innovations

Partners in Care FOUNDATION

Issue One, 2024

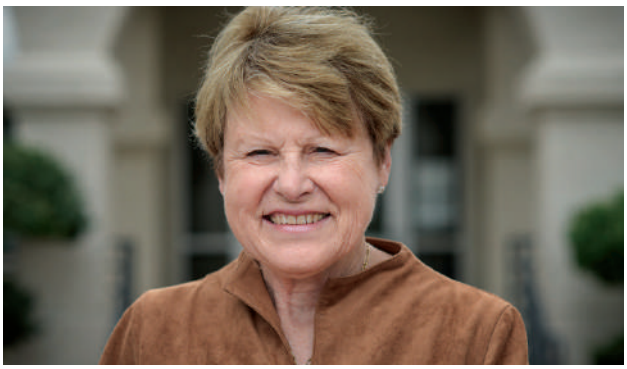
PARTNERS' TRANSITIONS OF CARE

Partners' Care Management Services Continue Expansion

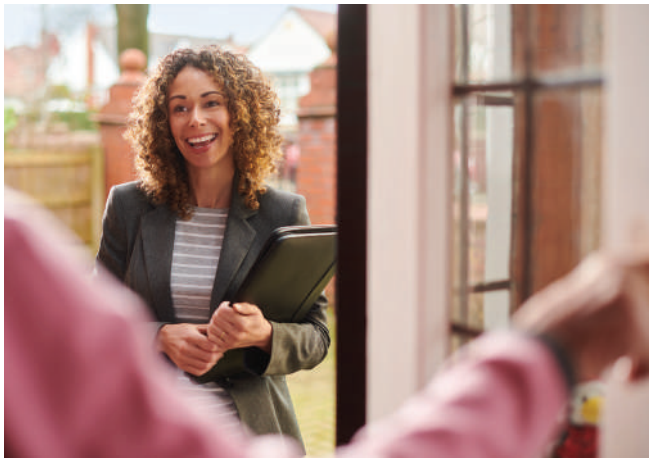
The need for social care management services is greater than it ever has been, and Partners is growing rapidly to expand the availability of our services to meet that need. We see demand increasing – especially as the number of older individuals grows and as California implements innovative programs for residents, such as the expansion of MediCal services through the CalAIM initiative.

The Partners in Care Foundation has been a leader in responding to social care service delivery for more than twenty-five years. In the process we have developed powerfully innovative social care services and tools that are community-based, low-cost, implemented by non-health care staff such as Community Health Workers or Social Workers, all of which enable people to receive services necessary to stay in their homes.

Our care transitions programs have been proven to reduce medical readmissions and ER visits, which in turn reduces medical costs, and ultimately, improves an individual's life. Our chronic disease self-management programs teach people how to take control of their care which leads to improved health, enhanced wellness, and transformed lives. Our long-term services and supports programs are committed to finding ways that support individuals in their homes so they can avoid care facilities.



June Simmons
Partners in Care Foundation President, and CEO



This agency's work bridges medical care and what a person is capable of doing in their own home as part of their recovery process following a medical event or through the normal process of aging. Partners manages the gaps in non-medical care that affect a person's recovery and overall health. This is accomplished either by our own staff or through a network of community-based organizations (CBOs) in California that make up Partners' Community Care Hub.

These efforts result in happier, healthier people cared for at lower expense in their own homes and communities. On the following pages you'll learn about our ongoing work to achieve those outcomes!

CalAIM Expansion Driving Partners' Growth

January 2022 saw the State of California begin an ambitious series of reforms broadly known as CalAIM designed to transform Medi-Cal completely by 2027. The state's Department of Health Care Services describe the initiative's goal as "ensuring that Californians get the care they need to live healthier lives."

Based on our deep experience implementing highly effective care management programs, Medi-Cal managed care plans such as Health Net, LA Care, Molina, Blue Shield Promise, CenCal, and Anthem eagerly began discussions with our agency to help them launch the Enhanced Care Management (ECM) program for their members, which is one of the most visible aspects of CalAIM.

ECM is an integral part of CalAIM, serving persons with complex social and medical needs, severe chronic conditions, who are frequent ER users, and may be homeless. This benefit provides extra services to help Medi-Cal members with complex needs get the care they need to stay healthy, such as physical, mental, and dental care, social services, access to housing and other resources, and connections/referrals to SDoH services.

In serving this population, Partners identifies, engages, and provides ongoing social care management. Partners ECM services are community-based, low-cost services that keep people in their homes. Our staff and the staff of our Community Care Hub members who also serve these individuals are highly knowledgeable about community-based services – where they are located and who the organizations are that can be of assistance.

Providing these services is staff intensive. Before January 2022, Partners employed a staff of just over 120 individuals. Currently the organization employs just under 250 to meet both the direct and indirect needs required to organize, deliver, track, and bill for services.

This initiative has led to exciting and unanticipated opportunities to find and serve eligible individuals. One has been a partnership with Coordinated Regional Care designed to eliminate challenges associated with fragmented care sometimes experienced by Enhanced Care Management (ECM) and Community Supports (CS) participants. The effort has been possible due to a $761,090 award from the California Department of Health Care Services. Another currently under discussion involves placing Community Health Workers in hospital emergency rooms to assist individuals who present with substance use disorder. Our new initiative with Kaiser Permanente (see following article) also fits this category.

For Partners, the primary benefit of California's CalAIM initiative is the ability to provide more services to those who need them, which is in line with the organization's Vision of "A world where every person has equitable access to affordable high-quality health and social care."

Kaiser Permanente Chooses Partners as 1 of 3 CBOs to Provide CalAIM Services

According to Partners' President & CEO June Simmons, "This is a wonderful continuation of our relationship with Kaiser Permanente that began many years ago. The whole team is excited to be providing services with Kaiser." Our agency will provide Enhanced Care Management (ECM) and Community Supports (CS) services to Kaiser members in the five southernmost California counties. Kaiser was able to bring forward IPP funding to help offset start-up costs.

In 2005 Home Palliative Care research jointly produced by Partners and Kaiser won Kaiser Permanente a national James A Vohs Award for Quality, and subsequently, as an actual benefit for all Kaiser members.

Our Community Care Hub team has been working diligently to identify, vet and onboard additional community-based organizations as new members of our Community Care Hub to provide services throughout the five-county Southern California region for which our agency is responsible.

According to Marie Rivas, Director of the Partners' Community Care Hub, "We've been pleased with the response from community-based organizations throughout the region. There is a strong interest in being part of this project with Kaiser."

KAISER PERMANENTE®

Partners Community Care Hub Members

- 1 Heart Caregiver Services
- Acasa Senior Care
- Accent Care
- Access TLC
- Accredited
- Alegre Home Care Agency
- At Home Caregivers
- California Caregivers
- Cambrian Home Care
- Comfort Paradise Home Care
- Easy Care Management
- Family Services Agency of Santa Barbara
- First Meridian Care Services
- FirstLight Home Care
- GA Food
- Green Tree
- Health Projects Center
- Home Care Partner
- Home Care SF
- Homewatch Caregivers
- Institute on Aging
- JM HomeCare
- Krista Care LLC
- Lifespring Meals
- Maxim Healthcare Services
- Meals On Wheels – Orange County
- MEND
- My Care Management
- Partners in Care Foundation
- Post Acute Care Partners
- Purfoods – MOMs Meals
- Resilient
- Rose's Agency Home Care
- San Diego Home Caregivers
- Senior Home Advocates
- Special Service for Groups
- Visiting Angeles Geneva SLO

"I'm Going to Enjoy the Rest of My Life"
Partners' ECM program at work in the community.

Nicholas Gonzales tapped on the window of a small, parked car. He'd already spoken by phone with the car's driver, Kurt Johnson.

Johnson peered out. He was an older man hunched over the steering wheel. Stacked in the backseat was just about everything he possessed.

Gonzales, a Partners in Care Foundation Care Coordinator, explained he had been sent to help Johnson find a home. Mr. Johnson cautiously opened the door.

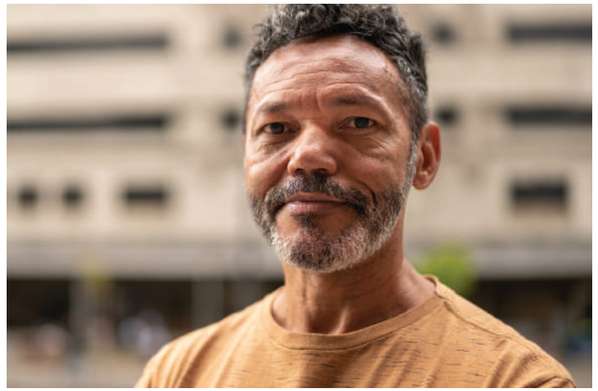
"I was sleeping in my car," says Johnson. At night he parked in a safe lot run by a nonprofit. Sometimes he stayed with relatives, but they could seldom take him in. During the day he just drove around. His car often broke down.

He told Gonzales he was in pain and had trouble breathing. His feet were going numb, and he couldn't see very well. "The street is no place for an old man," he said.

Johnson made big efforts to help himself, but they didn't work out. He states bitterly, "Nobody helped." He was told there was a six-year wait for housing. He couldn't get to his medical appointments when his car needed repairs. He remembers that "everything was bringing me down."

Finally, he'd found a lifeline. Partners specializes in social care that supports medical care. Staffed by professionals whose mandate is to go the extra mile, it helps people like Johnson live safely in a home of their own - not to be forced into an institution, and above all, the street.

Gonzales swung into action. He sent out a blizzard of applications for housing. Meanwhile, he worked to keep Johnson safe where he was and on track with his medical appointments and seven medications. He helped him buy food, clothing, and sanitary supplies which Johnson stashed in the trunk of his car. Gonzales stayed connected, making sure Johnson was OK, bolstering his spirits during a very dark time.



Slowly, slowly, Johnson began to rally. He suffers from serious medical conditions such as congestive heart failure, Diabetes, and asthma. Keeping on top of his healthcare isn't a luxury. It's a matter of survival.

Then his car broke down, and Gonzales showed him how to use free clinic transport. Scheduling medical appointments seemed an impossible task, keeping track of them even harder. Johnson gradually learned to do both. As Gonzales says, "Mr. Johnson doesn't let pride get in the way when he needs to ask for help, and he is always cordial and has integrity about what's going on with him." After a few visits to his doctor, Johnson started feeling better.

Partners found him a home a few months later, a record time in the face of a statewide shortage of housing for the homeless. It is a furnished small apartment in his old neighborhood with everything he needs to feel comfortable and secure.

Good things continue to happen. Instead of struggling to get by Johnson has a regular life and can focus on his health. His daughter and grandchild visit several times a week. Gonzales checks in with supplies and encouragement.

Best of all, Johnson sees his life back on path. Asked what he plans to do in the future, he laughs, "I'm going to enjoy the rest of my life!"

Recent Grants to Partners Supporting Our ECM-Focused Work

Cal Wellness: **$400,000**

The Cal Wellness grant will allow Partners to serve low-income medically fragile participants across the age, race, ethnicity, and income spectrum and expand HUB & ECM services in Santa Barbara, Riverside, San Bernardino, and San Diego counties.

National Council of Jewish Women, Los Angeles: **Twenty adult vouchers & ten youth vouchers**

The Los Angeles section of the National Council of Jewish Women (NCJW) generously donated twenty adult vouchers and ten youth vouchers for our participants, redeemable at one of their local Council Shops. The Council Shops offer a treasure trove of gently used clothing and household items, which brightened the holiday season for those who received this gift. Our participants reported that they used the vouchers to purchase new clothing for their rapidly growing children, including warm outerwear to protect against the colder temperatures, and an array of comfortable clothing that their low-and fixed-income budgets would not otherwise allow. We express our deepest gratitude to NCJW for their generosity and applaud them for their work to advance economic justice and equity for women.

Beverly Hills Rotary: **$2,500**

The Beverly Hills Rotary awarded Partners a $2,500 grant to assist our Urgent Needs Fund and support our clients in the Beverly Hills area. Our Urgent Needs Fund meets the critical needs of the very low-income people we serve by making purchases such as emergency housing support, adaptive equipment, home ramps, and other modifications essential to continued safe community living.

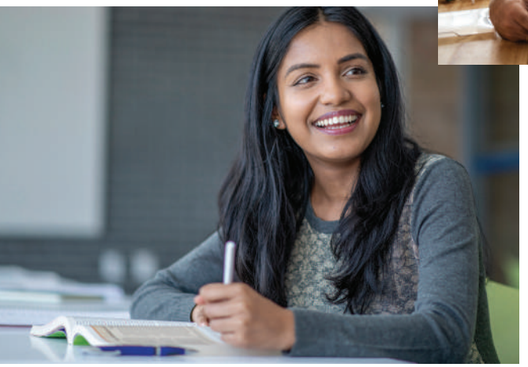
Ann Peppers: **$25,000**

Funding from Ann Peppers allows Partners to meet the urgent needs of participants in our Enhanced Care Management Program (ECM) living in the San Gabriel Valley. Our ECM participants are some of the most vulnerable individuals we serve. The agency's Urgent Needs Fund allows us to cover expenses that no other funding covers, allowing Partners to increase the quality of care and living for participants.

Partners Workforce Development Center Expands Impact

As has been observed elsewhere, the number of state residents qualifying for Medi-Cal ECM and Community Supports services – combined with a rapidly growing elderly population – is putting a strain on the available workforce necessary to provide services. Recognizing this situation, California has set a goal of adding an additional 25,000 Community Health Workers in the state by the year 2025 specifically to meet that workforce challenge.

This means identifying and then training individuals who are interested in this type of work. That is where Partners comes in. We have a long history in building the pool of Community Health Workers in California. The



agency pioneered the approach with Blue Shield of California and then built on that experience in partnership with LA Valley College and the Archstone Foundation. We established our Workforce Development Center several years ago and continue to offer high-quality, experience-based training to individuals who want to become Community Health Workers.

Several California agencies have developed funding streams that make it possible for organizations to train interested individuals. In many cases, they also provide incentive payments to individuals as a means of encouraging their participation in a training program. One of these programs is CalGROWS, which is underwritten by the California Department of Aging's Direct Care Workforce Training and Stipends Program.

Partners in Care Foundation won a $1,281,865 CalGROWS grant to develop both an online Community Health Worker (CHW) Training Program and to also facilitate two in-person training events. This program will recruit and train three hundred people to enter new careers or improve their skills in this field. The agency has already surpassed that goal.

According to Partners' Director of Workforce Development, Shad Cruz, "the response has been encouraging, and demonstrates there is an untapped workforce out there looking for this knowledge and training."

The online program is tailored to individuals who are currently working and is structured to make it easy for people to fit it in with life's other demands. "There is no set time to attend class," explained Cruz, "they can do it at their own speed. The important aspect is that they keep at it over time."

Participants represent organizations including Easter Seals, Area Agencies on Aging, Regional Centers, various community health centers and FQHCs, as well as numerous independent care providers throughout California.

The online CHW Training program was developed in two alternate pathways to better suit an individual trainee's needs. Partners is building a curriculum that will support a participant's certification once state certification requirements have been finalized and published. The Community Health Worker Training Track sequences the full curriculum to maximize benefit and includes live virtual discussion groups to enrich trainees' understanding by bringing real world experience to the information. Learners also benefit from hearing the experience of other CHWs. This pathway is designed to prepare participants for the California state certification process expected to be released in 2024.

The second pathway is the Professional Development Track, which allows trainees to choose from among all of the twenty-three lessons to customize their learning experience. It was designed to allow those with time constraints to benefit from the information most pertinent to them.

Learners who are participating in the program report "this is great information I can use every day" and "being that I'm currently a Care Navigator, [learning] how to ask questions, communicate effectively and organize my time was very helpful."

In addition to the online programs, Partners has coordinated two in-person training courses offered in collaboration with Care Coordination Systems. To be accessible to people throughout the state, sessions were scheduled in both Northern and Southern regions of California. The extensive in-person curriculum was developed in alignment with the C3 Community Health Worker Core Competencies and was designed to prepare graduates for state certification as Community Health Workers.

For each of the sessions, Partners connected with leadership from various agencies throughout California and invited them to send their direct service providers to the training to prepare them for certification. Participants completing the in-person training, including community health workers, were from throughout the Los Angeles and Sacramento Areas.

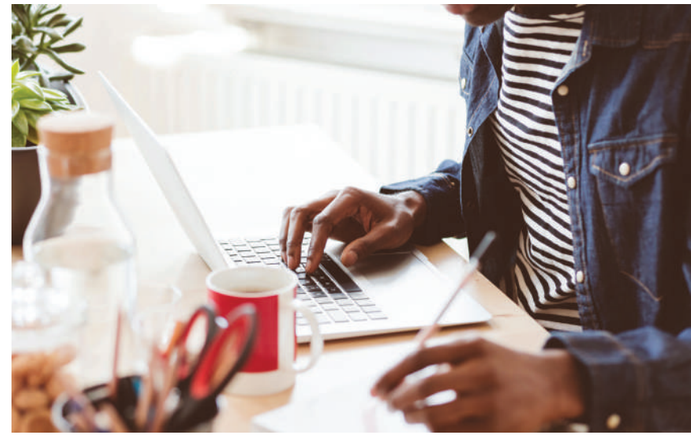
The Northern California training comprised an especially diverse group ranging in age from 19-87 years old and including staff providing services at the Sacramento Mexican Embassy, as well as to the Afghan and Ukrainian communities in Sacramento. It also helped to establish a relationship between Partners and the Health Education Council, a 2022 California Nonprofit of the Year. Both agencies are actively pursuing opportunities to continue working together.

Partners' Workforce Development Training Center continues to actively enroll individuals in its CHW training programs. To learn more about the Center and the various training options currently available, please contact Shad Cruz at scruz@picf.org or visit **https://www.picf.org/workforce-development-training-center/start-your-training-here/**

Additional Grant Support For Workforce Development-Focused Initiatives

Caring4Cal/HCAI - $460,483

Along with the CalGrows Training Initiative, Partners has received a grant from California's Department of Health Care Access and Information to offer additional training. This program focuses on equipping the service field with qualified personnel to deliver new models of care. Initiatives include developing and disseminating a curriculum to train Community Health Workers (CHWs) and expanding the supply of social workers to serve the increasing number of older adults. A future Innovations issue will provide greater information about this program.



Partners Joins California's Data Exchange Framework (DxF)

California has just launched a statewide health information exchange developed in conjunction with the state's Center for Data Insights and Innovation (CDII). It's an advance that represents dramatic opportunities for Partners to provide even better and more responsive services for those in our care.

The CDII describes its purpose this way – "Every Californian, no matter where we live, should be able to walk into a doctor's office, a county social service agency, or an emergency room and be assured health and human services providers can access the information they need to provide safe, effective, whole person care—while keeping our data private and secure."

According to the Center's website, "The DxF is not a new technology or centralized data repository; instead, it's an agreement across health and human services systems and providers to share information safely. That means every health care provider can access the information they need to treat you quickly and safely; health care, behavioral health and social services agencies can connect to each other to deliver what Californians need to be healthy; and our public health system can better assess how to address the needs of all communities."

Once fully implemented across California, the DxF will create new connections and efficiencies between health and social services providers, improving whole-person care. Joining the DxF requires the secure and appropriate exchange of health and human services information to enable providers to work together and improve an individual's health and wellbeing.

Health care facilities have already joined the DxF and will begin exchanging information and provide access by January 31, 2024. Physician organizations and medical groups with more than twenty-five providers will be joining the DxF by January 31, 2023.

Governmental organizations and community-based organizations are not required to join, though under the leadership of Anwar Zoueihid, Vice President Long Term Services & Supports, Partners eagerly joined, as have twenty of our Community Care Hub member agencies.

According to Partners' President and CEO June Simmons, "this step forward is a catalyst for this agency and our Community Care Hub members to work together in optimizing new delivery systems for the benefit of those in our care."

Zoueihid added "the DxF will help us improve the quality of care by allowing our staff to access participant data from other medical and social care providers which will allow us to optimize participant care and help make informed care decisions. It breaks down the "information silos" that we all have so we can focus on providing whole person care. For the first time ever, we will be able to exchange data with hospitals, physician groups, medical groups, skilled nursing facilities, health plans, disability insurers, clinical laboratories, and other social CBO's. "

Supporting this initiative is a $50,000 grant from the DxF Data Exchange to assist Partners IT department with data integration, enhance data sharing, and strengthen internal processes related to analytics and data tracking.

We are proud to have been the first CBO to sign onto this initiative. We believe making social care data available will drive better decisions and outcomes, support whole person care, advance health equity, promote individual data access, and improve overall care coordination between all social and medical providers associated with our participants.

How information exchange through the DxF supports the whole person:

HomeMeds℠ Combats Medication-Related Errors

Medication errors are one of the most commonly occurring of all medical errors. According to the Academy of Managed Care Pharmacy, medication errors harm at least 1.5 million people every year. A highly effective tool currently available to identify, prevent, and combat medication errors in the home is Partners' HomeMeds, a powerful, evidence-based,

in-home, medication risk tool used nationally to screen, identify, and assess potential medication-related hazards for individuals. Additionally, HomeMeds is designed to allow a non-healthcare staffer to do the identification and computer algorithm-supported analysis of meds in the home.

The software's proprietary algorithm identifies hazardous drug interactions, any fall risks or confusion related to possible inappropriate psychotropic medications, and any cardiovascular issues related to medication use. It is currently licensed for use by community-based organizations – like the Kenneth Young Center (see following story) – as well as by medical centers and health plans throughout the United States interested in reducing the frequency and impact of medication related errors in their communities.

HomeMeds has been the focus of extensive research and journal publications, including:

- **The Daily Sundown, The Chicago Tribune – "Safety Program Analyzes Medications for Potential Harmful Interactions"**
- **National Council on Aging – "What Medications Increase the Risk of Falling Among Older Adults"**
- **Journal of Patient Safety – "Linking Technology to Address the Social and Medical Determinants of Health for Safe Medicines Use"**
- **Patient Safety Network – "Care Managers Use Software-Aided Medication Review Protocol for Frail, Community-Dwelling Seniors, Leading to More Appropriate Medication Use"**
- **National Library of Medicine – "A Collaboration Among Primary Care Based Clinical Pharmacists and Community-Based Health Coaches"**
- **National Council on Aging – "Evidence-Based Programs: HomeMeds"**
- **America's Physician Group – "Letting Doctors Focus on Medicine"**
- **Administration of Community Living – "Administration of Community Living: HomeMeds"**
- **Evidence-Based Leadership Collaborative : "Evidence-Based Leadership Collaborative: HomeMeds"**

Links to each of these studies and articles is available on our website at:

www.picf.org/innovations-at-work/medication-management/homemeds/

If HomeMeds sounds like a service your organization should be considering, for a free, 30-minute demonstration, please email **HomeMeds@picf.org**

PARTNERS' INNOVATIONS

Kenneth Young Center Combats Medication Errors With HomeMeds℠

Not long ago, Molly Smith was taking twenty-nine prescribed and over-the-counter medications, and reported experiencing frequent weakness and dizziness. Smith is a member of the Kenneth Young Center in Elk Grove Village, Illinois, and staff there thought those problems could be connected to all her medications. Concerned about potential medication related problems, they identified her as an ideal candidate for a HomeMeds℠ medication review.

The Kenneth Young Center's care coordinator conducted a HomeMeds assessment with Smith, which involved inventorying all her prescribed medications, over-the-counter pharmaceuticals, herbals, and supplements she had and was using in her home.

That information was entered into the HomeMeds program which flagged a number of concerns. Those concerns went to pharmacist for review, who documented recommendations for Smith and her physicians.

Smith and her physicians received a letter from the reviewing pharmacist detailing recommendations on changing how and when to take certain medications. The pharmacist also sent her educational handouts tailored to her specific chronic conditions. She discussed those changes with her primary care physician and together they agreed to a new approach.

As a result of the HomeMeds assessment, Smith altered her diet to avoid certain foods that may aggravate her IBD symptoms and began incorporating foods that would calm the symptoms and promote healing. The HomeMeds pharmacist also suggested adjustments in her medications which Smith and her doctors implemented. Smith reports these have led to improvements in her IBD symptoms, less dizziness and in general, she "just feels stronger."

If HomeMeds sounds like a service your organization should be considering, for a free, 30-minute demonstration, please email HomeMeds@picf.org

AGENCY UPDATES

Shawn Sheffield

Chief Strategy Officer, Keck Medicine of USC

Partners in Care Foundation Board Member since May 2022

Shawn Sheffield, MBA, MHSA, serves as Chief Strategy Officer for USC's Health System, Keck Medicine, and is responsible for the health system's clinical strategies and expansion efforts. Sheffield leads external clinical growth, strategic and service line planning, health system marketing and communications, business development and healthcare mergers and acquisitions, including partnerships, capital, and venture planning, clinical integration, and physician alignment strategies.

During her tenure at USC, Sheffield has developed a scaled regional network of tertiary and quaternary care and transfer center volume through affiliation, partnership, and acquisition. The system has expanded to include four hospitals (Keck Hospital, Norris Cancer Hospital, Verdugo Hills Hospital, Arcadia Hospital) and a faculty practice plan with more than 1,800 employed physicians. In less than ten years, annual system revenue has more than tripled to $3.1 billion in 2021. Keck Medicine was named to US News and World Report top hospitals - has been ranked #23 in the nation with eight top-ranked specialty programs.

Prior to joining USC in 2012, Sheffield served as chief strategy and business officer and assistant vice-chancellor of resource, strategy and planning for University of California, San Diego, (UCSD) Health Sciences. She led the academic health system during a period of major growth and expansion, including development of a foundation model that integrated UCSD pediatric faculty with the largest pediatric private practice sub-specialty group in San Diego. Previously, she held academic leadership positions at the University of California, San Francisco, and Johns Hopkins University.

In 2020, Sheffield was named one of Los Angeles Business Journal's - Top Women Leaders in Health Care and in 2021 she was named Los Angeles Business Journal's - Hospital Executive of the Year. This year, she was named by the Beckers Hospital Review as "one of the 65 Health System Chief Strategy Officers to Know for 2023." Sheffield received both her Master of Business Administration and Master of Health Science Administration degrees from Arizona State University.

Excitement Building for 2024 Vision, Excellence and Leadership Dinner

For the past 23 years, the Partners in Care Foundation has recognized outstanding regional health care leaders at its Annual Tribute Dinner. The event honors individuals who are widely acknowledged as having reached the top of their profession and who significantly impact the field of health care.

This year the dinner will be honoring Gustavo Valdespino, President and CEO of Valley Presbyterian Hospital and Martha Santana-Chin, Medicare, and Medi-Cal President at Health Net California during the agency's upcoming 2024 Tribute Dinner.

Valdespino will receive the prestigious Vision and Excellence in Health Care Leadership Award. Santana-Chin will receive the distinguished Champion for Health Award.

This year the event will be held at a new venue. Instead of the Beverly Hilton, the dinner will take place on Wednesday, June12, 2024, at the Skirball Cultural Center on North Sepulveda Blvd. in Los Angeles.

Gustavo Valdespino

Martha Santana-Chin

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/**

Save the Date: 24th Annual Tribute Dinner

Wednesday, June 12, 2024

Skirball Cultural Center • 701 N. Sepulveda Blvd. • Los Angeles, CA 90049

6:00 PM – 9:00 PM

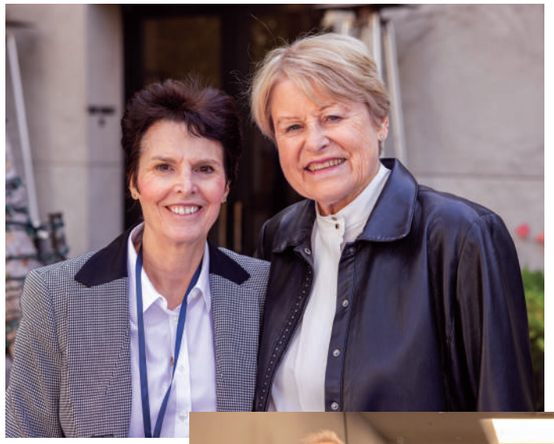
Partners Celebrates 25 Years of Success and Growing Impact

On Sunday, October 29th, Partners in Care Foundation formally celebrated completion of its 25th year with an afternoon reception at the Luxe Sunset Boulevard Hotel. Approximately one hundred guests were in attendance representing the birth and continuing evolution of the agency. Past Board members Scott Gaudineer and Adrian Stern served as Event Co-Chairs, hosting an afternoon that in the words of Barbara Solomon, a Founding Partners Board Member, was “a wonderful celebration for an outstanding organization.”

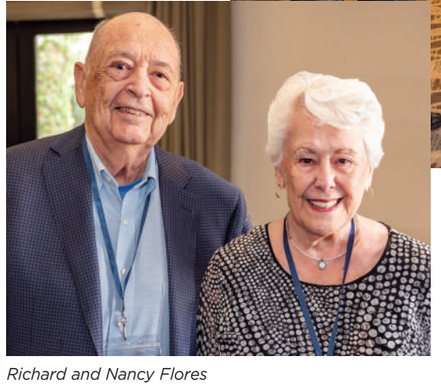
In her opening remarks, June Simmons, Founding President & CEO, stated “From day One we were pioneering the development of solutions to the societal challenges now known as the social determinants of health. We were very early in the vision which now is being adopted.”

The theme of the event was “Because of You”, which recognized the remarkable impact of every person that has contributed to the success of Partners. Jeff Wilcox, former EVP of United Way, secured Partners original funding of $275,000 for four years. Dr. Dorothy Fleischer guided the implementation of that funding to help people stay home and have access to quality care. Sylvia Whitaker came along for the bold new adventure and has worked with June for 37 years. Jody Dunn, our Co-Founder, stepped in to guide the development of the Partners brand. Jim Cook served as our first COO for 10 years. So many individuals played key roles that led to our success.

Partners current Board Chair, Jennifer Kozakowski remarked how rewarding it is to see what the agency has achieved in 25 years and that the health care industry recognizes the importance of health-related social needs and the social determinants of health.

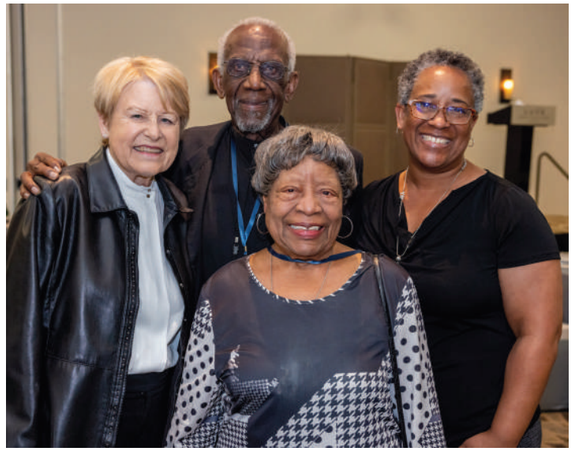


Partners Board Chair, Jennifer Kozakowski and Partners Founding President & CEO, June Simmons



Richard and Nancy Flores

(left to right): Partners Founding President & CEO, June Simmons with Visiting Nurse Association Charter Member, Barbara Solomon, PhD with family.



(left to right): Event Co-Chair Adrian Stern, Board Member Robert Lundy, JD, Partners Founding President & CEO June Simmons, Partners Co-Founder Jody Dunn, Visiting Nurse Association Charter Member Barbara Solomon,PhD, Board Member Gordon Johnson, and Event Co-Chair Scott Gaudineer.

Just as a Phoenix rises from the ashes, during the past twenty-five years Partners has become a nationally recognized organization. In recognition of their contributions through the years that have led to this recognition, Phoenix From the Ashes awards were presented to:

Jody Dunn
Marta Fernandez, JD
Scott Gaudineer
Fran Hanckel
Gordon Johnson
Robert Lundy, JD
Laura Manthey
Allen W. Mathies, MD In Memoriam
June Simmons
Barbara Solomon, PhD
Adrian Stern

Partners’ Founding President and CEO, June Simmons, and Co-Founder, Jody Dunn, were acknowledged for their visionary leadership in addressing the social determinants of health. Their commitment to aligning social care and healthcare has been integral to Partners’ mission, envisioning a world where every person has equitable access to affordable, high-quality health and social care.

Watch a video overview of Partner’s past 25 years of success:
https://youtu.be/YxvEAvPjmRc

Watch a video recording of the full 25th Celebration event:
https://youtu.be/Z7Ucnyb09Fs

As the event concluded, Partners expressed a big thank you to everyone who has supported their mission over the past 25 years. It is this collective effort that enables them to continue providing vital care to communities, ensuring that individuals can lead healthy and fulfilling lives in the comfort of their homes.

Recent Support For Partners' Crucial Work

Individual, corporate and foundation support make much of this agency's work possible. The following are recent corporate and foundation awards in support of Partners' Mission, which is to address the social determinants of health by aligning social care and healthcare. Our thanks to these organizations for their ongoing belief and support of our mission.

Beverly Hills Fire Dept: $182,600

The Beverly Hills Fire Department awarded Partners a generous $182,600 grant to support our commitment to implement a Fall Prevention Program. This funding will provide social services with training on Stopping Elderly Accidents, Deaths & Injuries and offer Matter of Balance workshops within the City of Beverly Hills.

Robert Wood Johnson Foundation: $500,000

The Robert Wood Johnson Foundation awarded the Partnership to Align Social care a $500,000 grant to support the group's efforts at elevating community voice in the design, implementation, and evaluation of health equity plans.

Los Angeles Department of Aging Ramp IIID

Partners received this highly competitive three-year award from the Los Angeles Department of Aging (LADOA) for the Title III-D Evidenced-Based Program for Disease Prevention (EBPDP). This funding provides older adults 60+ with services that will improve health and promote healthy lifestyles; reduce the impact that physical disorders have on the quality of life of older adults; promote and engage older adults in exercise and other health-related activities; and address issues related to polypharmacy, such as therapeutic duplication, drug interactions, contraindications, and regimen non-compliance.

The Ahmanson Foundation: $150,000

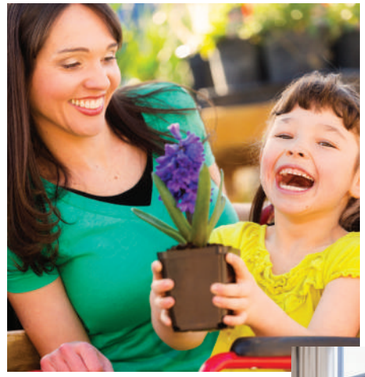
The Ahmanson Foundation awarded Partners a $150,000 grant to roll out and support a new care management software to all twenty-one of Partners programs that are eligible for technology upgrades.

Combatting Health Inequity at the Local Level

The Partnership to Align Social Care, which is Co-Chaired by the Partners in Care Foundation, is tackling the next logical step in driving alignment between social and medical care by launching Community-Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative. This Robert Wood Johnson Foundation-funded initiative seeks to answer a proliferation of regulatory requirements nationally promoting health equity and addressing health-related social needs (HRSNs) in communities.

Partnership to Align Social Care

A National Learning & Action Network



According to Partners in Care Foundation President and CEO June Simmons, "developing sustainable models addressing health equity and health-related social needs is key to alleviating disparities at the community level." Federal and state legislators, regulators, national accreditation organizations, health plans, and health systems recognize the detrimental effects of structural racism, discrimination, and disparate distribution of health care resources across multiple populations.

"Partnership to Align Social Care stakeholders share a unique collective commitment to cross-sector co-design and development of opportunities to effect meaningful alignment of health care and social care systems," explained Simmons "The effort to elevate community voice and promote multi-stakeholder collaboration in health equity planning is a natural evolution of the Partnership's work to achieve sustainable models that effectively and equitably align health and social care."

The Robert Wood Johnson grant enables the Collaborative's design and deployment for a two-year period. It has currently engaged thirty-nine sites across 26 states and includes people with lived experience of HRSNs and related social care services.

The teams are developing local strategies to sustainably address social needs and health equity and clinical quality measures for HRSNs. A key emphasis of the learning collaborative will be on local impact tracked by data exchange. This will foster clinical handoffs between payers, health systems, and CCHs/CBOs to identify, engage those in need and then to track and measure impact.

This work is a core component of the Partnership's work to advance health equity and dismantle the systemic power dynamics that perpetuate marginalization of historically underserved and under-represented communities and populations through local high impact demonstration of value with replicable models.

Partners in Care FOUNDATION

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