

# Tri Counties CalAIM PATH Collaborative

May 20, 2026



**Please introduce  
yourself in the  
chat!**

# Housekeeping



Please ensure you are **muted**



**Use the chat** to ask questions relevant to the topic(s) at hand



Unmute and share your questions or comments during **Q&A**



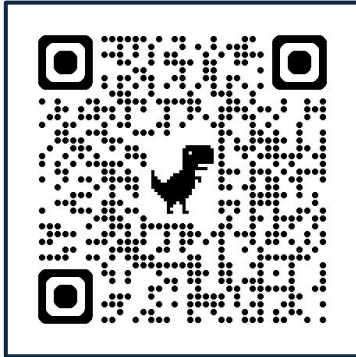
Add your organization to your Zoom Name

- Click **Participants**, hover over your name in the list and click **More**, select **Rename** from the drop-down menu, and enter your name and organization as you would like it to appear

Meeting slides will be shared with participants and posted to our resource center

# 2026 Scheduling

*Join us on Wednesdays in 2026!*



Register today to add  
the meetings to your  
calendar!

[Add to Calendar\(.ics\)](#) | [Add to Google Calendar](#) | [Add to Yahoo Calendar](#)

To edit or cancel your registration details, [click here](#).

Please submit any questions to: [pathinfo@bluepathhealth.com](mailto:pathinfo@bluepathhealth.com).

## WAYS TO JOIN ZOOM

**Join from PC, Mac, iPad, or Android**

## Meeting Calendar

January 21

February 18

March 18

Week of April 13th (in-person)

May 20

June 17

July 15

August 19

Week of September 14th (in-person)

October 21

November 18

December 16

# 2026 Collaborative Aim Statement and Drivers

**By December 2026, the Collaborative will develop a foundation for ongoing collaboration to support continuity beyond the PATH program.**

**Transform networking into formal and informal partnerships through in-person meetings**

**Prepare for implementation changes through regular policy updates and summaries**

**Strengthen capacity through trainings and co-development of tools and resources**

# Today's Agenda

| <b>Time</b>    | <b>Agenda Item</b>  | <b>Presenter(s)</b>   |
|----------------|---|---|
| 10:00-10:05 am | Welcome and Introductions   | BluePath Health   |
| 10:05-10:20 am | Local CalAIM Success Stories  | Interface Children and Family Services                            |
| 10:20-10:45 am | CalAIM Justice-Involved Initiative: Probation Updates on JI for Youth | Santa Barbara, San Luis Obispo, and Ventura                       |
| 10:45-10:55 am | MCP Updates   | Kaiser Permanente<br>Gold Coast Health Plan<br>CenCal Health Plan |
| 10:55-11:00 am | Policy Updates, Announcements, and Closing                            | BluePath Health   |

# Thank you for joining us in April!

- We heard provider spotlights from **Restorative Partners, Transitions-Mental Health Association, Family Services Agency, Many Mansions,** and **Ventura County Health**
- We were grateful to have **CenCal Health Plan, Gold Coast Health Plan,** and **Kaiser Permanente** provide guidance on developing **high-quality care plans** and making **Transitional Rent** referrals
- **Meeting Materials**
  - [April 14 Santa Maria](#)
  - [April 15 Camarillo](#)



# CalAIM Success Story: Interface Children and Family Services

*Dichele Harris*



# Enhanced Care Management Services: Justice Involved

Presented by Community Wellness  
& Coordinated Care Team





# Presentation Outline

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- 01 About Interface Children & Family Services
- 02 ECM Pre-Release Services
- 03 Sending Referrals
- 04 Contact us

# Interface Children & Family Services

## MISSION

Strengthening children, families, individuals, and communities to be safe, healthy, and thriving through comprehensive social services.



# PROGRAM AREAS

30 PROGRAMS ACROSS SIX DEPARTMENTS



211 Information & Assistance

Domestic Violence & Child Abuse Prevention

Human Trafficking Prevention & Intervention

Justice Services

Mental Health & Trauma Treatment

Youth Crisis & Homeless Services

# TYPES OF SERVICES

30 PROGRAMS ACROSS SIX DEPARTMENTS



Crisis response & advocacy

Emergency and transitional shelters

Prevention education

Child abuse treatment & trauma recovery

Positive Parenting Programs

Street outreach services

211 Information & Assistance for social service needs



# ECM Pre-Release Services at Interface

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# Highlight: Individuals Transitioning from Incarceration

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- Receiving referrals for members who are currently incarcerated and those who have been released within the past year
- Connect members to services prior to release to assist in acclimating back to community
- Assist members with ongoing justice involvement: accompany members to court and provide support with probation/parole activities
- With members permission, will collaborate with public defender, probation and parole, and other law enforcement agencies
- Care Plan goals specific to justice involvement in partnership with member
- Provide housing navigation services as requested

# Outreach & Engagement

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## **Transitioning from Incarceration**

Referrals provided by Gold Coast Health Plan (GCHP) Justice Services Liaison. Our team connects with the Pre-Release Coordinator (PRC) for the GC member prior to release. Using the Health Risk Assessment provided by PRC and through conducting a Warm Hand-Off with the client, ICFS ECM team schedules healthcare appointments and referrals to services to assist them in acclimating back to their community. The Warm Hand-Off is conducted virtually for state prisons and can be done in person when the member is in a county facility.

After release, ECM Case Manager connects with client where they feel comfortable: in their homes, shelters, probation office, court house, or sober living facility – anyplace someone might be in the community – to prevent transportation barriers from limiting service.

Our goal is to engage with enrolled members on a weekly to bi-weekly basis.

Our approach is supported by the following strategies:

- o Housing First model
- o Harm Reduction
- o Trauma Informed Practice

## **Recently Released from Incarceration**

Referrals provided by anyone or any agency in the community, including self-referrals. Once the referral is received, we will connect with the member using the same methods and strategies as above.

# Comprehensive Assessment & Care Management Planning

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Our assessment is meant to be targeted: Measuring how much and what type of assistance a member needs. This helps to inform which Care Manager they are assigned to and the Care Planning process.

Once the member is released from incarceration and enrolled in ECM, they work with their Care Manager to develop a comprehensive, person-centered, and individualized Care Plan that is specific to their justice involvement needs and broader goals.

The care plan is based on the member's health status, needs, preferences, and goals regarding:

- o Physical health
- o Mental health
- o Disabilities
- o Substance use
- o Probation/Parole requirements
- o Court mandates
- o Oral health
- o Community-based long-term services and supports
- o Supports to manage severe illness (e.g., palliative care)
- o Trauma-informed care needs
- o Income and employment
- o Shelter and housing
- o Access to food
- o Community and social services

# Enhanced Coordination of Care

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Services are provided to help the member implement their Care Plan and navigate and connect to needed health and community services. The member's Care Manager is a key point of contact.

Enhanced coordination of care activities may include:

- o Assist members with ongoing justice involvement: accompany members to court and provide support with probation/parole activities.
- o With members permission, will collaborate with public defender, probation and parole, and other law enforcement agencies.
- o Provide support to the member in ongoing SUD treatment, including coordinating medically assisted treatment with their identified provider.
- o Connect member to Ventura County Behavioral Health for mental health treatment.
- o Helping the member to identify, connect to, and communicate with health care and social services providers, including going with the member to appointments, as well as assistance with appointment and transportation scheduling, as needed.
- o Sharing information with the member's care team regarding their conditions, health status, medications, and any side effects.
- o Maintaining regular communication with all the member's providers and holding meetings for the care team to discuss the member's goals and needs.
- o Helping the member follow their treatment plans, including court mandated activities.

# Health Promotion

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The member is coached on how to better monitor and manage their health and identify and access helpful resources.

Health promotion activities may include:

- o Coaching the member on pro-social activities and coping strategies.
- o Supporting health education for the member and their family and/or personal support system.
- o Providing services that encourage and support the member to make choices that support healthier behavior.
- o Supporting the member in strengthening skills that help them identify and access resources.
- o Linking the member to resources for smoking cessation, chronic condition management, self-help recovery resources, and other services.
- o Using evidence-based practices, such as motivational interviewing, to engage and help the member manage their care.

# Comprehensive Transitional Care

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The member receives services to help them transition between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions.

This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, correctional facility, or other treatment center, and where a member stays or lives.

Comprehensive transitional care may include:

- o Developing strategies to reduce avoidable hospital stays or emergency department visits.
- o Developing and regularly updating a transition plan for the member.
- o Evaluating the member's medical care needs and coordinating any support services post-discharge.
- o Tracking the member's admissions and discharges and communicating with their care teams.
- o Educating the member on self management, rehabilitation, and medication management.

# Member and Family Supports

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The member, their family, and their personal support system are educated about the member's condition(s) and are connected to support reacclimating to the community and to help prevent re-incarceration.

Member and family support activities may include:

- o Documenting a member's family and/or personal support system and ensuring all required release of information forms are in place so they can communicate with the care team.
- o Regularly connecting with the member and their personal support system and communicating the member's needs and preferences to their providers in a timely manner.
- o Ensuring the member, their family, and/or their personal support system is knowledgeable about the member's needs and goals and obtain additional resources.
- o Providing education to the member, their family, and/or their personal support system about their care plan.

# Coordination of and Referral to Community and Social Supports

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The member receives referrals to community and social support services and follow-up to help ensure they get the services they need.

Referral and coordination activities may include:

- o Coordinating services in collaboration with Interface's Justice Services program, including Prop 47 diversion services.
- o Supporting the member in increasing their income, including SOAR supported SSI/SSDI applications.
- o Determining appropriate resources to meet the member's needs, including services offered through Community Supports.
- o Routinely assisting the member and following up to ensure needed services are obtained.
- o Monitoring referrals and needed services and supports, as well as coordination and follow-up.

# Program Design



Pre-Release Client screening is conducted during Warm Hand-Off with follow-up by Program Manager once released

Assessment completed by Program Manager who can use the assessment to match member with a Care Manager

Clients who have been released in the past year can be screened for eligibility over the phone and takes about 15-20 minutes

Currently have five Care Managers with caseload capacity of 35 clients each for a total of 175 clients across all Populations of Focus.



# Goal of our ECM JI Program

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- Help members increase their knowledge about their health care and how to meet their needs.
- Partner with members to set and reach holistic goals.
- Reduce frequency of recidivism through targeted interventions and connection to appropriate supports.
- Graduation: Help members feel like they can successfully manage their health and social conditions independently with little to no assistance.

# Client Stories



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- One client was incarcerated for several years. Following release, their case manager assisted them in getting needed identifying documentation and job search. The client has had several interviews and one job offer.
- Another client was released from prison after serving four years and is living with his mom. The case manager was able to get client's EBT and medi-cal Gold Coast card, and assist the client with signing up for DUI classes to obtain his driver's license. The client was able to successfully obtain his driver's license, leading to a recent job opportunity. He has since obtained partial custody of his eleven-year-old son. The client has been sober since his release and attends weekly meetings.



# Interface ECM Referral Process

**Pre-Release** clients referred through Gold Coast Health Plan

**Complete the Interface referral form:** [bit.ly/ecmreferralinterface](https://bit.ly/ecmreferralinterface)

**Client's or providers can call our ECM Referral Line:** 805-437-4982





# Pre-Release Work Group

Are you interested in or already providing Pre-Release or Justice Involved Services as the local jails join the ECM program?

We are planning to form a work group to address barriers, discuss service connections, and stay updated on changes.

Anyone interested in working with this population, please contact the PATH Collaborative to share that you would like to join.



# ECM Contacts

**Dichele Harris**

**Director of Community Wellness & Coordinated Care**

[dharris@icfs.org](mailto:dharris@icfs.org)

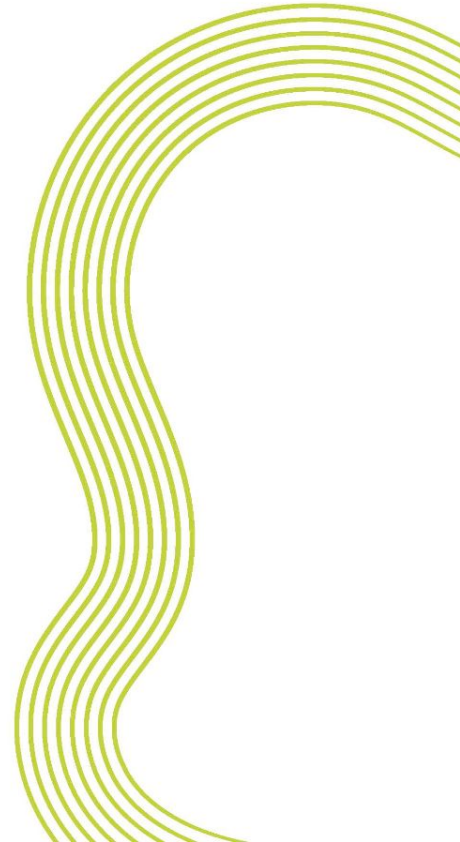
**Stephanie Shaker Sullivan**

**Associate Director of Community Wellness & Coordinated Care**

[ssullivan@icfs.org](mailto:ssullivan@icfs.org)

**General Questions**

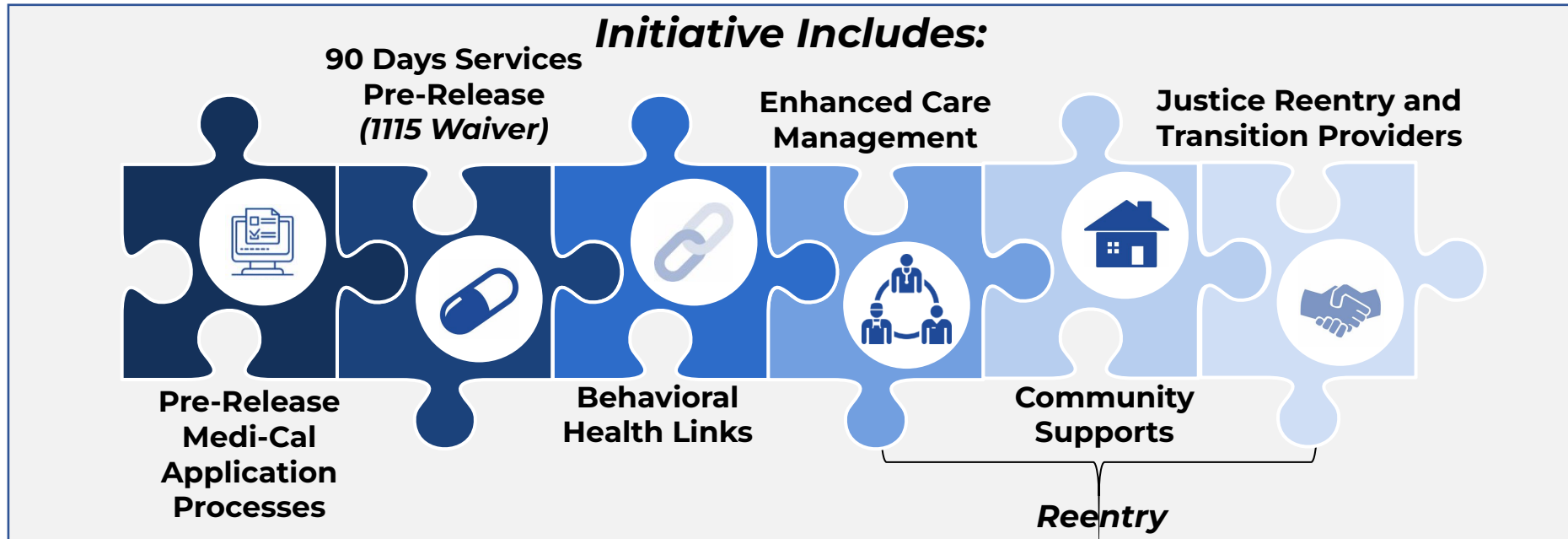
[ECM@icfs.org](mailto:ECM@icfs.org)



# CalAIM Justice-Involved Initiative: Probation & Youth Services

# Justice-Involved Initiative: Overview

The CalAIM Justice-Involved Initiative supports justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their reentry.



# JJ Initiative: Youth-Specific Considerations

- All incarcerated youth with Medi-Cal or CHIP coverage are eligible for CalAIM reentry services, **regardless of whether they have a qualifying medical condition**
- Eligibility for youth versus adult tracks is determined by the facility, not age alone—meaning **individuals up to and including age 25 may qualify for youth-focused CalAIM services** if they are served within the juvenile system
- **Juvenile Probation** is responsible for implementing the Justice-Involved Initiative for youth

# CalAIM Justice-Involved Initiative: Santa Barbara

*Katie McBain and Lesli Stamm*



COUNTY of SANTA BARBARA  
PROBATION

SANTA BARBARA COUNTY | CalAIM Justice-Involved Initiative

# Juvenile Justice Program

## Enhanced Care Management (ECM) Services

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Streamlined Referral Tracking & Provider Assignment  
Powered by Smartsheet — CenCal Health Partnership

May 2026

# Program Overview

## What is the JJ ECM Program?

### **Enhanced Care Management (ECM)**

is an intensive care coordination benefit under CalAIM for justice-involved individuals approaching release from custody.

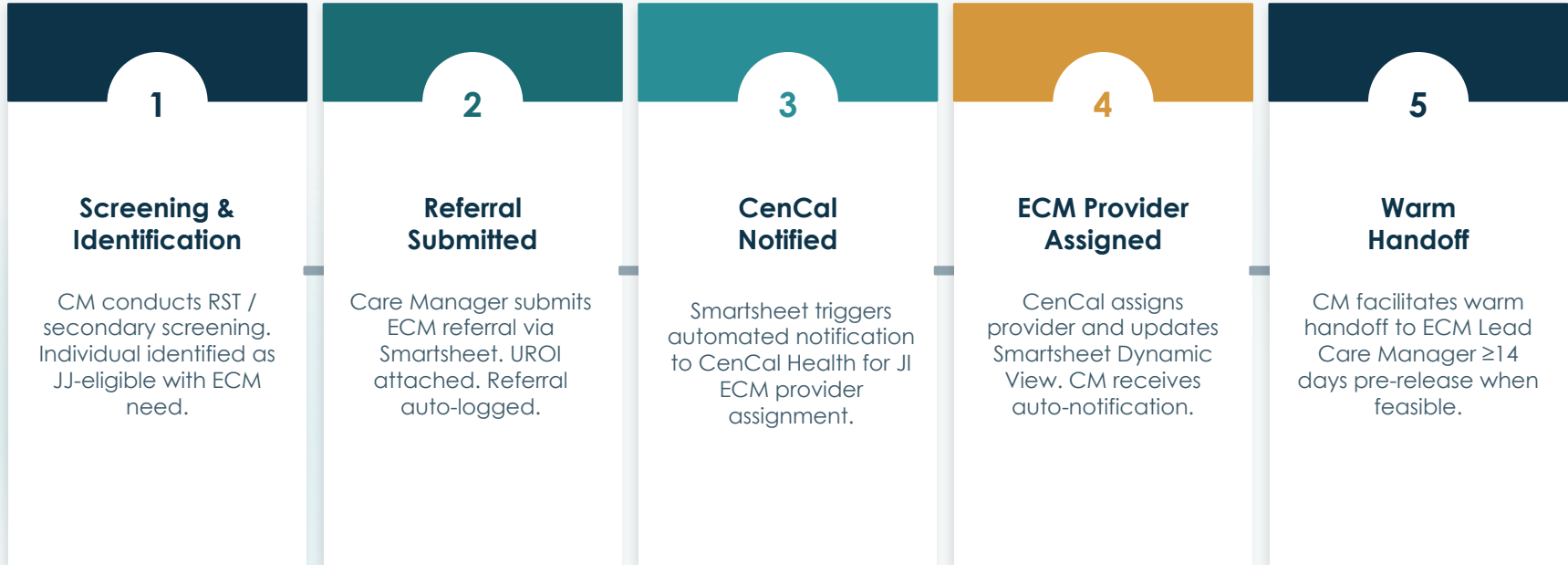
### **The Juvenile Justice (JJ) Program**

targets youth and young adults in the juvenile facility, ensuring seamless access to ECM services immediately upon release — consistent with DHCS and CalAIM JI Initiative requirements.

## Why It Matters

- Continuity of care from incarceration to community
- Presumptive/retroactive ECM authorization on day of release
- Coordinated behavioral health, medical, and social service linkages
- Closed-loop referral tracking — no referral falls through the cracks
- Supports DHCS Readiness Assessment compliance for go-live

# ECM Referral Workflow



Referral Status: Initiated → Acknowledged → Dispositioned → Scheduled → Service Initiated → Closed

# The Smartsheet Platform: How It Works



## Referral Submission

CM staff submit ECM referrals directly in Smartsheet, capturing client ID, needs, UROI status, release date, and eligibility. Each referral receives a unique tracking ID.



## Automated Notifications

Smartsheet triggers an immediate automated alert to CenCal Health upon referral submission. No manual handoff required — reducing delays and communication gaps.



## CenCal ECM Assignment

CenCal staff access their Smartsheet Dynamic View to review pending referrals and assign the appropriate ECM provider. Assignment is documented and date-stamped in the system.



## Closed-Loop Confirmation

Once CenCal assigns a provider, an auto-notification is sent to the CM confirming the ECM assignment. The CM then schedules the warm handoff meeting prior to release.

# Roles & Responsibilities

## Care Manager (CM)

- Conducts RST and secondary BH screening
- Submits ECM referral in Smartsheet with UROI
- Receives automated confirmation of ECM assignment
- Facilitates warm handoff  $\geq$  14 days pre-release
- Updates Reentry Care Plan with all confirmed linkages

## CenCal Health (MCP)

- Receives automated notification via Smartsheet
- Reviews and assigns ECM provider via Dynamic View
- Documents provider assignment with date-stamp
- Confirms assignment back to CM via Smartsheet
- Ensures presumptive/retroactive ECM authorization on day of release

## ECM Provider

- Receives ECM assignment and case information
- Conducts in-reach or custody appointment pre-release
- Reviews HRA and Reentry Care Plan at warm handoff
- Facilitates post-release linkage to BH, medical, and social services
- Bridges medications and confirms service initiation

# Key Timelines & Requirements

| Action / Milestone             | Timeline Requirement                                 | Responsible Party |
|--------------------------------|--|-------------------|
| Referral Submission            | Same day as BHL referral / ECM identification        | CM                |
| MCP Acknowledgement            | Within 3 business days of referral receipt           | CenCal            |
| ECM Provider Assignment        | Within 5 business days of referral receipt           | CenCal            |
| HRA Completion                 | By Day 8 (embedded) / Day 10 (in-reach)              | CM / Wellpath     |
| Reentry Care Plan              | By Day 14 of JI aid code activation — no exceptions  | CM                |
| Warm Handoff to ECM            | ≥ 14 days prior to anticipated release when feasible | CM / ECM          |
| Post-Release ECM Authorization | Day of release (presumptive/retroactive)             | CenCal            |

⚠ All timelines are CalAIM-mandated. Non-compliance constitutes an audit finding.

# Benefits of the Smartsheet System



## Streamlined Communication

Replaces manual phone and email chains with automated, documented notifications between JCM, CenCal, and ECM providers.



## Real-Time Tracking

All referral statuses are visible in real time. No referral can be lost, forgotten, or left in an indeterminate state.



## Audit-Ready Documentation

Every action is date-stamped and user-attributed. The system produces an exportable audit trail for DHCS readiness reviews.



## Closed-Loop Assurance

Referrals must progress through all required states before closure. No referral may close at 'sent' or 'pending' status.



## Integrated Records Access

CenCal staff access and update records through the Dynamic View, ensuring both sides of the referral always have current information.



## Performance Monitoring

Smartsheet data feeds directly into compliance dashboards tracking referral aging, network failures, and ECM assignment rates.

# Juvenile Justice Program

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## **Santa Barbara County Probation** CalAIM Initiative Summary

By

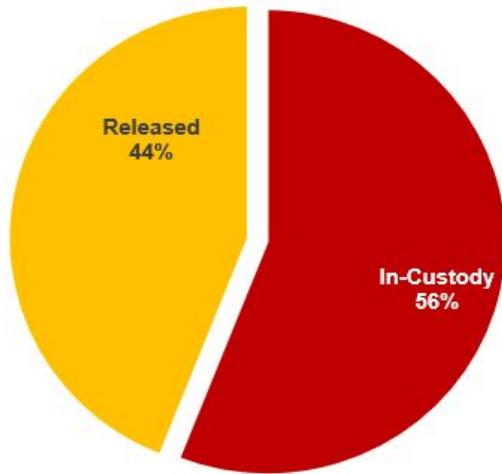
Probation Manager Lesli Stamm  
Department Business Specialist Irma Contreras

# Santa Barbara County Probation JJC CalAIM Initiative Summary

Reporting Period: 04/01/26-05/18/26

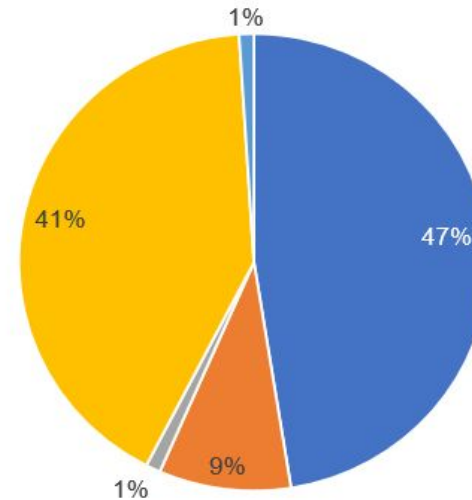
## JJC Population Custody

(n=78 Unique Booking No.)



## 90 Day Pre-Release JI AID Code Status

(n=78 Unique Booking No.)



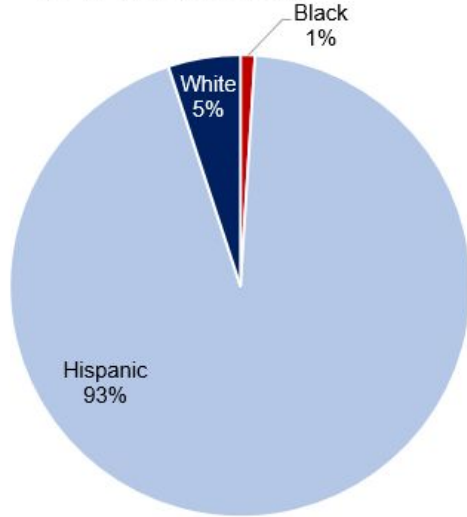
- In-Custody - Not Yet Eligible
- In-Custody - JI AID Code Activated
- Transferred - Not Eligible
- Released - JI AID Code Deactivated
- Released - Pending Retro-Activation Deactivation

# Santa Barbara County Probation JJC CalAIM Initiative Summary

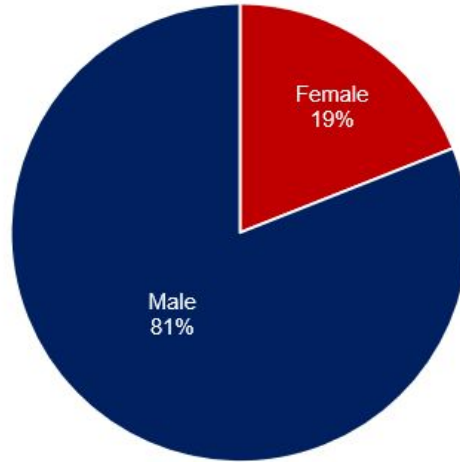
Reporting Period: 04/01/26-05/18/26

## JJC Population Summary by Race, Gender, and Age

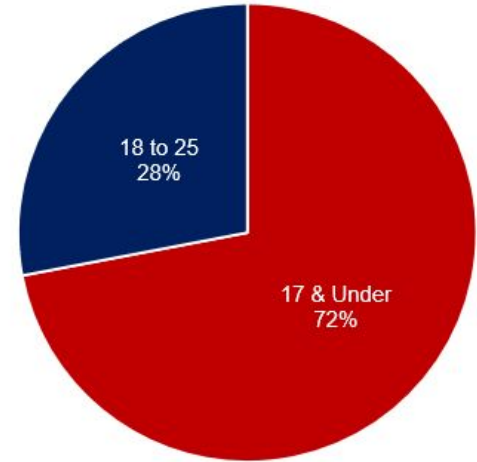
**Race/Ethnicity**  
(n=74 Unique PIN No.)



**Gender**  
(n=74 Unique PIN No.)



**Age**  
(n= 74 Unique PIN No.)



# CalAIM Justice-Involved Initiative: San Luis Obispo

*Melissa Trapani*



# CalAIM Justice-Involved Initiative: Ventura

*Yasmin Guerra and Holly Jacinto*



# VENTURA COUNTY PROBATION AGENCY JUVENILE FACILITIES



VENTURA COUNTY  
**PROBATION  
AGENCY**  
EST. 1909

Yasmin Guerra  
Program Administrator II-CalAIM  
Holly Jacinto  
Supervising Deputy Probation Officer  
Juvenile Facilities



# CalAIM Overview

## Populations of Focus

| #        | Population of Focus  | Adults   | Children & Youth |
|----------|--|----------|------------------|
| 1        | Individuals or families experiencing homelessness  | X        | X                |
| 2        | Individuals at risk for avoidable hospital or emergency room visits (high utilizers of multiple systems of care) | X        | X                |
| 3        | Individuals with serious mental or substance use disorders   | X        | X                |
| <b>4</b> | <b>Individuals transitioning from incarceration</b>  | <b>X</b> | <b>X</b>         |
| 5        | Adults living in the community at risk for long-term care  | X        | -                |
| 6        | Adults in nursing facilities transitioning to the community  | X        | -                |
| 7        | Children and youth enrolled in the California Children's Services program  | -        | X                |
| 8        | Children and youth involved with child welfare services  | -        | X                |
| 9        | Birth equity   | X        | X                |

# CalAIM JI Eligibility

Who is eligible for CalAIM Justice Involved reentry services?

## Adults

- Adults who are transitioning from incarceration or transitioned from incarceration **within the past 12 months**.
- Young adults (18-20 years of age) are not required to be screened for pre-release services in the jail facility (automatically eligible)
- Adults must meet **eligibility criteria** to be enrolled in the services

**Examples:** chronic mental illness, Substance Use Disorder (SUD), Chronic Disease (e.g., hepatitis C, diabetes), Intellectual or developmental disability Traumatic brain injury, HIV, or Pregnancy

## Youth

- 100% of youth are eligible for pre-release services and enhanced care management services for **up to 12 months** following release from a juvenile detention facility

# Pre-Release Services within Probation Juvenile Facilities

Medi-Cal reimbursable services up to the last 90 days of incarceration

- 1) Pre-Release Screenings
- 2) Health Risk Assessments
- 3) Clinical Consultations
- 4) Warm Handoffs
- 5) Reentry Care Plan
- 6) Care Coordination
- 7) Linkages & Referrals
- 8) Release Planning
- 9) Medi-Cal Billing
- 10) Monitoring, Oversight, and Reporting

# REENTRY CARE PLAN

## VENTURA COUNTY JUVENILE FACILITIES

PRE-RELEASE

PRE-RELEASE SERVICES

POST-RELEASE

Ventura County Juvenile Facilities



**Reentry care plan is initiated after booking and screening process**

"Assess the needs of the individual to develop a person-centered reentry care plan in collaboration with the individual, the clinician providing consultation services and reentry planning team"



**Incarcerated Person**

Printed copy of reentry care plan is handed to the individual at time of release

**Reentry Care Plan**



Digital version of reentry care plan is distributed to Medi-Cal Partners prior to the release date

Behavioral health referrals & linkages are coordinated for SMI/SUD prior to the release



Ventura County Behavioral Health & Full Service Partnership



Gold Coast Health Plan



**Assigned Enhanced Care Management Provider**

# Kaiser Permanente



# Ventura County Tri-Counties PATH CPI

**Gillian Stucki, Medi-Cal Local Engagement**

May 20, 2026

# CalAIM Justice Involved Trainings | Future training opportunities

## COUNTY, STATE AND FEDERAL REQUIREMENTS OF CALAIM

*One Day Training*

May 28 | 10:00 AM – 12:00 PM  
May 29 | 10:00 AM – 12:00 PM  
June 4 | 10:00 AM – 12:00 PM  
June 5 | 10:00 AM – 12:00 PM

## WHAT IS CALAIM & WHO IS ELIGIBLE

*One Day Training*

May 12 | 10:00 AM – 12:00 PM  
May 13 | 10:00 AM – 12:00 PM  
May 14 | 10:00 AM – 12:00 PM

## REENTRY PLANS AND TRANSITION PLANNING

*One Day Training*

September 15 | 10:00 AM – 12:00 PM  
September 16 | 10:00 AM – 12:00 PM  
September 17 | 10:00 AM – 12:00 PM  
September 18 | 10:00 AM – 12:00 PM

## ENHANCED CARE MANAGEMENT (ECM) – ADULT

*Option 1 – 2 Day Course*

June 16 | 9:00 AM – 12:00 PM  
June 17 | 9:00 AM – 12:00 PM

*Option 2 – 2 Day Course*

June 16 | 1:00 PM – 4:00 PM  
June 17 | 1:00 PM – 4:00 PM

*Option 3 – 2 Day Course*

June 23 | 9:00 AM – 12:00 PM  
June 24 | 9:00 AM – 12:00 PM

*Option 4 – 2 Day Course*

June 23 | 1:00 PM – 4:00 PM  
June 24 | 1:00 PM – 4:00 PM

*Option 5 – 2 Day Course*

June 30 | 9:00 AM – 12:00 PM  
July 1 | 9:00 AM – 12:00 PM

*Option 6 – 2 Day Course*

June 30 | 1:00 PM – 4:00 PM  
July 1 | 1:00 PM – 4:00 PM

## ENHANCED CARE MANAGEMENT (ECM) – JUVENILE

*Option 1 – 2 Day Course*

July 28 | 9:00 AM – 12:00 PM  
July 29 | 9:00 AM – 12:00 PM

*Option 2 – 2 Day Course*

July 28 | 1:00 PM – 4:00 PM  
July 29 | 1:00 PM – 4:00 PM

*Option 3 – 2 Day Course*

August 5 | 9:00 AM – 12:00 PM  
August 6 | 9:00 AM – 12:00 PM

*Option 4 – 2 Day Course*

August 5 | 1:00 PM – 4:00 PM  
August 6 | 1:00 PM – 4:00 PM

*Option 5 – 2 Day Course*

August 12 | 9:00 AM – 12:00 PM  
August 13 | 9:00 AM – 12:00 PM

*Option 6 – 2 Day Course*

August 12 | 1:00 PM – 4:00 PM  
August 13 | 1:00 PM – 4:00 PM

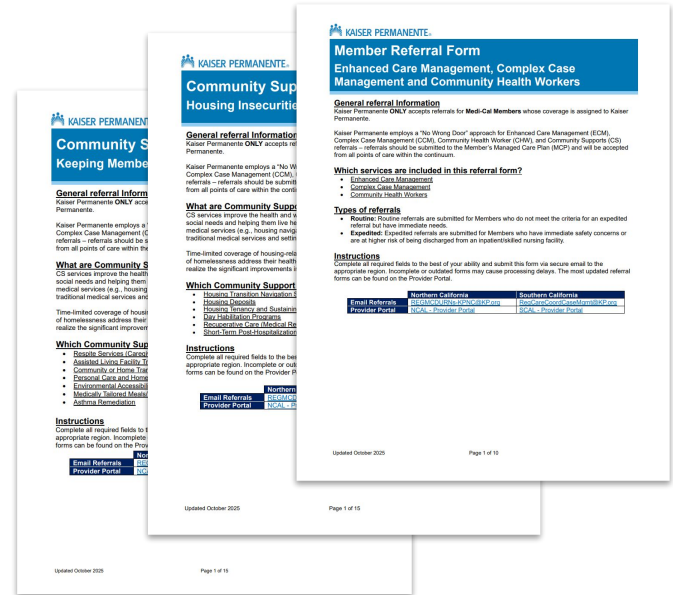
*This training is offered in partnership with and funded by Health Net Community Solutions, Blue Cross of California Partnership, Molina Healthcare of California, and Kaiser Permanente.*



# REMINDER: Kaiser Permanente Referral Forms

Kaiser Permanente has CalAIM referral forms. These referral forms aim to improve successful linkages and enhance information collected, thereby reducing authorization delays.

1. [Enhanced Care Management, Complex Care Management \(CCM\), California Integrated Care Management \(CICM\), and Community Health Workers Referral Form](#)
2. [Community Supports – Referral Form Housing Insecurities](#)
3. [Community Supports – Referral Form Keeping Members at the Home and Chronic Conditions](#)






More information available at [Provider Information](#) | [Community Provider Portal](#) | [Kaiser Permanente](#)

# Submitting Referrals | ECM, CS, and CHW

Kaiser Permanente (KP) has a no-wrong-door approach to referrals.

- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
- Referrals may be placed via email, via phone, or through KP Health Connect.
- Referrals are reviewed within 5 business days to determine if the Member is eligible.

|  <b>AREA</b>                     | <b>NORTHERN CALIFORNIA COUNTIES</b>  | <b>SOUTHERN CALIFORNIA COUNTIES</b>  |
|---|--|--|
|  <b>PHONE</b><br>(Member)        | 1-833-721-6012 (TTY 711)<br>Monday-Friday (closed major holidays)<br>8:30 a.m. to 5:00 p.m.  | 1-866-551-9619 (TTY 711)<br>Monday-Friday (closed major holidays)<br>8:30 a.m. to 5:00 p.m.  |
|  <b>EMAIL</b><br>(Counties/CBOs) | Send completed <a href="#">referral form</a> to <a href="mailto:REGMCDURNS-KPNC@kp.org">REGMCDURNS-KPNC@kp.org</a><br><br>Subject line: “ECM Referral” or “CS Referral” or “CHW services request”<br><br>All Enhanced Care Management, Community Support and Community Health Worker referral forms can be located at <a href="#">Provider Information   Community Provider Portal   Kaiser Permanente</a> . | Send completed <a href="#">referral form</a> to <a href="mailto:RegCareCoordCaseMgmt@kp.org">RegCareCoordCaseMgmt@kp.org</a><br><br>Subject line: “ECM Referral” or “CS Referral” or “CHW services request”<br><br>All Enhanced Care Management, Community Support and Community Health Worker referral forms can be located at <a href="#">Medi-Cal provider portal   Kaiser Permanente</a> . |

**For contracted providers/organizations submitting referrals to your own ECM/CS/CHW organization, please send the referral form directly to your contracted Network Lead Entity.**

# Gold Coast Health Plan

# CenCal Health Plan

# Policy Updates, Announcements, and Closing



# Key Changes to Medi-Cal Under H.R. 1

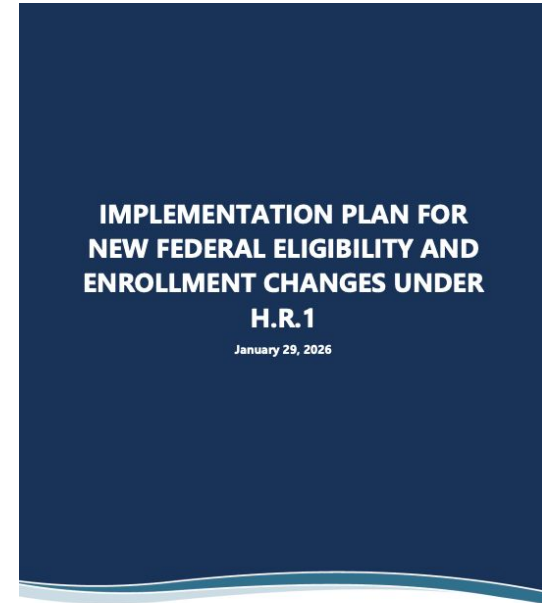
| Key Change                             | Effective Date  | Affected Population(s)   |
|--|-----------------|--|
| Immigrant Eligibility                  | October 1, 2026 | Numerous groups of immigrants including refugees and asylees (no longer eligible for federal funds and will move to restricted scope Medi-Cal) |
| Community engagement/Work requirements | January 1, 2027 | New Adult Group, ages 19 to 64 (with numerous exemptions)  |
| 6 month renewals                       | January 1, 2027 | New Adult Group, ages 19 to 64 (with some exemptions)  |



# Preparing for H.R. 1 Implementation

In January 2026, the Department of Health Care Services released an implementation plan outlining their strategy to address H.R. 1 impacts on Medi-Cal, including:

- Work and Community Engagement Requirements
- Six-Month Renewals
- Immigrant Coverage Changes



# DHCS Guiding Principles for H.R. 1 Implementation



***Automate*** to protect coverage



***Communicate*** with clarity and connection



***Simplify*** the renewal experience



***Educate and train*** those who serve Medi-Cal members



***Provide*** timely and transparent communication

# Coverage Ambassador Webinar

## Get and Keep Your Community Covered

Wednesday, May 27, 2026

11 a.m. to 12 p.m PDT

[Advance registration required](#)

### The webinar will:

- Provide an overview of the DHCS Coverage Ambassador Program, which supports Medi-Cal members in maintaining coverage and connecting to available services and resources.
- Review the [Birthing Care Pathway](#), which is designed to address physical, behavioral, and health-related social needs of pregnant and postpartum Medi-Cal members.

# CBO Readiness Assessment Opportunity



Pear Suite

Solutions ▾

Network ▾

About ▾

COMMUNITY BASED ORGANIZATION RESOURCES

## Assessment

Pear Suite and the California Health Care Foundation (CHCF) are working together to help Community-Based Organizations (CBOs) like yours. We have released a new CBO Readiness Assessment. This tool helps your team see what they need to better support the delivery of high quality, efficient and effective services to people enrolled in Medicaid in your community.

If you have not completed the CBO Assessment, please click on the button below to learn more!

CBO Readiness Assessment

Take the **Pear Suite and California Health Care Foundation (CHCF) [CBO Readiness Assessment](#)** to gauge your organization's readiness across **technology, operations, and workforce.**

Then explore **Pear Suite's** repository of [Free Resources](#) for tools to strengthen **leadership engagement, strategic planning, and Community Health Worker integration.**



# DHCS PATH Collaborative Survey

# DHCS requests your feedback

This statewide PATH Collaborative survey measures:

- The impact of participation in the collaborative
- The value of partnerships across organizations
- The sustainability of our progress



**Thank you for joining  
and see you next month  
on June 17!**

Questions? Please email [pathinfo@bluepathhealth.com](mailto:pathinfo@bluepathhealth.com).