KERN HEALTH SYSTEMS

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POLICY AND PROCEDURES

SUBJECT: Long-Term Care Transitions				POLICY #: 3.84-P	
DEPARTMENT: Utilization Management					
Effective Date: 11/2022	Review/Revised Date: 9/27/2023	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Compliance and Fraud Prevention Officer

_____ Date _____
Senior Director of Provider Network

_____ Date _____
Director of Utilization Management

_____ Date _____
Director of Population Health Management

_____ Date _____
Director of Enhanced Care Management

_____ Date _____
Director of Community Supports Services

PURPOSE:

To outline Kern Health System's (KHS) process in assisting LTC members with care transitions and coordination of care when they no longer require LTC benefits, their Medi-Cal coverage is scheduled to end or transition to another health plan, or there is a change in their condition requiring an alternate level of care such as acute hospitalization, hospice, community placement, and nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so etc.

POLICY:

Kern Health Systems shall promote a system that is both sustainable and person and family-centered by providing eligible beneficiaries with timely access to appropriate, coordinated health care services and community resources that enable them to attain or maintain personal health and well-being.

KHS will act to ensure continuity of care, despite discontinuation of benefits or disenrollment from continued coverage of LTC members. Care coordination and transitions will be arranged to ensure the member receives continuum of care to ensure there is no disruption in their treatment and as appropriate provide other supports to sustain them when transitioning to the community or an alternate setting. Discontinuing an active course of treatment resulting from the exhaustion or termination of a benefit or health coverage or alternate placement could cause a recurrence or worsening of the member's condition under treatment and interfere with anticipated outcomes.

KHS will provide care coordination and transitional services to ensure that all medically necessary and community covered benefits and wrap around services are provided to LTC members undergoing a transition in a manner that is sensitive to the beneficiary's functional and cognitive needs, language, and culture, and allows for the involvement of the beneficiary and caregivers (as permitted by the beneficiary).

DEFINITIONS:

Skilled Nursing Facility (SNF)	A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians. A SNF is a licensed facility with the staff and equipment to provide nursing care and/or rehabilitative services at different levels as needed. The levels of care can vary, but usually include Subacute Care, Skilled Care and Long-Term Care.
Long Term Care	Long-Term Care, also known as extended care or custodial care, and is recommended for patients who require longer stays when their care needs are no longer able to be met at a lower level of care. Patients with a chronic disease or debilitating medical condition such as Alzheimer's, heart disease, or stroke may require ongoing long-term care to improve their quality of life. This type of care provides patients with 24-hour care designed to support individual medical needs and may include a combination of a

	customized diet, restorative exercise, and assistance with daily activities. Long Term Care is: The member has been reviewed, assessed, and determined that discharge potential is not possible, and placement is assumed for care in a facility for longer than the month of admission plus one month.
Short Term Skilled Care	Short-Term Care, also known as skilled nursing or post-acute rehabilitation, is provided for patients recovering from a surgery, illness, or other type of injury that is expected to improve over a short period of time. Typically, patients only spend about 25-30 days in a short-term care center with the intention of successfully transitioning from hospital to home with the tools necessary for each phase of recovery. Short-term care is tailored to each patient's individual rehabilitation needs and may involve a range of services including speech, physical or occupational therapy. The goal for this level of care is to provide patients with the rehabilitation care they need to be able to return home to their active and independent lifestyle.
Enhanced Care Management DHCS Definition	ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of Members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems.
Community Supports DHCS Definition	Community Supports are medically appropriate and cost-effective alternatives to services covered under the State Plan. Federal regulation allows states permit Medicaid managed care organizations to offer Community Supports as an option to Members. Community Supports can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.
Community Support Services	• Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Short-Term Post-Hospitalization Housing • Recuperative Care (Medical Respite) • Respite Services • Day Habilitation Programs • Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF)

	• Community Transition Services/Nursing Facility Transition to a Home Personal Care and Homemaker Services • Environmental Accessibility Adaptations (Home Modifications) • Medically-Supportive -Food/Meals/Medically Tailored Meals • Sobering Centers • Asthma Remediation
Minimum Data Set (MDS)	The MDS is a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status. It is commonly used in long-term care facilities and outpatient and home-based social service programs for older adults.
Plan Of Care	1. Individual written plan of care in each patient's medical record. Institutional providers such as Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) must include a written plan of care individual written plans are required by CFR Title 42 , Chapter IV , Subchapter G , Part 483 to be approved and signed by a physician. Plans should include: A. Diagnosis, symptoms, complaints, and complications, B. Description of individual's functional level, C. Objectives D. Orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures, E. Plans for continuing care, and F. Plans for discharge.
Transitional Care Services (TCS)	Transitional Care Services ensures all high risk members are assigned a care manager that assist in timely transitions to and from SNF to prevent delays or interruptions of any medically necessary services or care, and all required transitional activities are completed.

PROCEDURE:

KHS focuses on improving coordination of care through identified points of contact. It ensures that a member's information is maintained, and care is accessible, continuous, comprehensive, and culturally competent. The KHS LTC Staff to include RN Case Manager, Care Coordinator, Social Worker, and as applicable, the member's assigned PCP and specialists will collaborate with LTC facility staff, and as appropriate, the assigned Medical Group Case Manager, Enhanced Care Manager (ECM), and other Community Based Service (CBS) providers in coordinating the clinical and social needs of the LTC to ensure safe transition to care continuum.

1. LTC transitioning services shall be initiated when the member meets up to and including, but not limited to the following criteria.
    A. No longer meets LTC facility placement criteria,
    B. The nursing facility is no longer capable of meeting the beneficiary's health care needs,

C. Exhausted 7-day bed-hold,
D. Converted to hospice care,
E. Change in eligibility to another health plan,
F. The beneficiary poses a risk to the health or safety of individuals in the nursing facility,
G. The beneficiary's health has improved sufficiently so that he or she no longer needs nursing facility services,
H. Will be discharged to home with family,
I. Is eligible for ERCF or ARCF waiver,
J. Change in level of care (e.g., Acute, ICF level to or higher SNF level),
K. LTC facility member is residing in, no longer has certification in good standing in congruence with CDPH and DHCS standards and KHS is made aware through notification provisions for LTC facility licensing,
L. The LTC Nursing facility resident is a strong candidate for successful transition back to the community and has a desire to do so.

2. To determine alternate arrangements for a LTC member such as the community or an alternate facility, the care manager shall assess the member's health care needs with the following considerations:
    A. Self-determined directive of the member/care giver for the placement,
    B. Geographical location of placement to maintain members in the community of their choice,
    C. The unique medical and psychosocial needs of the member,
    D. Assessment of community options/settings to safely maintain the member's health and social wellbeing.

3. Assessment of care coordination needs are identified from case manager reports, through the authorization referral process, provider notifications, member inquiries, and/or other processes such as reviewing member eligibility requirements for Linked and Carved-out Services.

4. Benefits coordination may include, but is not limited to the following:
    A. Those specific to the Member's Evidence of Coverage
    B. Physical or occupational therapy
    C. Behavioral Health Services
    D. Durable Medical Equipment
    E. Home Health
    F. Acute Rehabilitation Services
    G. MLTSS Services,
        a. CBAS, MSSP, IHSS
    H. Community Based Services

5. Care Management will discuss and educate patients on alternative care and resources available.

6. The Care Manager will request the help of LTC Social Services to assist as needed.
    A. The LTC Social Worker maintains a current list of community agencies and resources to help beneficiaries. Examples of resources include, 2.1.1 Kern County, Rainbow Directory of resources, CalAIM participating ECMs and CBS Providers by
        a. Agency type,
        b. Geographical location,
        c. Cultural and linguistic capabilities.

7. Coordination of data sharing amongst KHS and receiving providers will be performed ***as appropriate:***
    A. Durable Power of Attorney (DPOA) as applicable:
    B. TAR authorizations as necessary to support arranged services i.e., Home Health, DME, etc.,
    C. Medication list,
    D. Specialty care contact list,
    E. PCP contact information,
    F. LTC Minimum DATA SET Assessment,
    G. Most recent history and physical or physician's progress notes,
    H. Social Service and Care Management assessments and notes,
    I. Interdisciplinary care plan,
    J. Known community service and ECM contacts,
    K. KHS LTC team staff contact information to assist with questions and inquiries.

REFERENCES:

Revision 2023-08: Reviewed by UM Management, added additional Transitional Care services definition.
Revision: 2022-11: Policy developed for APL 22-018, LTC 9; DHCS approval issued on 1/15/2023.