New Provider Operations Guide

Key Information for Medi-Cal Providers

This document highlights some of CenCal Health's programs and requirements and meets the new provider training requirements set forth by the Department of Healthcare Services (DHCS).

This document is for training purposes only, and does not replace or change contractual obligations between Providers and CenCal Health. More details are available in the CenCal Health Provider Manual and online at Provider Manuals | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties in addition to CenCal Health's New Provider Orientation videos Welcome to the Network | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties . Should you find any discrepancies between this document and the Provider Manual, please follow the Manual's specifications. CenCal Health also has specific policies and procedures for each subject highlighted in this document.

If you have any questions regarding the information, please contact CenCal Health's Provider Relations Department at (805) 562-1676 or email psrgroup@cencalhealth.org .

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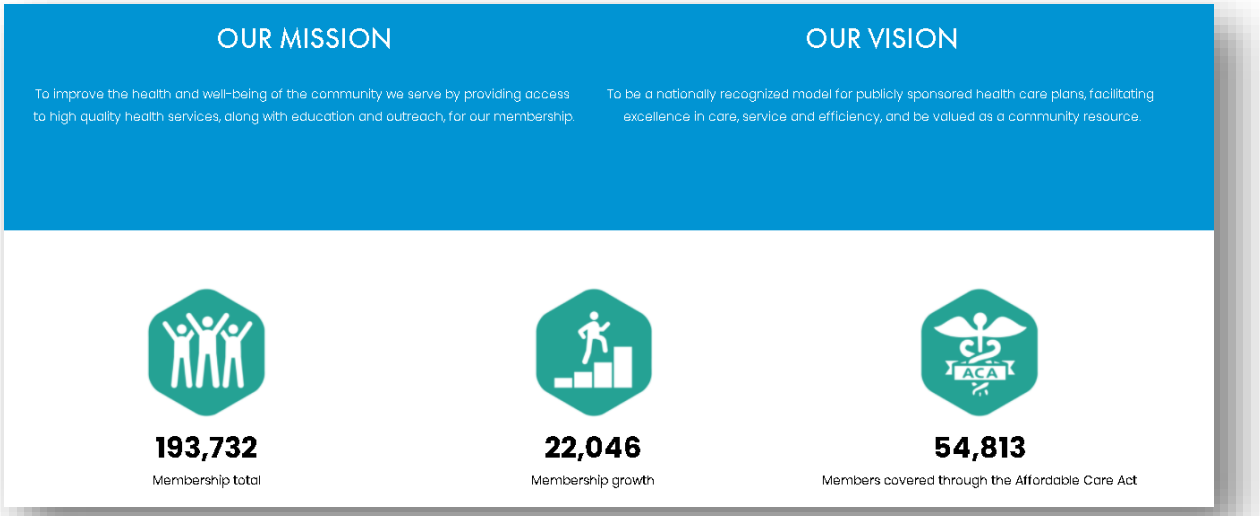
Welcome to the CenCal Health Provider Network!

CenCal HEALTH's success is a direct reflection on the efforts of local health care providers. Every one of our partnerships is essential. Together, we share the goal of improving the health and well-being of the people on the Central Coast. Our goal is focused on making it easier for local providers to serve our members and deliver the highest quality of care. We are publicly governed, non-profit and directly accountable to the communities we serve.

You are joining a large network of providers and hospitals. CenCal Health has the experience to understand your needs and the online tools to reduce administrative burden for you and your staff through our secure provider portal. Here is what you need to know before you see your first CenCal Health member.

If you need additional assistance, please contact the Provider Services Department at (805) 562-1676 and one of our Representatives would be more than happy to assist you.

Mission & Vision



Contact Information

Please contact CenCal Health for any questions or concerns. Hours of Operation: Monday through Friday, 8:00am – 5:00pm.

Contact Information	Phone Numbers
Member Services	(877) 814-1861
Provider Services	(805) 562-1676 (800) 421-2560 ext. 1676 Email: providerservices@cencalhealth.org
Claims Operations	(805) 562-1083 (800) 421-2560 ext. 1083 Email: cencalclaims@cencalhealth.org
Medical Management	(805) 562-1082 (800) 421-2560 ext. 1082 (877) 931-2227 Care to Care (Radiology Benefit Manager) Utilization Management (805) 562-1082 Option 1 Case Management (805) 562-1082 Option 2 Pediatric Case Management & CCS (805) 364-4950 Behavioral Health Department (805) 562-1600
Population Health	(805) 617-1997 Email: populationhelth@cencalhealth.org
Pharmacy Services	(805) 562-1080 (800) 421-2560 ext. 1080
Video & Telephonic Interpreter Services	**Phone Interpreter Service** (800) 225 -5254 Operator Customer Code: 48CEN

	Video Remote Interpreter Service Web Address: cencalhp.cli-video.com VRI Access Code: 48cencalhp **Email**: certifiedlanguages.com (877) 814-1861 - Sign Language
Finance-Recoveries Unit	(805) 562-1081 (800) 421-2560 ext. 1081
Fraud, Waste & Abuse Reporting	(866) 775-3944 Mail: CenCal Health Attn: Fraud Investigations – Compliance Coordinator 4050 Calle Real, Santa Barbara, CA 93110

Community Resources

Please note that CenCal Health is providing information as a resource only. It is not our intention to imply that organizations offer services that are covered benefits for our members.

CenCal Health partnered with Aunt Bertha (auntbertha.com), a company that created and maintains a social care network that makes it easy to find local, state, and federal resources available in our communities. Many of these resources are free or determined by income levels.

Please visit the Community Resources page on CenCal Health's website to view local community resources in your area. This information can also be found at https://www.cencalhealth.org/community/community-resources/

Telemedicine Policy

CenCal Health will reimburse for care delivered via telemedicine per DHCS guidelines.

- Capitated providers: Telemedicine services will be included in capitation payment.
- FFS providers: Telemedicine services will be paid at the contracted rate.
- BH providers: Telemedicine services for Behavioral Health is allowable and will be paid at the contracted rate.. If you are a FQHC and offer mental health services, please submit your claims with the Medi-Cal allowable codes. Visit DHCS' website and search "COVID-19 Medi-Cal Services and Telemedicine Notice."

Virtual Communication (audio and video)

Providers should continue to attempt to provide telemedicine services via HIPAA-compliant telecommunications methods. However, according to the Department of Health and Human Services (HHS) issued on March 23, 2020, "…covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telemedicine without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telemedicine during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."

We ask that you notify our Provider Services department by email psrgroup@cencalhealth.org if you intend to provide services over an electronic platform.

Telephonic Communication (audio alone)

This includes a brief communication with another practitioner or with a patient, who in the case of COVID-19, cannot or should not be physically present (face-to-face). Medi-Cal providers may be reimbursed using the below Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications.

HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

Member Eligibility

CenCal Health is a State contracted Medi-Cal Managed Care plan which Provides payment for its members in San Luis Obispo and Santa Barbara counties. If a member resides in a different county they may be eligible with another County Managed Care plan. Please check with the Managed Care plan in the county the member resides in for eligibility and guidelines.

The Department of Social Services (DSS) determines eligibility for CenCal Health members. AIM Members eligibility is determined by the designated AIM Program vendor.

SBHI and SLOHI are our two Medi-Cal Plans. Another smaller program administered by CenCal Health is AIM, serving Mothers and Infants during pregnancy up to 60 days after the birth.

Eligibility and PCP Assignment

Eligibility can change from month-to-month. Although CenCal Health members are issued ID cards, providers are responsible for verifying member eligibility on the day of service and prior to providing care

PCP Selection, Assignment, and Change

At the time of enrollment, new members are encouraged to select a PCP. When this does not happen, CenCal Health will automatically assign a PCP following an assignment algorithm that takes into account the members place of residence, primary spoken language, and other similar factors. CenCal Health members who are auto-assigned to a PCP may select another PCP at any time. All members may change PCP, to a PCP of their choosing and who is accepting new patients. In most cases, PCP changes will be effective on the first day of the following month.

Newborn Coverage

For the Managed Medi-Cal program, newborns are covered for eligible services under their mother's membership during the month of birth and the month following. All other programs cover newborns for only 30 days following birth.

Medi-Cal Benefits Identification Card & CenCal Health Cards

The identification number printed on the members Medi-Cal BIC Card up to the alfa character is identical to the number printed on the members CenCal membership card. This membership card should be used to determine a member's eligibility and we recommend making a copy for your patient records.

Verify Eligibility

Online Provider Portal

CenCal Health Website:
www.cencalhealth.org

Select Provider Login and sign in with your individual Username and Password

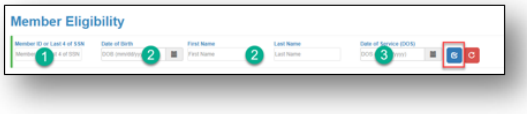
Select 'Check Eligibility'

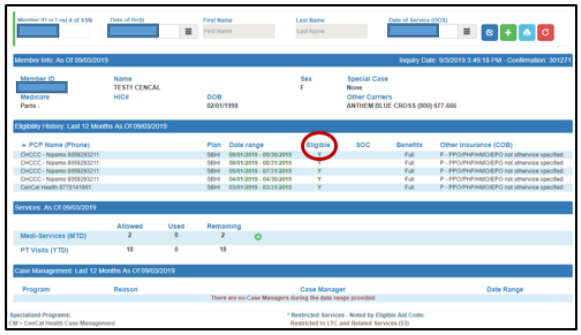
1. Member ID# or Last Member's last four (4) digits of their SSN
2. Date of Birth (MMDDYYYY format) or Members First/Last Name
3. Date of Service (DOS)
4. Click icon to submit

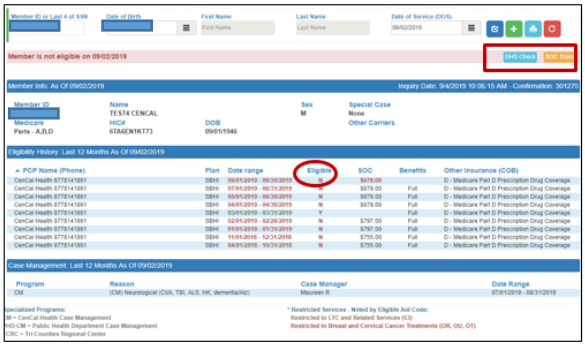
Eligible Member = '**Y**' Eligible
Non Eligible Member = '**N**' Not Eligible

If the member appears to be ineligible with CenCal Health, you can determine their State Medi-Cal eligibility through the CenCal website by selecting 'DHS Check'

1. Confirm the provider # box is populated with the correct NPI number
2. Enter your state provided PIN number
3. Enter the Date of service in (DDMMYYYY format) in the date of service box







What are Medi-Cal (SBHI & SLOHI) Special Case Members?

Members who are Special Case can be seen by any SBHI/SLOHI provider without a Referral authorization form (RAF). These members should be considered as fee-for-service and are considered to be more medically fragile (i.e. organ transplant, or Renal Dialysis members).

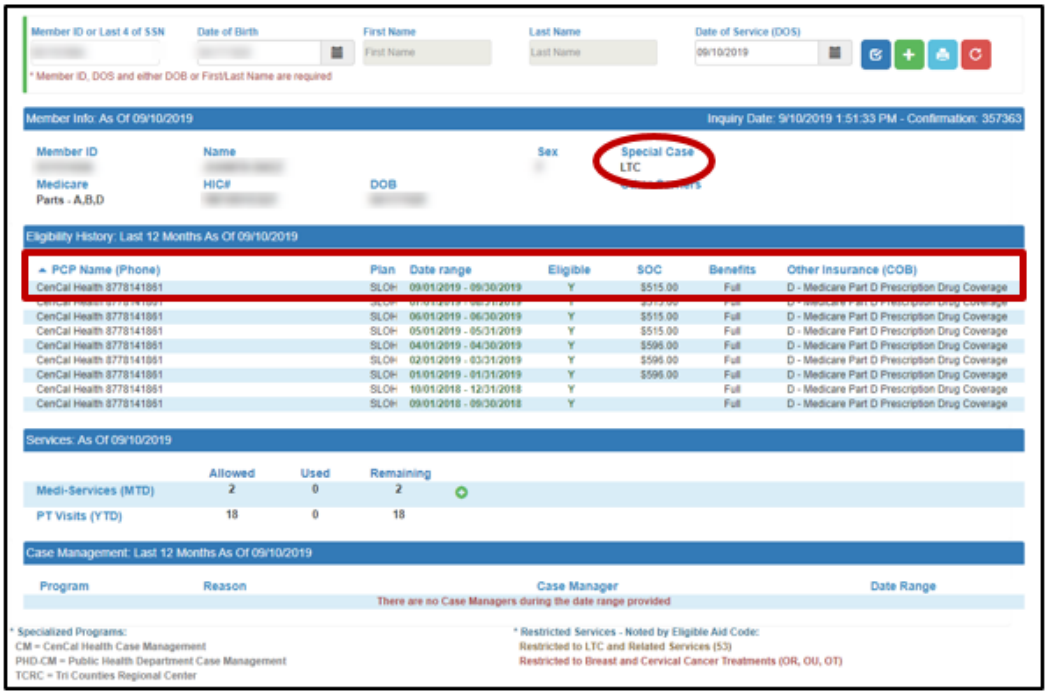
Special Case Members will be assigned to CenCal Health and it will appear under the Primary Care Section of the member's eligibility if they are a special class member.

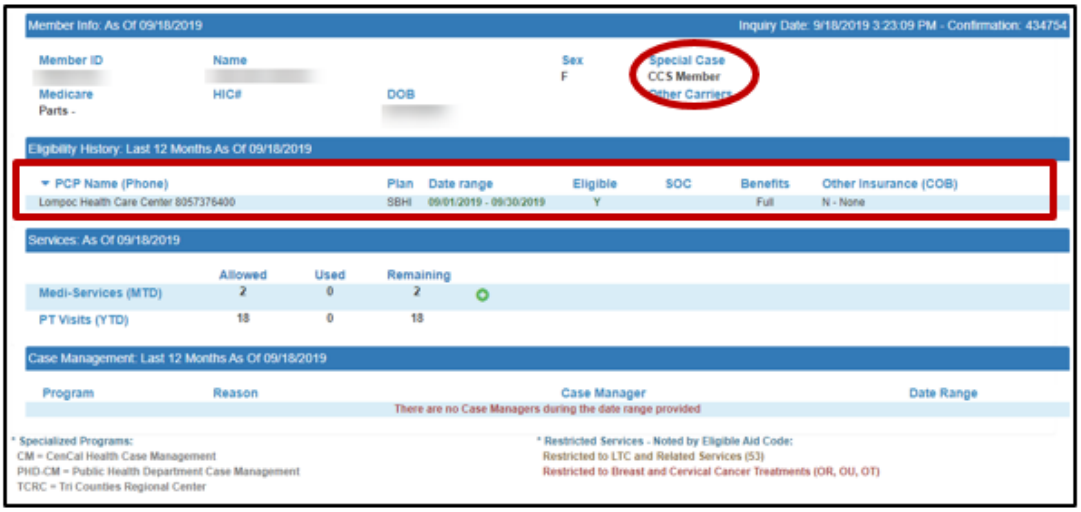
As stated above, if this is the case, this member does not need to obtain a RAF to see a specialist, and allows members open access to the network.

TIP: *It is important to check this each month as the member can be moved out of this class*

Categories for Special Class include:

- The First month of eligibility with CenCal Health
- Resident in a long-term care facility (skilled nursing or institutions for the developmentally disabled)
- Have met their share-of-cost
- Hospice
- Resides out of county
- Are qualified under the Genetically Handicapped Persons Program (GHPP)





By Phone

By Phone call CenCal Health's Member Services Department at (877) 814-1861 Option 3

Call State Medi-Cal EDS at 1 (800) 541-5555

Covered Benefits and Services

"Covered Services" refers to those medically necessary items and services available to a member through CenCal Health's Medi-Cal program. These services include Medi-Cal covered services and optional Medi-Cal services administered by CenCal Health, as well as Medi-Cal covered services not administered by CenCal Health.

Medi-Cal Covered Services Administered by CenCal Health

Medi-Cal Covered Services administered by CenCal Health include, but are not limited to, the following:

- Physician services
- Hospital inpatient and outpatient services
- Whole Child Model (WCM) and California Children's Services (CCS)
- Emergency care services
- Health education programs
- Home healthcare
- Maternity care services
- Family planning
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CenCal Health CHDP Program)
- Immunizations
- Prescription drugs
- Transportation — emergency
- Transportation — non-emergency medical transportation services
- Hospice

- Long-term care and skilled nursing care services
- Physical therapy/occupational therapy
- Vision services
- Mental health services

Medi-Cal Covered Services not Administered by CenCal Health

Certain Medi-Cal covered services are not administered by CenCal Health. The following identifies these covered services, as well as where to obtain more information in this provider manual about referrals for these services:

- Non CenCal Health members with California Children's Services (CCS) eligibility
- Dental services
- County Substance Use Services
- Local education agency services
- Specialty Mental Health Services

Access to Care Standards

According to the Department of Health Care Services and the Medicaid Managed Care Final Rule: Network Adequacy Standards, CenCal Health is required to adopt access to care standards for its provider network. Please see the table below for a summary of the regulations.

Appointment Time	Standard Time Frame
Non-urgent Primary Care Appointment	Within 10 business days to appointment from request
Non-urgent Specialty Appointment	Within 15 business days to appointment from request
Non-urgent OB/GYN Specialty Care Appointment	Within 15 business days to appointment from request
Non-urgent OB/GYN Primary Care Appointment	Within 10 business days to appointment from request
Non-urgent Mental Health (non-psychiatry) Outpatient Services Appointment	Within 10 business days to appointment from request
Non-urgent Ancillary Services Appointment (for diagnosis or treatment)	Within 15 business days to appointment from request
Urgent Care Appointment	Within 48 hours for services that do not require prior approval Within 96 hours for services that do require prior approval
Emergency Care	Immediately
+Primary Care Triage and Screening	Within 30 minutes
Mental Health Care Triage and Screening	Within 30 minutes
Wait Time in Office	Within 30 minutes

After Hours Care	24 hours a day
Telephone Access	24 hours a day

+ reflects "Triage" or "screening", and means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

Emergency Services and Urgent Care

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the member/enrollee reasonably believed that the absence of immediate medical attention could result in one of the following situations:

- Placing the health of the individual (or, in case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part,

A "psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others,
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency services include medical screening, examination, and medical and psychiatric evaluation by a physician, or – to the extent permitted by applicable law – by other appropriate personnel under the supervision of a physician, and within the scope of his/her licensure and clinical privileges, to determine if an emergency medical or psychiatric condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility.

In all instances when a member presents at an emergency room for diagnosis and treatment of illness or injury, pre-established guidelines for hospitals require appropriate triage of the severity of illness/injury.

An authorization is not required for emergency situations as defined by the examining physician. The examining physician determines required treatment to stabilize the patient.

In routine and non-urgent situations, treatment authorization by the PCP is required after completing the medical screening exam and stabilizing the condition. If the PCP does not respond, the Emergency Room/Department will proceed with treatment. Documentation and proof of the Emergency Department's attempt to reach the PCP and medical group and failure of response within 30 minutes of the first contact attempt will be accepted as authorization to diagnose and treat.

Terminating a Provider

In the event that a provider is terminated from the CenCal Health network, we must make every effort to ensure our obligations to the State and to our Members' care are met, including ensuring Members are notified and reassigned to another CenCal Health participating provider when appropriate.

As a Provider, it is important to ensure you notify CenCal Health in writing at least 60 days of any changes to your practice, including if you are moving, retiring, or resigning that may result in terminating your Agreement with CenCal Health. CenCal Health is required to notify DHCS of Provider Termination as applicable to our contract.

Providers must also ensure that access to Members' records and other information necessary to ensure any needed coordination or transfer of care to another provider may occur, as required by your Agreement, and by State and other laws. Providers are obligated to cooperate and assist with ensuring our Members' needs are met during this time.

CenCal Health will acknowledge your written Notice of termination with a returned acknowledgement notice via email, and also ask you to complete a Provider Exit Survey to gain valuable feedback and to identify opportunities for improvements to programs and services.

Referrals & Prior Authorizations

Referrals

PCPs must refer assigned CenCal Health members to specialists within the CenCal Health network. Referral Authorization Form (RAF) is required for all case managed CenCal Health members; however, there are a number of exceptions to this rule. Please reference the Authorization section of our website under 'Is a RAF required?' for more information

Prior Authorization

All requests for Prior Authorization must be sent to your medical group. Contact your medical group for a current list of services requiring Prior Authorization. Requests for non-emergent services subject to prior authorization should be submitted at least 14 calendar days prior to the anticipated service date.

Prior Authorization Exceptions

The following services do not require prior authorization:

- Sensitive services (see section Sensitive Services for more information).
- Obstetrical and gynecological services, including basic prenatal care and support services available through the member's medical group. The member will deliver in the hospital affiliated with her medical group. The member's obstetrical provider will request authorization for required testing.
- Emergency care (in or out of network).
- Preventive care (in network).
- Initial Assessment for Mental Health Services (psychotherapy or medication management)

Routine (Standard) Request

CenCal Health shall make best efforts to process prior authorization requests promptly. However, providers should be aware that a request might pend when additional pertinent clinical information is necessary to make the coverage decision or if the request is subject to clinical review. Decisions for a routine prior authorization request are usually made within 14 days from receipt of the information reasonably necessary to render a decision. The decision may be deferred and the above time limit extended an additional 14 calendar days when additional clinical information is needed for review and when the member, member's requesting provider or CenCal Health can justify that an extension would be in the best interest of the member. Physician Reviewers who hold an active, unrestricted California license make medical necessity decisions. Denial or Modification notices (Notice of Action or Notice of

Adverse Benefit Determination) are sent to the Provider by either fax or Provider Portal email. Members will receive denial or modification notices via U.S. mail within 3 working days of the decision.

Form	Type of Request or Service	Who Can Submit the Request?	Purpose	Processing Timelines for URGENT Request	Processing Timelines for Routine Request
Referral Authorization Form (RAF)	Referral from PCP to Specialist, for a Second Opinion, or Standing Referral for extended care	PCP (and occasionally, designated Provider Service Staff)	To determine the medical necessity of a referral to a specialist, tertiary care center or out of network provider.	no later than 3 working days* from the receipt of referral request	within 5 working days but up to 14 calendar days*
Treatment Authorization Request (TAR) Located below are three (3) different TAR form types					
50-1	Procedures, DME, Hospice, Home Health, **Elective** admission request	The provider of service, e.g. DME vendor, Home Health agency.	To determine the medical necessity of a requested service.	no later than 3 working days* from the receipt of request for service	within 5 working days but up to 14 calendar days*
18-1	Inpatient: acute, LTAC, Rehab. Concurrent or Retro review.	Admitting hospital or LTAC facility	To determine the medical necessity of continued acute care and to facilitate a transfer/transition of care	within 24 hours of admission notification or concurrent review (denial or modification, e.g. lower level of care), notify the treating provider/facility	
20-1	SNF, Subacute, CLHF	Admitting facility, hospital discharging member, PCP for Community to SNF Placements	To determine the medical necessity of continued stay in skilled nursing facilities (SNF), subacute, and congregate living health facilities (CLHF)	within 24 hours of admission notification and based on subsequent concurrent review timelines (denial or modification, e.g. lower level of care), notify the treating provider/facility	

*Can extend up to an additional 14 calendar days with an issuance of a NOA "delay".

CenCal Health Member Rights and Responsibilities

CenCal Health members have these rights:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a primary care provider within CenCal Health's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To access Minor Consent Services.
- To receive written member-informing materials in alternative formats (such as braille, large-size print and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by CenCal Health, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Service Facilities, midwifery services, Rural Health Centers, sexually transmitted disease services and Emergency Services outside CenCal Health's network pursuant to the federal law.

Member Grievance and Appeal Process

Providers can offer to help members file a grievance or an appeal. They can also file appeals on their behalf with their patient's approval. The following information explains the process for member grievance and appeal filing.

CenCal Health members have the right to file a grievance about their experiences with the Plan or its providers. While many providers have internal policies for resolving patient complaints/grievances, CenCal Health provides a Grievance and Appeal System for our members to express their dissatisfaction or to appeal a decision that they do not agree with. We do not delegate this activity to our provider network.

For appeals, members have 60 calendar days from the date of the Notice of Adverse Benefit Determination Letter (NABD) or decision to submit an appeal. For Grievances, there is no longer a time limit to file. NABD Letters were previously referred to as, Notice of Action Letters (NOA). An appeal or grievance request can be made by the member, the authorized representative or by a provider for appeals on behalf of the member.

If a member asks to file a grievance or an appeal with the provider, the provider's office staff should give him/her the appropriate forms and instructions. Forms are available in English and Spanish, and copies of these forms should be made readily available for CenCal Health members in your office, and are available at the following links:

Appeal Form: English or Spanish
Grievance Form: English or Spanish

How To Assist Members In Filing Grievances or Appeals

A grievance or an appeal can be filed by members or on behalf of members by any of the following methods:

- By calling CenCal Health's Member Service Department Representative at our toll free number (877) 814-1861.
- In person, by visiting CenCal Health.
- By completing a Grievance/Appeal Form and/or submitting in writing to:

CenCal Health
Attn: Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110

- Via website at this link: https://www.cencalhealth.org/members/file-complaint/

Standard and Expedited Review Processed

Standard - In most circumstances, grievance or appeal requests will be processed through the Standard Grievance/Appeal Review Process. This is a 30-day max timeframe for review. The timeframe may however be extended an additional 14 calendar days for appeals only, if there is a need for additional information to make a decision and/or if the delayed decision is in the best interest to the member.

The standard process include a written resolution of the grievance or appeal within 30 calendar days of filing.

Expedited - An expedited review of an appeal can be requested in certain cases. This is a 72-hour allowed timeframe for review. This process supports resolution of the appeal within 72 hours when a delay in a decision using the 30-day standard process may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. A CenCal Health physician reviewer will determine if the appeal request meets expedited criteria for processing.

If the expedited process is granted, a physician reviewer who was not involved in the original decision will complete the review and resolution of that appeal is provided to the requestor within the 72 hours of filing. An attempt will be made to notify the member verbally of the decision within the 72 hours and is also followed by written notification.

If the CenCal Health Physician Reviewer determines the appeal does not meet expedited criteria for processing, the process will revert to the standard appeal process for resolution.

Provider Responsibilities

Providers must cooperate with CenCal Health in identifying, processing and resolving all member grievances and appeals.

Cooperation in this process includes, but is not limited to:

- Speaking with CenCal Health Grievance & Appeals Coordinators to assist with resolving the grievance or appeal in a reasonable manner.
- Having designated staff available for grievance and appeal investigation.
- Completing a provider response in writing, if requested. Providers may choose to respond in writing at any time as well and often provide written documentation of their requests when filing on a member's behalf.
- Responding to all information/documentation requests made by CenCal Health related to the grievance or appeal: medical record requests, provider's response to the complaint, scheduling documentation/ phone logs and/or other supporting documentation needed for CenCal Health's review.
- Responding to requests timely (within 7 business days at a maximum).

If providers would like to file an appeal on behalf of a member, providers must now obtain written consent from members to do so. This signed consent should be submitted with your appeal request. CenCal Health is able to initiate an appeal filed by a provider for a member, with at the least, verbal authorization from the member. DHCS requires CenCal Health to request written consent even if verbal authorization is obtained, so it is best to obtain written authorization for submission when filing the appeal request.

CenCal Health's Grievance & Appeal Team is available to answer any questions you may have about this process at any time. Please contact us through the Member Services Call Center at (877) 814-1861 and ask to speak with a Grievance Coordinator.

Role of the Primary Care Provider (PCP)

The primary care provider (PCP) plays the central role in structuring care for CenCal Health members. The PCP is the main provider of healthcare services for CenCal Health members and is responsible for the delivery of healthcare to his or her assigned members. CenCal Health's model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

Responsibilities of the Primary Care Provider (PCP)

PCP responsibilities include, but are not limited to:

- Provide care for the majority of healthcare issues presented by the member, including preventive, acute, and chronic healthcare.
- Supply risk assessment, treatment planning, coordination of medically necessary services, referrals, follow up and monitoring of appropriate services, and resources required to meet the needs of the member.
- Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.
- Assure access to care 24 hours a day, seven days a week, including accommodations for urgent care, performance of procedures, and inpatient rounds.
- Coordinate and direct appropriate care for members, including:
    - Initial Health Assessments
    - Preventive services in accordance with established standards and periodicity schedules as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
    - Second opinions
    - Consultation with referral specialists
    - Follow-up care to assess results of primary care treatment regimen and specialist recommendations
    - Special treatment within the framework of integrated, continuous care
    - Screen members for mental health and substance use difficulties, provide treatment within scope of practice, and assist the member with referrals to appropriate treatment providers.

- Coordinate the authorization of specialist and non-emergency hospital services for members.
- Contact and follow up with the member when the member misses or cancels an appointment.
- Record and document information in the member's medical record, including:
    - Member office visits, emergency visits and hospital admissions.
    - Problem lists, including allergies, medications, immunizations, surgeries, procedures, and visits.
    - Efforts to contact the member.
    - Treatment, referral, and consultation reports.
    - Lab and radiology results ordered by the PCP.
    - Authorization to Release Information to and from the member's mental health and substance use provider.

- Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.
- If the member is currently receiving mental health or substance abuse treatment services, coordinate the member's care with the existing mental health or substance use provider.

Provider Complaints and Grievances

CenCal Health has developed a process to address provider complaints and grievances efficiently and fairly. This policy provides an avenue for contracted and non-contracted providers to bring concerns or opportunities for improvement to CenCal Health's attention, and thus drive CenCal Health operations and direction, as appropriate.

Procedure

1. Receipt of Provider Claims Inquiries, Disputes or Appeals; and Authorization Inquiries or Appeals
   If a provider contacts Provider Services with issues outside their purview (claims inquires or appeals, authorization inquiries or appeals, clinical or quality of care concerns), the Provider Services Customer Representative will "warm transfer" the caller to the appropriate department. The appropriate department, to address the grievance, unless otherwise requested, shall review and respond as appropriate.

   A. *Receipt and Resolution of a Provider Complaint or Grievance:*

      I. The Provider Services Department is charged with the resolution of provider complaints and grievances. The complaint may be related to: non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues. The provider may file a complaint with the Provider Services Department via a telephone call, fax, e-mail or handwritten letter.

      II. If a complaint has no clinical or quality of care aspect, the PSR determines whether the provider needs routine assistance or would like to file a formal grievance. Formal grievances must be submitted in writing, preferably on the provider's letterhead.

      III. Informal complaints and requests for routine assistance are addressed by the PSR, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters

      IV. If the provider submits a written formal grievance, the PSR will notify the Provider Services Quality Liaison, who will send a receipt acknowledgment letter within five business days.

      V. The PSR will collaborate with other staff as needed to investigate and resolve the provider's grievance. Following resolution of the complaint, the PSR will document the case and the outcome, and the Quality Liaison will send a resolution letter. All grievances are resolved within 45 business days.

Disclosure to Providers and Members

Providers are informed of their right to file complaints and grievances, and the availability of assistance in the filing process, in a variety of ways. This may include, but is not limited to: through their provider contract agreements or amendments, CenCal Health's website, Provider Bulletins, and in provider materials and manuals issued by CenCal Health and updated periodically.

CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the provider. The provider's failure to use these procedures does not preclude the provider's use of any other remedy provided by law.

CenCal Health's Chief Operating Officer and Legal Counsel should be notified immediately when a provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

CenCal Health will not discriminate or retaliate in any manner, including but not limited to the cancellation of the provider's contract, against a provider who files a grievance.

Grievances shall be received, handled, and resolved without charge to the provider. However, CenCal Health shall have no obligation to reimburse a provider for any costs incurred in connection with filing a complaint or grievance.

Confidentiality and Privacy Regarding Record Retention

All provider complaints and appeals shall be placed in designated files and maintained by the Provider Services Quality Liaison for at least ten (10) years after the resolution; the files of the previous two (2) years shall be in an easily accessible place at CenCal Health's offices.

Monitoring of the Process

Reports: The Provider Services Quality Liaison will prepare a quarterly summary of provider complaints and grievances to be presented to CenCal Health's Network Management Committee and Board of Directors. The summary shall summarize the number and type of provider complaints, grievances and appeals.

Behavioral Health Treatment

CenCal Health covers Behavioral Health Treatment (BHT) for individuals under the age of 21 under the EPSDT provisions. BHT services are evidence-based treatments that are effective in the treatment of behaviors that are typical of a neuro-developmental disorders such as Autism Spectrum Disorder, Cerebral Palsy or seizure disorders. Treatment services may include but is not limited to Applied Behavior Analysis (ABA), behavioral interventions and parent training.

A member may qualify for Behavioral Health Treatment Services if all of the following criteria are met:

- The member is under 21 years of age
- The member is presenting with a pattern of developmentally inappropriate behaviors that is significantly affecting their ability to function in the community and at home. Please note CenCal covered BHT services do not address behaviors affecting the member's functioning in the primary academic educational setting as outlined in an Individualized Education Plan (IEP)
- The behaviors are not a result of an untreated medical condition, sensory impairment or mental health disorder that can be treated with another modality (i.e. speech therapy, physical therapy, occupational therapy, counseling services or medication) or the behaviors can be further treated or ameliorated by the provision of BHT in addition to existing treatment modalities
- The member is medically stable
- The member is not in need of a 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities

Referral process

Primary care providers and specialists, including clinical psychologists, developmental behavioral pediatricians and pediatric neurologists, who believe that a CenCal member meets medically necessary criteria for BHT services, can submit a referral (RAFB) via the CenCal portal or by fax at (805) 681-3070 to the Behavioral Health Department providing the following supporting documents:

- Copy of a comprehensive developmental assessment completed in the past 2 years that provides a treatment recommendation that BHT services are medically necessary and clinically appropriate. Comprehensive assessments completed by an out-of- network clinical psychologist

or developmental behavioral pediatrician including a provider contracted by Regional Center will be accepted. Assessments completed by an Educational Psychologist as part of an evaluation for an IEP or IFSP may be provided in addition to required assessment documentation.

- Medical documentation to confirm that the member is medically stable and able to participate in services and that the member's behaviors are not due to an untreated medical condition.
- Supportive documentation providing information on the targeted behaviors that the member is exhibiting that is impairing the member's functioning at home and/or the community and a recommendation that the member will benefit from BHT services.

Providers that need a comprehensive assessment to be completed, can submit a referral (RAFB) to the CenCal BH Department via the Provider portal or by fax to the Behavioral Health Department at (805) 681-3070, please use the Behavioral Health fax sheet.

Mental Health Services

Mental health services are a covered benefit for CenCal Health members when medically necessary and may be provided by a PCP within scope of practice or by a licensed mental health professional employed by a CenCal Health contracted FQHC, Tribal Health Clinic or a mental health provider contracted with CenCal

CenCal Health covers outpatient services for adults (age 21 and older) presenting with a mental health diagnosis according to the DSM V that is resulting in mild to moderate impairment of mental, emotional, or behavioral functioning. Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or disability or to alleviate severe pain through the diagnosis and treatment of the illness.

For children and young adults under the age of 21, CenCal Health is responsible for providing medically necessary outpatient mental health services to members who do not qualify for Specialty Mental Health services under EPSDT criteria.

Mental Health services covered by CenCal Health include:

- Initial evaluation to establish medical necessity (require no pre-authorization)
- Individual, family and group mental health evaluation and treatment (psychotherapy)
- Psychological testing, when clinically indicated to evaluate a mental health condition or establish diagnosis for a neuro-developmental condition (Requires pre-authorization)
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation to a member to establish medical necessity for medication management of a psychiatric or behavioral disorder (Requires pre-authorization)Preventative family therapy services for pediatric members under the age of 21 elevated Adverse Childhood Experience (ACE) scores who are not presenting with a diagnosable mental health condition.

There are no defined limits on the number of visits a member can have with a mental health professional. Benefits will be arranged and provided based upon medical necessity and the level of care needed to make progress towards treatment goals.

Exclusions: Couples counseling or family counseling to only address relational problems are not covered.
CenCal Health MH benefits do not include Mental Health referrals to a tertiary care facility (i.e. UCLA Resnick). CenCal Health do cover admission to a specialized eating disorder inpatient facility for medical stabilization only.

Specialty Mental Health Services (including crisis response, inpatient and residential treatment and mental health services to children under EPSDT benefits) will continue to be the responsibility of the County Mental Health Departments. See Section F, F2 for more information on the criteria for specialty mental health services. County Mental Health Departments are available for psychiatric consultations to CenCal contracted primary healthcare providers.

Referral Protocols

Members can contact the CenCal Member services line to request assistance with linkage to a mental health provider for psychotherapy or medication management services or can contact an in-network provider directly to schedule an initial appointment. Primary care providers can submit a RAF via the CenCal portal requesting linkage to a mental health provider for psychotherapy or medication management services. A listing of contracted mental health providers can be obtained on the CenCal website.

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To facilitate collaborative services between healthcare providers and mental health providers, providers must obtain a signed release from every member who are currently receiving mental health services from County Mental Health.

CenCal Contact Numbers

Member services: Santa Barbara County Department of Behavioral Wellness
Access Line (24/7) (888) 868-1649
Psychiatry Consultation Services: 1-805 681-5103

San Luis Obispo Department of Behavioral Health
Access Line (24/7) (800) 838-1381
Psychiatry Consultation Services: (805) 781-4719

Non-Emergency Medical Transportation Services & Non-Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are accessible for members whose medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and specialized transportation is required for the purpose of obtaining needed medical care.

NEMT requires prior authorization (TAR). CenCal Health reviews the 'Physician Certification' form for medical necessity. This form can be filled and signed by the member's physician, dentist, podiatrist, physical or occupational therapist or mental health or substance use disorder provider.

Ventura Transit System (VTS) is CenCal Health's transportation vendor. To schedule transportation services, members or providers may contact VTS directly at (855) 659-4600. *Prior authorization is not required when it is medically necessary for a hospital discharge to a SNF, or for a transfer to another facility.*

The 'Physician Certification' form must include *at a minimum*, the following components:

a) **Functional Limitations:** The physician is required to provide the member's specific physical and medical limitations that preclude their ability to reasonably ambulate without assistance or be transported by public or private vehicles.

b) **Dates of Service:** The physician is required to provide start and end dates for the prescribed NEMT service; authorizations may be for a maximum of 12 months.
c) **Mode of Transportation:** The physician is required to list the mode of transportation to be used when receiving these services (ambulance, gurney/litter van, wheelchair van or air transport).
d) **Certification Statement:** The physician is required to certify that medical necessity criteria were met to determine the prescribed mode of transportation.

To view or print the 'Physician Certification' form, please go to www.cencalhealth.org.

Completed and signed Physician Certification forms should be submitted to CenCal Health, Utilization Management (UM) Department via fax or uploaded securely through the File Drop Link:

- CenCal Health UM Fax: 805-681-3071
- CenCal Health's Secure File Drop Link : https://transfer.cencalhealth.org/filedrop/hs

Health Assessments

Initial Health Assessment (IHA)

An IHA is an initial comprehensive preventive clinical visit with a primary care practitioner. DHCS requires that PCP's complete an IHA with new CenCal Health members within 120 calendar days of enrollment for all ages. The IHA, at a minimum, includes a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. It enables the member's PCP to assess and manage the acute, chronic, and preventative health needs of the member.

Bright Futures Recommended Periodicity Schedule:

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

American Academy of Pediatrics Immunization Schedule

Immunization Schedule (aap.org)

Staying Healthy Assessment (SHA)

In addition to an IHA, DHCS requires that PCPs and members also complete a SHA tool/questionnaire. The SHA is an age-specific risk assessment tool that is repeated at specific age intervals. It is used to assess a member's health habits and status, such as nutrition, physical activity, environmental safety, and sexual health and substance use as appropriate.

Program Components:: An IHA visit should include the following components:

- A comprehensive physical and mental developmental health history
- A physical exam
- Oral health assessment and dental screening and referral for children
- Assessment of need for preventive screenings or services
- Identification of high-risk behaviors
- Health education and anticipatory guidance appropriate to age
- Diagnosis and plan for treatment of any disease
- "Staying Healthy Assessment" (SHA) questionnaire; SHA questionnaires and provider instructions can be found on the DHCS website https://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

Child Health and Disability Program (CHDP):

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income and uninsured children and youth under 21 years of age in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. To provide these assessments, providers must enroll in the CHDP program. Health assessments are provided by enrolled private physicians, local health department clinics, community clinics, and some local school districts.

California Children's Services (CCS)

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services for children age 21 years and younger who have CCS-eligible physical disabilities and complex medical conditions. Services provided under the CCS program are reimbursed through CenCal Health. A CenCal Health member who is eligible for CCS services remains enrolled with CenCal Health, and the PCP coordinates and continues to provide care for all needs unrelated to the CCS condition.

Physicians and medical group staff are responsible for identification, referral, and case management of members with CCS eligible conditions. Until eligibility is established with the CCS program, the PCP and medical group continue to provide medically necessary covered services related to the CCS eligible condition. The member's PCP is responsible for all primary care and other services unrelated to the CCS-eligible condition and for coordinating care with CCS program staff and specialists.

Some eligible conditions include physical disabilities and complex medical conditions such as sickle cell anemia, cancer, diabetes, HIV, and major complications of prematurity.

Health Education

CenCal Health members must be provided with health education services at no cost. Health education services include but are not limited to primary and obstetrical care, clinical preventive services, education and counseling, and patient education and clinical counseling. These services can be provided through:

- Individual classes
- Group classes
- Workshops
- Support groups
- Peer education programs
- Disease management programs

Educational materials Health education services may include:

- Educational interventions designed to help members to access appropriate care
- Educational interventions that cover behaviors such as:
  - Tobacco use and cessation
  - Alcohol and drug use
  - Injury prevention
  - HIV/STI prevention
  - Family planning
  - Immunizations
  - Dental care

- Nutrition
- Weight control and physical activity
- Parenting

- Educational interventions designed to assist members to follow self-care regimens and treatment therapies for existing medical conditions, chronic disease, or health conditions including:
  - Pregnancy
  - Asthma
  - Diabetes
  - Substance abuse
  - Hypertension

Visit CenCal Health's website at https://www.cencalhealth.org/health-and-wellness/ to access the Health Education Library. Health education resources are available in CenCal Health's threshold languages (English, Chinese, Spanish, and Vietnamese).

Cultural and Linguistics Training

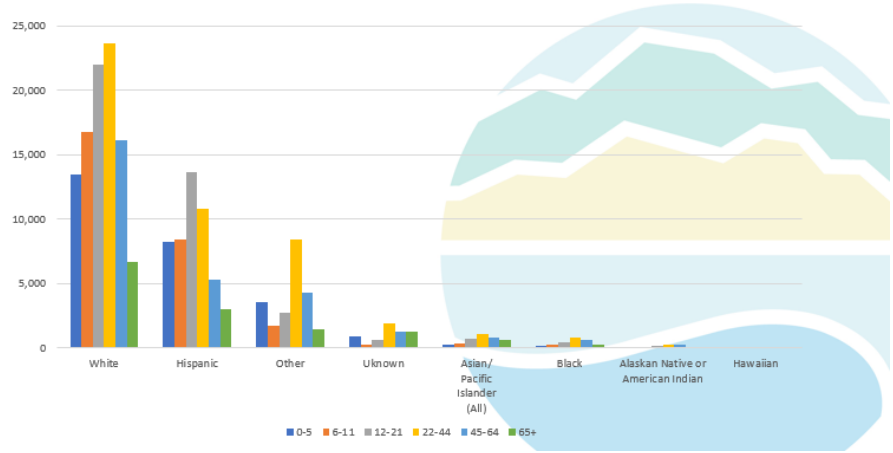
Professional interpreter services for medical encounters must be offered to CenCal Health non-English speaking or limited English proficient Medi-Cal members. Members have the right to receive oral interpreter services on a 24-hour basis at no cost to them. Interpreter services may be provided through an in-person interpreter or telephone language service.

Your medical group is required to provide this service to CenCal Health members. You must document a member's preferred language (if other than English) in the medical record. You must document the request and refusal of language/interpretation services in the member's medical record. You should discourage members from using friends, family and minors as interpreters.

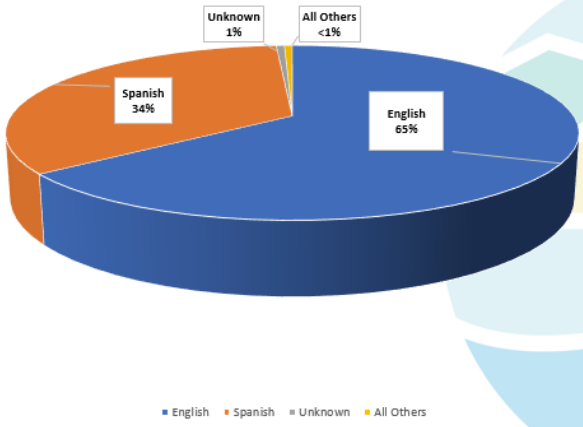
CenCal Health Membership Demographics

CenCal Health members come from many racial/ethnic groups. Nearly half of CenCal Health members have Limited English Proficiency (LEP)

CenCal Health Members by Race/Ethnicity



Members Preferred Language



Language	Member Count
English	118,682
Spanish	63,202
Unknown	1,014
Vietnamese	222
Chinese	183
Arabic	144
Tagalog	113
Korean	94
Russian	71
Farsi	50
Sign Language	23
Samoan	21
Cambodian	15
Portuguese	11
Thai	7
Lao	6
French	5
Ilocano	5
Japanese	4
Italian	2
Armenian	2
Hebrew	1
Polish	1
Turkish	1
Grand Total	183,879

Linguistic Services Terms

- Limited English Proficient (LEP): When an individual cannot speak, read, write, or understand the English language at a level that permits him or her to interact effectively with clinical or non-clinical staff in a health care setting.
- Language Access Services: Language access services is the collective name for any service that helps an LEP patient obtain the same access to and understanding of health care as an English speaker would have. This can include the use of bilingual staff and interpreters. It also includes the provision of translated documents.
- Interpretation: The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.
- Translation: The conversion of a written text into a corresponding written text in a different language.

Why is Linguistic Access Important?

Accurate communication between patient and health care provider is essential for proper diagnosis, treatment, and patient compliance. It also:

- Helps reduce health disparities
- Helps improve quality of care and patient satisfaction
- Makes business sense
- Is important for compliance with federal and state requirements

Linguistic Access Reduces Health Disparities. Patients with language barriers:

- Experience more outpatient drug complications,
- Experience an increase in other medical problems and lower medication compliance,
- More likelihood of serious side effects
- More likelihood of unnecessary and invasive tests

Business Value Linguistic Access

- Reduce medical errors
- Increase patient satisfaction
- Increase compliance
- Decrease costs for diagnostic testing
- Reduce unnecessary admissions
- More efficient member interactions
- Better community relations

Regulations Mandating the Use of Interpreters for LEP Patients

Federal

- Title VI of the Civil Rights Act of 1964
- EMTALA
- Hill-Burton Act
- Executive Order 13166
- CMS

State

- DMHC, SB853
- DHCS (Medi-Cal)

Interpreter Services & Requirements

CenCal Health believes in the importance of providing services in the language of choice for our membership. We recognize the importance of clear communication with your patients and committed to assisting you through telephonic, face-to-face, and video remote interpreter services, and is free of charge to our eligible CenCal Health members. Please reference our website for resource guides and resources at https://www.cencalhealth.org/providers/cultural-linguistic-resources/

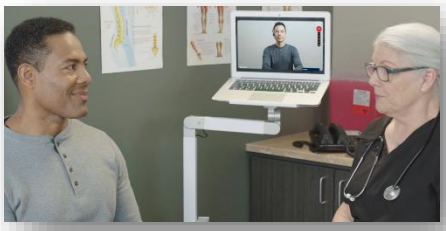
Interpreter Tips

- Interpreter services must be available 24/7 at no charge to patient
- The following should be documented in the medical record:
  - Patient's preferred language
  - Patient's refusal of interpreter services
- Discourage the use of friends, family members, or minors as interpreters (unless specifically requested by the member after being offered professional interpreter services at no charge)
- Patients have the right to file grievances or complaints if linguistic needs are not met
- Interpreters and bilingual staff should be qualified (assessed for language capacity)
- Train providers and office staff about linguistic access and cultural awareness

Telephonic Interpreter Service

From the moment you place a request with a Certified Language Interpreter (CLI) operator, you are immediately connected to a professional interpreter. Please follow these easy steps to connect to a telephonic interpreter in more than 200 languages.

Video Remote Interpreting (VRI) Services



Providers should continue to use the telephonic interpreting whenever possible, and Primary Care Providers should continue to supply their own spanish interpreter, except if they do not offer it for urgent needs. Providers will need to supply their own device (laptop, tablet, phone, etc.) for this service and not utilize a members phone.

Online Access Link: **cencalhp.cli-video.com**
Provider Access Code: 48cencalhp

Asking about Language Preference

How you ask a patient about his or her language will affect the response you receive:

You won't need an interpreter, will you?"

Asking the question this way discourages the patient, or the person who is making the appointment, from asking for the language assistance that he or she may need.

"What language do you speak at home?"

This question will get you information about the patient's home language, but ignores the possibility that the patient may be bilingual in English as well.

"Will an interpreter be needed? In what language?"

Patients may say no because they believe they have to either bring their own interpreter or have a family member interpret.

"In what language do you prefer to receive your health care?"

Asking the question this way will provide you information on the language the patient feels he or she needs to speak in a health-related conversation.

If the answer is a language other than English, you can plan to have language assistance available for the patient, and you should add this information to the record.

Best Practices for Providing Interpreter Services

Avoid using family, friends or minors as interpreters

- They may withhold information from patient from embarrassment, protection, emotional involvement
- May have their own agenda
- Children: parent disempowerment, role reversal
- Can cause guilt & trauma
- May not be familiar with medical vocabulary
- Serious mistakes can occur

Documenting Language Preference

It is important to record information on interpreter needs and language preference in the patients' medical record.

Basic: Add a color or letter code to the patient's chart, noting that he or she needs an interpreter. Designate a code or color for each language.

Better: Add the information under "Notes" in a patient's entry in your patient database, so that when a receptionist calls up the patient's record to make an appointment, the information about the need for an interpreter and the language can be noted as well.

Best: Add a question on your patient registration form or in your practice management system. Not only will you know when a patient is scheduled that he or she will need an interpreter, you will also be able to track how many patients you have who speak a particular language and how often they are seen.

Working with Interpreters by Phone

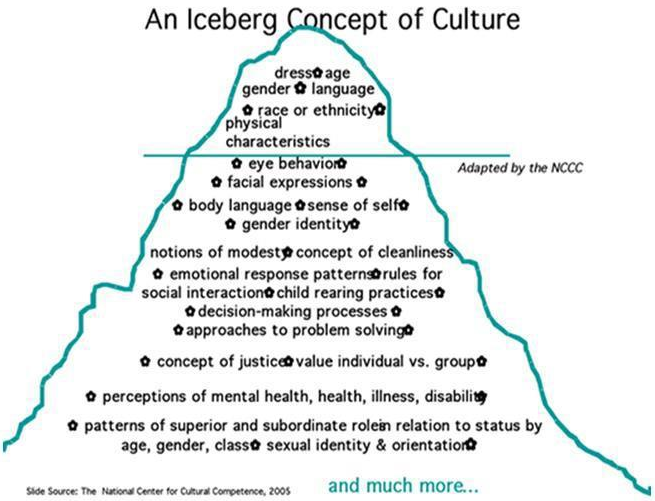
- When working with an interpreter over the phone, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room.
- When the interpreter comes onto the line, let the interpreter know who you are, who else is in the room, what sort of office practice this is, what sort of appointment this is.
- For example, "Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam."
- Give the interpreter the opportunity to quickly introduce him/herself to the patient.
- If you point to a chart, a drawing, a body part or a piece of equipment, verbalize what you are pointing to as you do it.

What is Culture?

Culture consists of a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that is shared among members of a particular group, and that group members use to interpret their experiences of the world.

- **Cultural awareness** is being cognizant, observant, and conscious of similarities and differences among and between cultural groups.
- **Cultural and linguistic competence** is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that **enables effective work** in cross-cultural situations.
- **Cultural humility** is a commitment and active engagement in a **lifelong process** that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves.

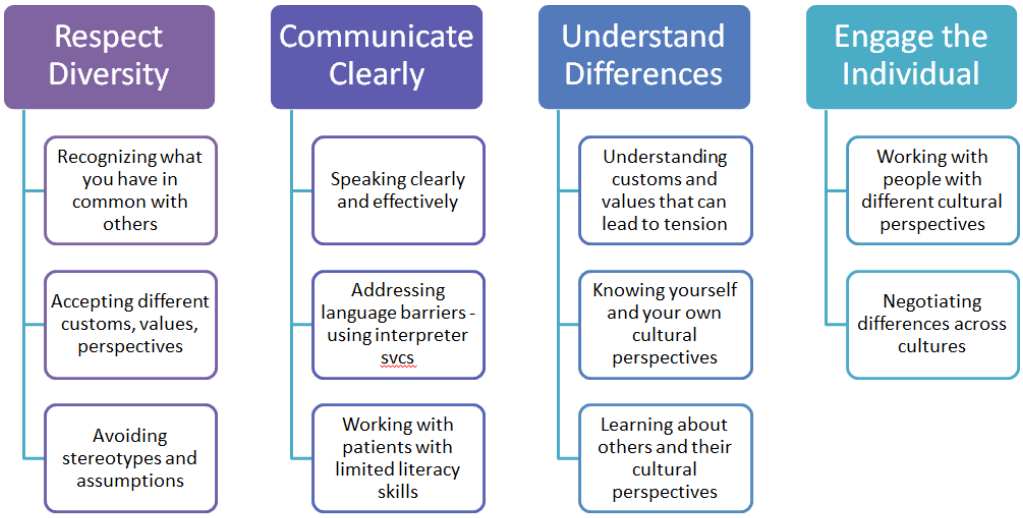
Influences can be above or below the surface, seen and unseen



What is Cultural Competence in Health Care?

- Recognition that people of different cultures have different ways of communicating, behaving, interpreting, and problem-solving.
- Recognition that cultural beliefs impact patient's health beliefs, help-seeking activities, interactions with health care professionals, health care practices, and health care outcomes, including adherence to prescribed regimens.

Tips for Cross Cultural Communication



Source: QualityInteractions

Caring for LGBTQ+ Communities

- CenCal Health members have diverse sexual orientations
  - Identify your own LGBTQ+ perceptions and biases as a first step in providing the best quality care.
  - Many LGBTQ+ people do not disclose their sexual orientation or gender identity because they don't feel comfortable or they fear receiving substandard care.

- CenCal Health members have diverse gender identities
    - Cisgender – people whose gender identity and gender expression align with their assigned sex at birth
    - Transgender – people whose gender identity and/or gender expression differs from their assigned sex at birth (people may or may not choose to alter their bodies hormonally and/or surgically)

Source: Fenway Health

Tips for Working with Transgender Patients

- Treat transgender people as you would want to be treated.
- Always refer to transgender people by the name and pronoun that corresponds to their gender identity.
- If you are unsure about the person's gender identity, ask:
    - *"How would you like to be addressed?"*
    - *"What name would you like to be called?"*
- Focus on care rather than indulging in questions out of curiosity.
- The presence of a transgender person in your treatment room is not an appropriate "training opportunity" for other health care providers.
- It is inappropriate to ask transgender patients about their genital status if it is unrelated to their care.
- Never disclose a person's transgender status to anyone who does not explicitly need information for care.

Source: Transgender Law Center

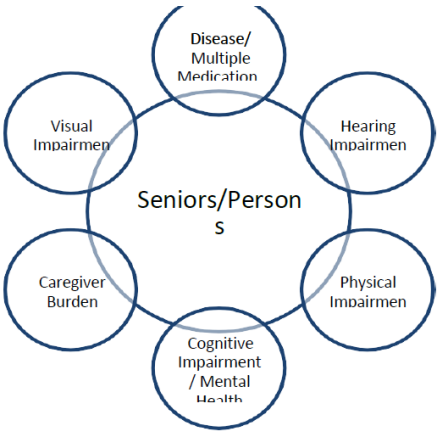
Caring for Seniors and Persons with Disabilities (SPDs)

- Meeting the individual accommodation needs of SPDs to the extent possible ensures the following:
    - The practice provides appropriate and effective care
    - Compliance with the federal Americans with Disabilities Act (ADA) and Section 504 of the 1973 Rehabilitation Act.
    - The ADA and Section 504 require that healthcare services provide certain accommodations that ensure equitable and non-discriminatory access to care.
    - 70% of CenCal Health members with disabilities live with 2+ chronic conditions and 16% of these members have diabetes (compared with 7% in gen. pop.)
    - About 25% have 4+ chronic conditions
    - 30% of beneficiaries with disabilities receive treatment for mental health conditions annually

Accommodations: What Patients May Need

- Physical accessibility
- Effective communication
- Sign language interpreters, assistive listening devices, print materials in accessible formats
- Policy modification (for example, to allow more time for an office visit)
- Accessible medical equipment

Dimensions of Disability



Source: US Dept. of Health and Human Services, 2007

Examples of Preferred Terms

- He had polio
- A person who uses a wheelchair
- She has a disability
- A person with a spinal curvature

- He was stricken with or a victim of polio
- Confined to a wheelchair, wheelchair-bound
- She is crippled
- Hunchback, Humpback

Interacting with Seniors

- Avoid ageist assumptions when providing information and recommendations about care.
- Offer information in a clear, direct, and simple manner.
- Don't assume limitations exist just based on age.
- Recognize the senior as the expert in their own life.

Quote from a senior activist: "*As Seniors we know our capabilities and energy are diminishing, but want to retain the right to limit ourselves when the time comes, and not have young people put those limitations on us, to make them feel better.*"

Interacting with People with Physical Disabilities

- Mobility and physical disabilities range from people who have mild to those with significant limitations.
- If shaking hands is appropriate, do so. People with limited hand use or who use prosthesis can usually shake hands. If people have no arms, lightly touch their shoulder.
- When speaking to a person using a wheelchair or scooter for more than a few minutes, try to find a seat or kneel so you are at the same eye level.
- Ask for permission before moving someone's cane, crutches, walker, or wheelchair.

Interacting with People with Speech Disabilities

- Some (not all) people with limited speech have difficulty understanding what people say to them because of their disability, age, a hearing loss, cognitive difficulties and/or language differences.
- Don't raise your voice. People with speech disabilities can hear you.
- Always repeat what the person tells you to confirm that you understood.

- Ask questions one at a time. Give individuals extra time to respond.
- Pay attention to pointing, gestures, nods, sounds, eye gaze, and blinks.
- If you have trouble understanding a person's speech, it's ok to ask them to repeat what they are saying, even three or four times. It is better for them to know that you do not understand, than to make an error.

Interacting with People with Cognitive, Intellectual, or Psychiatric Disabilities

- A cognitive, intellectual, or psychiatric disability can affect a person's understanding, memory, language, judgment, learning and related information processing and communication functions. These disabilities include individuals with intellectual disabilities, head injury, strokes, autism, Alzheimer's disease, and emotional disabilities.
- Offer information in a clear, concise, concrete, and simple manner.
- If you are not being understood, modify your method of communicating. Use common words and simple sentences.
- Allow time for people to process your words, respond slowly, or in their own way.
- Make sure the person understands your message.

Interacting with People with Visual Disabilities

- People can have a range of visual disabilities, from having no vision to people who have low vision and may be able to read large print.
- When offering help, identify yourself and let people know you are speaking to them by gently touching their arm. If you leave people's immediate area, tell them so they will not be talking to empty space.
- Speak directly facing the person. Your natural speaking tone is sufficient.
- When giving directions, be specific. Clock clues may be helpful, such as "the desk is at 6 o'clock." When guiding a person through a doorway, let them know if the door opens in or out and to the right or to the left.

Need more information? Contact HealthEducation@cencalhealth.org