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40th ANNIVERSARY
1983 - 2023

CalAIM Whole-Person Care Webinar

January 2024

Agenda

- **CenCal Health & CalAIM Goals** – Cathy Slaughter, Director of Provider Relations Department
- **Enhanced Care Management (ECM) Medi-Cal Benefit** – Dona Lopez, Provider Relations Supervisor
- **Community Supports (CS) Services** – Dona Lopez, Provider Relations Supervisor
- **Provider Resources** – Cathy Slaughter, Director of Provider Relations
- **New Benefits Available** – Cathy Slaughter, Director of Provider Relations
- **Q&A Chat with CenCal Health**

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CenCal Health
CalAIM Primary Goals

Cathy Slaughter
Director of Provider Relations

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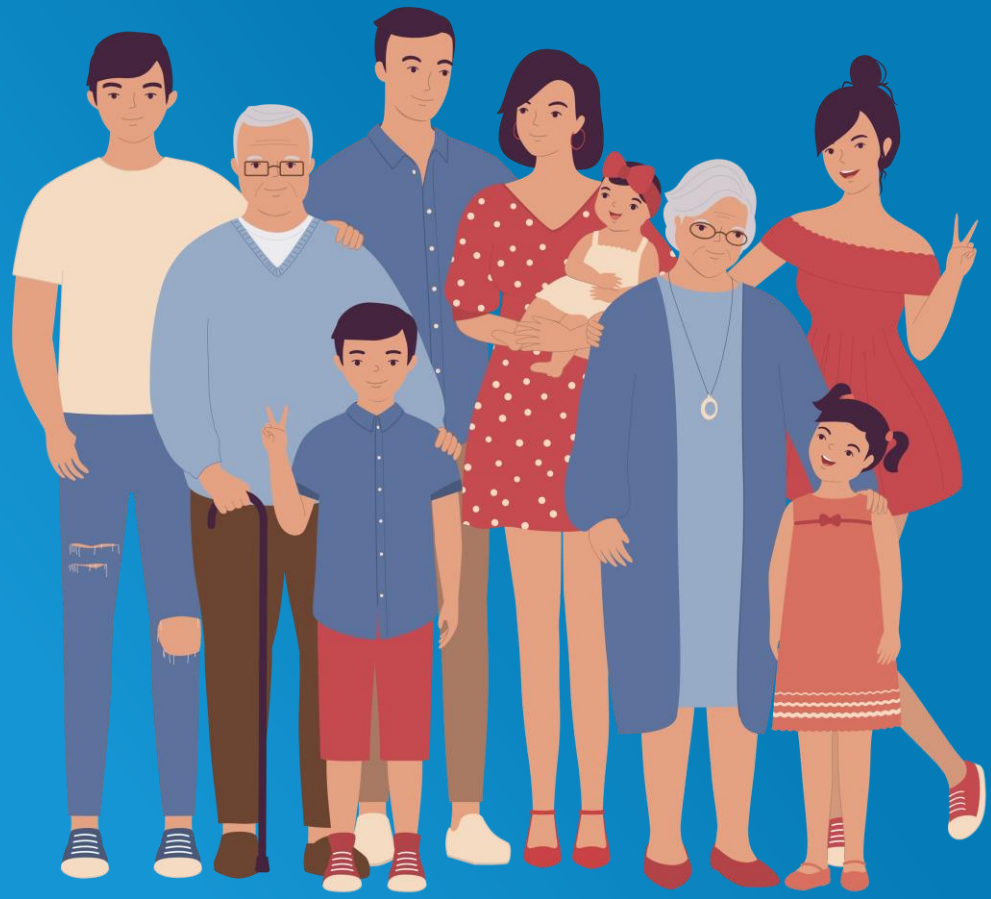
Our Membership

240,784

As of January 1, 2024

Membership covered through the Affordable Care Act full-scope Medi-Cal:
15,775+



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CalAIM | DHCS

What is CalAIM?

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year set of initiatives developed by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of the Medicaid population in California by implementing a broad delivery system as well as program and payment reform.

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Primary Goals

California Advancing and Innovating Medi-Cal

Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health (SDOH);

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform

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Celebrating our CalAIM growth!

July 2022

Medically Tailored Meals & Recuperative Care

Individuals & Families Experiencing Homelessness, Adults At Risk for Avoidable Hospital & Emergency Department (ED) Utilization , Adults with SMI/SUD Needs

Jan. 2023

Housing Services & Sobering Centers

Adults Living in the Community At Risk for Institutionalization , Adults who are Nursing Facility Residents Transitioning to the Community

July 2023

Pregnant or Postpartum Individuals

Children & Youth Populations of Focus (Individuals Experiencing Homelessness or At Risk for Avoidable Hospital or ED Utilization , Serious Mental Health and/or SUD Needs, Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM with Additional Needs Beyond the CCS Condition, Involved in Child Welfare, Intellectual/Developmental Disability)

Jan. 2024

Short-term Post Hospitalization, Day Habilitation, Respite Services, and Personal Care and Homemaker Services

Individuals Transitioning from Incarceration

Birth Equity - Adults and Youth

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Enhanced Care Management

Dona Lopez
Provider Relations Supervisor

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Enhanced Care Management (ECM)

ECM is **person-centered, community-based care management provided to the highest-need Medi-Cal enrollees,** primarily through in-person engagement where enrollees live, seek care, and choose to access services

Enrollees with complex needs have their care coordinated by a Lead Care Manager knowledgeable of community resources and services available to **coordinate care addressing both medical and social drivers of health.**

ECM is California's first statewide effort to address complex care management, leveraging the promising results from California counties' **Health Homes Program and Whole Person Care Pilots.**

Medi-Cal Managed Care Population Health Management Program

ECM

ECM for high-risk, high-need and/or high-cost Medi-Cal enrollees

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ECM Core Service Components

1. Outreach and Engagement
2. Comprehensive Assessment and Case Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

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ECM Populations of Focus Timeline

Phase 1

7/1/2022

Individuals & Families Experiencing Homelessness (POF 1)

Adults At Risk for Avoidable Hospital and Emergency Department (ED) Utilization (POF 2)

Adults with SMI/SUD Needs (POF 3)

Phase 2

1/1/2023

Adults Living in the Community At Risk for Institutionalization (POF 5)

Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)

Phase 3

7/1/2023

Children & Youth Populations of Focus (POF 7, 8, 9)

Phase 4

1/1/2024

Adults & Youth Transitioning from Incarceration (POF 4)

Birth Equity: Adults & Youth (POF 10)

Please refer to DHCS Policy guide for the most up to date POF's and criteria Enhanced Care Management and Community Supports (ILOS)

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ECM Populations of Focus

ECM Population of Focus (POFs)		Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Individuals with I/DD	✓	✓
10	Pregnant and Postpartum Individuals; Birth Equity Population of Focus	✓	✓

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Member Participation

There is no cost to be enrolled for ECM Services

Members have the choice to join the program

Their healthcare providers will not change

Members can leave the program at any time & come back

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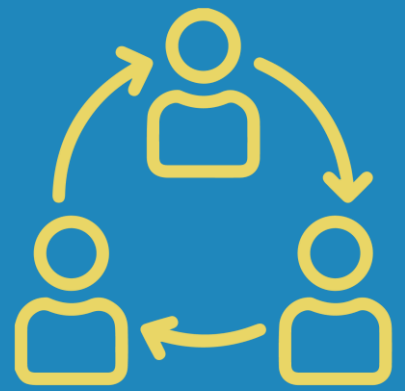
Member Identification



Member Identification can happen in three (3) ways:

1) CenCal Health will use claims and/or other data available to identify members presumed eligible for ECM.

2) Providers, Community and Government agencies can identify and refer a potential ECM member.

3) The member or the member's representative can refer them(selves) to the program.

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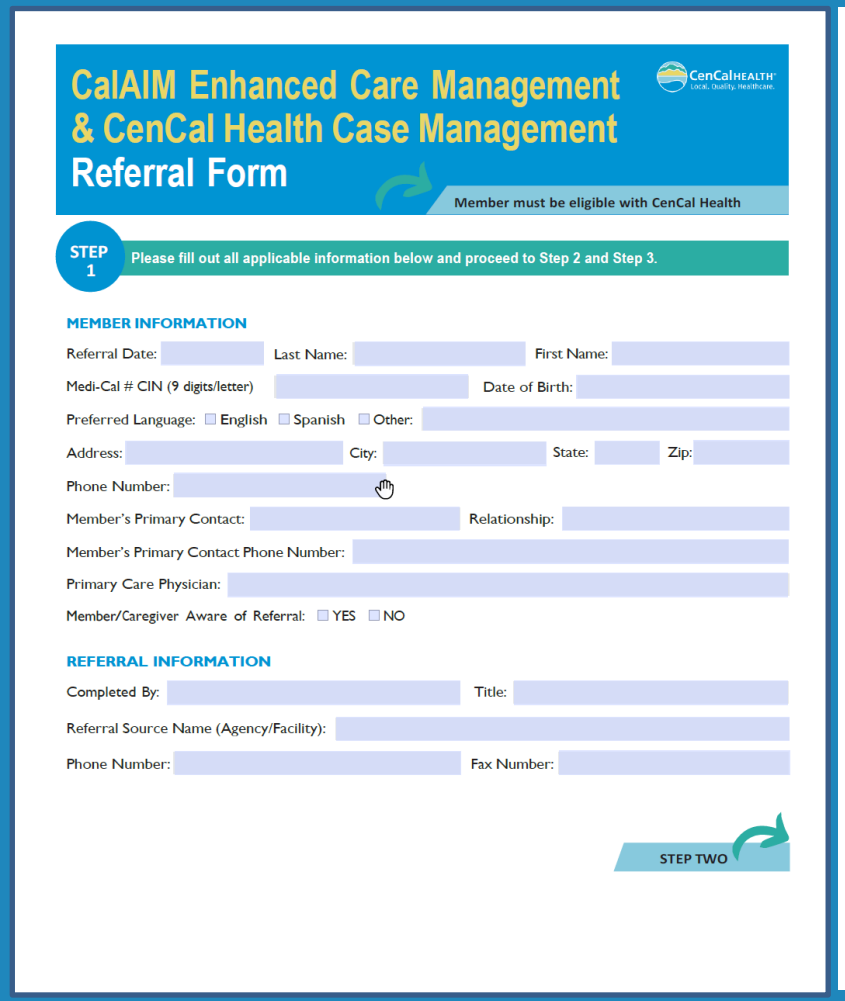
Referring a Member to ECM:

Providers can refer qualified Members to CenCal Health by:

1. Calling our ECM/CS Department (805) 562-1698
2. Faxing the ECM/CM Referral Form (805) 681-3038
3. Secure link https://gateway.cencalhealth.org/form/ecm

CenCal Health will determine member eligibility and provider assignment within 10 business days



CalAIM Enhanced Care Management & CenCal Health Case Management
Referral Form

Member must be eligible with CenCal Health

STEP 1 Please fill out all applicable information below and proceed to Step 2 and Step 3.

MEMBER INFORMATION

Referral Date: Last Name: First Name:

Medi-Cal # CIN (9 digits/letter) Date of Birth:

Preferred Language: English Spanish Other:

Address: City: State: Zip:

Phone Number:

Member's Primary Contact: Relationship:

Member's Primary Contact Phone Number:

Primary Care Physician:

Member/Caregiver Aware of Referral: YES NO

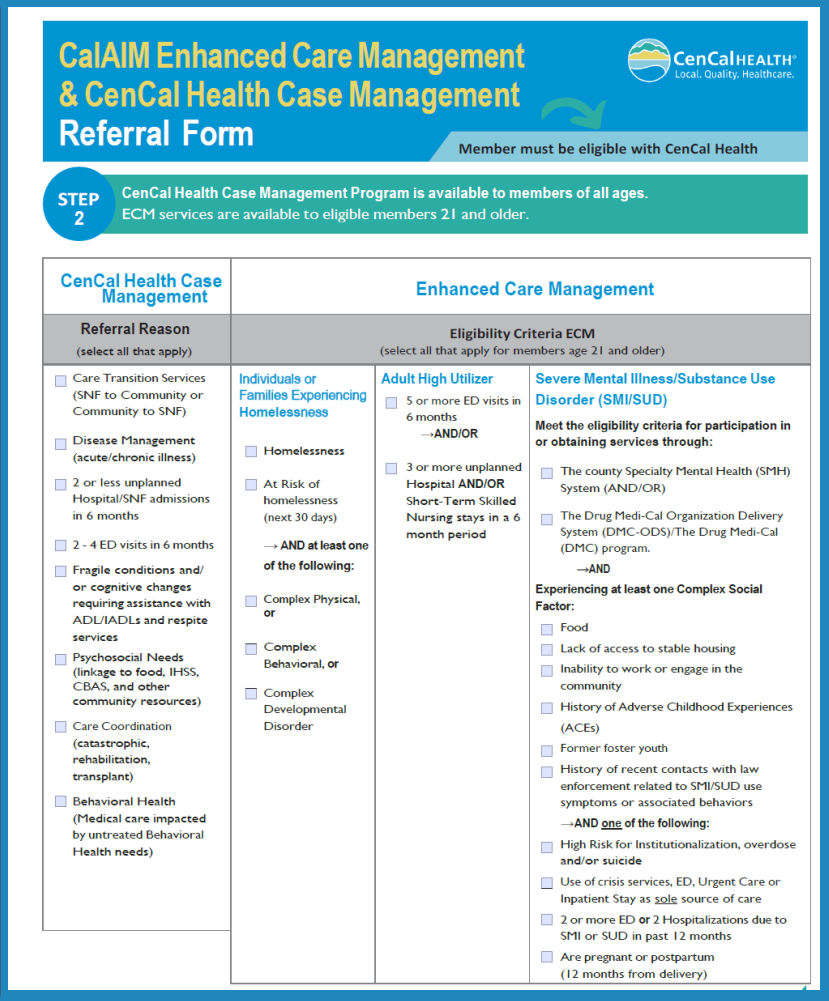
REFERRAL INFORMATION

Completed By: Title:

Referral Source Name (Agency/Facility):

Phone Number: Fax Number:

STEP TWO



CalAIM Enhanced Care Management & CenCal Health Case Management
Referral Form

Member must be eligible with CenCal Health

STEP 2 CenCal Health Case Management Program is available to members of all ages. ECM services are available to eligible members 21 and older.

CenCal Health Case Management	Enhanced Care Management		
Referral Reason (select all that apply)	Eligibility Criteria ECM (select all that apply for members age 21 and older)		
☐ Care Transition Services (SNF to Community or Community to SNF) ☐ Disease Management (acute/chronic illness) ☐ 2 or less unplanned Hospital/SNF admissions in 6 months ☐ 2 - 4 ED visits in 6 months ☐ Fragile conditions and/or cognitive changes requiring assistance with ADL/IADLs and respite services ☐ Psychosocial Needs (linkage to food, IHSS, CBAS, and other community resources) ☐ Care Coordination (catastrophic, rehabilitation, transplant) ☐ Behavioral Health (Medical care impacted by untreated Behavioral Health needs)	Individuals or Families Experiencing Homelessness ☐ Homelessness ☐ At Risk of homelessness (next 30 days) → AND at least one of the following: ☐ Complex Physical, or ☐ Complex Behavioral, or ☐ Complex Developmental Disorder	Adult High Utilizer ☐ 5 or more ED visits in 6 months →AND/OR ☐ 3 or more unplanned Hospital AND/OR Short-Term Skilled Nursing stays in a 6 month period	Severe Mental Illness/Substance Use Disorder (SMI/SUD) Meet the eligibility criteria for participation in or obtaining services through: ☐ The county Specialty Mental Health (SMH) System (AND/OR) ☐ The Drug Medi-Cal Organization Delivery System (DMC-ODS)/The Drug Medi-Cal (DMC) program. →AND Experiencing at least one Complex Social Factor: ☐ Food ☐ Lack of access to stable housing ☐ Inability to work or engage in the community ☐ History of Adverse Childhood Experiences (ACEs) ☐ Former foster youth ☐ History of recent contacts with law enforcement related to SMI/SUD use symptoms or associated behaviors →AND one of the following: ☐ High Risk for Institutionalization, overdose and/or suicide ☐ Use of crisis services, ED, Urgent Care or Inpatient Stay as sole source of care ☐ 2 or more ED or 2 Hospitalizations due to SMI or SUD in past 12 months ☐ Are pregnant or postpartum (12 months from delivery)

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ECM Case Worker Care Plan Example

- Members are authorized for ECM services for 12 months
- Additional time in the program may be requested by ECM provider

Enhanced Care Management (ECM) Care Management Plan (CMP) (FORM D)

INDIVIDUALIZED CARE PLAN (ICP) WITH GOALS		
GOAL (short and long-term)	**INTERVENTION**	**DUE DATE (MM/DD/YY)**
PHYSICAL HEALTH		
Increased access to primary care and consistent access to and adhereance with medications as prescribed.	LCM will address barriers to access to care as identified below.	10/1/2023
Schedule appointment with PCP to establish care.	LCM will call with memberto schedule appointment, send a reminder of appointment.	6/30/2023
Arrange transportation for member to access PCP.	Contact Member Services and arrange covered medical transportation services.	Date determined within 5 days of PCP appontment being scheduled.
Medication access.	LCM will assist with arranging 90-day medication refills through delivery service.	5/20/2023
Ability to take medications as prescribed.	Assist with obtaining daily pill box with automated reminders.	6/2/2023

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Discontinuation of ECM Services

- The member has met all care plan goals
- The member is ready to transition to a lower level of care management services
- The member no longer wishes to receive ECM or is unresponsive or unwilling to engage, including instances when a Member's behavior or environment is unsafe for the ECM provider
- The ECM Provider has not been able to connect with the member after multiple attempts

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Community Supports

Dona Lopez
Provider Relations Supervisor

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Community Supports (CS) Services

- Builds upon Whole Person Care (WPC) Pilots
- Flexible wrap-around services to be implemented into Population Health Strategies
- Substitutes or avoids other services such as hospital or SNF admission or discharge delay
- Integrates with Enhanced Care Management for high risk members
- Voluntary (but strongly encouraged) for plans and optional for beneficiaries
- DHCS has provided a list of fourteen (14) pre-approved services that plans are encouraged to offer

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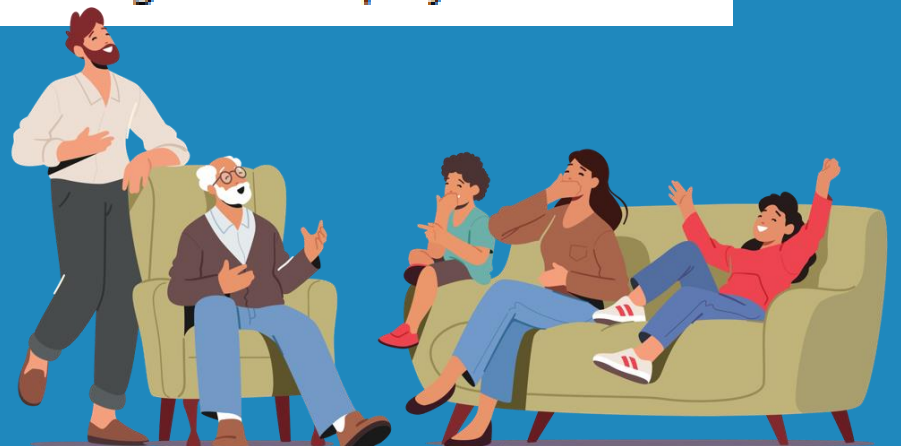
Community Supports (CS) Services

Medi-Cal members with **complex health needs and unmet social needs** are at higher risk of both poor outcomes and requiring higher cost services, such as hospitalization and institutionalization.

People experiencing homelessness have higher rates of diabetes, hypertension, HIV, and mortality, **resulting in longer hospital stays and higher readmission rates than the public**.

About 20 percent of Californians are food insecure. California spends approximately $7.2 billion annually on health care associated with food insecurity.

More than 65 percent of Medi-Cal members are from communities of color. Addressing members' health-related social needs is key to advancing health equity.



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Community Support Programs

Effective July 2022

Medically Tailored Meals program provides meals to members with but not limited to:

- Diabetes
- Cardiovascular Disorders
- Congestive heart failure
- Chronic kidney disease
- **And must have one of the following**
- Who have had an inpatient hospital visit, emergency room (ED) visit, or skilled nursing facility discharge within 6 months.

Meals are made for member's needs based on their medical conditions. Nutrition support is available to help members stay healthy.

Recuperative Care Services are for members who are:

- Homeless
- Recovering from an acute illness or injury
- Being discharged from the hospital.

Recuperative care provides:

- Temporary housing
- Medical care
- Case management
- Self-management support
- Help with housing

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Community Support Programs (cont.)

Housing Transition Navigation Services acts as a quick and effective pathway to permanent housing through a low-barrier approach.

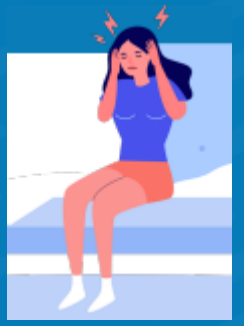
HTNS includes:
- Tenant Screening
- Housing Assessment
- Individual Housing Support Plan
- Securing Housing
- Landlord education & engagement

Housing Deposits provides monetary support to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board.

Services may include:
- Security Deposits
- Support with establishing utilities
- First and last month's rent
- Additional services and/or goods for health and safety

The goal of **Housing Tenancy and Sustaining Services** is maintaining safe and stable tenancy once housing is secured.

Services may include:
- Early identification and intervention for behaviors that may jeopardize housing
- Education on the role, rights and responsibilities of tenants and landlords
- Developing and maintain relationships for successful tenancy
- Assistance in resolving disputes with landlords/neighbors to reduce possible eviction



Sobering Center Services provide an alternative destination for members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to jail or emergency department.

Services may include:
- Medical care
- Temporary bed
- Rehydration and food
- Showering and laundry facilities
- Substance use education and counseling
- Coordination of other services that may be beneficial for members

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New Community Support Programs

Effective January 1, 2024

Short-term Post Hospitalization Housing

Day Habilitation Programs

Respite Services

Personal Care and Homemaker Services

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Contact Provider Relations if you are interested in becoming a provider
(805) 562-1676 or email psrgroup@cencalhealth.org

Short-Term Post Hospitalization Housing

Provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting the following settings: inpatient hospital; residential facilities for substance use disorder treatment, recovery, mental health treatment; correctional or nursing facilities; and recuperative care, etc.

Continuity of Care: Members can seamlessly transition from institutional care to a supportive community environment.

Community Integration: Members can reintegrate into their communities more successfully, fostering a sense of belonging and support.

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Day Habilitation Services

Designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment; it is often considered peer mentoring.

Enhanced skills: Supports Members to make tangible progress in self-help, socialization, and adaptive skills.

Independence: Enables Members to successfully reside and thrive in their natural environments.

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Respite Services

Provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis for relief of those persons who normally care for and/or supervise them and are non-medical in nature.

Reduce Caregiver Burnout: Caregivers can engage in self care activities and social interaction.

Family Bonding: Respite care helps strengthen the bond between caregivers and their loved ones.

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Personal Care Services and Homemaker Services

Provides assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding as well including assistance with Instrumental ADLs such as meal preparation, grocery shopping and money management.

Improved Well-being: Proper nutrition and personal care contribute to overall health and happiness.

Enhanced Quality of Life: Members can enjoy a higher quality of life, even with limitations.

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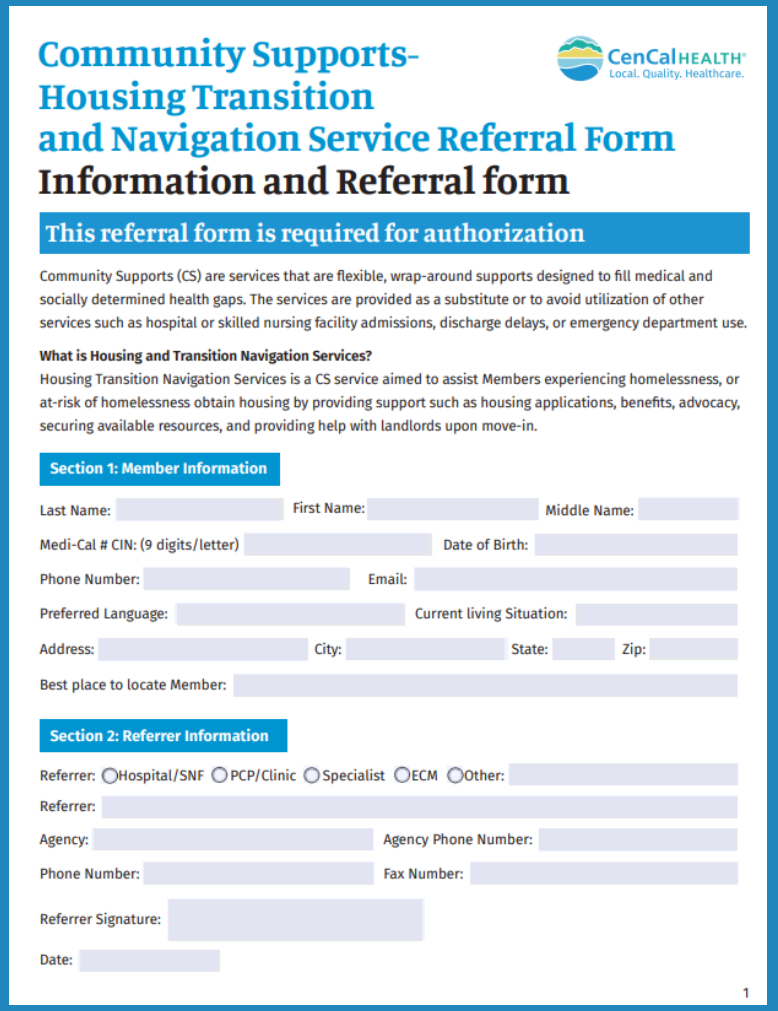
Referring a Member

Members, Authorized Reps, Medical & Behavioral Health Providers, ECM Providers, and CBO's can refer members for CS services by completing the associated Information & Referral (I&R) form and sending it to CenCal Health.

- By Fax to (805) 681-3038
- By using our the secure link: https://gateway.cencalhealth.org/form/ecm

Note: All Information and Referral Forms must have a referrer signature and member consent

If you have questions, please call the ECM/CS Units at (805) 562-1698 or email us at ecmcsreferrals@cencalhealth.org



Community Supports-
Housing Transition
and Navigation Service Referral Form
Information and Referral form

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This referral form is required for authorization

Community Supports (CS) are services that are flexible, wrap-around supports designed to fill medical and socially determined health gaps. The services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

What is Housing and Transition Navigation Services?
Housing Transition Navigation Services is a CS service aimed to assist Members experiencing homelessness, or at-risk of homelessness obtain housing by providing support such as housing applications, benefits, advocacy, securing available resources, and providing help with landlords upon move-in.

Section 1: Member Information

Last Name: First Name: Middle Name:
Medi-Cal # CIN: (9 digits/letter) Date of Birth:
Phone Number: Email:
Preferred Language: Current living Situation:
Address: City: State: Zip:
Best place to locate Member:

Section 2: Referrer Information

Referrer: ◯Hospital/SNF ◯PCP/Clinic ◯Specialist ◯ECM ◯Other:
Referrer:
Agency: Agency Phone Number:
Phone Number: Fax Number:
Referrer Signature:
Date:

1

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www.cencalhealth.org/providers/calaim/

provdir.cencalhealth.org/Home/SearchForFacilities/Community_Supports)

Community Supports-Housing Tenancy and Sustaining Services Information and Referral form

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This referral form is required for authorization

Community Supports (CS) are services that are flexible, wrap-around supports designed to fill medical and socially determined health gaps. The services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

What are Housing Tenancy and Sustaining services?
Housing Tenancy and Sustaining Community Supports services helps to maintain safe and stable residency once housing is secured for members who had been experiencing homelessness and are now newly housed.

Section 1: Member Information

Last Name: First Name: Middle Name:

Medi-Cal # CIN: (9 digits/letter) Date of Birth:

Phone Number: Email:

Address: City: State: Zip:

Housed Date: Preferred Language:

Section 2: Referrer Information

Referrer: ☐ Hospital/SNF ☐ PCP/Clinic ☐ Specialist ☐ ECM ☐ Other:

Referrer:

Agency: Agency Phone Number:

Phone Number: Fax Number:

Referrer Signature:

Date:

Section 3: Eligibility Criteria

Member must meet one or more of the following eligibility criteria:

☐ Member is currently receiving or has received Housing Transition Navigation services **AND** one of the following:

- ○ Have one or more serious chronic condition or serious mental illness.
- ○ At risk of institutionalization or require residential services because of SUD or Serious Emotional disturbance.
- ○ Enrolled with ECM
- ○ Transition-Age Youth with significant barriers to housing stability.

☐ Member is prioritized for permanent supportive housing unit or rental subsidy through Coordinated Entry System (CES) or similar system **AND** one of the following:

- ○ Have one or more serious chronic condition or serious mental illness.
- ○ At risk of institutionalization or require residential services because of SUD or Serious Emotional disturbance.
- ○ Enrolled with ECM
- ○ Transition-Age Youth with significant barriers to housing stability.

☐ Member meets the Housing and Urban definition (HUD) of homelessness **AND** one of the following:

- ○ Have one or more serious chronic condition or serious mental illness.
- ○ At risk of institutionalization or require residential services because of SUD or Serious Emotional disturbance.
- ○ Enrolled with ECM
- ○ Transition-Age Youth with significant barriers to housing stability.

☐ Member is at risk of experiencing homelessness **AND** one of the following:

- ○ Have one or more serious chronic condition or serious mental illness.
- ○ At risk of institutionalization or require residential services because of SUD or Serious Emotional disturbance.
- ○ Enrolled with ECM
- ○ Transition-Age Youth with significant barriers to housing stability.

Community Supports-Housing Tenancy and Sustaining Services Information and Referral form

Section 3: Eligibility Criteria (cont.)

- ○ The individualized Housing Support Plan is attached which showcases the documented needs.

Organization who helped develop the Housing Support Plan:

Housing Transition Navigation Overlap Timeframe: ☐ If Yes: ☐ No

- ○ Member consented to Housing Tenancy Referral and acknowledges the once in a lifetime restriction.

If not submitted via the Provider Portal, you may fax this form to: (805) 681-3038

For any questions, please call the Community Supports Unit at (805) 562-1698.

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Discontinuation of Services

- The member completed the program.
- The member is ready to transition to a lower level of care.
- The member no longer wishes to receive CS or is unresponsive or unwilling to engage, including instances when a Member's behavior or environment is unsafe for the CS provider
- The CS Provider has not been able to connect with the member after multiple attempts

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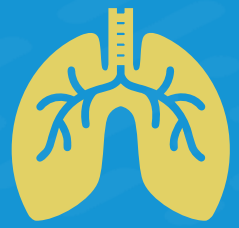
New Community Support Programs

Effective July 1, 2024

Nursing Facility Transition/Diversion to Assisted Living Facilities



Asthma Remediation

Environmental Accessibility Adaptions (Home Modifications)

Community Transition Services/Nursing Facility Transition to Home

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(805) 562-1676 or email psrgroup@cencalhealth.org

Faces of Medi-Cal's Transformation: Meet Jackie

Jackie has diabetes and was hospitalized.

While recuperating in the hospital, Jackie was scared she wouldn't be able to manage her diabetes care and learning how to manage her food intake. Jackie's **Enhanced Care Management Lead Care Manager** worked with CenCal Health (Medi-Cal managed care plan) to provide her with a **Community Support service—Medically Tailored Meals**.

Jackie is now connected with Tangelo, the contracted Medically Tailored Meal provider and receives meals delivered to her home, and education on how to manage her diabetes. The Community Support meal service helped Jackie to stay healthy with a balanced diet, learned how to manage her blood pressure and cholesterol, and has avoided her from being hospitalized again!

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Provider Resources

Cathy Slaughter
Director of Provider Relations

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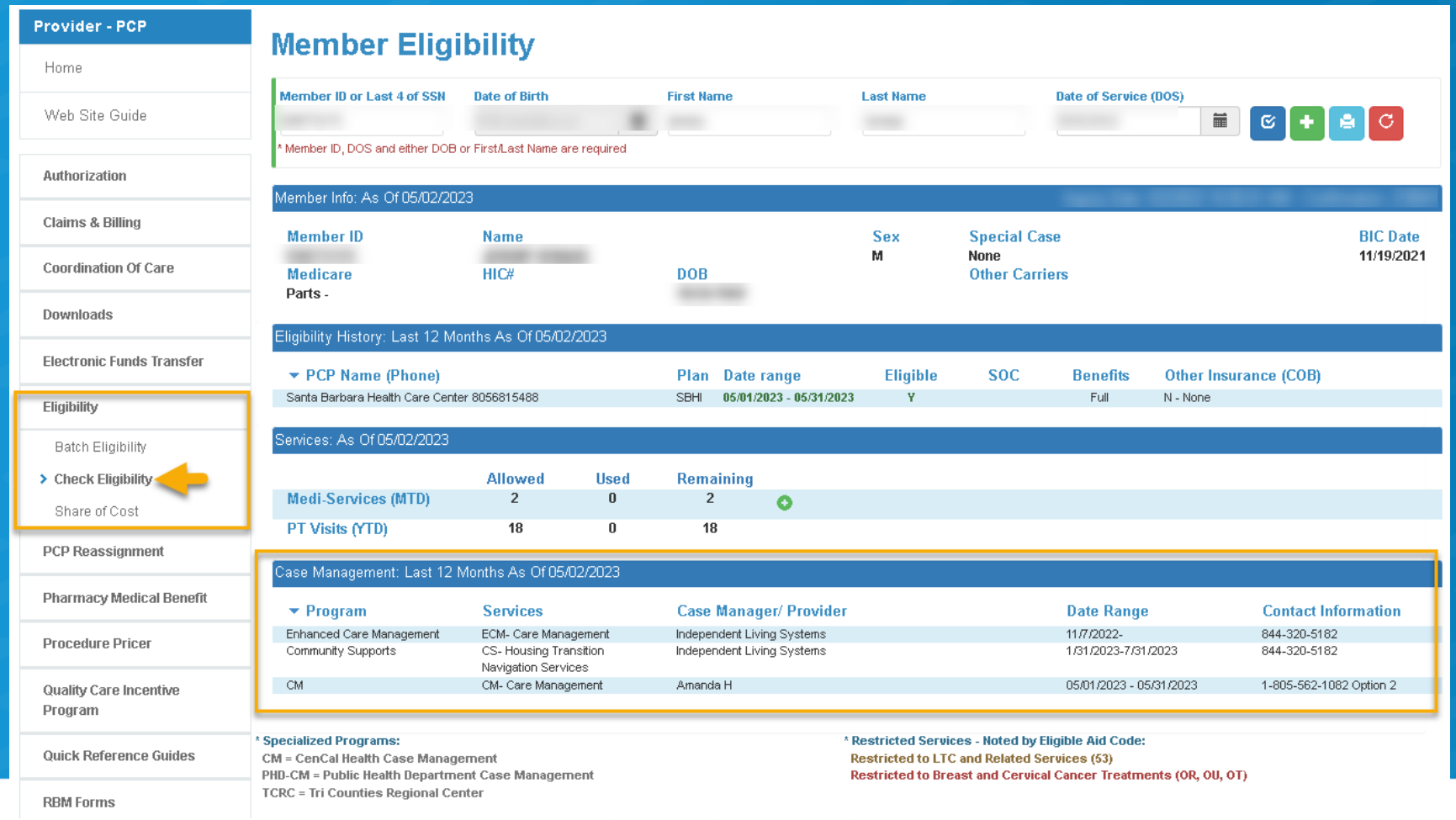
Is your member enrolled in Community Supports and Enhanced Care Management Services?



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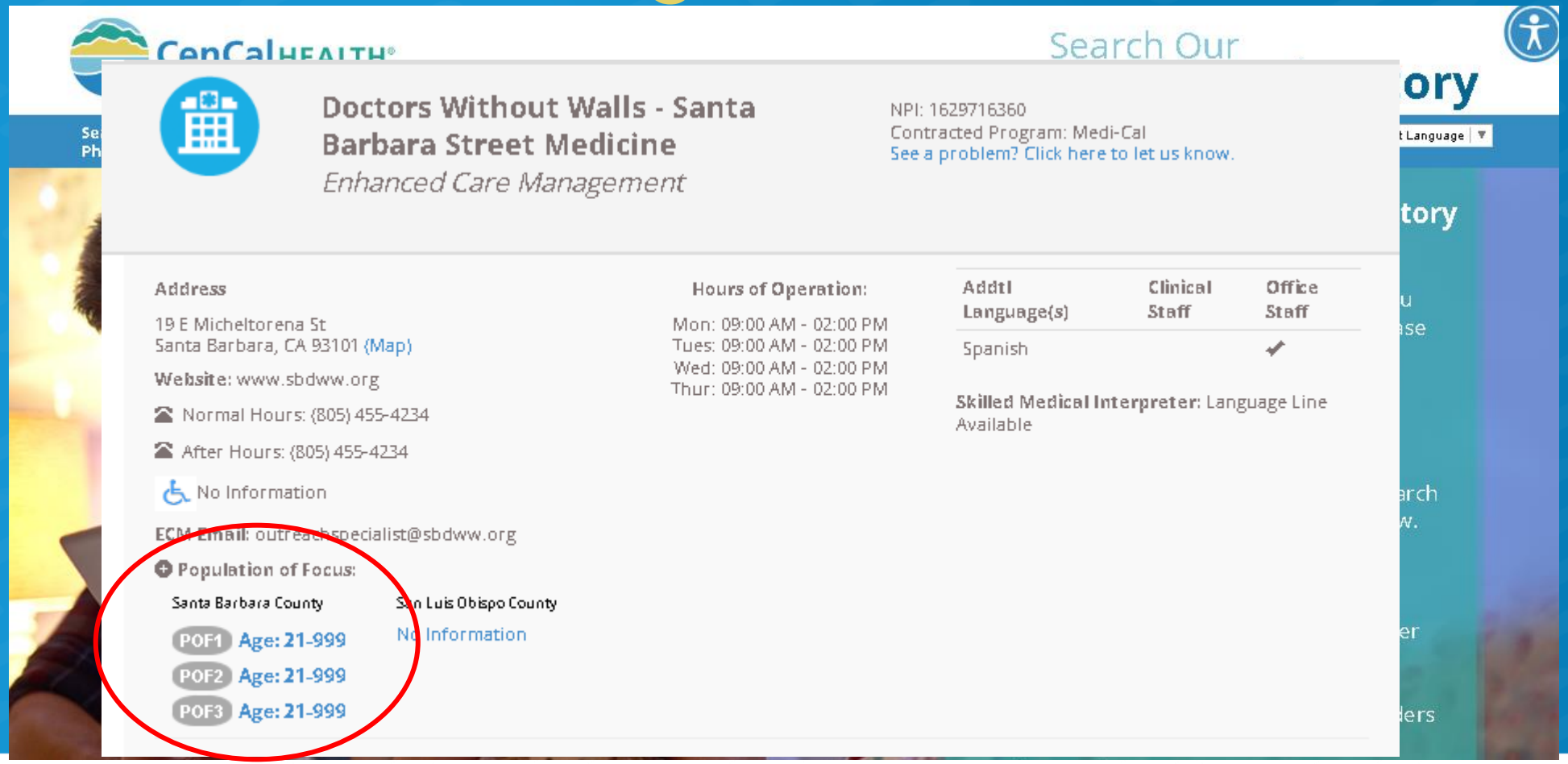
Refer to a contracted Community Supports and Enhanced Care Management



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CalAIM Enhanced Care Management (ECM) & Community Supports (CS) Online Resources

www.cencalhealth.org/providers/calaim/

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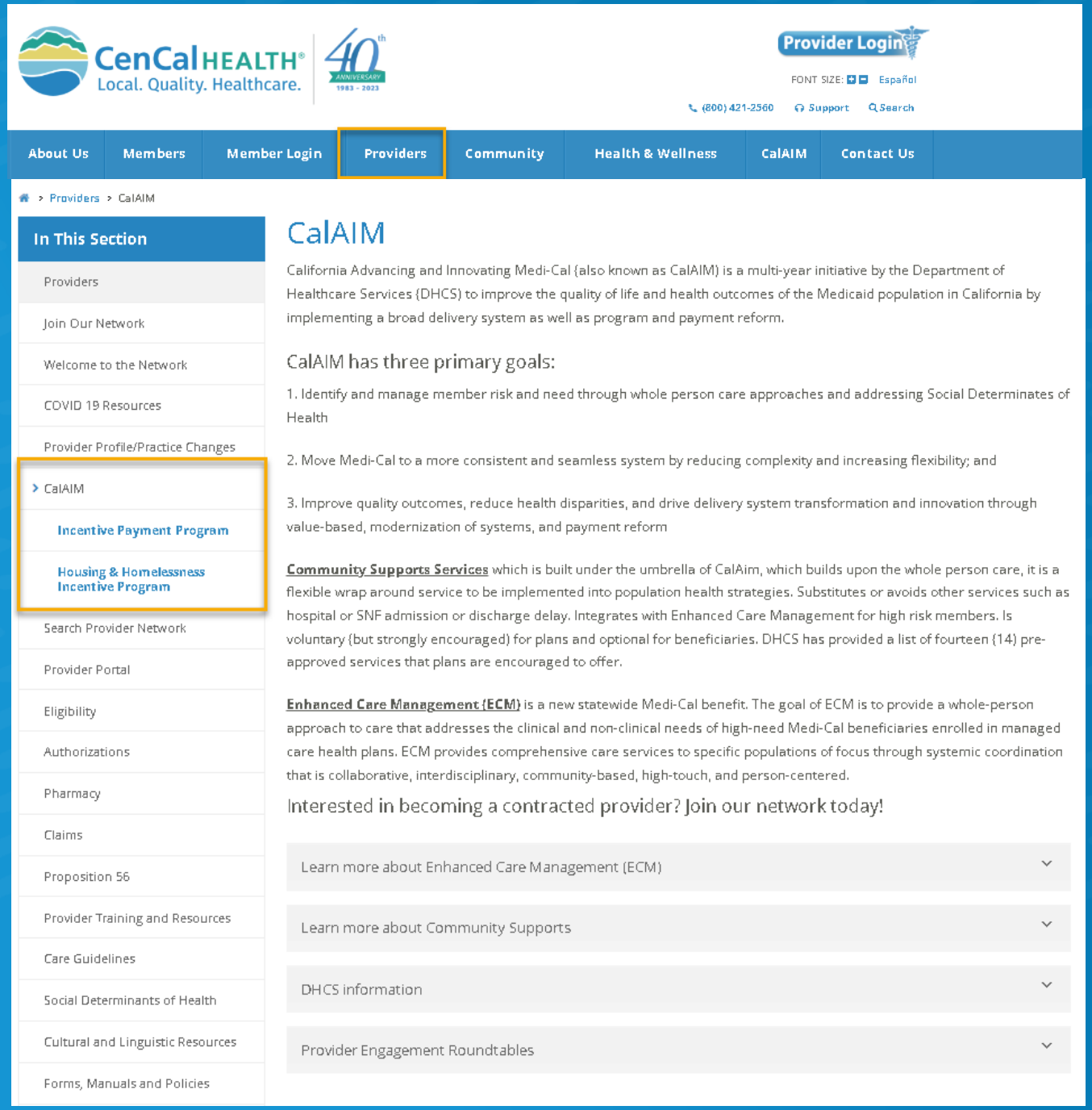

New CenCal Health Benefits

Cathy Slaughter
Director of Provider Relations

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40th ANNIVERSARY
1983 - 2023

Street Medicine Benefit

Street Medicine refers to health and social services developed to address the unique needs of individuals experiencing unsheltered homelessness.

- Street medicine is designed to provide services to members outside of clinic walls.
  - Can be provided via a mobile unit or on the streets
- Street Medicine can be provided by MDs, DOs, Physician Assistants, Nurse Practitioners and Certified Nurse Midwives.
- Street Medicine providers are critical in ensuring linkages to needed medical, behavioral and social services, including referrals to Enhanced Care Management and Community Supports Programs.

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Onboarding as a Street Medicine Provider
Contact Provider Relations (805) 562-1676 or email psrgroup@cencalhealth.org

Doula Services

- Include health education; advocacy; and physical, emotional, and nonmedical support provided before, during, and after childbirth or end of a pregnancy, including throughout the postpartum period.

- Are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

- Require written recommendation that must be submitted to CenCal Health by a physician or other licensed practitioner of the healing arts acting within their scope of practice.
  - The recommending licensed provider does not need to be enrolled in Medi-Cal or be a Network Provider.

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Medi-Cal State Provider Manual for Doula Services:

medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf

Who's Eligible for Doula services ?

- A CenCal Health member who is pregnant or was pregnant within the past year
- Has a recommendation for doula services which can be provided during:
  - Pregnancy
  - Labor and delivery
  - Miscarriage
  - Abortion
- CenCal Health member is eligible during each visit

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Covered Services

Any licensed practitioner may make the recommendation for doula services via a Treatment Authorization Request (TAR). This TAR includes the following covered services:

- One initial visit (90 minutes)
- Up to eight additional 1hour visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery, abortion or miscarriage.
- Up to two extended 3hr postpartum visits after the end of pregnancy.
    - During the postpartum period, an additional TAR is required if extra visits are medically necessary.
        - This additional recommendation can include up to nine additional 1hour postpartum visits
        - Authorization will be provided on an individual basis based on medical necessity

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Community Health Worker (CHW) Benefit

- Provides preventive health services to prevent disease, disability, and other health conditions or their progression.
  - To prolong life
  - To promote physical and mental health
- Recognized effort to provide equitable, and culturally competent services.
- CHW providers have lived experience which aligns with and provides a connection to the member/population being served.

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Community Health Worker Covered Services

Health education: promotion, coaching

Health navigation: assisting access and connection to resources, understand the health care system, or engage in their own care

Screening and assessment: those not requiring a license and assist a CenCal Health member to connect to appropriate services to improve their health

Individual support or advocacy: assists in preventing the onset or exacerbation of a health condition or preventing injury or violence

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Medi-Cal State Provider Manual for CHW Services:
https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf

Who's Eligible for CHW services ?

CenCal Health members who meets one or more criteria, including the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed
- Presence of medical indicators of rising risk of chronic disease (for example, elevated blood pressure, elevated blood glucose levels, etc., that indicate risk but do not yet warrant diagnosis of a chronic condition)
- Positive Adverse Childhood Events (ACEs) screening
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity
- One or more visits to a hospital emergency department within the previous six months
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization
- One or more stays at a detox facility within the previous year
- Two or more missed medical appointments within the previous six months
- Beneficiary expressed need for support in health system navigation or resource coordination services
- Need for recommended preventive services

Who's Eligible for CHW services (cont.)?

CHW violence preventive services are available to a CenCal Health member who meets any of the following circumstances:

- Has been violently injured as a result of community violence.
- A licensed health care provider has determined that the member is at significant risk of experiencing violent injury as a result of community violence.
- Has experienced chronic exposure to community violence.

Services may be provided to a parent or legal guardian of a CenCal Health member under the age of 21 for the direct benefit of the member , in accordance with a recommendation from a licensed provider. A service for the direct benefit of the member must be billed under their Medi-Cal member ID#. If the parent or legal guardian of the member is not enrolled in Medi-Cal, the member must be present during the session.

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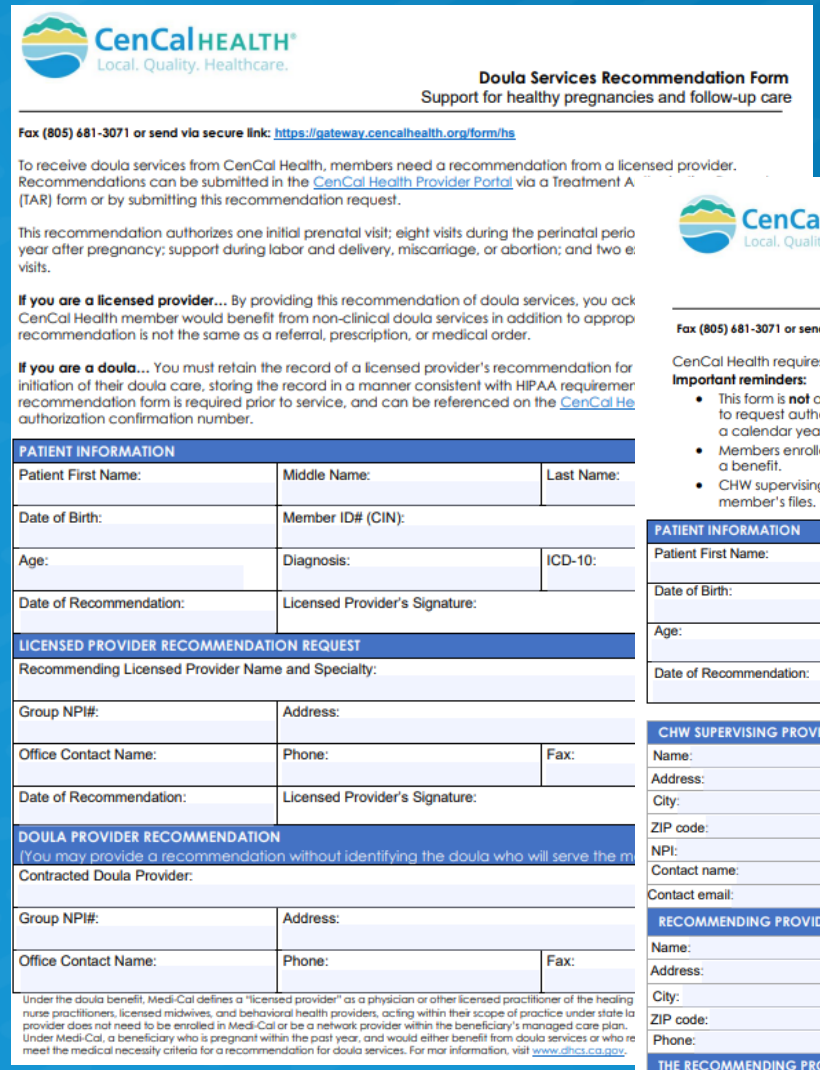
Recommending Doula & CHW Services

- Contracted providers can recommend Doula services through the CenCal Health Provider Portal
  - TAR Screen will feature a Doula option for easy recommendations
- Providers may also utilize our new downloadable Recommendation Forms located online
  - cencalhealth.org/providers/forms-manuals-policies/forms-library/



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Doula Services Recommendation Form
Support for healthy pregnancies and follow-up care

Fax (805) 681-3071 or send via secure link: https://gateway.cencalhealth.org/form/hs

To receive doula services from CenCal Health, members need a recommendation from a licensed provider. Recommendations can be submitted in the CenCal Health Provider Portal via a Treatment A (TAR) form or by submitting this recommendation request.

This recommendation authorizes one initial prenatal visit; eight visits during the perinatal perio year after pregnancy; support during labor and delivery, miscarriage, or abortion; and two e visits.

If you are a licensed provider... By providing this recommendation of doula services, you ack CenCal Health member would benefit from non-clinical doula services in addition to approp recommendation is not the same as a referral, prescription, or medical order.

If you are a doula... You must retain the record of a licensed provider's recommendation for initiation of their doula care, storing the record in a manner consistent with HIPAA requiremer recommendation form is required prior to service, and can be referenced on the CenCal He authorization confirmation number.

PATIENT INFORMATION		
Patient First Name:	Middle Name:	Last Name:
Date of Birth:	Member ID# (CIN):	
Age:	Diagnosis:	ICD-10:
Date of Recommendation:	Licensed Provider's Signature:	

LICENSED PROVIDER RECOMMENDATION REQUEST		
Recommending Licensed Provider Name and Specialty:		
Group NPI#:	Address:	
Office Contact Name:	Phone:	Fax:
Date of Recommendation:	Licensed Provider's Signature:	

DOULA PROVIDER RECOMMENDATION (You may provide a recommendation without identifying the doula who will serve the m		
Contracted Doula Provider:		
Group NPI#:	Address:	
Office Contact Name:	Phone:	Fax:

Under the doula benefit, Medi-Cal defines a "licensed provider" as a physician or other licensed practitioner of the healing nurse practitioners, licensed midwives, and behavioral health providers, acting within their scope of practice under state la provider does not need to be enrolled in Medi-Cal or be a network provider within the beneficiary's managed care plan. Under Medi-Cal, a beneficiary who is pregnant within the past year, and would either benefit from doula services or who re meet the medical necessity criteria for a recommendation for doula services. For mor information, visit www.dhcs.ca.gov.

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Community Health Worker (CHW)
Supervising Provider Service Recommendation Form

Fax (805) 681-3071 or send via secure link: https://gateway.cencalhealth.org/form/hs

CenCal Health requires submission of recommendations of community health worker (CHW) services.
Important reminders:

- This form is **not** a request for authorization. Use the *Authorization Request Form for Additional Units* to request authorization for services beyond 12 units of services (or 8 units for Asthma Prevention) in a calendar year.
- Members enrolled in Enhanced Care Management are excluded from receiving CHW services as a benefit.
- CHW supervising providers are required to retain a copy of the recommendation in the member's files.

PATIENT INFORMATION		
Patient First Name:	Middle Name:	Last Name:
Date of Birth:	Member ID# (CIN):	
Age:	Diagnosis:	ICD-10:
Date of Recommendation:	Licensed Provider's Signature:	

CHW SUPERVISING PROVIDER INFORMATION	
Name:	
Address:	
City:	State:
ZIP code:	County:
NPI:	Tax ID:
Contact name:	Contact phone:
Contact email:	Contact fax:

RECOMMENDING PROVIDER INFORMATION IF DIFFERENT FROM THE CHW SUPERVISING PROVIDER	
Name:	Title:
Address:	
City:	
ZIP code:	
Phone:	Email:

THE RECOMMENDING PROVIDER HAS DETERMINED THAT THIS MEMBER MEETS MEDICAL NECESSITY FOR CHW SERVICES BASED ON ONE OR MORE OF THE FOLLOWING:
☐ Diagnosis of one or more chronic health (including behavioral health) conditions or a suspected mental disorder or substance use disorder that has not yet been diagnosed

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