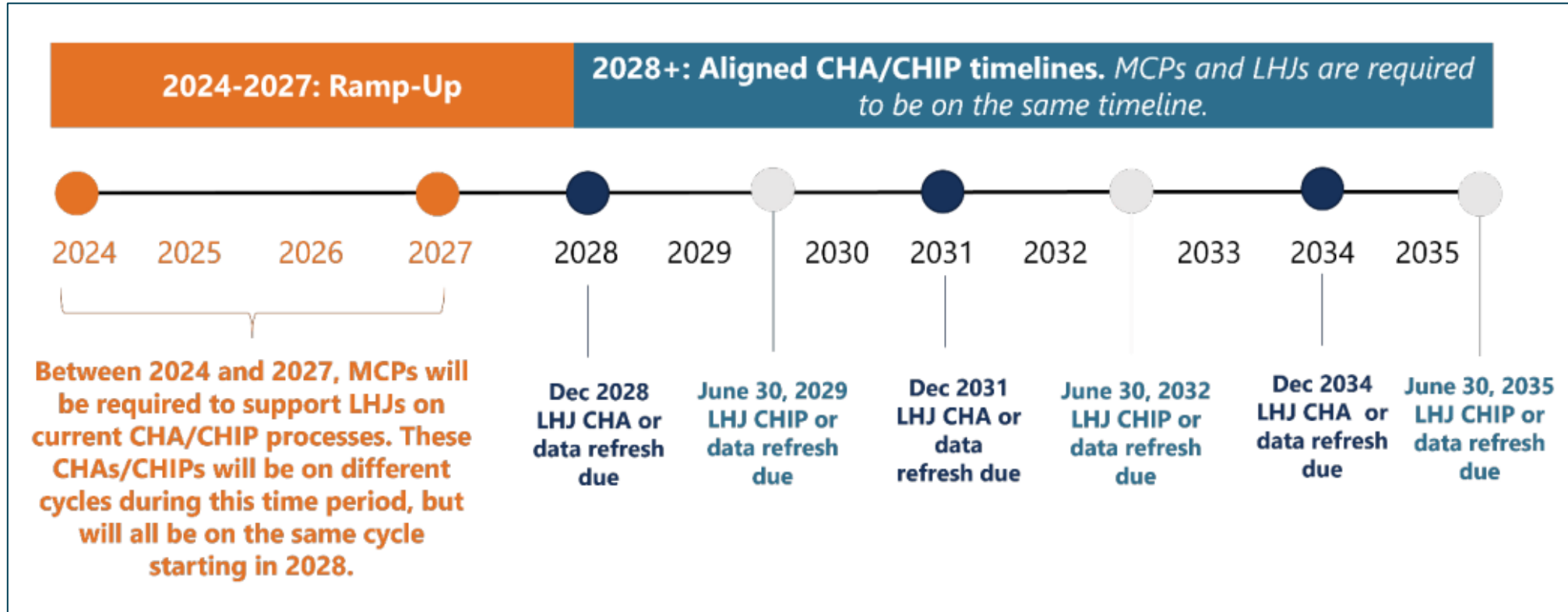
Services and
Supports for
Justice-Involved
Individuals

Enhanced Care
Management +
Community
Supports

Population Health Management (PHM)

- DHCS is establishing a standardized, statewide approach to PHM through which Managed Care Plans (MCPs)
 - (1) are responsive to community needs, and
 - (2) work within a common framework to improve outcomes and reduce disparities
- Under the PHM Program, MCPs fulfill their Population Needs Assessment requirement by **meaningfully participating in the Community Health Assessments and Community Health Improvement Plans conducted by Local Health Jurisdictions**

PHM Timeline



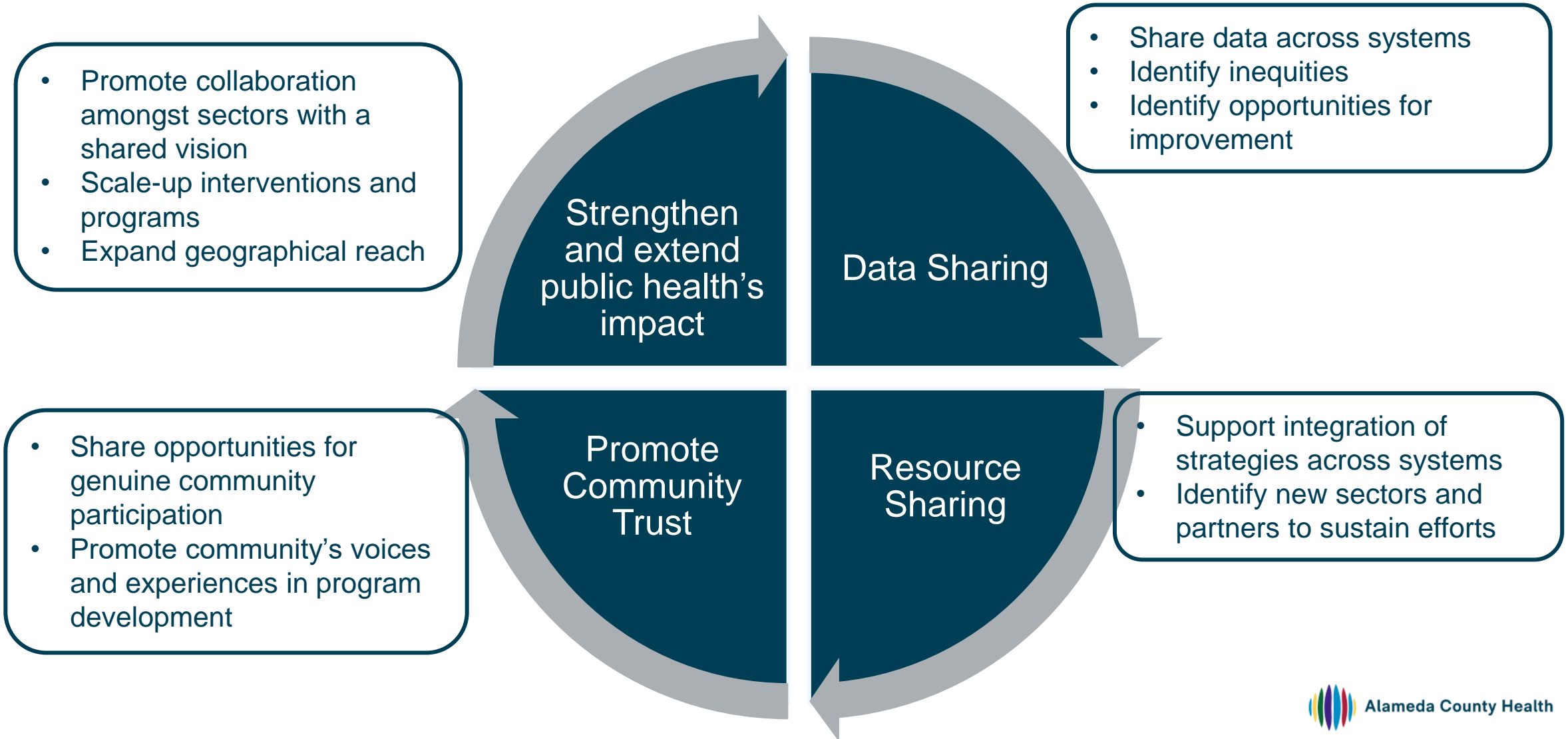
Upcoming important deadlines

2024: MCP and LHJ begin to identify join priority areas	2025: MCP required to share data & contribute resources
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Focusing on the partnership required to make this happen in Alameda County



Alignment between Public Health & AAH





Public Health Department: Community Health Needs Assessment (CHNA) & Community Health Improvement Plan (CHIP)

Public Health Accreditation Foundational Plans





ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

Community Health Needs Assessment

2022-2025



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.

2022-2024 CHNA RESULTS



1 ACCESS TO CARE

2 MENTAL AND BEHAVIORAL HEALTH

3 INCOME & EMPLOYMENT

4 HOUSING & FOOD SECURITY

5 PEACEFUL FAMILIES AND COMMUNITIES

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](#)

WOMEN INFANT AND CHILDREN (WIC)

Results Addressed:
Access to care
Food security
Economic Security
Peaceful families
Premature child death

IMMUNIZATION

Results Addressed:
Early Access to Care
Prevention services
Screening
Economic security
Premature death

EMBRACEHER

Results Addressed:
Access to early care
Mental health
Economic security
Peaceful families

CHIP SIGNATURE PROGRAMS 2024

SEXUAL AND REPRODUCTIVE HEALTH

Results Addressed:
Access to care
Economic security
Premature death

FRONT DOOR

Results addressed:
Access to care
Economic security
Peaceful families and communities

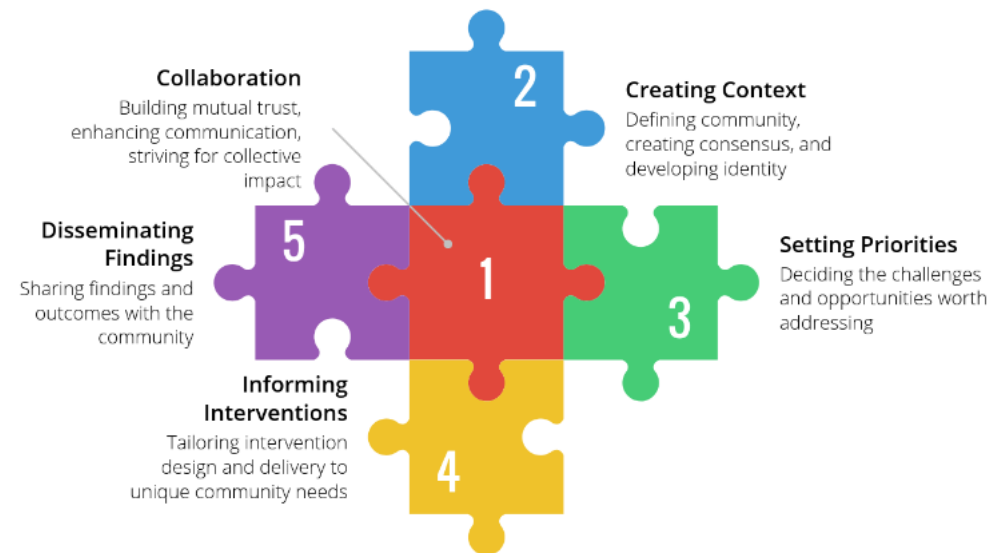
OFFICE OF VIOLENCE PREVENTION

Results addressed:
Economic security
Peaceful families and communities

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
- Participation will include MCPs community advisory members

Community Advisory Board Responsibilities



CHNA & CHIP Timeline for 2024-2027 Cycle



Ongoing CHNA & CHIP Partners 2024-2027



Stanford
HEALTH CARE



Alameda Alliance for Health

Who We Are

- ▶ The Alliance is a local, public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to Alameda County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

Mission

- ▶ Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

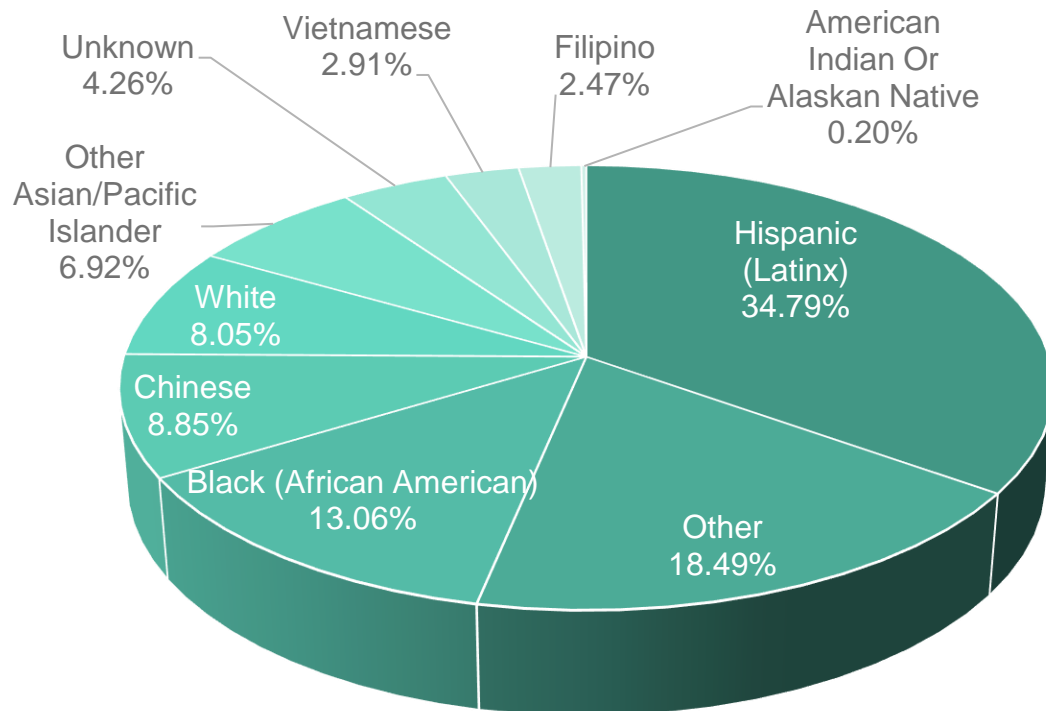
Vision

- ▶ All residents of Alameda County will achieve optimal health and well-being at every stage of life.

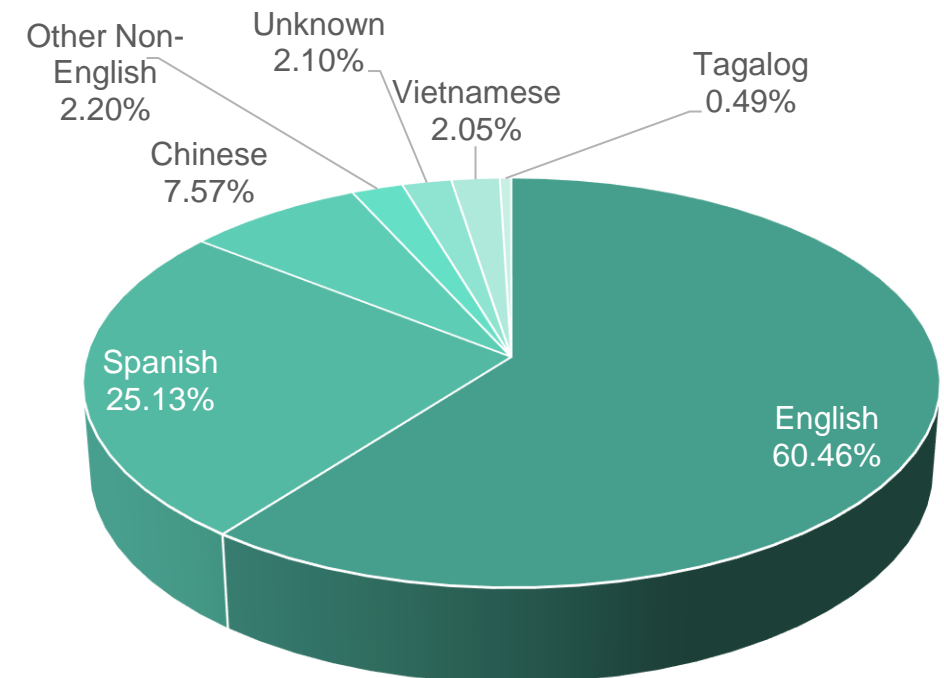
Alliance Members - August 2024

- ▶ Medi-Cal - 400,849 (~85% of all Alameda County Medi-Cal enrollees)
- ▶ Group Care (IHSS) - 5,685 Group Care

Members by Ethnic Group



Members by Primary Language

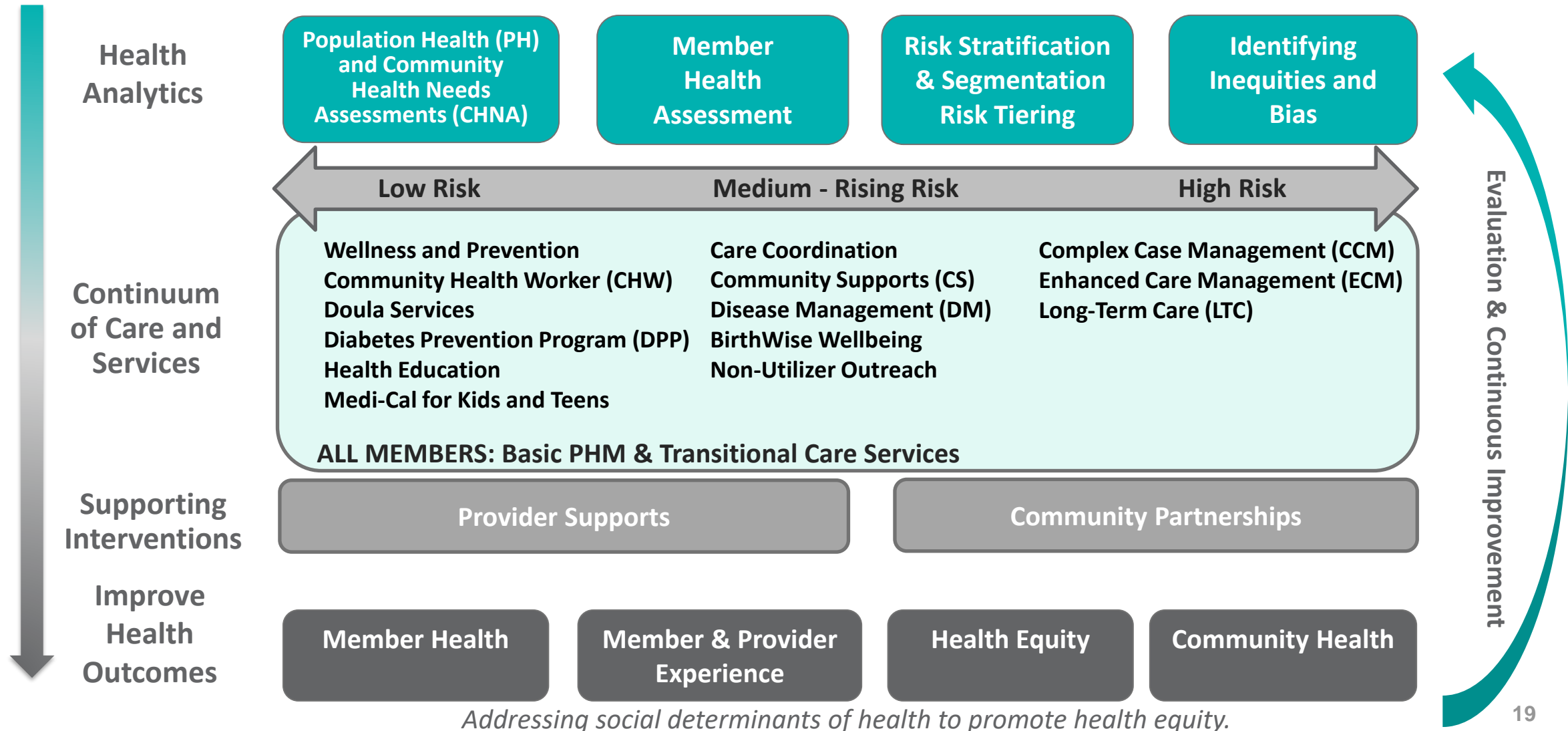


The Alliance PHM Program

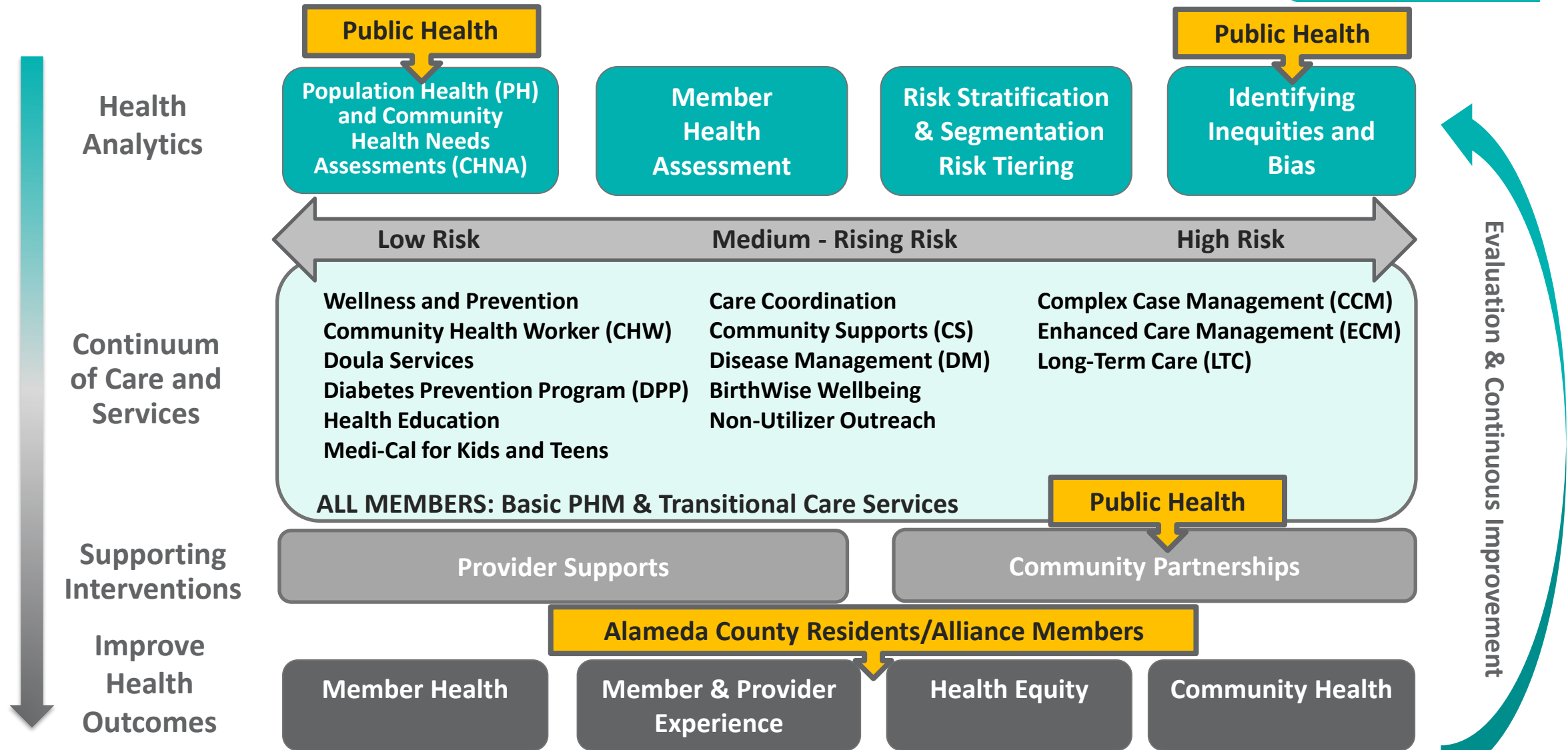
- ▶ Our Aim
 - ▶ Optimal health and well-being for all members.
- ▶ The Need
 - ▶ Not all members need the same care or receive the care they need when they need it. Health care inequities exist in our current health delivery system that are rooted in historical and systemic racism.
- ▶ The PHM solution
 - ▶ Understanding Alliance members through assessment and identifying groups of members at risk and those receiving inequitable care.
 - ▶ Providing targeted, equitable access to necessary wellness and prevention services, care coordination, and care management programs.
 - ▶ Collaborating with providers and community partners.
 - ▶ Desired outcome: Improving health and equity for Alliance members and our community.



The Alliance PHM Framework






The Alliance PHM Framework cont.



Addressing social determinants of health to promote health equity.

2024 PHM Strategy

Strategic Pillars	2024 Programs
 <p>Address primary care gaps and inequities</p>	<ul style="list-style-type: none"> • Non-utilizer outreach campaigns • Breast cancer screening – Equity • Under 30 months well-visits – Equity
 <p>Support members managing health conditions</p>	<ul style="list-style-type: none"> • Multiple Chronic Disease Management • Diabetes Prevention Program (DPP) • Post ED Visit for Mental Illness
 <p>Connect members in need to whole person care</p>	<ul style="list-style-type: none"> • BirthWise Wellbeing – Equity • Complex Case Management (CCM) • Transitional Care Services (TCS)

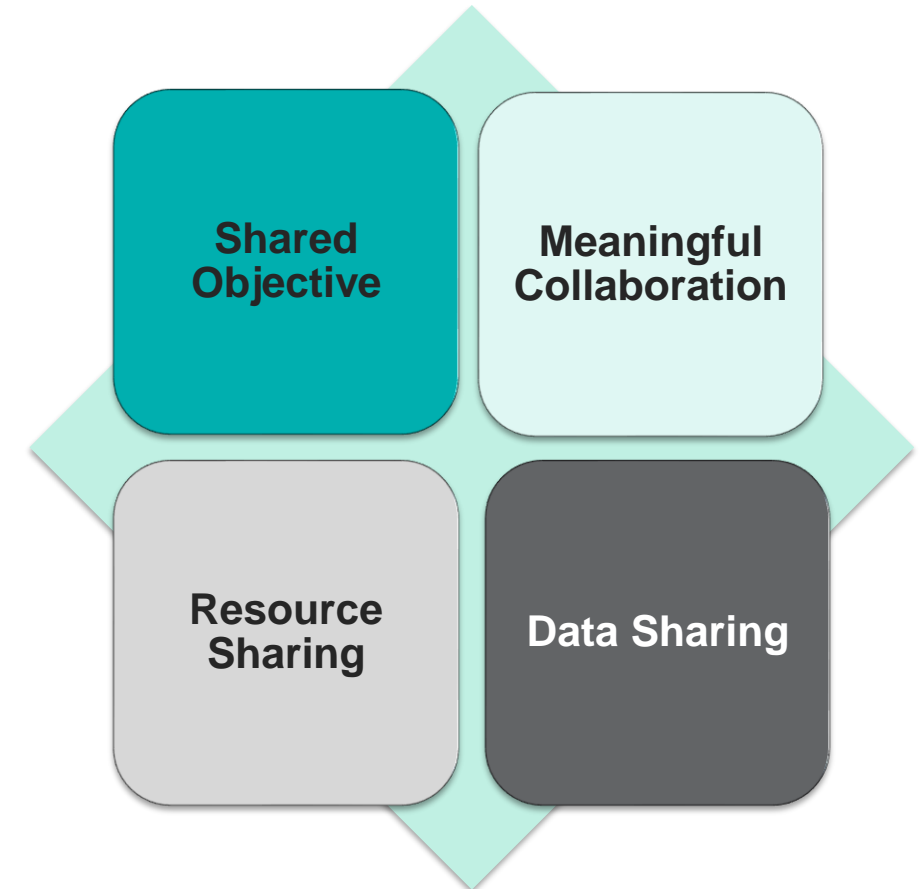
Shared Objective



Alliance – ACPHD Collaboration

Meaningful Participation

- ▶ Shared objective
 - ▶ Increase access and engagement with doula services for Black Medi-Cal members.
- ▶ Meaningful collaboration
 - ▶ ACPHD CHIP workgroups; CHNA steering committee
 - ▶ Alliance Community Advisory Committee (CAC)
- ▶ Plan to offer financial and or staffing resources to support ACPHD and/or CHIP
- ▶ Bilateral data sharing to support ACPHD CHNA and Plan Population Health Assessment
- ▶ Timeline alignment – by Saturday, June 30, 2029



ACPHD – Alliance Collaboration

Lessons Learned

- ▶ Strong, experienced partners
 - ▶ ACPHD – CHNA and CHIP established processes
 - ▶ Alliance – PHM
- ▶ Regular communication to keep work moving forward
 - ▶ Monthly meetings
 - ▶ Invite to other’s meetings
 - ▶ Single point of contact
- ▶ Sharing methodologies

Managed Care Plans & CHIP Goals and Activities

Example: Birth Equity Project

EmbraceHer Program

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

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

Activities:

- **Medi-Cal doula benefit forums** to inform community doulas about Medi-Cal benefits that support maternity care and orient them to Managed Care Plans contracting to ensure an adequate, culturally affirming doula network.
- **Focus groups with doulas and Black members with recent birthing experiences** as a part of the Community Health Needs Assessment.
- Investigate and share with MCP contracted doulas best practices for **HIPAA-compliant record keeping**.
- Facilitate **meetings with birthing hospitals** to communicate about the doula benefit and identify ways to improve doula access.
- **Outreach to providers about doula benefits** and Abundant Birth Project to increase patient referrals to doula services and support engagement in the Abundant Birth Project.

Questions

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