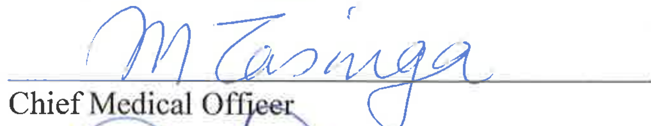
KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Care Coordination				POLICY #: 18.05-P	
DEPARTMENT: Health Homes					
Effective Date: 08/13/2019	Review/Revised Date:	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer
Date 8/13/19


Chief Medical Officer
Date 8/12/19

Chief Operating Officer
Date 8/8/19

Senior Director of Health Services
Date 8/7/19

Administrative Director Health Homes Program
Date 8/5/19

PURPOSE:
To establish a policy guideline to ensure that coordination occurs (a) at the system-level between Kern Health Systems (KHS), contracted CB-CMEs, and other participating providers contributing to the management of health Homes Members (HHMs).

POLICY:
1. KHS shall ensure care coordination of services provided to HHP members through effective communication between KHS, the CB-CME's and other CBO providing care to HHP members. The CBO include but are not limited to
    a. BH providers (KHBRS)
    b. CCS
    c. CBAS
    d. MSSP
    e. IHSS

f. Targeted case management entities
g. County housing services occurs between the Plan, the CB-CME systems and other support systems to include behavioral health, long term support services, community-based providers, targeted case management entities and other support systems. Service coordination shall occur to meet the identified needs of the individual, ensure implementation of the plan of services, and to avoid unnecessary duplication of services.

PROCEDURE:

1. Service coordination shall occur to meet the identified needs of the member and ensure implementation of the goals of the HAP.

2. Care coordination activities will include but not be limited to:

   a. Establishing accountability and agreeing on responsibility.
   b. Communicating/sharing knowledge.
   c. Helping with transitions of care.
   d. Assessing patient needs and goals.
   e. Creating a proactive care plan.
   f. Monitoring and follow-up, including responding to changes in HHMs needs.
   g. Supporting HHMs self-management goals.
   h. Linking to community resources.
   i. Working to align resources with member's individual needs as indicated in the members HAP.

3. The primary responsibility for care coordination is that of the CB-CME team and the member assigned care coordination are responsible for care coordination. Care Coordination will include communication between designated professionals involved in specialty care and the interdisciplinary care team members.

4. Key functions of care coordination include:
   - Outreach and engage eligible members in the HHP
   - Ensuring continuity of care as appropriate to prevent any disruption of HHMs services and care
   - Following up on Member referrals;
   - Identifying the needs for LTSS services, appropriate community-based resources such as housing/utilities, meals etc.;
   - Identifying the need for behavioral health services;
   - Communication with county mental health clinics to discuss diagnoses (medical, behavioral, and social needs);
   - Coordinate other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.;
   - Coordination between designated professionals involved in specialty care, such as between a psychiatrist and a primary care physician and other inter-disciplinary team members.
   - Coordination of Services (Appointments, Referrals, DME, food banks, homeless shelters, etc.);
   - Referral to and collaboration with county/ community agencies to provide support such as substance abuse programs, housing, counseling;
   - Assisting with the coordination of care across all settings;
   - And reduce duplication of efforts

- Ensure non duplication of services

5. Documentation of outreach attempts must include:
   - Name of the agency and key designee contacted
   - Date and time of the outreach attempt;
   - The method of the outreach attempt (phone, email, fax, in-person); and
   - The outcome of the outreach attempt.
   - A brief review of communication that transpired to discuss the Member's needs and services.

6. The CB-CME care coordination efforts are supported by a variety of evidence-based Techniques and interventions which include but not limited to:
   - Trauma informed care management
   - Motivational Interviewing and principles
   - The use of member engagement techniques by which the team is able to assist the member in enhancing his or her autonomy and collaboration within his or her care team
   - Providing emotional support/ active listening,
   - Utilizing culturally sensitive conducts.
   - Review of disease signs/ symptoms
   - Teach-back techniques

7. Other care coordination activities include but are not limited to:
   - Scheduling and arranging appointments, referrals, DME, etc.)
   - Performing Medication Reconciliation
   - Referring to health education services
   - Referring to disease management
   - Scheduling and coordination of transportation

8. Care coordination interventions should be planned and based on the member's level of risk-tier assignment and tailored in response to the member's assessed needs and stated goals.

9. All care coordination activities are documented and stored securely in the B-CME electronic medical record which is assessable to the ICT team members.

10. HHMs who experience a change in condition where their needs cannot be met by Case Management will be evaluated for discharge from the Program.
    a. Instances, by which cases may be closed to care coordination for reasons other than completion of the ICP or goals of care coordination, may include:
       - Member is no longer responsive to outreach efforts after 45 calendar days and multiple attempts
       - Care coordination staff, ICT and CB-CME leadership agree that member is uncooperative as evidenced by not demonstrating consistent adherence to the care plan.
       - Member is obtaining case management services through another agency that duplicate the services offered.
       - Nursing Facility Residents
       - Hospice Recipients

- Members with Targeted Case Management TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or Aids Health Foundation (AHF)
- Members in Cal MediConnect.
- Continued inappropriate (derogatory, profane, abusive) behaviors towards the care coordination team with no improvement after documented discussions regarding the need for behavioral change.
- Cases closed to care coordination may be re-evaluated if the member's condition, or desire to participate, changes.

References:

- APL 18-012 Health Home Program Requirements
- California Department of Health Care Services Medi-Cal Health Home Program Guide; http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram
- Contracts with CB-CME
- 18.03-I Assignment of Care Coordination Risk Level

Revision 2019-07: Policy created to comply with the Medi-Cal Health Home Program Guide. Previously approved by DHCS.