Partners in Care FOUNDATION

innovations

Autumn 2021

Introducing the Partners in Care Foundation **Council for the Future**

An Invitation to Preserve Your Legacy of Giving

For the last 24 years, Partners in Care Foundation has been instrumental in providing care management services and supports to the most medically frail, low-income residents of Los Angeles and beyond. Serving over 24,000 individuals a year, in the most underserved and culturally diverse communities, we are there for the neediest in the most critical situations. We offer a caring hand to keep our clients from hospitalization and institutionalization by arranging for them to be surrounded by supportive services in the community or medical home of their choosing.

The needs are great and demand for services is high. Our annual operating budget of over $22 million is always stretched to its limits to ensure that no one that qualifies for our services goes without our assistance. Yet, there is a limit to what government funds can cover and we must turn to the philanthropic community to fill ever-widening gaps in funding.

To ensure a full range of needs are met today and into the future, we invite caring donors like you to join our Council for the Future by creating your own legacy with a planned gift to Partners in Care Foundation.

What is planned giving?

Planned giving is a win-win approach to philanthropic donations that gives you the ability to support a nonprofit organization such as Partners in Care Foundation. Simply put, "planned giving" is the transfer of assets to a designated nonprofit organization during a person's lifetime or as part of an estate plan. This forward-thinking approach to giving is "planned" because often these assets are not liquid, have tax consequences, and are generally transferred via a will or other written means.

You can create YOUR OWN personal legacy!

Are you someone who cares to make a difference in the lives of others? Is charitable giving an important part of your life and your core values? Like so many of us, do you want to know that the causes and organizations you care about today will continue to thrive in the future?

The good news is you do not have to be a person with great financial wealth to create a meaningful philanthropic legacy. In addition to supporting the work of your favorite organizations like Partners in Care Foundation through cash donations, please consider making a planned gift as a way to create lasting impact today and well into the future.

Gifts at a Glance

Donor Profile	How It Works	Benefits to Donors	Suggested Gift Type
Donors of any age or income level	Gift of any amount through a will, trust, life insurance policy, or IRA	Estate tax benefits	Bequest
Donors of any age, most often middle-aged Good for complex or appreciated assets	A gift of cash in return for variable payments (% of gift) Upon death, remainder is distributed to the charity	Annual income that can adjust over time; acts as hedge against inflation May avoid capital gains taxes on appreciated assets. Income tax charitable deduction in year of gift	Charitable Remainder Trust
Older donors who want to help a charity, have liquid assets (such as stocks, CDs, savings accounts) Middle-aged donors who want to provide income for their parents or others	A gift of cash or stock in return for fixed payments to the donor for life Upon death, remainder is distributed to the charity	Security of a fixed income for life Knowledge it is guaranteed by organization Income tax charitable deduction in year of gift	Charitable Gift Annuity
Older donors who own their own homes	A gift of primary residence, vacation home, or other property	Donor can continue to live in or use property Income tax charitable deduction in year of gift	Retained Life Estate

Planned Giving is easy.

Planned giving is easy to do. Whether it is naming your favorite charity in your will or trust for any amount of money or giving a gift of a house or investment account, there is an easy option that is right for you.

Planned Giving can involve assets you might never think of.

A life insurance policy. Real estate. Stocks. Business holdings. A checking or savings account. These are all assets that can be leveraged in planned gifts. Each is the kind of gift that generates benefits you can enjoy now and in the future.

Planned Giving can generate an income stream for the donor.

In return for a donation of real estate, stocks, or other assets, donors or their designee can receive a series of regular payments. Not only are you contributing to the sustainability of our organization, but also helping to meet your personal current financial priorities for yourself and your survivors.

Planned Giving can provide generous tax benefits.

Depending upon the type of gift, short-term and/or long-term tax benefits may apply. Donors at a variety of income levels can benefit. Be sure to consult with your financial or estate planner for more specifics.

Planned Giving can work in tandem with other family priorities.

Planned giving is not an "all or nothing" option. Gifts can exist side-by-side with other beneficiaries and personal priorities to preserve your family's legacy and involve future generations in philanthropic pursuits.

Your planned gift will be long remembered.

In addition to the satisfaction of making a meaningful gift, most planned gifts have immediate and/or long-term benefits. This chart can help you find the type of gift that is right for you.

Please, won't you join us as an inaugural member of Partners in Care Foundation's Council for the Future?

We are so grateful to the more than 40 donors who have already created legacy gifts for the benefit of *Partners*. Designating a planned gift automatically makes you a member of the Partners in Care Foundation legacy society, our Council for the Future. Members of our Council for the Future will receive immediate recognition on our organization's website and in our publications and receive invitations to special events.

Please speak with your legal and financial advisors about making a Planned Gift to Partners in Care Foundation today. For more information about how you can support our work and create a lasting legacy for you and your family, please contact **Karen Schneider, Vice President Development, at kschneider@picf.org.**

To make a planned gift to Partners please use this important information:
Legal Name: Partners in Care Foundation, Inc.
EIN: 95-3954057

Meet the *Partners* Team

For over 20 years, *Partners* has been a significant change agent in the social determinants of health arena. We have been called a "powerful innovator," a "leader of change" and a "source of charity for those most in need of help." Our success is due to people who are passionate about making things happen and have the skills to bring ideas to fruition. In each issue, we introduce staff and Board members who have helped shape *Partners*' success.

Alexander Strachan, Jr., MD, MBA

Senior Vice President & Chief Medical Officer, National Inpatient Care Management

Enterprise Clinical Services, Optum

Board Member *of Partners in Care Foundation since August 2013*

Dr. Strachan has more than 25 years of clinical experience as a practicing emergency and urgent care physician, internist and hospitalist. In 2019, Dr. Strachan joined OptumCare as CMO of MedExpress, a national Urgent Care platform seeing 4 million patient encounters per year across 257 medical centers in 19 states. He was responsible for enterprise-wide medical operations, the development of clinical protocols, and implementation of evidence-based practices. In 2020, Dr. Strachan was promoted to United Health Group's Executive Leadership Team as Chief Medical Officer and Senior Vice President for Inpatient Care Management Strategy and Operations, overseeing inpatient care management activities for United Healthcare's three lines of business (E&I, M&R and C&S) related to in-hospital care for United Healthcare's 37+ million members. He is responsible for overall inpatient care clinical operations, leading a team of 200 non-clinical support staff, 1,100 RNs and nearly 200 MDs, managing a budget of over $200 million. In partnership with ECS leadership and United Clinical Services, Dr. Strachan is charged with developing the overarching value-based strategy for ICM as a business unit within ECS and serves on the Physician Executive Council for United Health Group.

Dr. Strachan received his BA from Fordham University, MD from Columbia University College of Physicians and Surgeons, and his Internal Medicine Residency at the University of California San Francisco. He is also a graduate of the University of California Irvine's Health Care Executive MBA program.

Mari Zag, MPH

Director, AArete, LLC

Board Member *of Partners in Care Foundation since June 2010*

Mari Zag has over 25 years of executive-level leadership experience in risk-bearing organizations from integrated large health systems, payors, smaller start-up managed care medical groups, and IPAs. Her areas of expertise include Health Services/ Medical Management, Global Pop Health, Utilization and Care Management, Claims, Network Contracting, Managed Care Organization regulatory compliance, and Total Cost of Care analytics. She led teams toward highly efficient performance, improved cost and quality by applying analytics, reporting, and evidence-based medicine across the state while meeting system budgetary constraints. She advocated for innovation to remove barriers and simplify care delivery and aligned financial incentives to improve quality and reduce cost. She led the AArete Audit Readiness Team and successfully brought the plan through their first 3-year California State licensing regulatory audits, complete medical survey, Financial Exam and Claims Audit with excellent outcomes through careful execution of executive preparedness, project management activities, development, and audit readiness training under a compressed timeline. Mari received her bachelor's in science from Pennsylvania State University in Biological Health & Biochemistry, and her master's in public health from the University of Michigan.

Alexis Cisneros

Chief Financial Officer, Partners in Care Foundation

Alexis Cisneros has been with *Partners* since 2018. She holds a bachelor's degree in accounting from Louisiana State University. She recently was promoted to Chief Financial Officer, having previously served as Vice President of Finance. Alexis is responsible for all of *Partners* financial functions, including accounting, audit, treasury, and investment relations. She also oversees and manages contracting, contract management, IT, and infrastructure for the entire organization. She has been instrumental in leading the agency to significant financial stability, followed by growth, applying a decade's worth of experience building financial processes and leading innovation planning for efficiencies. Prior to joining *Partners*, Alexis served in several management positions for other community-based organizations.

Partners at Work in the Community

Partners' Engagement Center is the Crucial Link

The ability to reach and begin working with clients is a crucial part of *Partners*' success in providing services. If people can't be reached or found, they cannot be served. Fortunately, *Partners* has a team of individuals with the skill, training, and dedication necessary to find individuals and engage them. That team staffs *Partners*' state-of-the-art Engagement Center, which not only supports *Partners*, but is contracted with Health Plans throughout the country to aid in effectively and efficiently reaching their members.

Even now, in the 21st century, a phone call still remains one of the most effective means of reaching and communicating with customers, patients, or members. Proof of this took place recently when *Partners* was hired to conduct outreach and enroll high-utilizing California health plan members into a social care coordination program.

Social Determinants of Health assessments were completed on those members by a *Partners* Engagement Specialist, and then passed to a *Partners* Care Coordinator to craft and implement a care plan coordinating that member's needs over a 30 to 90-day period. Besides California, this same process was happening at the same time in eleven other locations with other organizations handling the outreach.

Partners' Engagement Staff achieved a 93% engagement rate within their viable referrals list, compared to the next highest location, which achieved a still respectable 76%. The remainder of programs elsewhere in the country achieved results from 34% to 68%.

Why such a spectacular achievement? *Partners* Engagement Center staff are experts at targeted outreach strategies, engagement through motivational interviewing and call scripting, followed by enrollment and scheduling processes.

Their high rate of success in reaching individuals is complemented by their equally high rate of success in convincing individuals of the importance of health services and appointments. The team and technology are equally efficient and effective at:

- Building volume
- Delivering relevant information across all channels
- Integrating patient, customer, and provider data
- Closing gaps in care
- Improving client quality scores through effective outreach

Partners' Engagement Center staff frequently support outreach for clinics, offices, and health plans with the goal of improving participation in the following areas:

- Enrollment/Engagement Services
- Customer/Patient Satisfaction Surveys
- Inbound Call Center
- Campaign Tracking
- Event Registration
- Appointment Scheduling
- Referrals
- Post-discharge calls
- Reminded Care
- Outbound Follow-up
- Feedback/Response
- Telephonic Case Management

When asked about the "secret sauce" behind *Partners*' success, Virginia Carone, Senior Director of the Engagement Center describes it as a "triad of training, experience, and technology." If you are interested in learning more, contact Virginia by email at vcarone@picf.org or by phone at 818-837-3775.

Making a Difference in Laura's Life

When Laura was assigned to Coach Nairy to assist with her hospital-to-home transition, she had diagnoses of congestive heart failure, pulmonary hypertension and pneumonia. She was referred to Partners in Care Foundation by a hospital case manager, to address her needs for low-sodium meals, caregiver and socialization resources, and follow-up on medical appointments.

Laura was familiar with the benefits of caregivers, as several of her friends have them. During the home visit, she and Nairy discussed how shortness of breath and physical weakness rendered her unable to take care of her life basics, like housekeeping and meal preparation. They worked together to identify potential caregivers and Nairy empowered Laura to speak with her friends about her needs. "I didn't want to be a bother to anyone, but Coach Nairy encouraged me to seek caregiving support and now my home is spotless!" Laura is also utilizing the meal delivery programs recommended by her coach, and dutifully attended all of her scheduled follow-up medical appointments.

Another of Laura's pressing challenges was the cost of medications - one prescription alone ran her $800 a month. Her coach identified several potential funding sources for patients with pulmonary hypertension and is helping her apply for a grant through My Good Days.

Social isolation was an issue Coach Nairy addressed through connections with senior centers, local community activities and volunteer work in Laura's neighborhood. Together, they discussed the barriers to socialization, and set goals for getting out and about in a safe and comfortable manner. During a follow-up phone call, Laura told Nairy she had volunteered to tutor and mentor two at-risk students after school.

Laura's successful transition has kept her out of the hospital and doing quite well in her spotless home.

Partnership with CHLA & HCBA

Partners' Home and Community-Based Alternatives (HCBA) Waiver program collaborate with Children's Hospital of Los Angeles (CHLA) Medical and Social Work Care Coordination Team to ensure children at risk of institutional placement are informed of the available Long Term Community Based Support Services (LTSS). HCBA's Whole Person Approach model is the ideal resource for CHLA children and families as it provides a safety net to help sustain the family unit by alleviating stressors and immediate connections to necessary resources. HCBA assists with care coordination services provided by a multi-disciplinary team comprised of a Social Worker and Registered Nurse. The most valuable Waiver Services offered are medical, behavioral health, caregiver support, and/or adapting the environment to meet the child's physical needs. The collaboration between CHLA and *Partners* HCBA Waiver is crucial to helping parents spend more time on creating memories with their children and less on the coordination of care. We look forward to our ongoing partnership to ensure our children and familys' needs are met.

Our Wish List

The lives we touch are the most disadvantaged in our community – the frail, the chronically ill, the poor, the elderly, and children with complex medical conditions and disabilities. In these challenging times, their needs have only increased.

Fortunately, with generous donors like you, we can continue to meet the needs that other sources cannot. We can buy clothing, provide grocery cards, patch a leaky roof, pay for rides, replace refrigerators, and so much more. These items make all the difference for the individuals and their families we serve. In many cases, they are the difference between staying in a home and having to move into a facility.

At *Partners*, we are proud of the role we play in supporting the chronically ill and disabled elderly, children, and their families. We specialize in complex care management, but we need your assistance to continue!

With your help, we can make the coming season easier and brighter for those in need. Join us in this effort by making a generous gift today to our Special Needs Fund.

$2,500	Adopt a family struggling to care for a loved one with medically complex challenges so that they may have a safe and warm holiday season. Provide household items, nutritious food, transportation vouchers, minor home repairs, and other essentials.
$1,000	Provide meaningful support, encouragement, and recognition for 50 older adults as they achieve significant milestones on the path to better health.
$700	Provide one week of skilled respite care for the caregiver of a frail individual.
$500	Give one of our older clients a mobile device and one year of internet service to help them combat social isolation and stay connected with friends, family, and clinicians.
$400	Arrange for home repairs and modifications to help a frail individual live safely in their home.
$200	Serve nutritious food to a low-income senior for an entire month.
$100	Support a child with complex medical needs by providing cozy pajamas, slippers, and age and medically appropriate toys that we want every child to enjoy during the holidays.

Recently Awarded Grants

Individual, corporate, and foundation support make much of our work possible. Here are the most recent corporate and foundation awards in support of *Partners*' Mission:

$287,851
Administration for Community Living (ACL), U.S. Department of Health and Human Services: No Wrong Door – Network Lead Entity

Partners received this highly competitive two-year award to develop, test, and implement a software solution to strengthen the impact of our work as a network lead entity (NLE), The NLE provides administrative, contracting, training, and quality assurance for partner community-based organizations (CBO) delivering direct services. *Partners* pioneered the first statewide home and community-based services network of community-based organizations. Through our network leadership, we partner with hospitals, physicians, health plans, and large public systems that contract with us for their members, hospitals, or patients. These contracts support *Partners* and our CBO network to address the Social Determinants of Health (SDOH) leading to patient readmission reduction, health self-management, fall reduction, care transitions, or caregiver support. This ACL grant will fund our development of an integrated information technology system to continue and strengthen our care management and ensure delivery of the highest quality evidence-based SDOH services for California adults.

$25,000
Ann Peppers Foundation

Partners is using this award to meet the needs of the over 200 participants in our Health Homes Program (HHP) living in the San Gabriel Valley. Our HHP participants are some of the most vulnerable individuals we serve. They have chronic and complex medical and social needs, and many do not have a home or are on the cusp of losing their home. Unfortunately, for many of these participants, government funding does not cover all the goods and services that they require to live safe and healthy lives in a community-based medical home of their choosing. This area of unmet need creates an ideal opportunity for private philanthropy to fill a critical funding gap and allows *Partners* to purchase vital services and supports for participants that are otherwise not paid for by government funding. By underwriting our Special Needs Fund for HHP participants in the San Gabriel Valley, the Ann Peppers Foundation is contributing in a meaningful way to our ability to maintain people in the community, maximizing their health, safety and independence, and avoiding homelessness, hospitalization, and institutional nursing home care.

$120,000
Benefits Enrollment Center

The National Council on Aging has awarded *Partners* a two-year grant to continue our operation of our Benefits Enrollment Center. We will serve approximately 1,400 Medicare/Medi-Cal dually eligible beneficiaries in Los Angeles, Kern, and Santa Barbara counties. Many program beneficiaries are individuals who are already enrolled in, or on the wait list for, one of *Partners*' long-term services and supports programs. Our staff, representing the cultural and linguistic profiles of those we serve, screen for eligibility for five core government-funded benefits, including LIHEAP and SNAP. If eligible, *Partners* staff will assist these clients with their applications and overcome any barriers to

their receipt of these benefits. As operators of this Benefits Enrollment Center since 2017, we can attest to the importance of this screening and application assistance service to ensure that our clients can maximize the benefits of government services for which they are eligible.

$26,876
Kaiser Permanente Baldwin Park

This award supports Partners' commitment to improving health outcomes in the San Gabriel Valley by enrolling eligible individuals in the Enhanced Care Management (ECM) Program, which builds upon and will replace our Health Homes Program (HHP) in January 2022. The target population is low-income adults that tend to be frequent emergency room users with chronic medical conditions and who are enrolled in a Medi-Cal managed care health plan in Baldwin Park and El Monte. Our experienced Engagement Center staff will contact up to 500 individuals in the target geographic areas on the ECM referral list, with highest acuity first, to remind them of the program, assess their eligibility, and obtain their consent for enrollment. Partners' Care Coordinator will work with interested and eligible individuals to enroll at least 50 in the ECM program, conduct the assessment of their individual needs, develop an individualized care plan, and begin making referrals for services. Our ongoing care management services are designed to improve their ability to self-manage their health, minimize emergency room and hospital use, avert homelessness, and improve their overall well-being.

Partners' Enhanced Care Management Model

On January 1, 2022, the State of California will be changing the way it provides services to residents who are currently receiving services through a program known as the Health Homes Program. Starting next year in 2022, the Health Homes program will be replaced by the Enhanced Care Management (ECM) program. These changes are part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative that has been under development for over two years.

The California Department of Health Care Services (DCHS) describes Cal AIM as "a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program." CalAIM modifications affect the entire Medi-Cal program. In this issue, we would like to introduce you to our plan for providing services.

Who qualifies for Enhanced Care Management services? They are available to individuals with Medi-Cal managed care benefits who meet both chronic health related and acuity-based criteria. The program will address social determinant of care needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

Partners' ECM service provides all core services delineated by DHCS.

- Outreach and Engagement
- Comprehensive case management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Community and social support services referrals, including housing

Our ECM Model of Care

We are proud of the ECM model our staff has put together in response to the state's new requirements for services. This model is based on deep experience caring for Medi-Cal participants who are typically very frail, very poor, and disadvantaged in many ways. We believe it is a perfect reflection of our mission to align statement that says we "align social care and health care to address the social determinants of health and equity disparities affecting diverse, under-served and vulnerable populations."

Components of our ECM model:

1. Provide a full model of care with Long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems
2. Provide full clinical care coordination with MCO, PCP, FQHC, Homeless Service Providers, Mental Health, Drug Treatment – strong care transitions experience
3. Proven results
4. Deep knowledge of community resources and relationships with them to get real connections, not just referrals

5. In-person/home visits wherever and whenever possible
6. Blended Multidisciplinary Staffing Model using most appropriate skill level
7. Timely and Accurate data collection and reporting – Salesforce Intake, Outreach & Engagement, Care Management, Analytics/Data, Reporting Tools, Auditing Tools, Encounter Data
8. Partners is NCQA accredited
9. Utilization of Collective Medical's Emergency Room patient data
10. Evidence-based, In-home medication use analysis with HomeMeds®
11. Partner with the Homeless Management Information System (HMIS) and services to expedite homeless members in entering the Coordinated Entry System (CES)
12. Primary reliance on evidence-based tools - especially for chronic disease self-management
    - Motivational Interviewing
    - Problem Solving Treatment for Primary Care (PST-PC)
    - Behavioral Activation
    - Fall prevention
    - Chronic pain and chronic disease management, such as for arthritis, diabetes, and related conditions.

Partners in Care FOUNDATION

The Social Determinants Innovators

732 Mott Street, Suite 150
San Fernando, CA 91340
818-837-3775
www.picf.org

Donate Now
picf.org/donate

Driving **Social Care & Health Care** Alignment

Save the Date
22nd Annual Tribute Dinner

Monday, June 20, 2022 • The Beverly Hilton Hotel
(In-person & Virtual)

Arthur M. Southam, MD

Executive Vice President Health Plan Operations Kaiser Permanente

Vision & Excellence in Healthcare Leadership Award

Sachin H. Jain, MD

President & Chief Executive Officer, SCAN Group and SCAN Health Plan

Champion For Health Award

For more information, please visit our website: www.picf.org/support-us/tribute-dinner/