innovations

Partners in Care FOUNDATION

Issue Two, 2024

PARTNERS' TRANSITIONS OF CARE

# Care Transitions Makes the Most of Medical Recovery

Luciana has lived independently for most of her 84 years. Not long ago she was admitted to the hospital for treatment of chemotherapy-related side effects. Unfortunately for her, this was just the latest in a series of medical conditions afflicting her senior years. Now that Luciana is ready to go home, she will be doing so with the support of a Partners in Care Foundation Transitional Care Coach to ensure that her social care needs don't impact her ongoing health care.

The National Institutes of Health defines care transitions as "the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness." Luciana moving from her hospital stay to home is an example of transitioning from one care site to another. While patients often look forward to leaving the hospital and returning to the familiarity and comfort of home, it also is a period when all the good achieved by the hospital stay can potentially become unraveled by what look like the simplest of things at home.

For example, follow-up medical visits may be missed because transportation is unavailable. Lack of food affects nutrition and recovery lags. A refrigerator stops working and spoils the insulin. Narrow doorways limit wheelchair use, and thus mobility. Unclear medication instructions lead to therapeutic duplication of medications and resulting medication related problems. The list could go on.

The Partners in Care Foundation's Mission is to align social care and health care to address the social determinants of health and equity disparities affecting diverse, under-served and vulnerable populations. The agency focuses on improving chronic disease self-management, identifying, and resolving dangerous medication errors, preventing falls, averting costly hospitalizations, and preventing premature nursing home placement through care coordination.

For someone like Luciana, the care transition process starts with a visit by a Partners staff person either while she is still in the hospital, or shortly after she returns home. In this case, Coach Delia visited Luciana a day after she left the hospital. During that initial visit, Delia performed a social care assessment to determine what social services Luciana was already receiving, what she was eligible for, and to identify any other health-related social needs that could impact Luciana's recovery process.

The inventory identified that Luciana was already receiving some hours of In-Home Supportive Services (IHSS) each week but was eligible for more. A daughter nearby served as primary caregiver, but she was overwhelmed by her mom's growing list of medical issues. Getting her some support would also help the daughter. Delia also noted that Luciana, who had become even more frail due to her chemotherapy treatment, was at risk for nursing home placement, thus losing her independence and home. Therefore, Delia quickly identified Luciana as a strong candidate for long-term care coordination through a MediCal waiver program, Multipurpose Senior Services Program (MSSP).

Together, Luciana and Delia determined that the two most critical issues facing the family were to prevent Luciana from being sent to the hospital or nursing home by assisting her daughter in dealing with the demands of Luciana's care. Shared goals best ensure a strong outcome from the process.

Two days after Luciana was discharged from the hospital, a home visit took place. Home visits are a critical component of the care transition process. During this visit the Coach and patient discuss what is needed for self-care as part of the Personal Health Record during the medical recovery, early red flags that indicate when to call their primary care physician and when to call Urgent Care or 911. The Coach ensures the patient, and members of the care team – in this case Luciana's daughter – understand when the next medical appointments are scheduled for, that there is transportation available, and identifies any health-related social needs to address. This is where Luciana, her daughter, and Delia agreed to ask for a re-evaluation by IHSS of current hours and apply for additional time. They also agreed to complete a Multipurpose Senior Services Program (MSSP) application which would provide additional support and enable Luciana to remain in her home.

At the start of the process, Delia and Luciana discussed what they wanted to achieve through the Care Transitions process. Luciana wanted to avoid a readmission to the hospital, and through Coach Delia's assessment, they were able to build the case for additional IHSS hours. This one change also helped address her daughter's sense of being "burned out" from serving as her mother's primary care provider. Along the way, Coach Delia also made sure that follow up medical appointments were made and kept, but the critical issues identified at the very start were successfully addressed. Upon the close of the 30 day care transitions intervention, Luciana was connected with a social worker care manager through the MSSP program who continued to monitor and support her SDOH needs.

Using one of Partners' Care Transitions programs helped see Luciana past the critical point following her hospital discharge when she might have needed readmission. It also resulted in a lessening of pressure on Luciana's daughter, which in turn, helps her provide her mom with better care. And, both mother and daughter deeply appreciate the help, support, and advice provided by Delia. A testimony to the success of Partners' Care Transitions Choices program.





# Social Care Supports a Cancer Patient

Johnnie and his wife Wanda did not always have a place to sleep or food to eat. For the past four years, they had nowhere they could call home, moving from one homeless shelter to the next, sometimes sleeping on cold park benches and grimy sidewalks. They solely relied on social security payments, which was barely enough to sufficiently live in Riverside, California.

They were on a long waiting list for Section 8 housing when 55-year-old Johnnie was abruptly hospitalized due to abnormal body pains, which led to discovery of stage four cancer in his neck and throat. Most people wait several months or even years for housing vouchers, but Johnnie did not have the luxury of time, and the streets were not a place for someone with cancer. Older people seem to be ever more vulnerable to homelessness these days. Fortunately for him, Partner's has deep experience dealing with the social issues that impact older individuals.

Following Johnnie's hospitalization, his health plan referred him to Partners' Enhanced Care Management (ECM) program. ECM provides comprehensive care management services to address individual's clinical and non-clinical needs. He met the eligibility criteria as a Medi-Cal member experiencing chronic homelessness and living with a serious medical condition.

An ECM care coordinator conducted a social care assessment to evaluate Johnnie's social care needs, and they worked together to develop a care management plan that focused on addressing barriers to housing stability and developing goals to better manage his cancer.

Due to the severity of Johnnie's cancer, he was given priority for Section 8 housing benefits and quickly received a housing voucher that would start on February 1, 2024.

His care coordinator discussed temporary housing availability while waiting for the February 1st move in date. Through Partners' Urgent Needs Fund, his care coordinator was able to arrange for Johnnie and his wife to stay in a hotel near his primary care provider for 30 days at no cost to him. Thanks to many generous donors, Partners' Urgent Needs Fund is able to help provide those in our care with services or items for which government programs don't fund.

While waiting for permanent housing, Johnnie's care coordinator referred him to a cancer pain management center. In Johnnie's initial assessment, he mentioned experiencing persistent muscle aches and a sharp stabbing pain that comes and goes, also known as cancer pain. The pain management center provided Johnnie with various treatment options, which included medication and non-drug treatments that provided relief.

ECM also connected Johnnie with a dietician who helped him understand the importance of proper nutrition during cancer treatment. He was used to only eating what he had access to. Fresh fruits and vegetables were not an option due to their short shelf life, and food banks mostly consisted of nonperishable goods, which were often highly processed. From the dietician, he learned that to heal, increase energy and better manage treatment sides effects, a balanced diet was instrumental to feeling good and getting stronger. They set him up with a plan and food service to meet his nutritional needs.

Johnnie and Wanda officially moved into their permanent residence on February 1, 2024. Since moving in, Johnnie feels less stressed and is focused on his medical condition and receiving treatment. Living with cancer, Johnnie must still deal with many physical, emotional, and psychological changes, but thanks to the Partners in Care Foundation, the couple have a roof over their head, nutritional food in the apartment, ongoing medical care with help navigating all its complexities, and crucial pain management services. For Johnnie and Wanda, it is a new morning towards a better life.

# Dignity at Home Prevents Falls

Eloise has lived in her home for over 30 years. In that time, as she has aged, her health has declined, and it has become more difficult to get up and down the stairs she uses to go in and out of her house. In her younger days, she felt confident using the steep stairs and never gave any thought to the fact that they lacked handrails for support. These days, though, that isn't the case. And Eloise's close friends who once loved attending parties at her home, found the stairs daunting. Some of them even stopped visiting because of how uncomfortable they were using them to visit. For a highly social person, losing visits from her friends was a significant loss.

Recently, Eloise enrolled in Partners' Dignity at Home Falls Prevention Program. It helps older adults with disabilities – those who have fallen and/or are at risk of falling - by providing them with fall and injury prevention information, education, referral services, equipment, and more. The process starts with a Partners staff person doing a STEADI falls risk assessment over the phone. This tool tells us about an individual's risk for falls, and once we identify that they are at risk, we work with them to identify the problems in their home that may contribute to that risk. In Eloise's case, we determined there were issues with stairs both inside and outside her home, and lighting issues as well.

Discussing the findings of the assessment, Eloise agreed that her mobility issues often cause her to lose balance as she moves around her home. Those issues also contribute to her discomfort on the outside stairs. As they talked about the challenges she faces, Eloise repeated that her friends also found the stairs uncomfortable to use, and that the steepness kept some of them from visiting, which made her sad. And, once inside, there was little to no illumination in an entry hallway that had also contributed to falls in the past.

Armed with this information from both the assessment and conversation with Eloise, Partners' Dignity at Home Falls Prevention Program arranged for the installation of handrails on the stairs to help her with balance, and automatic security lights now light up dim areas like the entry stairs and her hallway as one more means of preventing potential fall-related injuries.

Said Eloise, "I'm going to be 82 years old, and I feel safe and secure again in my home. I value the rails so much because they help with my balance problem. And my friends who visit feel better about going down the steps because there is something to hold onto. The security lights now mean you can see where you are stepping! This was a positive experience."

Eloise has started inviting friends again to her home, and they have said that they feel more secure going down her steps as they have the new handrails to hold onto. Having friends in her home again is as important to Eloise as is the security that she is now less likely to fall. Two important outcomes from this process.

The Dignity at Home Fall Prevention program ensures participants can live securely, safely, and independently even as they age. Learn more about the Dignity at Home Fall Prevention Program and how others can apply by emailing homemod@picf.org.





# Building Workforce - Social Workers in Elder Care

According to June Simmons, President, and CEO of the Partners in Care Foundation, "As we look at the workforce crisis as well as the future, it is clear the current workforce isn't large enough or prepared to provide the care that is and will be needed by the growing elderly population in California. The Geriatric Social Work Consortium (GSWEC), its eight affiliated Schools of Social Work and the 14 Centers of Excellence where student interns get field practice are crucial in growing the number of individuals trained and prepared to deal with that challenge."

That need to care for an older relative is what has brought Ira Stone to the profession. A student at Azusa Pacific University in the MSW program who will graduate in May 2024, he is currently a GSWEC intern with the Partners in Care Foundation.

Says Stone, "I have a personal connection to pursuing a GSWEC internship. My passion for helping older adults started with being a caretaker for my elderly mother and seeing the struggles she endured. I pursued a GSWEC internship after learning more about its mission and collaboration with other universities. As a lifelong learner, I wanted to be a part of a network to help improve the care and well-being of older adults through geriatric education and training. "

The California Department of Aging's Master Plan for Aging (https://mpa.aging.ca.gov/) estimates that by the year 2030, 10.8 million Californians will be an older adult, making up one-quarter of the state's population. This adds weight to the importance of GSWEC's efforts.

The current 2023-2024 Academic Year marks the 25th year that GSWEC has been training graduate social workers in the skills needed to work effectively with older adults. Over one thousand graduates are in the field now.

The organization's goal is to continue to increase the number of social work students who specialize in working with older adults by developing "aging-rich" field internships in graduate social work education programs within both Los Angeles and Orange County. Ultimately, it is to increase the number of social workers prepared to serve as leaders in the field of aging. The program is available to MSW students.

"The wealth of knowledge I'm exposed to at my internship from the social workers, RNs, and leadership staff has been a wonderful experience," explained Stone. "As an MSW student who is brand new to social work, I've seen the compassion, empathy, and dedication to help participants from staff. As an intern in the Home and Community-Based Alternatives program at Partners in Care Foundation, we aim to help persons at risk of nursing homes or institutional placement by providing a multidisciplinary care team that coordinates treatment plans to better help individuals stay at home where they are most comfortable. The staff are a dedicated bunch willing to go the extra mile to help participants, it's been a rewarding experience to be a part of this team."

GSWEC is the nation's first large multi-university integrated regional network aimed at improving geriatric social work education and field training. Founded in 1998 by the Partners in Care Foundation and a handful of like-minded social work schools and social service agencies, the inter-organizational collaboration currently involves eight Southern California Schools of Social Work and fourteen non-profit agencies comprising our Centers of Excellence where internship field placements occur.

Funding from the John A. Hartford Foundation helped establish the Consortium. At the time, it was supporting

programs designed to strengthen geriatric social work education, prepare competent social workers, and as a result, improve the care and well-being of older adults and their families. Now the Unihealth Foundation has provided strong support for 3 years.

GSWEC developed "Geriatric Social Work Competencies" as a foundation for geriatric field placement experiences. The Consortium's Field Instructors and students use these competencies to identify a student's learning goals, and to provide the basis for learning assignments and assessment of the student's progress. The competencies emphasize geriatric social work values, knowledge, and skills encompassing micro-to macro-level practice in four general areas:

- Values, Ethics and Theoretical Perspectives
- Assessment
- Intervention
- Aging Services, Programs and Policies

These five components provide an integrated, coordinated, and comprehensive program designed to attract students to geriatric social work practice, and to educate them to demonstrate expertise in working with older adults. According to Stone, there are many benefits in being in the GSWEC program, "from training, networking, and learning perspectives. The benefit of being in GSWEC is that it is developing my skill set and improving my awareness and knowledge to better help the lives of older adults in my career." Pioneering stipends in private agencies of $4000 is key as well.

The GSWEC selection process is competitive. According to Partners in Care Foundation President and CEO June Simmons, "GSWEC recruits actively with the schools of social work and the students compete to win a place – for the prestige of the program and quality of its education."

"The selection process just comes down to the individual," explained Stone. "Most often it's about being authentic, having a desire to help improve the lives of older adults, and then having a willingness to learn and grow."

Individuals selected for GSWEC internships tend to be among a school's highest achieving and most motivated students. By the time they graduate from the GSWEC program, they are ready to join the other highly skilled geriatric social workers who have participated in GSWEC's internship opportunities during the past twenty-five years.

When asked if he would undertake a GSWEC internship again, Stone was enthusiastic. "I would join GSWEC all over again because of the opportunity to gain experience and grow. I feel being in it has helped me gain confidence as a social worker and given me tools to take with me in my professional career. I would like to someday return to give back to the next generations of social workers."

### The GSWEC Consortium Includes:

**Southern California Graduate Schools of Social Work (8)**

- Azusa Pacific University
- California State University, Dominguez Hills
- California State University, Fullerton
- California State University, Long Beach
- California State University, Los Angeles
- California State University, Northridge
- University of California, Los Angeles
- University of Southern California

**Centers of Excellence in Geriatric Social Work Field Education (14):**

- AltaMed
- Alzheimer's Los Angeles
- Alzheimer's Orange County
- Beach Cities Health District
- Huntington Health
- Jewish Family Service
- Motion Picture and Television Fund
- Pacific Clinics
- Partners in Care Foundation
- SCAN Health Plan
- Special Service for Groups/SILVER
- VA Greater Los Angeles Healthcare System
- VA Long Beach Healthcare System*
- WISE & Healthy Aging



AGENCY UPDATES

# Partners to Honor Two Outstanding California Leaders at 24th Annual Vision and Excellence in Health Care Leadership Dinner.

## The event is Wednesday, June 12 at LA's Skirball Cultural Center.

Each year we bring together regional top executives of healthcare to salute and celebrate one or two remarkable leaders whose work has transformed health care through inspiring vision and commitment to excellence. This year is no exception as we are recognizing two outstanding leaders: Gustavo Valdespino, President of Valley Presbyterian Hospital and Martha Santana-Chin, Medicare and Medi-Cal President at Health Net California.


Valdespino will be honored with the prestigious Vision and Excellence in Health Care Leadership Award. Santana-Chin will be honored with the distinguished Champion for Health Award. Both will be recognized at the agency's 24th Annual Tribute Dinner, to be held June 12, 2024, at the Skirball Cultural Center in Los Angeles.

June Simmons, President, and CEO of the Partners in Care Foundation, notes "These two are such outstanding members of the greater Los Angeles health care community, and it is our privilege to recognize the passion, commitment and impact they bring to caring for our community."

For the past twenty-five years the Partners in Care Foundation has recognized those leaders who have reached the top of their profession and are widely seen as having significantly impacted California's health care. Due to the caliber of those honored each year, the Vision and Excellence in Health Care Leadership Award Dinner has become the region's premier health care executive networking event. Past honorees include Paul Viviano, Elaine Batchlor, MD, Diana Dooley, George Halvorson, Thomas Priselac, Yoshi Honkawa, Robert Lundy, JD, Paul Torrens, MD, Arthur Southam, MD, and Sachin Jain, MD, among others.

### Valdespino is a gifted leader.

Gustavo Valdespino is the 2024 recipient of Partners in Care Foundation's Vision & Excellence in Healthcare Leadership Award.

A gifted leader with over 40 years of hospital management experience, Gustavo Valdespino was appointed President and Chief Executive Officer of Valley Presbyterian Hospital in September 2009 where he has provided transforming results. Prior to joining Valley Presbyterian Hospital, his roles included Senior Vice President of Operations for Tenet Health Corporation's Southern California region, President and Chief Executive Officer of

St. Vincent Medical Center and CEO of Big Brothers/Big Sisters of Orange County.

Valdespino has received the "Up and Comer" award from Modern Health Magazine, the National Medical Enterprises "Circle of Excellence" award, the Tenet Healthcare Corporation "Circle of Excellence" award, the "Leading Hispanic Executive" award from Hispanic Business Magazine, the 2021 Trailblazer award from One Generation, the 2017 Hospital CEO of the Year from the

Los Angeles Business Journal and the 2022 Leukemia and Lymphoma Gold Coast Man of the Year Award.

Gustavo Valdespino said he's grateful to be honored with the Vision & Excellence in Healthcare Leadership Award because it gives him the chance to tell the story of Valley Presbyterian Hospital.

Gustavo Valdespino

"I think it's a unique story about a freestanding, independent hospital serving a poor community and doing it well," he said. "I've been here now 14 years. Between myself, our board, and our executive team, we have really focused on being a high-quality safety-net provider. That's an achievement in this day and age when healthcare is not easy.

According to Valdespino, "Some folks want to be part of something bigger or be part of an academic medical center. We've said, this is who we're going to be. We're going to take care of as many folks as we can, and I think we've done quite well with that through the years."

Valdespino holds a bachelor's degree in economics from the University of New York at Stony Brook, a master's degree in public health from the University of California, Los Angeles, and completed the advanced management program at the Harvard Business School.

You can read more about Valdespino as part of an exclusive online interview with him published at:

https://www.picf.org/events/tribute-dinner/gustavo-valdespino-interview/

## For Santana-Chin her work is "deeply personal."

Martha Santana-Chin is the 2024 recipient of Partners in Care Foundation's Champion for Health Award.

Santana-Chin is a recognized managed care plan leader with nearly three decades of experience in managed care, operations, delivery system strategy, provider relations, network management, value-based care programs and overall business unit accountability. She has designed and led transformational programs to improve access to care for California's most vulnerable residents, advance health equity and scale value-based care models. Her extensive healthcare leadership experience includes working with independent physician practices, risk bearing provider organizations, hospitals, Federally Qualified Health Centers, and health plans, serving Medi-Cal and low-income communities.

Martha Santana-Chin

In her current role, Santana-Chin leads Health Net's operations in California as well as the Medicare and Medi-Cal business lines, which serve over two million members. She is accountable for long-term strategic planning, plan operations and the successful execution of annual plans to deliver high-quality affordable care. To help ensure that Health Net meets the unique needs of local communities, she collaborates with leaders in the healthcare delivery system and community stakeholders.

"Making healthcare work is deeply personal to me," said Santana-Chin, Medi-Cal and Medicare President of Health Net and whose family once relied on Medi-Cal to access health care. "I am eternally grateful for the safety net the program provided to my family." Her mother, who died at 62, suffered from diabetes and struggled with bipolar depression, which was not diagnosed until late in her life. "Had she been diagnosed and treated earlier, the quality of her life would've been much different. She might even be here with us today.

"As an industry, we still have a lot of work to do. We have an opportunity to positively impact generations by providing culturally competent, appropriate care. By ensuring that our communities are served by people that look like them, we are more likely to markedly improve health outcomes. We have the tools to positively impact individuals and their families by creating career pathways that lift people out of poverty, as we provide culturally congruent care. While early in my career I kind of fell into working in healthcare out of necessity to provide for my family, now there's nowhere else I'd rather be. There's a lot of work to do to advance health equity and I'm optimistic and excited about this next part of our journey."

Said Santana-Chin, "I struggled with all the things you hear about, including not feeling like you belong, imposter syndrome. But I had someone once tell me, 'To be an extraordinary leader, there's no one better you can be than yourself.'"

Santana-Chin graduated from California State University, Long Beach, with a Bachelor of Science degree in business finance, She later earned a master's degree in business administration from the University of California, Irvine.

You can read more about Santana-Chin as part of an exclusive online interview with her published at:

https://www.picf.org/events/tribute-dinner/martha-santana-chin-interview/

## An Impressive Event from an Impressive Committee

The honorary Co-Chairs for this year's event are Castulo de la Rocha, President, and CEO of AltaMed, and Paul Viviano, President, and CEO of Children's Hospital Los Angeles.

We are tremendously grateful to the following Tribute Dinner Committee that has been hard at work arranging for sponsorships, making connections, and spreading the word to assure that this signature event remains a success. Partners is honored to have the leadership of Jennifer Heenan as Chair for the third year and everything that goes into it are members of the Partners in Care Foundation Tribute Dinner Board Committee:

**Jennifer Heenan**
***Committee Chair***

**Sajid Ahmed**

**Amanda Flaum**

**Maria Khatcherian**
***Representing Valley Presbyterian Hospital***

**Jennifer Kozakowski**

**Manoj Mathew**

**Darrel Ng**
***Representing Health Net***

**Evelyn Pacis**
***Representing Valley Presbyterian Hospital***

**Jack Schlosser**

**Shawn Sheffield**

**Jerry Sullivan**

If you haven't already, please make plans to be part of this impressive event as either a sponsor, attendee, or both. Information about the upcoming 2024 Tribute Dinner, interviews with past honorees, and an impressive list of past recipients can be found at https://www.picf.org/events/tribute-dinner/

# Partners in Legacy Society Profile—Richard and Nancy Flores

Richard and Nancy Flores have been residents at MonteCedro, a senior retirement community in the foothills of Altadena operated by Episcopal Community Services, since 2016. For many years, Richard had enjoyed a fast-paced career in the high-tech industry and the couple traveled widely, living in several different cities both in the United States and abroad. Especially while living in Germany and Japan, they were able to observe how other countries care for their elderly and more frail populations and this became a focus of interest for them. Richard and Nancy have always been philanthropic, believing that it is essential to support charities that align with their interests.


About six years ago, they became aware of Partners in Care Foundation by attending a salon at the Valley Hunt Club in Pasadena at the invitation of founding Board Chair of Partners and MonteCedro Board Member the late Allen Mathies, MD and his wife Weta. They were intrigued with a presentation given by June Simmons and Dr. Scott Kaiser on the services Partners provides to assist individuals and families, especially older adults, who wish to continue living in their homes or another community setting, and they felt drawn to support Partners. At that point in their lives, Richard and Nancy felt fortunate to be able to live in the MonteCedro continuum of care community, and the message from Partners resonated with them.

In the last few years at MonteCedro they have become increasingly aware of the growing issues of residents losing their ability to live independently and experiencing loneliness and social isolation. It is critical to them that Partners continue to address these challenges such as risk of falling, medication challenges, illness management, and knowledge of how to maintain good physical and mental health.

Richard is especially impressed that Partners is working with health care organizations and providers to address the issue of loneliness and social isolation among older populations, which is a concern of great importance to him.

Several years ago, Richard and Nancy created a charitable remainder unitrust, a popular and versatile planned giving vehicle that can provide both a current income stream to income beneficiaries and a remainder to a charity or charities of the donor's choice when the trust terminates. As a result of their growing admiration for Partners and desire to support its work both currently and in the future, they have named Partners as one of the charitable beneficiaries of the trust remainder, in addition to making annual gifts. It is their hope that their gifts can be used to provide educational opportunities for Partners' social workers and community care staff.

As a result of their visionary planned gift, we are pleased to honor Richard and Nancy as inaugural members of the Partners in Legacy Society. As Richard noted regarding their relationship with Partners: "We are firmly committed to support and promote Partners, especially within our community. Its leadership in assisting individuals and families to navigate a complex health care system and in addressing the social determinants of health is critical to maintaining healthy communities." Richard and Nancy, Partners is grateful for your generous support and your many years of attending the Annual Vision, Excellence and Leadership Dinner!

For more information about making a planned gift to Partners and becoming a member of the Partners in Legacy Society, please contact Allyson Simpson, Senior Director of Development, at asimpson@picf.org or visit our planned giving website at www.partners-legacy.org.





# Recent Support For Partners' Crucial Work

Individual, corporate, and foundation support make much of this agency's work possible. The following are recent awards in support of Partners' Mission. Our thanks to these organizations for the belief in, and support of, our Mission.

## NCOA Benefits Enrollment Center Grant
**$125,000**

This renewal grant provides for comprehensive screening and application assistance to diverse and underserved populations across multiple counties. Through our various programs, including those for Medi-Cal beneficiaries, we currently serve over 4,500 low-income older adult community members with complex needs.

## Parsons
**$50,000**

This funding allows us to expand the CCH network and increase the number of ECM participants that we serve in Los Angeles County. It will also support provision of ECM services for diverse low-income individuals with complex social and medical needs including those with severe chronic conditions, frequent emergency room users, and the homeless.

## HUD
**$1,200,000**

Partners was awarded this in collaboration with Blue Marble Health, WizeView, and Bridgera. It will allow the collaborating organizations to measure fall risk among low-income, older homeowners and renters, age 62+ in Los Angeles County (LA) through participant self-reporting, Occupational Therapist (OT)/Certified Aging in Place Specialist (CAPS) assessment in the home, and ongoing monitoring and assessment through a digital platform. It can support home modifications, as well as equip these individuals with appropriate knowledge, tools, and resources to sustain the positive benefits of program participation.

## Data Exchange Umbrella
**$1,000,000**

The California Health and Human Services (CalHHS) awarded Partners in Care Foundation an umbrella grant of $1 million to facilitate 20 Community-Based Organizations (CBOs) essential operational and technological changes necessary to align with DSA requirements and promote data exchange under the DxF framework. These funds will support Partners' leadership within the CBO community to strengthen the real time bidirectional data exchange between the Managed Healthcare Plans, CBOs, and Partners.

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# Have You Signed Up Yet?

VISION EXCELLENCE LEADING CHANGE

## Partners in Care Foundation 24th Annual Vision & Excellence in Health Care Leadership Dinner

*Honoring:*

**Gustavo Valdespino**
President and Chief Executive Officer
Valley Presbyterian Hospital
**Vision & Excellence in Healthcare Leadership Award**

**Martha Santana-Chin**
Medi-Cal and Medicare President
Health Net
**Champion for Health Award**

**Wednesday, June 12, 2024**
Skirball Cultural Center • 6:00 PM – 9:00 PM
To learn more or make reservations: **www.picf.org/events/tribute-dinner/**