KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Integration of Long Term Support Services and Social Support				POLICY #: 18.14-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 Health Homes Program

PURPOSE:

To describe the process of integrating available Long Term Support Services (LTSS) and social supports to support Health Homes Program (HHP) eligible members Health Homes Members (HHMs) through the Medi-Cal Benefit package.

POLICY:
Kern Health Systems (KHS) HHP will use the Care Coordination structure to help members obtain services they are eligible to receive by coordinating benefit coverage with Community Based Organization (CBO) providing LTSS and social supports.

DEFINITIONS:

1. LTSS coverage includes several vehicles and over a continuum of settings, ranging from institutional care of community-based long-term services and supports. These services include Community Based Adult Services (CBAS), Managed Security Service Provider (MSSP), In-Home Supportive Services (IHSS) and long term care.

PROCEDURE:

Long-Term Support Services (LTSS)

1. LTSS for eligible members are identified through multiple avenues. The Community Based Care Management Entities (CB-CME) Care Coordinator and supportive team will refer Health Homes Members that may benefit from these services to KHS designated staff.

2. Member identification includes, but is not limited to, case management daily rounds, case management case review and care planning, primary care physician referral, Interdisciplinary Care Team (ICT) referral, CB-CME Care Coordinator referral, caregiver/member request.

3. The KHS designee will coordinate LTSS services in compliance with KHS State and Federal requirements.

4. The KHS designee will contact the CB-CME care coordination to plan and facilitate activities to assist in qualifying and preparing with assessment processes medical record exchanges and other communications required to admit HHMs to the LTSS program.

5. All LTSS referrals and ongoing communication with the LTSS program will be documented and stored in the electronic member medical record. This information is accessible to all ICT team members.

6. LTSS assessments and care plans performed through the LTSS program will be integrated into the CB-CME members' medical record which is stored in the Electronic Medical Records (EMR) at the CB-CME.

In-Home Supportive Services (IHSS)

1. IHSS include cleaning, cooking, dressing, grooming, bathing and shopping. It is considered an alternative to out-of-home care, such as nursing homes or board-and-care facilities.

2. HHMs who receive IHSS, will be able to select providers-care givers apprised that they can select providers-care givers, and they can hire, fire as desired.
    a. The county IHSS social worker will assess the HHP member's needs and approve IHSS hours. The CB-CME ICT is responsible for the identification of IHSS eligible members. The CB- CME Social Worker is responsible coordination of reassessment of eligibility by IHSS social workers when applicable.

b. The CB-CME social worker is accountable for presenting IHSS eligibility status and hour allocation to the ICT to include, but not limited to coordination required due to change of condition related to inpatient/outpatient events and reassessment status.

Community Based Adult Services (CBAS)

1. CBAS services are provided to older adults, or adults with disabilities, to restore or maintain their capacity for self-care and delay moving into an institutionalized setting. Its services are classified as benefit for adults eligible for Medi-Cal. CB-CBE ICT will identify members eligible for CBAS services. The CB-CME social worker will coordinate the authorization and approval of CBAS services in collaboration with KHS staff and KHS contracted CBAS vendors.

2. CBAS services include:
   - An individual assessment
   - Professional nursing services
   - Physical, occupational and speech therapies
   - Mental health services
   - Therapeutic activities
   - Social services
   - Personal care
   - A meal
   - Nutritional supplements/counseling, and
   - Transportation to and from the participant's residence and the CBAS center.

3. Data collected will be stored in the members EMR record and accessible to all members of the interdisciplinary care team for care planning and care coordination.

Multipurpose Senior Service Programs (MSSP)

(MSSP) is a program that provides social and health care management of frail elderly clients who are certifiable for placement in nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

Members receiving MSSP will be excluded from the State Target Engagement List (TEL) lists per the Department of Health Care Services (DHCS) HHP program guidelines. If a member already receiving MSSP services is referred either by a provider or self-referral and meets state eligibility criteria, would be engaged and given HHP overview and be allowed to choose between the HHP or continue with MSSP services. Per the guidelines the member must choose one or the other programs but cannot participate in both.

Nursing Facility Care

1. KHS designee along with the CB-CME Care Coordinator and supporting team will assist with referral and placement arrangements to coordinate long-term care for people who cannot live independently at home.

2. Health Homes Members that go into this program will be disqualified from continuing in the Health Homes Program based on DHCS Medi-Cal Health Homes Program disenrollment criteria.

3. Data collected and stored in the EMR is accessible to all members of the interdisciplinary care team for care planning and care coordination.

HAP Element Documentation related to LTSS

1. Care coordination activities for LTSS coordination will be fully documented in the HAP to include:
   - Consent from LTSS recipients or their authorized representatives to include LTSS providers in care planning, coordination, and ICT.
   - Such invitation must be documented in the care plan.
   - The Care Coordinator will document the LTSS assessment to reflect the following:
     - The date of referral for LTSS services and when those services are received.
     - The qualifying factor for member referral
     - If applicable the member CBAS transportation time between home and CBAS center.
     - If applicable the IHSS contact social worker and provider care giver (based on members consent).
   - LTSS providers will be invited to participate in HHMs ICT

References:

California Code, Welfare and Institutions Code- WIC 9250
APL 18-012
KHS CBAS Policy
California Department of Health Services Medi-Cal Health Homes Program
https://www.dhcs.ca.gov/services/pages/healthhomesprogram.aspx