KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Kern Health System Health Home Program Infrastructure				POLICY #: 18.13-P	
DEPARTMENT: Health Homes					
Effective Date: 05/08/2020	Review/Revised Date:	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Douglas A. Hayward
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Claims

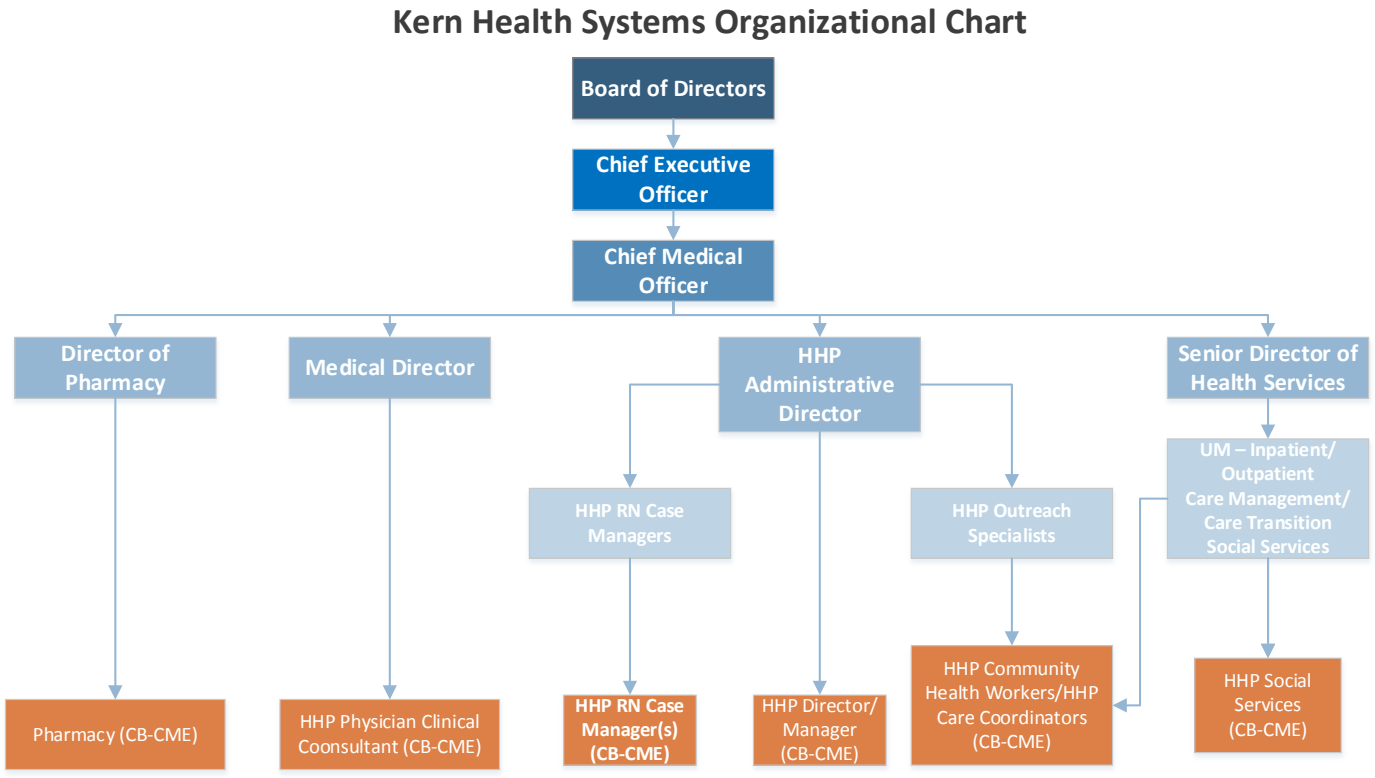
_____ Date _____
Chief Network Administration Officer

_____ Date _____
Administrative Director of Health Homes Program

Policy:
To describe Kern Health Systems (KHS) Health Homes Programs (HHP)/ Community Based Care Management Entities (CB-CME) infrastructure in regards to Models for HHP, Staffing, and data exchange outlined in the Department of Health Care Services (DHCS) Program guide.

Organizational Model:

KHS's HHP will deliver a comprehensive system of care by integrating and coordinating all primary, acute, behavioral health (including mental health and substance use) and long term services and supports for individuals with chronic medical conditions. KHS will support both Model 1 and Model 2. KHS is also contracted with a vertically integrated health care system (Kaiser) for providing of all health care services for KHS assigned members. Kaiser has a service agreement with KHS to provide Medi-Cal services to all KHS members assigned to Kaiser. KHS members assigned to Kaiser are former Healthy Family's Program members, who were transitioned to Medi-Cal, in compliance with Assembly Bill (AB) 1494 (2012) (Transition). Kaiser membership accounts for 3% of all KHS membership. Health Home Program services will be provided to HHP eligible KHS members who are assigned to Kaiser. These services will be provided in compliance with State HHP requirements and Kaiser Foundation Health Plan/KHS medical services agreement. KHS fully delegates the provision of services to Kaiser. In implementing the Health Home Program, Kaiser will provide HHP defined services to KHS HHP eligible members in compliance with KHS delegation agreement and state requirements for the HHP. KHS will receive the Target Engagement List (TEL) for the State. KHS will analyze the list and identify eligible members assigned to Kaiser. The lists of assigned members will be securely transfer to Kaiser. The transfer of information will be in compliance with all state and federal requirements. KHS will monitor provision of HHP services incompliance with the delegation agreement between Kaiser and KHS.



Procedure:

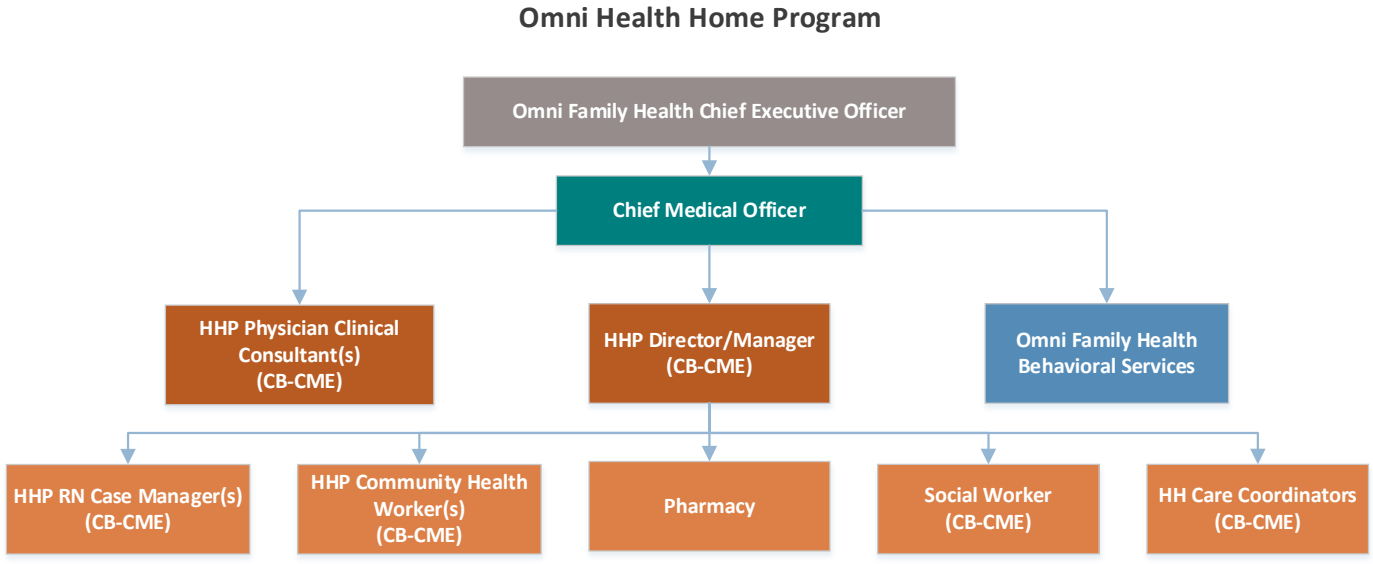
Model 1

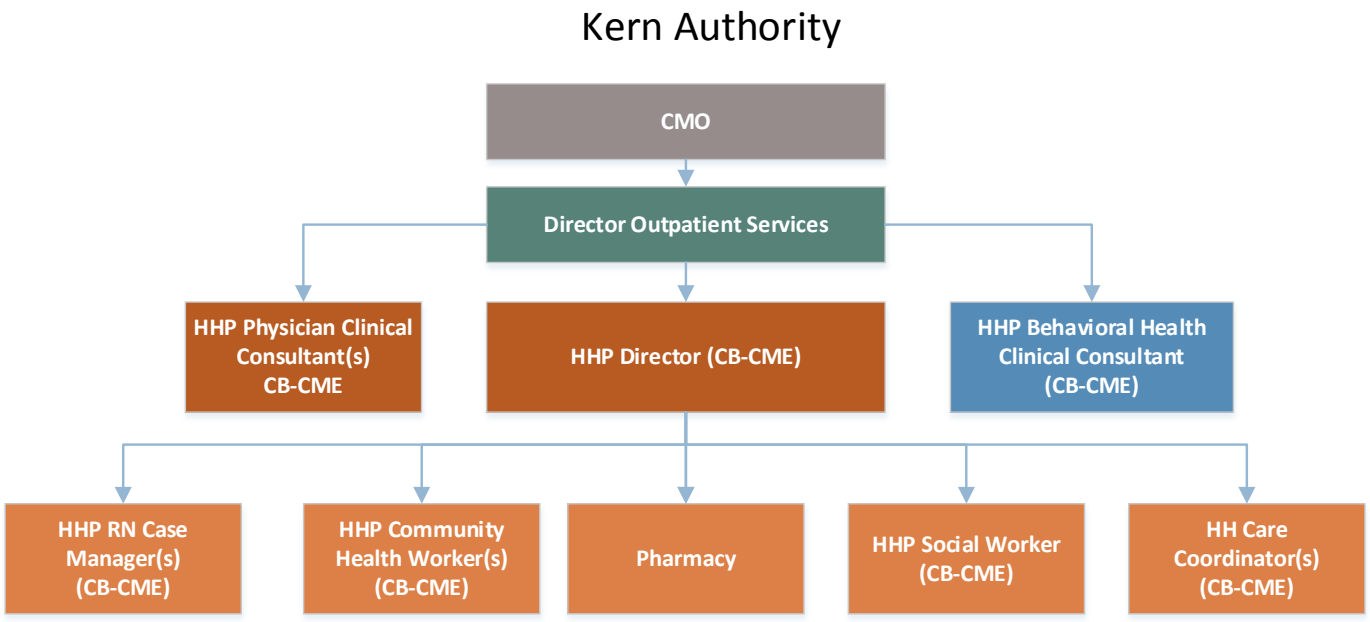
KHS is contracted with 2 Federally Qualified Health Center (FQHC)'s (OMNI and Clinica Sierra Vista (CSV)) and a safety net provider organization (Kern Authority). These 3 organizations are assigned approx. 50% of KHS membership. The remaining KHS members (excluding Kaiser) are assigned to individual or group primary contracted physicians in Kern County. FQHC's and Private sector providers have infrastructure, experience, and expertise in the management of patients with chronic conditions.

In 2016 KHS grant funded the provision of HHP like services to potential HHP eligible member. In this grant program KHS worked collaboratively with these 3 organizations to develop and implement policies and procedures and Information Technology (IT) structure to ensure the provision of core measures in a patient centered model.

In implementing the State HHP KHS has included these three organizations as community based CB-CME's. The CB-CME's will hire required staff and KHS will evaluate their ability to perform all HHP services and augment to meet state requirement staffing ratios. KHS will continually monitor the activities performed to ensure compliance with the state program.

This model will serve the greatest majority of KHS members who will be identified from KHS currently assigned members. KHS will identify HHP eligible members from members already assigned to these three organizations.





Model 2

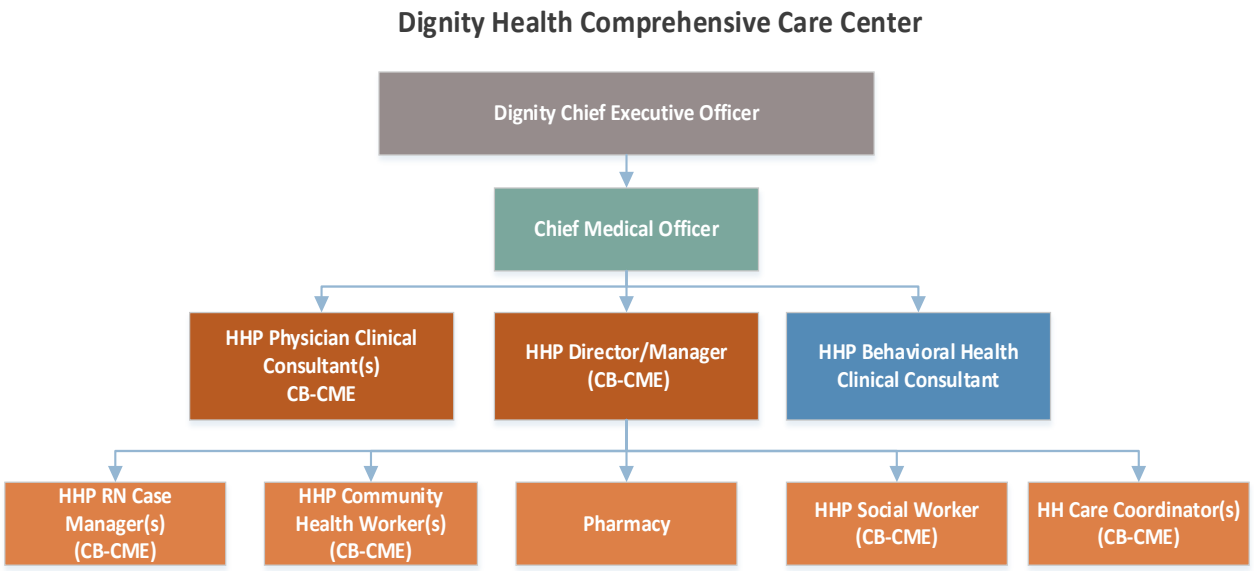
Model 2 will take care of HHP eligible members who are not assigned to the safety net or FQHC's organizations.

The members in Model 2 are currently assigned to individual providers in the county who do not have the infrastructure to provide member centered team based care coordination. KHS has partnered with 2 providers: Dignity Health and Premier Medical Group.

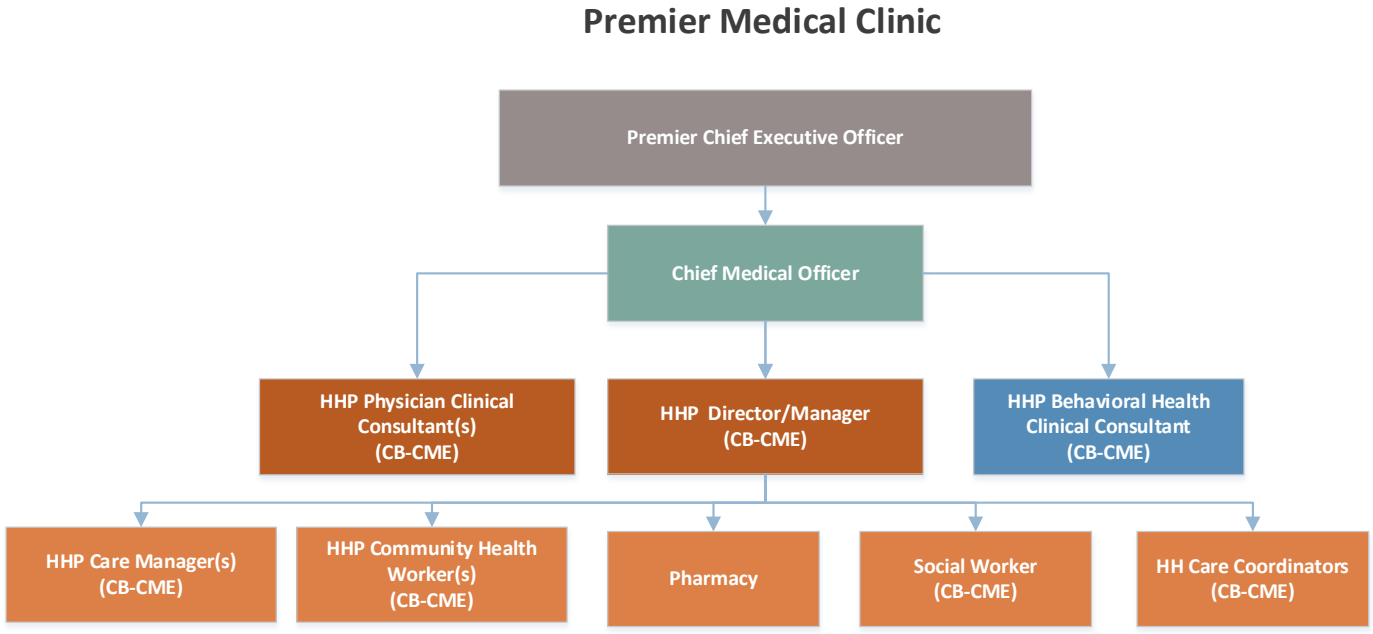
1) Dignity has experience in providing HHP services to Medicare members in Kern County. Through data analysis and geo mapping, KHS identified Dignity Health Comprehensive Care Center (CCC) as a location that is suitable to serve KHS HHP members assigned to low volume providers (Central Bakersfield). Through KHS grant program, Dignity is currently providing HHP services to 600 HHP eligible members. KHS has worked collaboratively with Dignity to develop and implement policies and procedures to ensure the 6 core elements required for an HHP program are provided.

   The team resides within the center. The interdisciplinary team includes a HHP Physician Clinical Consultant, HHP Director, HHP Behavioral Health Clinical Consultant, HHP Registered Nurse N) Case Managers, HHP Community Health Workers, Pharmacy, HHP Social Worker, and HHP Care

Coordinators.



2) Premier Group is a group of Primary and specialty physicians who currently provide services to KHS membership. Through data analysis and geo mapping, KHS identified Premier Clinic as a location that is suitable to serve KHS HHP members assigned to low volume providers in that geographical area. (Southwest area of Kern County). Through KHS grant program, Premier is currently providing HHP services to 200 HHP eligible members. KHS has worked collaboratively with Premier to develop and implement policies and procedures to ensure the 6 core elements required for an HHP program are provided.



Both care team resides within the center. The interdisciplinary team includes a HHP Physician Clinical Consultant, HHP Director/Manager, HHP Behavioral Health Clinical Consultant, HHP Registered Nurse (RN) Case Managers, HHP Community Health Workers, Pharmacy, HHP Social Worker, and HHP Care Coordinators. KHS plans to develop and implement other models to expand the network of providers during the course of the Health Home Program.

In the process of the grant program, sites had to submit details of the CB-CME Model 1 and 2 network assessment and readiness process. Please see the Provider Health Homes Readiness section of this document. KHS will work with all sites to make sure they are compliant with the state program.

The CB-CME sties will be responsible for services outlined in the HHP delegation standards and agreement. Services not described in this document will be management in compliance with KHS Utilization Management (UM) program policies and procedures.

Model 1 CB-CME and Model 2 Clinics – UM

KHS currently does not delegate UM activities to contracted HHP CB-CMEs, individual provider clinics, or FQHC Centers. These functions are fully retained by KHS. UM functions are performed by designated KHS UM staff and overseen by qualified health professionals. Therefore KHS will support care coordination service referral activities and care delivery outcomes and monitoring activities for specialty, ancillary and institutional care.

KHS UM Program elements and processes are structured in compliance with Local Initiative Health Plan State of California Department of Health Services Contract requirements and in accordance with California Code of Regulations Title 22-For Medi-Cal Members (Title 22). KHS UM functions are designed to be comprehensive-integrated processes that actively evaluate and manage utilization of health care resources delivered to all members. The delivery system is intended to assure that:

- Trauma informed care approach
- Members receive the appropriate quantity and quality of healthcare service,
- Service is delivered at the appropriate time,
- The setting in which the service is delivered is consistent with the medical care needs of the individual.

KHS UM activities are continuously monitored through systematized methodologies to provide reliable mechanisms to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues. Information captured through these processes is presented to the Utilization Management Committee (UMC) for evaluation and suggestions. The UMC has historically included contracted network providers representing primary care and high volume specialists. Provider input to medical policy is welcomed and encouraged by KHS. This tradition will continue with an emphasis on including contracted HHP CB-CME and clinic site providers to attend and provide insight and strategic development of best practices in providing services to HHMs

The scope of covered services and activities defined by the UM Program includes:

➢ Prior authorizations/referral management ➢ Primary and Specialty Care ➢ Tertiary referral coordination ➢ Behavioral/Mental Health management ➢ Autism Spectrum Disorder Management ➢ Concurrent review ➢ Retrospective review ➢ Continuity of Care ➢ Recommendations for policy decisions ➢ Guidance of studies and improvement activities ➢ Complex/Targeted Case management Coordination ➢ Medication Therapy Management ➢ Transitional Care ➢ Community Based Adult Services ➢ Respite Care (*KHS Board approved benefit enhancement*) ➢ Pulmonary Rehabilitation(*KHS Board approved benefit enhancement*) ➢ Maternity Care ➢ Gender Dysphoria ➢ Acupuncture ➢ Chiropractic ➢ Utilization data management	➢ Genetics ➢ Major Organ Transplants (kidney, cornea) ➢ Discharge planning/Rehabilitation Services ➢ Prescription Drug Program in coordination with the Director of Pharmacy ➢ Out-of-area Case management ➢ Emergency service management ➢ Emergent/Non-emergent Medical Transportation ➢ Ancillary service management ➢ Home Health ➢ Cardiac Rehabilitation ➢ Hospice Services ➢ Palliative Care ➢ Diagnostic Services; including laboratory, radiology, and genetic counseling ➢ Inpatient certification ➢ Skilled Nursing and Long Term Care ➢ Denial/appeals management ➢ Social Services (i.e. tracking of appropriate usage of services, mental health service assistance, social services assistance ➢ After Hours Nurse Triage Services ➢ Recommendations for any additional needed actions

KHS utilizes qualified licensed nursing staff, support coordinators and administrative staff to perform a wide range of case management activities. KHS has robust technologies and software programs to maintain veracity of case management documented functions. KHS case managers have historically worked with KHS contracted provider groups and clinic sites to assist in managing complex members and coordinating care transition processes to ensure safe and smooth care transitions from institutional settings in order to prevent unnecessary readmissions and emergency department encounters. These transitions include the sharing of vertical data information amongst KHS contracted providers. KHS will continue to support HHP contracted CB-CMEs and clinic sites with the aforementioned traditional case management interventions and utilize expanded strategies and resources for Health Homes Member (HHMs) in congruence with DHCS specifications and Triple AIM goals.

These services will be provided by coordination of the different staff to ensure compliance with care coordination ratio requirements for the HHP.

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population. To develop the aggregate population care coordinator ratio requirement, DHCS assumed that after two years:

- Tier 1 – 20% of population; care coordinator ratio of 10:1
- Tier 2 – 30% of population; care coordinator ratio of 75:1
- Tier 3 – 50% of population; care coordinator ratio of 200:1

B. STAFFING, ROLES AND RESPONSIBILITIES

KHS defines the constitution of the interdisciplinary team to be hired by the CB-CME and trained in collaboration with KHS to provide services in compliance with State HHP description. Each site will have an interdisciplinary team which includes: a provider, Nurse Practitioner (NP), Nurse case manager, care coordinator, support staff.

KHS will maintain case managers and care coordination staff to support in care transitions, inpatient management and specialty care management. KHS has medical directors available to CB-CME for referral and coordination of services provided by other Community Based Organization (CBO) contracted with KHS.

In addition to the interdisciplinary team, the sites will hire enough staff to support the Interdisciplinary Care Team (ICT) in provision of services in compliance with the State guidelines. Number of number and type administrative staff will be dependent on number of membership assigned.

Composition of the ICT:

Clinical Physician Consultant primary care physician or specialist physician *Primary Care Medical Doctor (MD) who has experience with chronic conditions hired by the site and credentialed by KHS.*

HHP Physician Clinical Consultant:

Serves in a leadership capacity promoting and implementing the health home and medical home model by:

- Participates in health home planning meetings and activities
- Participates in development and maintenance of health home program structure and policies Promotes health/medical home transformation to all physicians
- Works with physicians to facilitate best practices and strategies to support health home/medical home model
- Review data showing results of health home implementation

HHP Director at the CB-CME:

Serves as a key member and leader of the HHP Team at the CB-CME. This position is requires collaboration with the health care team members, patients, families and caregivers to ensure safe, appropriate, comprehensive planning and delivery of care. The HHP Program Director is responsible for management of operations of the care team. The HHP Program Director has responsibility for quality measures and reporting them to the CB-CME and the Managed Medi-Cal plan. This position assists in development and implementation of policies and procedures, assists in marketing the program to stakeholders and services as an ambassador for Patient Centered Care. This position provides leadership on the ensuring the culture is informed and engaged.

HHP RN Case Manger(s) (CB-CME)

The Health Homes Program Registered Nurse Case Manager(s) (RNCM) will co-manage cases with the Health Homes Program Care Coordinators (CC) and provide medical case management to HHP members. This position will be based within the CB-CME and/or KHS corporate office but will involve, as needed, time in the community (at clinics and hospitals, with community-based organizations, and home visits). The RNCM

will conduct medical assessments, chronic condition education aimed at self-management, medication reconciliation, as well as provide medical/nursing ongoing consultation to (CC). The RNCM will be responsible for co-managing a range of members in different HHP contracted community based case management entity CB-CME and clinic locations. The RNCM will work closely the multi-disciplinary care team in developing and maintaining the HHM Health Action Plan (HAP). The RNCM will be the formal presenter in the Multi-disciplinary also referred to as Inter-disciplinary Care Team (ICT) meetings in tandem with the member's PCP or designated physician provider and other ICT members. The RNCM will participate in group supervision meetings, consultation with ICT for clinical issues.

Community Health Worker

Community Health Worker (CHWs) will support a client-centered service delivery model and perform tailor service delivery to assist in meeting a full range of needs of each individual person. The CHW will have existing partnerships with community-based organizations and connect people to those services as needed. The CHW will have the ability to assist in coordinating medical and behavioral health care and social services by:

- Engaging Health Home Member trust and collaboration
- Scheduling appointments for support services;
- Preparing HHMs for visits
- Assisting with homeless referrals to KHS
- Escorting HHMs to their appointments
- Serving as advocates for members and are givers.

Pharmacy:

CB-CME's will hire Pharmacists to perform Medication Therapy Management (MTM). Management of a patient's medication is important to the overall health outcome of patients with chronic medical conditions. Pharmacists will conduct MTM with all HHP members to optimize drug therapy and improve therapeutic outcomes for those members. The MTM will be completed within 90 days of enrollment, as needed and annually and can be conducted with the member face to face or telephonically.

Social Worker

Each CB-CME will hire a Social Workers to manage the social needs of the HHP members. KHS also has a team of Social Workers who will support the activities of the CB-CME social workers as needed. The Health Homes Program Social Worker (HHPSW) will help eligible HHMs to manage social, economic, emotional, and behavioral problems. The HHPSW will be a key advocate and team participant in helping HHM individuals and groups overcome difficulties in their daily lives. The HHSW will provide counseling and referral services to help HHM in improving their quality of life by adjusting to significant life changes, such as divorce, job loss, death, illness, addiction, homelessness, and poverty. The HHPSW will provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses. HHPSW services will include advising family care givers, providing patient education and counseling, and making referrals for other services. The HHPSW will work with the HHP RN case manager and assigned HHM Care Coordinator by providing input to the assessment of HHMs and the health action plan (HAP); with a principle focus of assisting in the development of social interventions designed to promote member health,

prevent disease, and address barriers to access related to socio-economic obstacles. The HHPSW will work in tandem with the Community Health Worker to formulate integrated strategic community planning to sustain HHP objectives in coordinating community services and supports to include housing support for the homeless.

Health Homes Care Coordinator

Care coordination will be provided by the care coordinator staff at the CB-CME. The KHS care management teams will support and provide care coordination for services that are the responsibility of the health plan. KHS utilizes CB-CMEs and individual provider clinic sites to fulfill an adequate network of contracted Health Homes Program (HHP) providers to serve HHM's. The Health Home Care Coordinator (HHCC) works with HHMs that have chronic health conditions, which may be compounded by high-risk social needs, and are high users of the healthcare system. Using excellent communication skills, the HHCC will provide services and coordination to HHMs to ensure continuity of care across health and social service programs and community based and Long term-support service programs. This position requires strong interpersonal and organizational skills in order to build rapport with HHMs and to coordinate referrals and care amongst various healthcare providers and community services. Comfort and confidence in addressing medical topics, social issues and in doing community and or home visits is essential.

The HHCC is the dedicated navigator and a central point of contact for HHMs. The HHCC facilitates HHM's engagement to foster a "whole person" approach for Health Homes Program eligible members. This is done by working directly with the member and acting as a liaison in referring and coordinating HHM encounters through a "person centered system of care" by accessing a full array of services to include: primary, specialty, behavioral, long term support, social, substance abuse, homeless and community based.

Housing Navigation

KHS has a contract with Kern County Housing Authority. The Kern County Housing authority is contracted with numerous community based organization in Kern County to provide housing navigations services to the homeless population in Kern County. KHS in its agreement with the Housing Authority will pay for housing navigation services that are provided through the CBOs. KHS SW will work collaboratively with the CBOs to provide housing navigation services for KHS members in the HHP who need these services.

The following housing navigation services include but are not limited to:

- Finding immediate housing in the form of emergency shelters, recuperative care facilities, temporary housing, transitional housing and long term housing.
- Work closely with Homeless Coalition and Housing Authority on HHMs referrals for services
- Individual housing transition transactions to include conducting and screening housing assessments
- Identifies the participant's preferences and barriers related to successful tenancy,
- Collect information on potential housing barriers,
- Developing an individualized housing support plan based upon the housing assessment that:
    - Addresses identified barriers, includes short and long-term measurable goals for each issue
    - Establishes the participant's approach to meeting the goal,
    - Identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

- Assisting with the housing application process.
- Assisting with the housing search process
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses,
- Ensuring that the living environment is safe and ready for move-in.

Clinical Behavioral Health Service

KHS is contractually responsible for the management of members with mild to moderate behavioral problems. KHS contracted network of psychiatrist and other behavioral health providers are available to the CB-CMEs for via telehealth for consultation. KHS has a Memorandum of Understanding (MOU) with Kern Behavioral health and recovery services for management of patients with severe persistent mental illness. The MOU facilitates timely access to services for members with Serious and Persistent Mental Illness (SPMI) to appropriate services

The Clinical Consultant for Behavioral Health (CCBH) will work closely with a multi-disciplinary team in health home model, the behavioral health clinical consultant will lead the provision of integrated behavioral health services at the site and foster strategies to promote information sharing between the County mental health system and HHM providers to integrate medical, social and behavioral care of HHM's in a holistic comprehensive manner. The CCBH will focus on managing a population of patients

The CCBH will support the care team to include but not limited to:

- Support care team in identifying and behaviorally intervening with patients to improve their physical health condition
- Assist with high utilizers
- Behavioral supports to assist individuals in improving health status and managing chronic illnesses
- Assistance with medication adherence, treatment plan adherence, self-management support/goal setting, and facilitate group classes
- Brief interventions for individuals with behavioral health problems (not long term hour long therapy sessions)
- Brief coaching sessions for Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Development and provision of individual and group behavioral health services as an integrated component of the HHP contracted sites.

Support to care coordination provided through KHS:

Medical Directors

- KHS has medical directors available to CB-CME for referral and coordination of services provided by other CBO contracted with KHS.
- KHS will have Medical Directors available as a resource to the CB-CME's and will be instrumental in the medical review for dis-enrolled members from the program with recommendations for continued enrollment or referral to other programs within the health plan

based on the member's needs and compliance.

HHP Administrative Director

- KHS employs a HHP Director who oversees the MCP HHP and provides oversite for the contracted CB-CME's. Serves as a key member and leader of the KHS HHP Team. The HHP Program Director works in collaboration with the CB-CME HHP sites to ensure compliance with the DHCS requirements. The HHP Program Director has responsibility for quality measures and reporting them to the CB-CME and the Managed Medi-Cal plan. This position assists in development and implementation of policies and procedures, assists in marketing the program to stakeholders and services as an ambassador for Patient Centered Care. This position provides leadership on the ensuring the culture is informed and engaged.

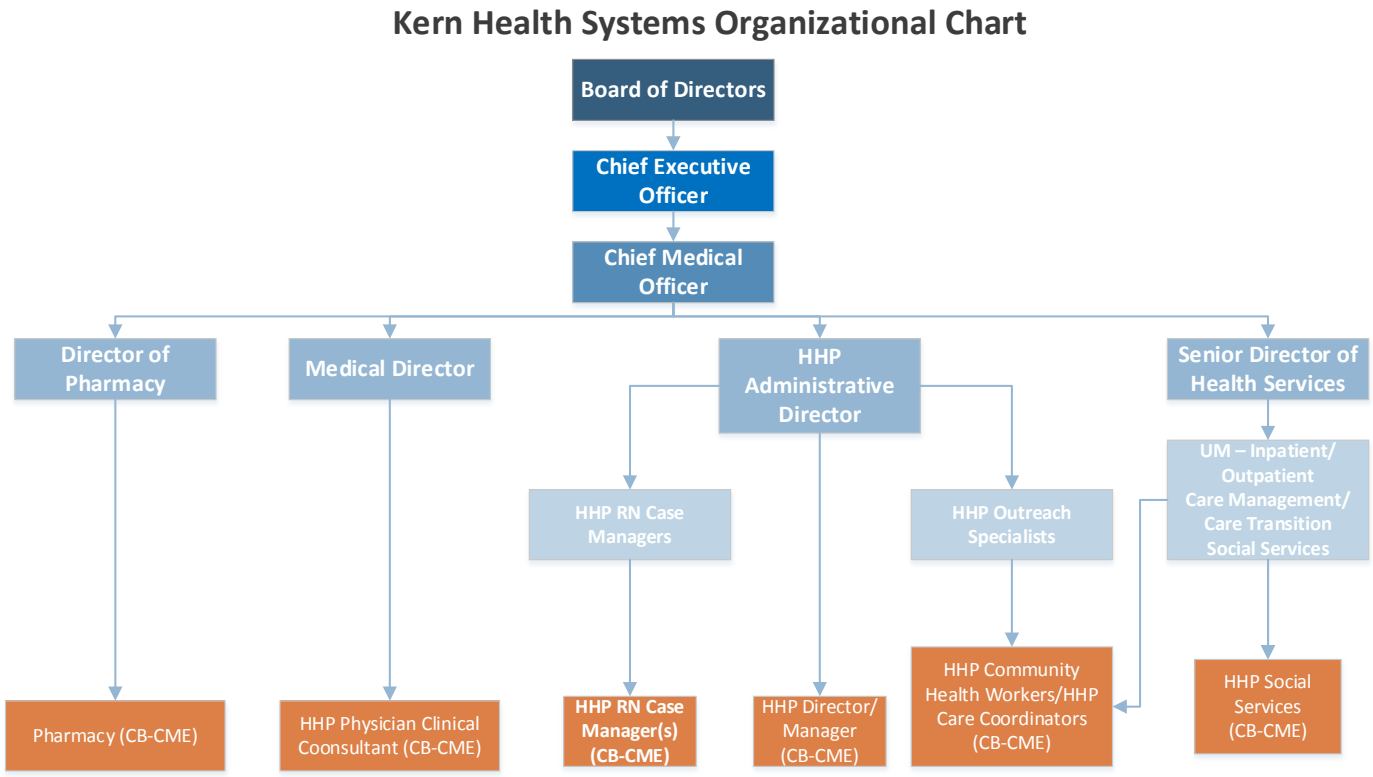
Outreach Specialist (OS) teams

- KHS employs outreach specialists to support the KHS HHP and CB- CME's in their outreach and engagement efforts to eligible members. They provide support and oversight of the outreach processes at the CB-CME's.

HHP RN Case managers

- The HHP Case Manager, RN is responsible for working collaboratively with the CM staff and leadership of assigned HHP sites, providing guidance and support with Certified Case Manager (CCM), specific in the completion, over site and reporting for the programs core measures defined in the State mandated health home program. This collaboration will ensure that each member is receiving all required services for their physical, behavioral and social needs. They will act as a resource and liaison, assisting sites in navigating the healthcare system to facilitate the appropriate delivery of care and services. These services are provided utilizing available resources across a continuum of care and in collaboration with HHP sites, community based services and community providers.

KHS as a Knox Keene licensed Managed Care Plan contracted with DHCS for management of Medi-Cal population in Kern County, also has in place care management programs that will support the care coordination of members enrolled in the KHS HHP.



KHS job descriptions are established and these positions are in place to serve the KHS member population including HHP.

C. TECHNOLOGY

KHS will use technology to ensure timely, accurate, and secure sharing of information with Health Homes Providers to support HHMs care coordination and comply with DHCS Medi-Cal Health Homes Guide requirements. KHS uses secure electronic transfer of electronic medical information to facilitate communications between KHS and CB-CME sites. Data sharing relationships are supported through the use of a KHS standardized data-sharing agreement with CB-CME. The agreements will include specifications to ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other relevant federal and state regulations.

Reporting Guidance for 2019 Core Measures

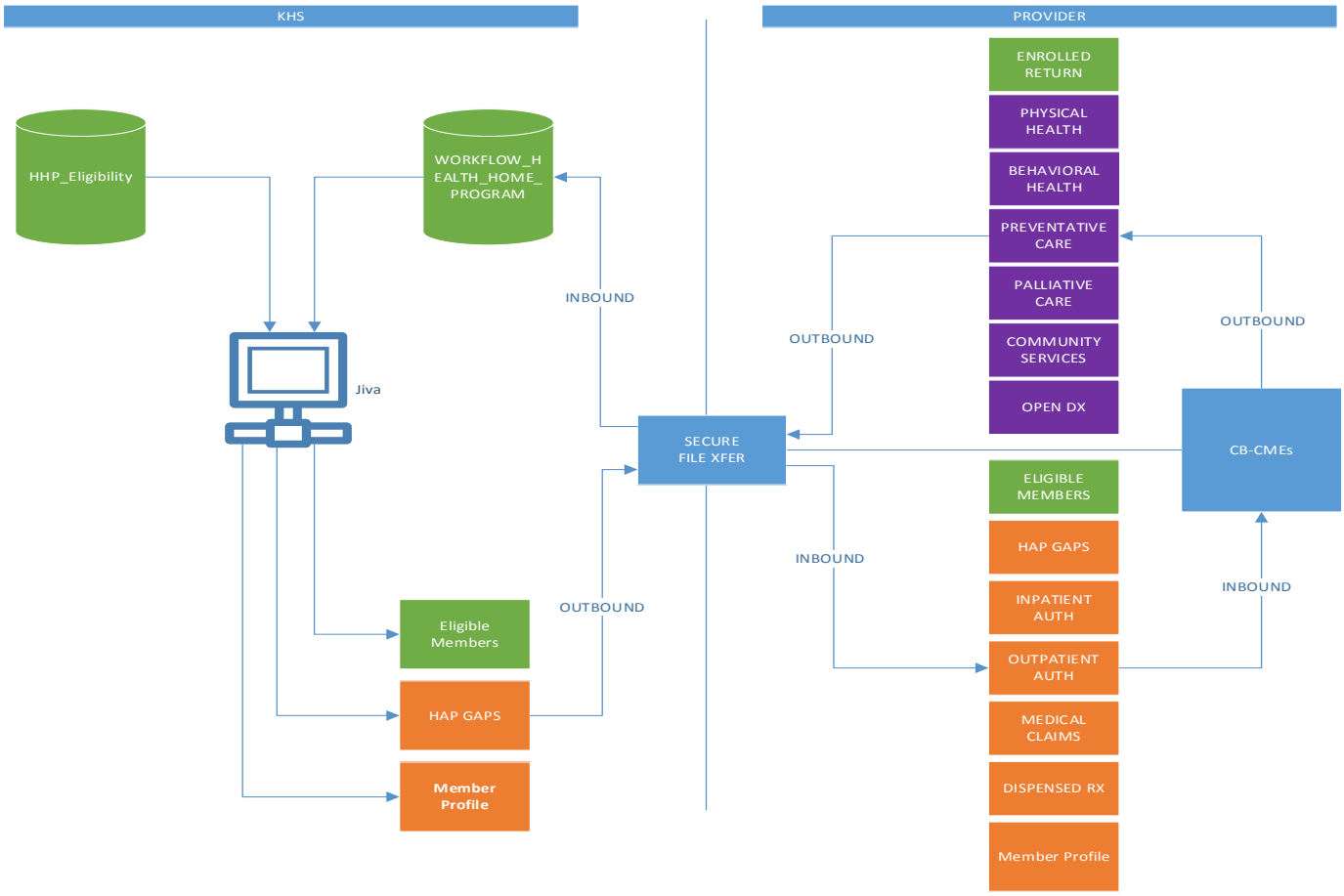
Data Exchange Processes:

Examples of data sharing activities utilized by KHS include but are not limited to:

1. Notify the CB-CMEs of inpatient admissions and Emergency Department (ED) visits/discharges
2. Track and share data with CB-CMEs regarding each member's health history:

3. Track Centers for Medicare & Medicaid Services (CMS)-required quality measures and state-specific measures:
4. Enrollment:
5. Ability to electronically capture and share the patient-centered care plan across care team members.
6. Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
7. Secure electronic messaging between providers and patients to increase access outside of office encounters.

Illustration of KHS DATA Sharing



Resources:

KHS Data Sharing P&P

Kaiser Agreement