Community Health Workers and Supervising Provider Organizations

Overview

- Overview of Community Health Worker (CHW) Services
- CHW Minimum Qualifications & Certification Pathways
- Overview of Supervising Provider Responsibilities
- Member Eligibility
- Written Recommendation
- Annual Training Requirements for CHWs
- Assessment and CHW Services
- Billing
- Linkages to Health Plan services
- CHW Services Impact on Quality

Community Health Worker

Overview

Community Health Worker Overview

CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health

1. **Community Health Worker** (CHW) may include individuals known by a variety of job titles, such as Promotores, Community health representatives, Navigators and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified.

2. **Supervising Provider** are the organization employing or otherwise overseeing the CHW, with which the MCP contracts. The Supervising Provider ensures that CHWs meet the qualifications, oversees CHWs and the services delivered to MCP Members, and submits claims for services provided by CHWs. The Supervising Provider must be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

Community Health Worker

Minimum Qualifications & Certification Pathways

Community Health Workers

Lived Experience

CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served.

This may include, but is not limited to, experience related to:

- Incarceration
- Military service
- Pregnancy and birth
- Disability
- Foster system placement
- Homelessness
- Mental health conditions
- Substance use
- Being a survivor of domestic or intimate partner violence or abuse and exploitation.

Lived experience may also include:

- Shared race
- Ethnicity
- Sexual orientation
- Gender identity
- Language
- Cultural background with one or more linguistic, cultural, or other groups in the community

Community Health Workers
Certification Pathways

CHW Certificate

Work Experience Pathway

Violence Prevention Professional Certificate*

Community Health Workers
Certification

CHW Certificate

- A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas:
  - Communication
  - interpersonal and relationship building
  - Service coordination and navigation
  - Capacity building
  - Advocacy
  - Education and facilitation
  - Individual and community assessment
  - Professional skills and conduct
  - Outreach, evaluation and research
  - Basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider
- **Certificate programs must also include field experience as a requirement.** A CHW Certificate allows a CHW to provide all covered CHW services, including violence prevention services.

Community Health Workers
Certification

Work Experience Pathway

- An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months.
- A CHW who does not have a certificate of completion must earn a certificate of completion, within 18 months of the first CHW visit provided to a Member.

Community Health Workers
Certification

Violence Prevention Professional Certificate*

- For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute.
  - A VPP Certificate allows a CHW to provide CHW violence prevention services only.
  - A CHW providing services other than violence prevention services **must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate**.

Member Eligibility Criteria for CHW Services

CHW Violence Prevention services

CHW violence prevention services are available to Members who meet any of the following circumstances as determined by a licensed practitioner:

- The Member has been violently injured as a result of community violence.
- The Member is at significant risk of experiencing violent injury as a result of community violence.
- The Member has experienced chronic exposure to community violence.

CHW violence prevention services are specific to community violence (e.g., gang violence).

CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

California Department of Health Care Access and Information (HCAI)

The state issued CHW/P/R Certificate demonstrates that the holder has the core competencies to provide Medi-Cal reimbursable CHW services.

While the state-issued CHW/P/R Certificate is a pathway to have CHWP/R services reimbursed through Medi-Cal, the Certificate is NOT required to work as a CHW/P/R in the state of California. The HCAI state-issued CHW/P/R Certificate will be available in early 2024.

Additionally, while there is an age requirement of 16 years old to receive a state-issued CHW/P/R Certificate, individuals must be at least 18 years old to be eligible to bill Medi-Cal.

Additional HCAI CHW guidelines

Community Health Worker

Supervising Provider Responsibilities

Community Health Workers

Supervising Provider

The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services.

Supervising Providers do not need to be physically present at the location when CHWs provide services to Members.

Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider.

However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.

Supervising Provider
Oversight

Supervising Providers must provide direct or indirect oversight to CHWs.

Direct oversight includes, but is not limited to:	Indirect oversight includes, but is not limited to:
• Guiding CHWs in providing services • Participating in the development of a plan of care • Following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.	• Ensuring connectivity of CHWs with the ordering entity • Ensuring appropriate services are provided in compliance with all applicable requirements.

CHW Documentation Requirements
Plan of Care Summary

For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

The Provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.

CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers referenced in this section.

*Reminder 1 unit is 30 minutes

CHW Documentation Requirements
Plan of Care Requirements

The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition
- Include a list of other health care professionals providing treatment for the condition or barrier
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health
- List the specific services required for meeting the written objectives
- Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

A licensed Provider must review the Member's plan of care at **least every six months** from the effective date of the initial plan of care.

The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.

If there is a significant change in the recipient's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

Supervising Provider & Community Health Workers

Annual Training Requirements

Community Health Workers

Annual Training Requirements

CHWs must complete a minimum of six hours of additional relevant training annually.

The Supervising Provider must maintain evidence of this training. Supervising Providers may provide and/or require additional training, as identified by the Supervising Provider.

COMMUNITY HEALTH WORKER

Benefit Overview

Community Health Worker
Member Journey

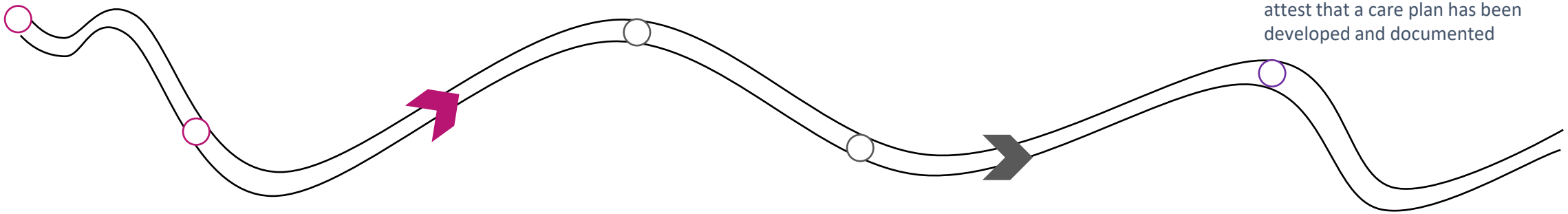
Identification and Eligibility	CHW Services	Care Plan

Eligibility
(Based on DHCS criteria see slide 15)

Determine Assistance Needed

Identify needs from Member

***Care Plan**
(Only if support is needed beyond 12 units)
*Supervising provider needs to attest that a care plan has been developed and documented



Written Recommendation
Providers should submit these written recommendations on HN's provider portal

Individual Support
Begin linkage to other services and service providers (ex: CS housing suite and other community supports as identified)
- Other community supports as identified

Community Health Worker Benefit

Eligibility

Member Eligibility Criteria for CHW Services

Eligibility

The recommending Provider must determine whether a Member meets eligibility criteria for CHW services based on the presence of 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.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.

One or more visits to a hospital emergency department (ED) 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.
- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

Member Eligibility Criteria for CHW Services

Eligibility

Verify member Medi-Cal eligibility

Confirm that the member is not currently enrolled in Enhanced Care Management

Save Time Navigating the Provider Portal guide

Verify member eligibility

Choose the option that works for you to view and verify eligibility.

Option 1

Use this option to verify eligibility of one member at a time.

1. *Log in to provider.healthnetcalifornia.com, select the applicable line of business from the drop-down menu > Go.*
2. *Fill in the required information to view member's information under Quick Eligibility Check.*

Option 2

Use this option to verify eligibility for multiple members.

1. *Log in to provider.healthnetcalifornia.com, select the applicable line of business from the drop-down menu > Go.*
2. *Select Eligibility at the top of the page > Eligibility Check.*
3. *Fill in the required information under Eligibility Check to view the member's information.*
4. *If you have to check eligibility for additional members, repeat #2 above.*

Tips

- *Include the alpha letter with the numeric number on the member's identification (ID) card; use only the letter and numbers.*
- *If searching by last name, include the suffix, such as Jr., as listed on the member's ID card.*
- *Remember to also include the date of birth (DOB) since this is a required field.*
- *If the complete member ID number and DOB were entered and this does not provide eligibility status for the specific patient you are verifying, try using the last name and DOB instead.*

Community Health Worker

Written Recommendation

Member Eligibility Criteria for CHW Services
Written Recommendation

CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law

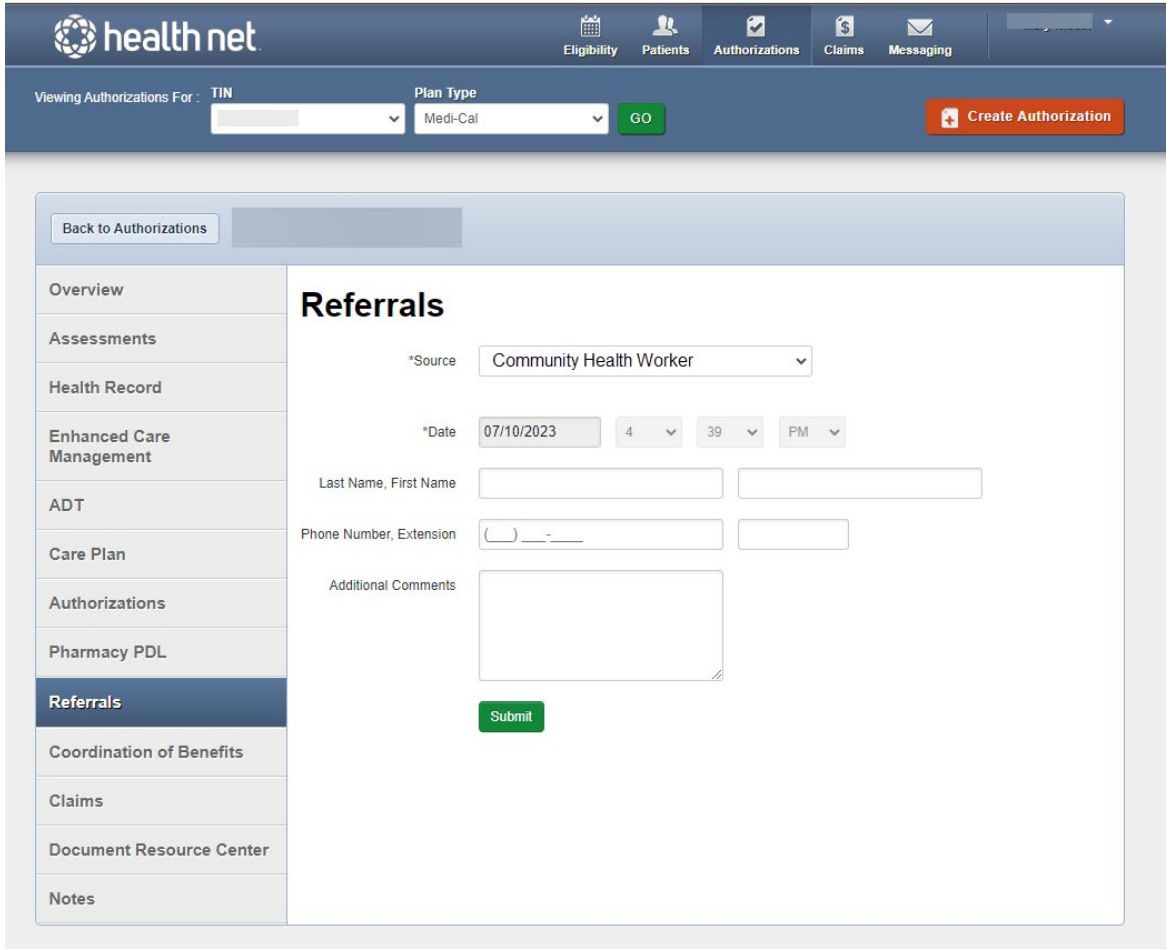
Other licensed practitioners who can recommend CHW services within their scope of practice include:

- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Podiatrists
- Nurse midwives
- Licensed midwives
- Registered nurses
- Public health nurses
- Psychologists
- Licensed marriage and family therapists
- Licensed clinical social workers
- Licensed professional clinical counselors
- Dentists
- Registered dental hygienists
- Licensed educational psychologists
- licensed vocational nurses
- Pharmacists.

Member can not be enrolled in Community Health Worker services and Enhanced Care Management (ECM) at the same time

Provider Portal Documentation of Written Recommendation

- Recommending provider with access to the provider portal should document the recommendation in the portal (form will not be uploaded).

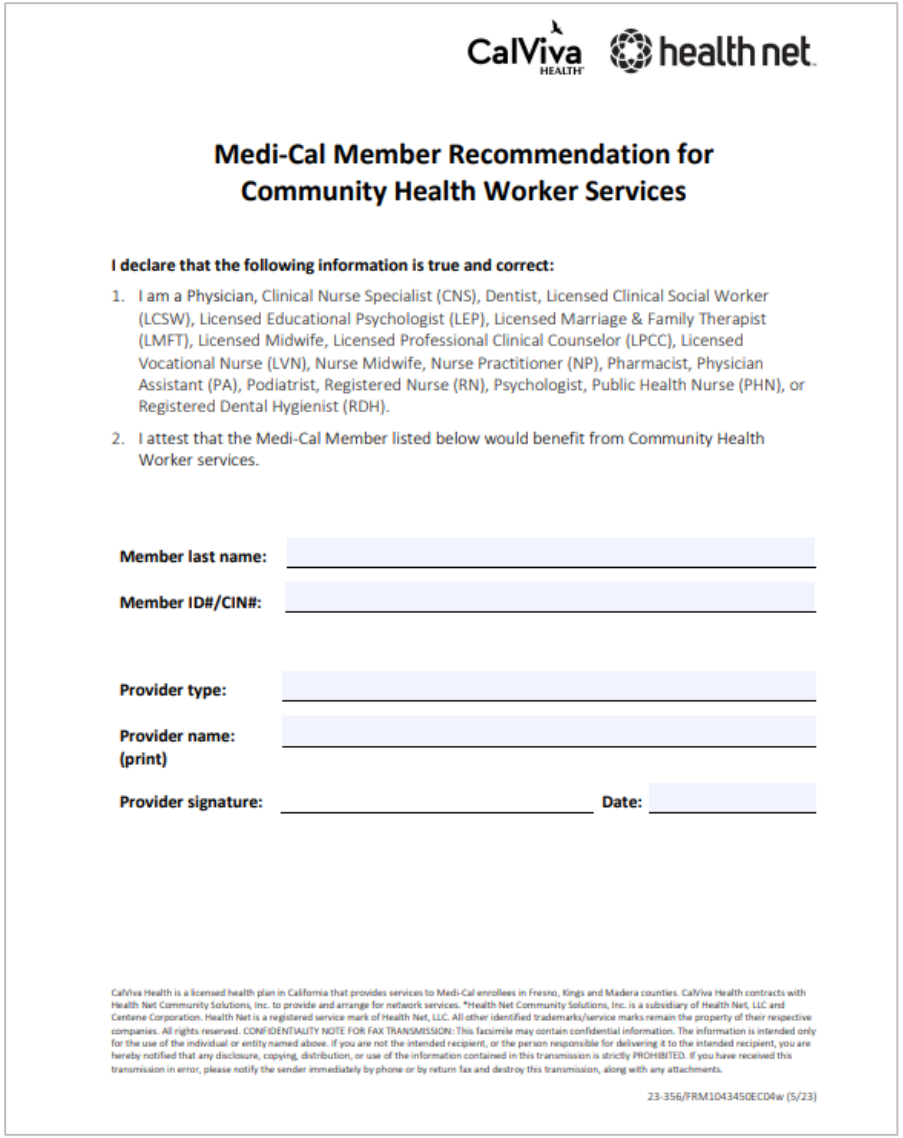


Providers with out access to the Provider Portal

Providers without access to the provider portal can complete this recommendation to provide to the member and/or CHW.

The CHW and/or Supervising provider should upload this information (not the document) into the provider portal.

- Medi-Cal Member Recommendation for Community Health Worker Services – Health Net – English (PDF)
- Medi-Cal Member Recommendation for Community Health Worker Services – CalViva Health – English (PDF)



CalViva HEALTH health net

Medi-Cal Member Recommendation for Community Health Worker Services

I declare that the following information is true and correct:

1. I am a Physician, Clinical Nurse Specialist (CNS), Dentist, Licensed Clinical Social Worker (LCSW), Licensed Educational Psychologist (LEP), Licensed Marriage & Family Therapist (LMFT), Licensed Midwife, Licensed Professional Clinical Counselor (LPCC), Licensed Vocational Nurse (LVN), Nurse Midwife, Nurse Practitioner (NP), Pharmacist, Physician Assistant (PA), Podiatrist, Registered Nurse (RN), Psychologist, Public Health Nurse (PHN), or Registered Dental Hygienist (RDH).
2. I attest that the Medi-Cal Member listed below would benefit from Community Health Worker services.

Member last name: _____

Member ID#/CIN#: _____

Provider type: _____

Provider name: (print) _____

Provider signature: _____ **Date:** _____

23-356/FRM1D43450ECD4w (5/23)

Community Health Worker Benefit

Community Health Worker (CHW) Services

CHW Documentation Requirements
Services

CHWs are required to document the dates and time/duration of services provided to Members.

- Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.
- Documentation must be accessible to the Supervising Provider upon their request.
- Documentation should be integrated into the Member's medical record and available for encounter data reporting.
- CHW's National Provider Identifier (NPI) number should be included in documentation.

For example, documentation might state:
"Discussed the patient's challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with the Supplemental Nutrition Assistance Program application for 30 minutes. Referred patient to [XYZ] food pantry."

CHW Services
Screening/Assessment

Screening and Assessment focuses on providing screening and assessment services that do not require a license and assisting a Member with connecting to appropriate services to improve their health.

CHW Services
Health Education

Health Education focuses on promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics.

Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.

CHW Covered Services
Format

- Covered CHW Services include Violence Prevention Services.
- CHW services can be provided as individual or group sessions.
- The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits.
- Supervising Providers should refer to the Telehealth section in Part 2 of the Provider Manual for guidance regarding providing services via telehealth

CHW Services
Individual Support/Advocacy

Individual Support or Advocacy focused on assisting a Member in preventing the onset or exacerbation of a health condition or preventing injury or violence.

- This includes peer support as well if not duplicative of other covered benefits.

CHW Services
Health Navigation

Health Navigation is providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care.

This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs.

Under Health Navigation, CHWs can also:

- Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team
- Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
- Help a Member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.

CHW Services
Non- Covered Services

Non-covered CHW services:

- Clinical case management/care management that requires a license
- Child care
- Chore services, including shopping and cooking meals
- Companion services
- Employment services
- Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
- Delivery of medication, medical equipment, or medical supply
- Personal Care services/homemaker services
- Respite care
- Services that duplicate another covered Medi-Cal service already being provided to a Member
- Socialization
- Coordinating and assisting with transportation
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license

Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.

Quality

How CHW Services Support Quality Improvement

Covered CHW Services support Healthcare Effectiveness Data Information Set (HEDIS®) performance

- Health plans measure and compare quality of care through Healthcare Effectiveness Data and Information Set (HEDIS®) metrics.
- HEDIS® quality metrics reflect a spectrum of health-related topics and outcomes.
- CHWs can help members use appropriate healthcare services (e.g., have a primary care visit).
- CHW's can provide screening and assessment services (e.g., depression screening) and individual peer support to prevent the onset or exacerbation of a health condition.

CHW services can directly or indirectly close HEDIS® care gaps

- CHW service procedure codes can directly close the HEDIS® care gaps.
- Health navigation and health education can indirectly close care gaps by helping the member receive appropriate services, fill medications, address barriers to disease management, etc.
- CHW's can help collect data necessary to close HEDIS® care gaps.

HEDIS® improvement is critical to complying with Medi-Cal quality requirements

- There are a priority set of HEDIS® measures, known as the Managed Care Accountability Set (MCAS) that are reported to the Department of Healthcare Services.
- Managed Care Plans (MCPs) must meet the minimum performance level (MPL) on the qualifying MCAS metrics.
- CHW services will support the MCAS requirements through HEDIS® improvement.

Collaborating with Quality Improvement (QI) to Support HEDIS® Performance

1. QI identifies CHW candidates

- HEDIS® and population health data used to identify members that meet CHW eligibility.
- Examples include but are not limited to: Members with one or more chronic health conditions, those at risk for a chronic health condition or environmental health exposure, and those who face barriers to meet health or health-related social needs, or would benefit from preventive services.

2. QI submits recommendation to appropriate CHW supervising provider

- Eligibility criteria confirmed and member lists are coordinated with Enhanced Care Management (ECM), Case Management, and Member connections teams.
- Based on member needs, QI will identify the appropriate CHW supervising provider.
- QI will work with Health Net's Regional Leads and the corresponding CHW supervising provider to initiate the CHW outreach project.

3. QI partners with CHW supervising providers

- QI will meet and work with CHW supervising providers to support care gap closure through CHW services.
- CHW supervising provider submit member list for referrals for CHW services (written recommendation) through Health Net provider portal.
- QI will provide data collection templates and talking points to support outreach.
- Following project closure, QI may follow up with the CHW supervising provider if more information is needed.

Thank you

Appendix

How CHW services impact HEDIS® performance

CHW service procedure codes indicate if the member meets criteria for a service or health condition. The criteria for a service or condition may signify a member is in the HEDIS® numerator* or denominator** based on the measure's technical specifications.

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Action
ADD	Follow-Up Care for Children Prescribed ADHD Medication	The percentage of children ages 6 – 12 newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period. Two rates are reported: • **Initiation Phase:** one visit within 30 days of the first ADHD prescription with a practitioner with **prescribing authority** • **Continuation and Maintenance (C&M) Phase:** two more visits (on different dates) with any practitioner from 31 days to 9 months after the initial prescription	Indicates members meets numerator compliance for the continuation & maintenance phase (i.e., CHW visit closes the care gap)	• Connect with parents of pediatric members that have been prescribed the medicine for ADHD for at least 7 months. If the pediatric member continues to stay on the medicine for 10 months, ensure to have 2 visits within 9 months of the initial prescription. • Provide health education about the importance of routine visits with their doctor. • Employ health navigation to assist the parent and pediatric member to access the child's doctor, facilitate appointment scheduling, or help the parent find a new doctor for their child. • Appropriately code for the visit with 98960, 98961, or 98962.
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	This measure captures the percentage of members 12 years of age and older who were screened for clinical depression using a standardized Instrument between January 1 and December 1 of the measurement Year. If the member screened positive, they should receive follow-up care within 30 days.	Indicates members meets numerator compliance for follow-Up on positive screen (must be paired with depression diagnosis or other behavioral health condition)	• Connect with the member within 30 days of the date of the positive screen for depression. • If needed, appropriately screen the member with a Patient Health Questionnaire 9-item (PHQ9). Based on screening results, assist the member in connecting to appropriate services. • When documenting CHW services, please include the diagnosis of depression or other behavioral health condition.

Magenta font indicates the CHW service codes (98960, 98961, and/or 98962) is in the HEDIS numerator value set, directly closing the care gap

*Numerator definition: Members who meet compliance criteria based on the HEDIS® technical specifications for appropriate care, treatment or service

**Denominator definition: Members who qualify for the measure criteria, based on HEDIS® technical specifications

How CHW services impact HEDIS® performance

CHW service procedure codes indicate if the member meets criteria for a service or health condition. The criteria for a service or condition may signify a member is in the HEDIS® numerator* or denominator** based on the measure's technical specifications.

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Action
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (MCC)	The percentage of (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	Indicates members meets numerator compliance	• Connect with the member within 7 days of the ED visit. • Members with MCC require high levels of care coordination, particularly as the transition from the ED to the community. • Employ health navigation to address communication gaps between ED and outpatient providers, between patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. • Appropriately code for the visit with 98960, 98961, or 98962
FUA	Follow-Up After Emergency Department Visit for Substance Use	The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (DUD), or any diagnosis of drug overdose, for which there was follow-up within 7 days of the ED visit (8 total days) or within 30 days of the ED visit (31 total days).	Indicates members meets numerator compliance (must be paired with substance use disorder diagnosis)	• Connect with the member within 7 days of the ED visit • Employ health navigation to ensure coordination for members who are discharged from the ED following high-risk substance use events. • Health education and individual support are key as these individuals may lose contact with the health care system. • When documenting CHW services, include the substance use disorder diagnosis.

Magenta font indicates the CHW service codes (98960, 98961, and/or 98962) is in the HEDIS numerator value set, directly closing the care gap

*Numerator definition: Members who meet compliance criteria based on the HEDIS® technical specifications for appropriate care, treatment or service

**Denominator definition: Members who qualify for the measure criteria, based on HEDIS® technical specifications

How CHW Services Impact HEDIS® performance

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Action
FUM	Follow-Up After Emergency Department Visit for Mental Illness	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, for which there was follow-up within 7 days of the ED visit (8 total days) or within 30 days of the ED visit (31 total days).	Indicates members meets numerator compliance (must be paired with a principal diagnosis of mental health disorder)	• Please contact the member within 7 days of the ED visit. • Health education to encourage follow-up care in the outpatient setting. • Health navigation to facilitate the transition between ER discharges to a healthcare provider, and coordinate care with the managed care plan and county treatment services. • Research suggests low-intensity interventions such as appointment reminders, and high-intensity interventions such as assertive engagement and meeting members in the community, can support timely follow-up care. • Recommend CHW's with behavioral health lived experience. • When documenting CHW services, include the principal mental health diagnosis associated with the ED visit. • If the ED visit was for self-harm, please document the CHW service with the principal diagnosis of intentional self-harm, with a diagnosis of a mental health condition.
IET	Initiation and Engagement of Substance Use Disorder Treatment	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. • **Initiation of SUD Treatment:** Initiation of treatment within 14 days of the diagnosis. • **Engagement of SUD Treatment:** Treatment Engagement (2 more visits) within 34 days of initiation.	Indicates members meets numerator compliance (must be paired with any substance use disorder diagnosis)	• Please contact the member within 14 days of the initial substance use diagnosis. This will help initiate treatment with the member. • Ensure the member has two more visits within 31 days of initiating treatment. • Employ health navigation to coordinate care with the managed care plan and county treatment services, refer the member to appropriate services to help them engage in their own care. • Recommend CHW's with behavioral health lived experience. • When documenting CHW services, include the substance use disorder diagnosis.

Magenta font indicates the CHW service codes (98960, 98961, and/or 98962) is in the HEDIS numerator value set, directly closing the care gap

*Numerator definition: Members who meet compliance criteria based on the HEDIS® technical specifications for appropriate care, treatment or service

**Denominator definition: Members who qualify for the measure criteria, based on HEDIS® technical specifications

How CHW Services Impact HEDIS® performance

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Action
PND-E	Prenatal Depression Screening and Follow-Up	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported. • **Depression Screening**: The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • **Follow-Up on Positive Screen**: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Indicates members meets numerator compliance for Follow-Up on Positive screen (must be paired with a depression diagnosis)	• Connect with the member within 30 days of the date of the positive screen for depression during the perinatal period. • Based on the type of screening done (e.g., Patient Health Questionnaire – 2 Item (PHQ2), appropriately screen the member with a Patient Health Questionnaire 9-item (PHQ9). Based on screening results, assist the member in connecting to appropriate services. • When documenting CHW services, please include the diagnosis of depression or other behavioral health condition.
PDS-E	Postpartum Depression Screening and Follow-Up	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported. • **Depression Screening**: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • **Follow-Up on Positive Screen**: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Indicates members meets numerator compliance for Follow-Up on Positive screen (must be paired with a depression diagnosis)	

Magenta font indicates the CHW service codes (98960, 98961, and/or 98962) is in the HEDIS numerator value set, directly closing the care gap

*Numerator definition: Members who meet compliance criteria based on the HEDIS® technical specifications for appropriate care, treatment or service

**Denominator definition: Members who qualify for the measure criteria, based on HEDIS® technical specifications

How CHW Services Impact HEDIS® performance

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Action
FUH	Follow-Up After Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1) The percentage of discharges for which the member received follow-up within 7 days after discharge. 2) The percentage of discharges for which the member received follow-up within 30 days after discharge.	Indicates members meets numerator compliance (must be billed by a mental health provider)	• Please contact the member within 7 days of the date of discharge. This will help initiate treatment with the member. • Recommend deploying CHW's with behavioral health lived experience. • Employ health navigation to coordinate care with the managed care plan and county treatment services, refer the member to appropriate services to help them engage in their own care. • When documenting CHW services, ensure the supervising provider is a licensed mental health provider.

Magenta font indicates the CHW service codes (98960, 98961, and/or 98962) is in the HEDIS numerator value set, directly closing the care gap

*Numerator definition: Members who meet compliance criteria based on the HEDIS® technical specifications for appropriate care, treatment or service

**Denominator definition: Members who qualify for the measure criteria, based on HEDIS® technical specifications

Recommended CHW Actions to Impact HEDIS® performance

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Actions
AMR	Asthma Medication Ratio	This measure assesses the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Can indirectly support care gap closure by helping the member adhere to the total asthma medication ratio.	• Health navigation to help members understand pharmacy benefits or access Pharmacy to pick up medicine. • Health education and coaching to help member understand the difference between a controller and rescue medication. Help the member identify their asthma triggers and the importance of an asthma friendly home environment. • Consider helping the member build an asthma action plan, and health navigation to help set up appointments with the member's providers as need to review members asthma action plan. • Social determinants of health screening to help identify member barriers and potential solutions to condition management. • Consider conducting the "Asthma Control Test" to help determine if asthma symptoms are controlled. • Based on member needs and home environment, consider referral to Community Supports. • Health education on the proper use of inhalers/spacers (if the CHW is trained to do this).

Recommended CHW Actions to Impact HEDIS® performance

Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Actions
HBD	Hemoglobin A1c Control for Patients With Diabetes	This measure assesses the percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • HbA1c poor control (>9.0%).	Can indirectly support care gap closure by helping the member to either get the necessary HbA1c screening, or to help the member control their HbA1c levels (<8.0%).	• Health education and coaching to help the member manage their diabetes and blood sugar control. • Health navigation to help connect the member to transportation or translation services if needed to reach their doctor for follow-up visits. • Social determinants of health screening to help identify member barriers to condition management. • Health coaching to help the member problem solve barriers to treatment. • Health navigation to provide referrals to assist members in accessing community services. • If CHW has lived experience, provide peer support to help prevent exacerbation of condition. • Consider following up with the member to monitor their progress with diabetes management.

Recommended CHW Actions to Impact HEDIS® performance

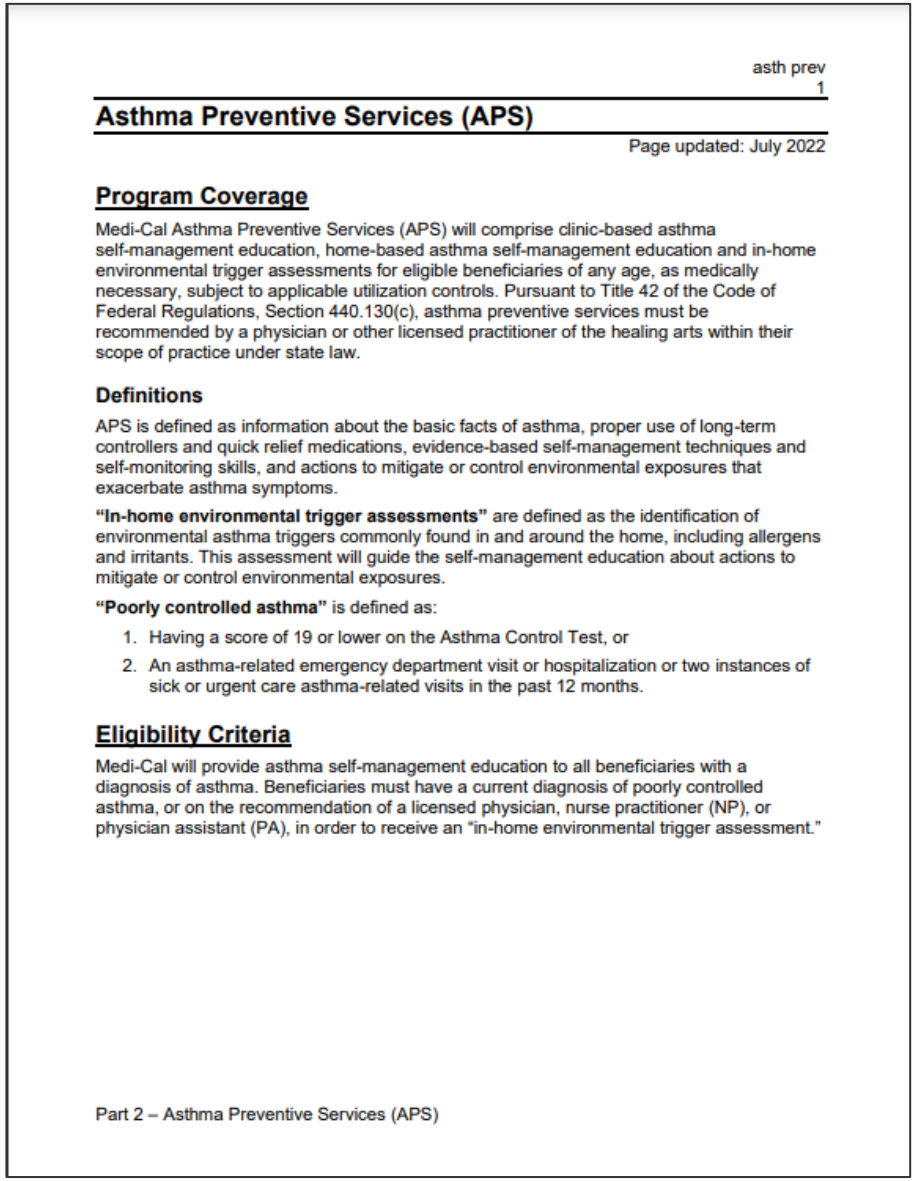
Measure Abbreviation	Measure Name	Measure Description	How CHW Services Impacts the Quality Measure	Recommended CHW Actions
CBP	Controlling High Blood Pressure	This intermediate-outcome measure assesses members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Can indirectly support care gap closure by helping the member to either get the necessary blood pressure screening, or to help the member adequately control blood pressure (<140/90 mm Hg).	• Health education and coaching to help the member manager their hypertension. • Health navigation to help connect the member to transportation or translation services if needed to reach their doctor for follow-up visits. • Social determinants of health screening to help identify member barriers to condition management. • Health education to address misconceptions regarding alternative remedies, promote low-sodium diets, and physical activity, how to take their own blood pressure measurements. • Health navigation to help the member access BP cuffs for self-measured blood pressure monitoring. • Educate members to share the results with their provider.

Community Health Worker Services & Asthma Prevention Services

Asthma Prevention Benefit

Asthma prevention services may be provided by licensed providers such as Physicians, NP's and PA's.

These services may also be provided by unlicensed providers such as community health workers (CHW), promotores, or community health representatives who meet the qualifications of an asthma preventive service provider



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Asthma Preventive Services (APS)

Page updated: July 2022

Program Coverage

Medi-Cal Asthma Preventive Services (APS) will comprise clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments for eligible beneficiaries of any age, as medically necessary, subject to applicable utilization controls. Pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), asthma preventive services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

Definitions

APS is defined as information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms.

"In-home environmental trigger assessments" are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment will guide the self-management education about actions to mitigate or control environmental exposures.

"Poorly controlled asthma" is defined as:

1. Having a score of 19 or lower on the Asthma Control Test, or
2. An asthma-related emergency department visit or hospitalization or two instances of sick or urgent care asthma-related visits in the past 12 months.

Eligibility Criteria

Medi-Cal will provide asthma self-management education to all beneficiaries with a diagnosis of asthma. Beneficiaries must have a current diagnosis of poorly controlled asthma, or on the recommendation of a licensed physician, nurse practitioner (NP), or physician assistant (PA), in order to receive an "in-home environmental trigger assessment."

Part 2 – Asthma Preventive Services (APS)

- https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf