Partners in Care FOUNDATION

Driving alignment between social care & health care

732 Mott Street, Suite 150
San Fernando, CA 91340
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www.picf.org

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Partners' Urgent Needs Fund Wish List

With generous donors like you, our Urgent Needs Fund allows us to meet the needs that other sources cannot. The items on our wish list 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.

Please help us reach those in dire need - the frail, the chronically ill, the poor, the elderly, and children with complex medical conditions and disabilities. We turn your generosity into compassion and support for tens of thousands in our community each year.

Examples of our services include:

$2,500	**Support a family in desperate need of respite care**
$1,000	**Sponsor health and mobility classes for older adults**
$700	**Purchase adult clothing and hygiene supplies**
$500	**Provide a tablet and one year of internet access to fight isolation**
$400	**Arrange to pay home electricity, heating, and cooling bills**
$200	**Order nutritious meal services for low-income seniors**
$100	**Help a child with complex medical needs**

Every dollar donated makes a difference in the services *Partners* can provide to those in our care. We cannot help everyone on our own. But with your help our staff can reach the people in dire need. Won't you join us today by making a gift, recognizing that together, we can make a difference in someone's life?

Partners in Care FOUNDATION

innovations

Autumn 2022

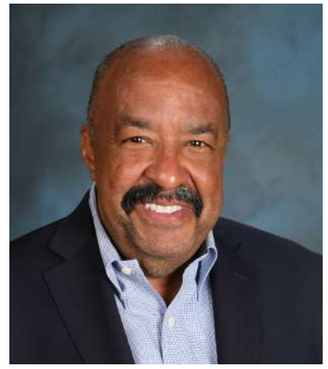
2023 Tribute Dinner Honorees Unveiled

"We are so honored to have two such significant recipients this year," said June Simmons, *Partners*' President and CEO in announcing the individuals being honored at the agency's 2023 Tribute Dinner. "Both these leaders have had outsized impact on healthcare in California, and thus were prominent choices for these two prestigious awards."

Johnese Spisso, RN, MPA

President, UCLA Health; CEO, UCLA Hospital System, Associate Vice Chancellor, UCLA Health Sciences

Vision & Excellence in Healthcare Leadership Award



Robert K. Ross, MD

President and Chief Executive Officer, The California Endowment

Lifetime Achievement Award

According to Simmons, this year's dinner theme is "innovation and impact." "We couldn't have chosen two individuals to better illustrate the twin values of innovation and impact," she explained, "than Johnese Spisso and Robert Ross."

Ms. Spisso, who will receive the *Vision & Excellence in Healthcare Leadership Award*, heads UCLA's hospital system, which consists of the UCLA Ronald Reagan Medical Center, UCLA Mattel Children's Hospital, Resnick Neuropsychiatric Hospital at UCLA, UCLA Santa Monica Medical Center, the expansive network of over 200 UCLA Health primary and specialty care clinics throughout Southern California, the UCLA Health Homeless Health Care Program, and the Faculty Practice Group. She is also responsible for all aspects of the health system and the regional outreach strategy in the local, state, national and international programs.

"This selection," Simmons explained, "reflects Ms. Spisso' s role as a nationally recognized academic healthcare leader with more than 40 years of experience, both here in California, and nationally as well."

Recent recipients of *Partners' Vision & Excellence in Healthcare Leadership Award* have included Arthur Southam, MD of Kaiser Permanente; Paul Viviano of Children's Hospital Los Angeles; Elaine Batchlor, MD of Martin Luther King Jr. Community Hospital; Diana Dooley then of California HHS; Rod Hochman, MD of Providence St. Joseph Health; and Don Crane then of America's Physician Groups.

Robert K. Ross, MD, who will receive the *Lifetime Achievement Award*, is President and Chief Executive Officer for The California Endowment, a private, statewide health foundation established in 1996 to address the health needs of Californians. Prior to his appointment in September 2000, Dr. Ross served as Director of the Health and Human Services Agency in

San Diego County and as Commissioner of Public Health in the City of Philadelphia.

According to Simmons, "Honoring Dr. Ross with this award recognizes his role in supporting the vision of transforming underserved communities and supporting grassroots leaders for a healthier California and a healthier America." This is only the third time in twenty plus years that Partners in Care Foundation is honoring someone with the *Lifetime Achievement Award*.

Recent recipients of *Partners*' *Lifetime Achievement Award* include in 2018 C. Duane Dauner of the California Hospital Association and in 2021 Paul Torrens, MD, Professor Emeritus of Health Policy and Management of the UCLA Fielding School of Public Health and Founder of the Paul Torrens Health Forum at UCLA.

Consideration criteria for both awards include (among other points):

- Decades of excellent healthcare leadership
- High impact in the healthcare industry
- Outstanding signature/recognizable achievement
- Widespread acknowledgement of standing by other key leaders
- Key mentor to rising leaders in healthcare industry

For the past 25 years, *Partners*' Tribute Dinner has served as a networking must for the healthcare industry. Each year, the event brings together regional titans of healthcare innovation to salute and celebrate individuals whose work is transforming healthcare through remarkable vision and commitment to excellence. This year's dinner will take place on Monday, June 12, 2023 at the elegant Beverly Hilton Hotel. For more information regarding the event, please visit: https://www.picf.org/events/tribute-dinner

Partners in Care Foundation turns 25!

It was twenty-five years ago on October 8, 1997, that Partners in Care Foundation began its extraordinary work. At that time, an exceptional group of individuals coalesced around a shared vision of what was needed to meet the social care needs of the frail, the chronically ill, the disadvantaged, and the elderly. Even at that early time, we were building out and implementing the concepts that would come to be known today as the social determinants of health – SDOH.

Through the intervening years, *Partners* has continued to serve as a thought leader, exploring and developing those innovative approaches that can impact the social determinants of health in real life. We remain focused on changing the shape of healthcare by defining, then demonstrating the value of social care in furthering the healing process, thus enabling people to maintain their independence and remain at home. *Partners* has been recognized as a "visionary" for our development of innovative and powerful models of social care coordination. Just as critically, we have translated those visions – those bold and innovative approaches to care – into real care systems that provide evidence-based and effective services to thousands of people every year.

During our history, *Partners* has worked to align social care and health care to improve the lives of people with complex health needs. In that time, we have seen our care models adopted both in California and nationally. *Partners* serves as co-chair and founding member of the Partnership to Align Social Care, a vital national think tank that is redefining the relationships between community-based organizations like ours, health systems, physicians, and health insurance plans. Its goal is to codesign how social care and health care work together in a synergistic manner to improve the health outcomes and well-being of people with complex healthcare needs.

This strategic alignment of health care and social care is already taking shape here in California. Under the state's recent Medicaid redesign, known as CalAIM, we are starting to witness the earliest evidence of its improvements in health and wellness for the highly vulnerable, medically complex people we serve. As CalAIM creates the mechanisms to address individual social drivers of health, we are seeing results and the healthcare industry – both here in California and across the country – has taken notice!

Yet, there is more to do. We see real possibility for meaningful change to improve people's health, social circumstances, and lives. Whether an employee, a volunteer, a Board member, a Councilor, a Donor, or a professional colleague, you each have a role to play in realizing this vision.

Working together we keep these innovations advancing so that we can ensure the opportunity for everyone, regardless of life circumstance, to live with dignity and optimal health in a home of their choosing!

Over the next 12 months we will be periodically sharing snippets of our history and remembering those many special people who helped found, steer, and shape this agency. It will be a time for celebrating twenty-five years of extraordinary and powerful service to our communities. And of course, looking forward to the promise of an equally impactful twenty-five years to come.

With deep affection and regard,

June Simmons

Founding President and CEO

Helping Seniors Get Vaccinated

Even after a year into the pandemic, many seniors remain conflicted on whether to get vaccinated against COVID-19 due to differing messages from media reports and individuals in their life. Partners in Care Foundation encourages vaccines and boosters, especially for seniors 65+ who are at high risk of hospitalization from COVID-19.

In a recent study funded by the California Health Care Foundation (CHCF), researchers have found that care managers may have more success than physicians at persuading medically fragile, home-based adults enrolled in Medi-Cal to get vaccinated.

Partners' played a major role in the study as many *Partners*' care managers saw success in speaking to senior participants about COVID-19, and the benefits of being vaccinated at their age. Greg Chukuryan, a social work care manager in the Multipurpose Senior Services Program (MSSP), refers various services to participants and has offered to set up vaccine appointments for many. Shawn Callahan, a care manager under the Enhanced Care Management (ECM) team, facilitated numerous conversations about vaccine status with participants, most of whom were experiencing homelessness and did not have access to phones or computers to set up appointments. With their continuous efforts, many *Partners*' participants welcomed the help to get vaccinated.

Partners is proud of our care managers' participation in the CHCF study. We understand the importance of collecting data, and how these types of partnerships have the potential to improve care for vulnerable populations.

Read more about the CHCF study and *Partners*' role in increasing vaccination rates in the San Fernando Valley here: bit.ly/3gEg24c

Meet the *Partners* Team

For 25 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 Board members and staff who have helped shape *Partners*' success.

Al Poirier

Deputy Fire Chief, Beverly Hills Fire Department

Partners in Care Foundation Board Member since August 2021

Al Poirier is a 36-year veteran of the fire service. He served with the Los Angeles City Fire Department from 1986 to 2022, and then joined the Beverly Hills Fire Department in September of 2022. He was the Chief Deputy of Emergency Operations in Los Angeles and is currently the Deputy Fire Chief in Beverly Hills. His responsibilities include command, coordination, and oversight of all Firefighting and Emergency Medical Services line functions of the Fire Department. He also has extensive experience working with innovative fire department units including nurse practitioners, physician assistants, and mental health professionals in seeking solutions for unique challenges that impact people's health, well-being, and quality of life.

Chief Poirier worked across the City of Los Angeles in a variety of emergency operations assignments including Downtown, Boyle Heights, Lincoln Heights, Silverlake, Hollywood, Van Nuys, South Los Angeles, North Hollywood, and Westchester – and he is a veteran of several dozen large scale emergency events including multiple devastating wildland fires, the 1992 Civil Disturbance and the 1994 Northridge Earthquake. He was a member of the FEMA Urban Search & Rescue Team (CATF-1) in Los Angeles for over 20 years with deployments that included the World Trade Center event in NYC on 9/11, and to the Gulf Hurricane Disaster in 2005. He has also worked in a number of investigative, administrative, and emergency management assignments throughout his career.

In early 2016, Chief Poirier was selected by Mayor Eric Garcetti to serve as the Interim General Manager of the Los Angeles Emergency Management Department. Working in this senior leadership role, he managed the City's Emergency Operations Center and facilitated the Emergency Operations Board activities, while coordinating the emergency preparedness efforts of multiple separate Los Angeles City departments and bureaus.

Chief Poirier completed undergraduate studies in Fire Protection Administration at Cal State University Los Angeles, he has a bachelor's degree in Emergency Services Management from Union Institute and University, and a master's degree in Security Studies from the Naval Postgraduate School in Monterey, California.

He has worked with several non-profit organizations. His greatest joy is his family, having been married for nearly 30 years, and he has four children. In his spare time, he plays golf, and he is an avid mountain bike rider.

Partners at Work in the Community

MSSP Success Story

After fracturing his hip and shoulder from a serious fall at home, 85-year-old David was placed in a nursing facility for four months where he received round the clock supervision and care. Complicating his recovery, David lives with numerous health conditions, including hypertension, high cholesterol, heart problems, arthritis, and depression. He also relies on an electric wheelchair for mobility due to weakness, joint pain, and stiffness in his lower extremities.

The *Partners*' Multipurpose Senior Services Program (MSSP) is designed specifically to help people like David stay in their home. It does this by assessing an individual's circumstances, and where possible, creating a plan of social care that supports an individual's desire to stay in their home.

During the transition back to his home, David shares with his *Partners*' MSSP Care Manager his desire to reduce his risk of falling and avoid returning to a nursing home. He also wanted an easier and safer way to move in and out of his house without major assistance, which was impossible with the rickety portable ramp he had.

Due to the difficulties of moving in and out of his house, David would often miss medical appointments, was unable to attend church with his family, or enjoy other family outings. The *Partners*' care manager identified David at risk of feeling socially isolated and lonely, which could be a factor in his depression.

Through *Partners*' MSSP, David was provided with an upgraded modular ramp with handrails. The new ramp allows him to safely exit and enter his home and the installed handrails help him avoid potential accidents that could lead to another injury and being admitted to the emergency room. MSSP also provided David with a portable emergency response device in the case of a fall's incident, a new mattress designed to alleviate joint pain for his arthritis, as well as curb-to-curb transportation services to and from medical appointments and community events to reduce social isolation.

With the newly installed ramp and transportation services provided by MSSP, David can now attend church and participate in family events, which has significantly improved his mood. David also feels safer at home now with his newly installed handrail and emergency device and is grateful to the services provided to help keep him from being readmitted in a nursing home.

Upcoming Events

INNOVATION *and* IMPACT

23rd Annual Tribute Dinner

Honoring Johnese Spisso, RN, MPA and Robert K. Ross, MD

Monday, June 12, 2023 | 6:00 PM – 9:00 PM
The Beverly Hilton Hotel

INNOVATE • IMPACT
25 YEARS
CODESIGN • CHANGE

25th Silver Anniversary Celebration

October 2023 | Details to follow

HomeMeds Helps Seniors Live Better

HomeMeds℠ is a *Partners*' evidence-based program for identifying potential patient medication-related problems through medication screening. This medication management software helps to reduce emergency room visits, risk of falls, use of high-risk medication, and hospitalization readmission, which can often be costly.

The Kenneth Young Center, a non-profit organization that provides services for youth and seniors in the community, is a *Partners*' HomeMeds licensee that utilizes the evidence-based tool to help seniors better manage their medications to live independently and safely at home.

Recently, the Kenneth Young Center had an 83-year-old participant that experienced frequent dizzy spells and falls. Her health conditions include congestive heart failure, hypertension, osteoarthritis, end-stage renal disease, and more. She reported shortness of breath, extreme weakness in her legs, and had trouble standing for longer than five minutes. At the time, she was taking 17 prescribed and over-the-counter medications. After a care coordinator conducted a HomeMeds assessment, she received a pharmacist notice that alerted her to the fact that one of her medications was contraindicated for someone with congestive heart failure.

In fact, the medication was known to make symptoms of congestive heart failure worse! The pharmacist proposed modifications and her medications were adjusted accordingly. The member now notices less dizziness, confusion, and better balance control after switching medications, as well as switching physicians.

The participant expressed a high amount of gratitude for the HomeMeds service and now feels more confident and safer with her new medication prescribed.

HomeMeds helps organizations like the Kenneth Young Center and their members better understand the medications they are taking through an in-depth assessment and review process. If HomeMeds sounds like a service your organization should be considering, please visit www.picf.org/innovations-at-work/medication-management/homemeds or email HomeMeds@picf.org

Partners Launches HomeMeds℠ Advisory Panel

Recognizing that science and medicine are ever evolving, *Partners* has launched an Advisory Panel to work with HomeMeds℠, the agency's evidence-based, medication safety intervention program. The Panel's nine individuals have backgrounds covering a wide range of both medicine and pharmacy. Collectively, they bring professional perspectives and knowledge to HomeMeds and will help us anticipate pharmacological needs and identify related improvements to the program. Our goal is to maintain its already high standards of quality in terms of medication safety.

HomeMeds was designed to help to keep patients safe from potential negative outcomes due to poor medication adherence, therapeutic duplications, or other common medication errors. As a bridge between medical care and what a person can do in their home, *Partners* has long been a leader in work related to social determinants of health, managing the gaps in non-medical care impacting a person's recovery and overall health outcomes. HomeMeds is a crucial piece of that "bridging infrastructure."

Co-Chairing the Advisory Panel are two individuals with great backgrounds to meet the challenge of keeping the program at the cutting edge of medication safety. Manoj Mathew, MD, SFHM, is both a member of *Partners*' Board of Directors and an internal medicine physician. Among his former affiliations he served as National Medical Director at Agilon Health. His Co-Chair is Carol K. Taketomo, PharmD, Director of Pharmacy and Nutritional Services at Children's Hospital, Los Angeles; Adjunct Assistant Professor of Pharmacy Practice at USC School of Pharmacy. Given the growing concern related to pediatric medication safety, Dr. Taketomo's knowledge will be invaluable in guiding our work.

Assisting the co-chairs in managing the Panel's activities are Dianne Davis, VP of HomeMeds, Community Wellness and Workforce Development, along with Amy Adams, Director, HomeMeds.

The Panel's primary task is to provide strategic guidance related to HomeMeds' growth, serving new populations, and addressing changing science and its impact on the program. The Panel is charged with identifying needed protocols to be added into the program covering additional patient populations beyond elderly adults. These additional new groups include:

a. Adults 18-55 and their commonly used medications
b. Behavioral Health patients and their commonly used medications:
   · Substance abusers
   · Bi-polar
   · Schizophrenic
c. Children and their commonly used medications
d. Others as identified

The Advisory Panel will also review protocols for each of these groups that fit HomeMeds' mission of addressing important problem areas that affect individuals, such as:

1. Unnecessary therapeutic duplication.
2. Falls and confusion related to possible inappropriate psychotropic medications.
3. Cardiovascular problems such as continued high/low blood pressure or low pulse.
4. Inappropriate use of non-steroidal anti-inflammatory drugs (NSAIDs) in people with high risk of peptic ulcer/gastrointestinal bleeding.
5. Review effectiveness of opioid prescriptions and alternate options.

Identifying unique problem areas of concern for each of the new target groups/populations for inclusion in this list of problem areas will be a crucial piece of the Panel's work. To achieve this, the Advisory Panel has organized itself into three sub-groups, each of which will tackle specific areas of concern: behavioral health issues, mid-life adult issues, and children's pediatric issues. These groups have already begun meeting to identify initial areas of exploration.

HomeMeds Advisory Panel Members

1. **Kyle R. Allen, DO, AGSF**, 2020 – 2021 Health and Aging Policy Fellowship; Division Chief Geriatric Medicine, Geriatric Medicine Fellowship and Medical Director, Summa Health System Institute for Seniors and Post-Acute Care
2. **Jessica Abraham, PharmD, APh**, Director of Population Health at USC School of Pharmacy
3. **Bahar Davidoff, PharmD**, Vice President of Pharmacy, Regal Medical Group and Adjunct Professor of Pharmacy at USC School of Pharmacy
4. **Yaneya Hall, PharmD**, Consulting Pharmacist for Partners in Care Foundation
5. **Manoj Mathew, MD, SFHM**, Former National Medical Director at Agilon Health
6. **Carly Ranson, PharmD**, Thomas J. Long School of Pharmacy; Assistant Professor of Pharmacy Practice at the University of the Pacific School of Pharmacy
7. **Alexander Strachan, Jr., MD, MBA**, Senior VP, Chief Medical Officer, Inpatient Care Management at Optum
8. **Patrick K. Tabon, PharmD, APh, BCPS, BCGP, BCACP**, Assistant Professor Clinical Pharmacy
9. **Carol K. Taketomo, PharmD**, Director of Pharmacy and Nutritional Services at Children's Hospital, Los Angeles; Adjunct Assistant Professor of Pharmacy Practice at USC School of Pharmacy

ECM Outreach Story

Not all the people cared for by the Partners in Care Foundation's Enhanced Care Management (ECM) team are easily reached. Many are homeless. Often, the phone number we have is not current. At times, family do not know where individuals are. Regardless, it is our responsibility to help them access services.

One way to do this is through what we call "street outreach." Back in early 2022 we planned an initiative to reengage Medi-Cal members, gather updated contact information, identify health concerns, and share information on services and resources offered through the *Partners*' ECM program.

Our outreach effort took place over the span of three days, with teams of *Partners* ECM care coordinators and supervisors visiting various cities including San Fernando, LA South Central, Hollywood, Downtown LA, San Gabriel, Long Beach, and Antelope Valley. In addition, we provided outreach gift bags with hygiene supplies, PPE, and ECM flyers to ECM members we met with during the outreach effort.

ECM members are enrolled in Medi-Cal, live with chronic health conditions, are impoverished and disadvantaged in many ways. During the street outreach, *Partners* engaged with over 250 ECM members – most of whom were unhoused or lived in government funded facilities that were not up to safety and healthy living standards, including for example, not having working elevators.

Care coordinator Keith Orr shared his experience with the street outreach. "We focused on talking with people about ECM services. We wanted to make sure everyone we spent time with during those three days knew what they were qualified for, and entitled to, in the way of benefits."

Not only were members shocked to discover the vast number of resources they had access to, like meal services, transportation, referrals to social support services, etc., but many of their neighbors and family members, had strong interest in becoming direct referrals for ECM.

Care coordinator, Krystal Ford, visited members residing in mental health program apartments. After hearing about services that could help them live more comfortably at home, many residents living on the same floor as ECM members wanted to know the eligibility requirements and learn how they could get referred into the program. "The street outreach was emotional, in a positive way," said Ford. "The smallest of services can be life changing for some people, and that is what makes this job fulfilling."

Keith Orr and his team conducted outreach in downtown Los Angeles and Hollywood, where they met with many members who are unhoused, with limited access to food, clean water, clothes, and very little access to bathrooms. Most days, showering was not an option, and many urinated and defecated on street corners.

"We live in a first world country but have communities of individuals who are living similar to what we imagine third world countries are like," Keith reflects. He stressed the importance of programs like *Partners*' ECM, and the help that the services can provide to improve the overall health and wellbeing of vulnerable and impoverished populations.

Along with providing education on ECM, care coordinators were gathering updated contact information, conducting quick home assessments, helping participants locate and set up appointments with their primary care physician, and getting referrals to see medical specialists for members' specific health conditions.

ECM Supervisor, Gurpreet Rai, noted that many individuals had some type of chronic health conditions, yet were current with their medical appointments. "One participant had medication bottles scattered around his apartment," she remembered. "He couldn't figure out if they were expired, or even if he still needed them."

Gurpreet located the member's primary care physician and scheduled an appointment to get updated information on the medications he needed. She recommended that the member write down all the medications he has been taking and bring that information with him to the appointment for re-evaluation.

The experience with the street outreach has reinforced *Partners*' care model focusing on in-person visits so as to build trust and open channels to better communication, which ultimately improves quality of care that members receive. The street outreach resulted in referrals for recuperative care, sobering centers, housing navigation, and housing sustaining services for members.

Partners has a history of innovative approaches to connecting low-income, medically complex individuals with care. Utilizing the street outreach experience can refine member engagement as the ECM program grows to offer its many services and supports to more members in need.

Improving a Member's Diabetes Care Quality

62-year-old Martin lives with diabetes, hypertension, and chronic kidney disease. These issues impacted his daily life in significant ways until the Partners in Care Foundations' Enhanced Care Management (ECM) Team got involved to help him learn to manage these conditions. Through ECM, Martin was connected to a *Partners'* care coordinator who identified his need for better diabetes management at home. The care coordinator helped Martin apply for *Partners'* Urgent Needs Fund that helps to meet the critical needs of low-income individuals. Martin became prone to falls after his toes were amputated due to his diabetes, and the Urgent Needs Fund provided him with special shoes and socks that allow for him to have better balance and control when walking. He was also provided with a small refrigerator to keep his insulin medication at the correct temperature, which is needed to maintain product potency. Martin is extremely grateful for *Partners'* continuous effort to ensure that he has the appropriate items to better manage his health and live safely at home. Martin now takes regular walks in his new shoes to stay healthy and is happy knowing his medication is stored properly.

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Partners Legacy Society– An Invitation to Preserve Your Legacy of Giving

We are so grateful to the following donors who are preserving their legacy of giving for the benefit of *Partners*.

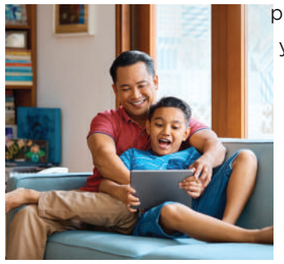
Paul Craig & Mary Jo Webb
Frances Hanckel, Sc.D.
Leeba Lessin*
John Simmons
June Simmons and Jody Dunn

*In Memoriam

Designating a planned gift automatically makes you a member of the Partners in Care Foundation's Legacy Society. Members of our Legacy Society will receive immediate recognition on our organization's website and in our publications and receive invitations to special events.

Join us as an inaugural member of Partners in Care Foundation's Legacy Society

Please consult with your legal and financial advisors about making a planned gift to Partners in Care Foundation today. If you have already named us in your will and estate plans, please let us know. 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

Partners in Care Foundation is a registered 501(c)(3) charitable organization. Contributions are tax deductible to the extent allowed by law. Gifts of all sizes are welcome and appreciated. When making a charitable donation, please use the following information and pass it along to your advisors: Legal Name: Partners in Care Foundation, Inc. EIN: 95-3954057

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:

$25,000
Ann Peppers Foundation

Partners received a $25,000 grant to support the needs of participants in our Enhanced Care Management (ECM) Program living in the San Gabriel Valley. By underwriting our Urgent Needs Fund, the Ann Peppers Foundation is contributing in a meaningful way to our ability to significantly enhance enrollees' community living experience, achieving maximum possible health, safety and independence. We will provide necessary purchases and vital services that are not covered by Medi-Cal reimbursements for our ECM participants.

$25,000
Office of Supervisor Holly J. Mitchell, LA County Board of Supervisors, Second District

Supervisor Holly J. Mitchell has awarded *Partners* a grant in the amount of $25,000 to support programs that reduce poverty and homelessness. This funding will be used to meet the urgent, otherwise unmet needs of participants in our safety net programs who live in the Second District of Los Angeles County.

$60,806
L.A. Care Health Plan

L.A. Care Health Plan has awarded *Partners* a one-year grant to support and expand the Enhanced Care Management (ECM) infrastructure for the purpose of improving healthcare access for eligible Medi-Cal member populations in Los Angeles County. *Partners* will use this funding to increase our ECM provider capacity by enhancing project oversight and reporting capabilities, building member outreach and engagement capacity, and hiring and training staff to meet growing demand.

Keeping Maggie Home Through MSSP

Meet Maggie. At 74 years old, she lives with chronic pain, arthritis, heart arrhythmia, and limited mobility from edema in her legs. Three steep steps on her front porch make it difficult to leave home and impact her ability to attend medical appointments. Maggie was at-risk of being placed in a nursing facility until she was referred to *Partners*' Multipurpose Senior Services Program (MSSP).

During a home assessment, *Partners*' identified numerous safety issues and provided Maggie with non-slip bathmats, emergency response devices, and had grab bars and bed rails installed to prevent falls and injuries that can often result in costly emergency room visits.

These essential services enabled Maggie to attend scheduled medical appointments, avoid nursing home placement, and be able to live safely and independently at home. To learn more about MSSP, visit: bit.ly/3ENn66z

Refer a senior in need of care management services today! Email MSSP@picf.org