Kern Family Health Care™

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Enhanced Care Management Core Measures and Services				POLICY #: 18.23-P	
DEPARTMENT: Enhanced Care Management					
Effective Date: 1/2022	Review/Revised Date: 3/29/2023	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Emily Duran
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date _____
Senior Director of Provider Network

_____ Date _____
Director of Claims

_____ Date _____
Administrative Director of ECM

POLICY:

Kern Health Systems (KHS) and Enhanced Care Management (ECM) Providers will provide comprehensive care management through a whole person, interdisciplinary approach that addresses the clinical and non-clinical needs of ECM Members.

PROCEDURES:

A. Comprehensive care management services include, but are not limited to:
   1. Engaging with Members authorized to receive ECM through primarily in-person contact whenever possible. Use of text, email, phone, community outreach when in-person communication is unavailable or does not meet the needs of the Member. KHS will train on culturally appropriate communication.
   2. Developing a comprehensive, individualized, and person-centered care plan by working with the Member to assess risks, needs, goals and preferences and

collaborating with the Member as part of the ECM process that leverages input from care team members, support networks, and caregivers, as appropriate.

3. Incorporating needs into the development of the Member's Care Plan related to physical and developmental health, mental health, dementia, SUD (Substance use Disorder), community based LTSS (Long Term Support services), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing.

B. ECM Providers and the KHS ECM Care Team have extensive experience administering health risk assessments and developing individualized care plans. Responsibilities of the ECM Provider and ECM Care Team include:
    1. ECM Providers and ECM Care Team staff must complete the comprehensive assessment and health risk assessment for all ECM Members within 30 days of notification of ECM Provider or ECM Care Team enrollment.
    2. ECM Providers and ECM Care Team will conduct the comprehensive assessment upon enrollment and annually thereafter or when there is a significant change(s) in the Member's condition.
    3. ECM Providers and ECM Care Team will conduct follow up assessments based on risk status and clinical judgement.
        a. High Risk Members and Emerging Risk Members will receive a follow up assessment every 3 months or when there is a significant change(s) in the Member's condition.
        b. Medium Risk Members will receive follow up assessments every 6 months or when there is a significant change(s) in the Member's condition.
        c. Low Risk Members will receive follow up assessments every 12 months or when there is a significant change(s) in the Member's condition.
    4. ECM Providers will assign a Member to a Contact Care Management Tier based on the Member's risk assessment and health acuity. The ECM Provider and ECM Care team will utilize this Tier as a guide for contacting the member for follow up:
        a. Tier 1: The High Contact Care Management group has the greatest needs with the highest health acuity and psychosocial concerns or barriers and will be contacted as follows:
            i. The Member will be contacted at least 2 times per month, and or more frequently if needed based on the member's health condition.
            ii. Visits will be every 2 weeks with one visit in-person and the other via telehealth.
            iii. Contact every 7-14 days or more frequently if needed
        b. Tier 2: The Medium Contact Care Management group has a lower health acuity and psychosocial need that may benefit from more frequent contact and monitoring to stay on a healthy track.
            i. Member contact will be one in-person contact per month and or more frequently based on the member's health condition.
            ii. Contact every 14-21 days or more frequently as needed
        c. Tier 3: The Low Contact Care Management group has a low health acuity with minimal psychosocial needs but has a potential for increasing risk and requires some assistance in keeping their self-management skills up to date so that they can continue to live full lives and avoid future complications.

5. Member contact will be an in person visit at least once every other month or more frequently if needed based on the Member's health condition.
    a. Contact at least once monthly or more frequently as needed.
    b. ECM Providers and ECM Care Team must develop a comprehensive, individualized, and person-centered care plan for every Member enrolled in ECM. The care plan must be reviewed and updated at each comprehensive and follow up assessment with the Member. All care plans must include at least (1) person centered goal.
    c. ECM Provider and ECM Care Team is responsible for sharing a copy of the Member's care plan with the Member and Primary Care Provider and information about how to request updates.
    d. ECM Provider, ECM Lead Care Manager or ECM Care Team is responsible for communicating with the Member and chosen family/support persons, including guardians and caregivers(s) ensuring they are knowledgeable about the Member's condition(s) and that they know that the ECM Lead Care Manager is the primary point of contact.
    e. ECM Provider or the ECM Care Team is responsible for providing appropriate education to the Member, guardians, and caregivers on care instructions for the Member.
    f. ECM Providers and ECM Care Team is responsible for assessing health promotion and coordinating services that support Members to make lifestyle choices based on healthy behavior, supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions, and working with Members to identify and build on successes and potential family and support networks.
    g. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by KHS as Community Supports services (In Lieu of services).
    h. Coordinating and referring Members to available community resources and following up to ensure services were rendered.

C. ECM Provider and ECM Care Team Training
1. ECM Providers and ECM Care Team will receive training on how the comprehensive assessment is administered during:
    a. New Hire Orientation
    b. General Staff Training on ECM
    c. On-Demand
2. The ECM Provider and ECM Care Team Training Plans include:
    a. Identification of necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care.
    b. Comprehensive Care plan development that is individualized and person centered. This includes techniques on how to work with the Member to assess risks, needs, goals and preferences and collaborating with the Member as part of the ECM process that leverages input from the multi-disciplinary care team members, support networks, and caregivers as necessary.

c. Incorporating into the Member's Care Management Plan identified needs and strategies to address those needs, including physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.
d. Member reassessment at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Plan.

D. Components of the Comprehensive Assessment and Care Plan Workflow

1. The ECM Assessment tool is a comprehensive assessment of the Member's physical, behavioral, and social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs. When a Member begins receiving ECM services, the Member will receive a comprehensive assessment and a Care Plan will be created. The Care Plan will be reassessed at a frequency appropriate for the Member's individual progress or changes in needs and as identified in the care plan. The comprehensive assessment includes:
    a. Verification that an assessment of eligibility and appropriateness for ECM services has been conducted.
    b. Screening that evaluates high risk behavior that may jeopardize the individual's overall health and well-being.
    c. A detailed description of the Member's medical and behavioral health (mental health and substance use), as well as psychosocial conditions and needs.
    d. An assessment of social determinants of health including a Member's lifestyle behaviors, social environment, health literacy, communication skills and care coordination needs as well as housing and employment status.
    e. Self-management skills and functional ability (thinking and planning, sociability/coping skills, activity/interests).
    f. The Member's strengths, support system, and resources.
    g. Member's chosen caregiver(s) or family/support person.
    h. Supports needed for the Member and chosen family/support persons to manage the Member's condition.
    i. Service needs currently being addressed.
    j. Service and resource needs requiring referral.
    k. Gaps in care and barriers to access.
    l. The Member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making.
    m. Assessment of Member's readiness to change.
2. For members with LTSS needs, the Lead Care Manager will develop care plans in accordance with federal requirements (42 CFR § 438.208; 42 CFR § 441.301(c)(1) and (2)) and ensure that DHCS's standardized LTSS referral questions (as established in All Plan Letter (APL) 17-013) are included in the Comprehensive Assessment.
3. The assessments are made available to all multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the Lead Care Manager will work with the ECM Member and their family/support persons in developing the Care Management Plan.

4. The assessment is also available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all ECM Members.
5. The ECM Provider and ECM Care Team will assess for risk factors; this may include using standardized best practice screening tools in addition to the KHS Health Assessment Tool. The assessment will include:
    a. Chronic conditions that are poorly managed
    b. Behavioral health issues
    c. Persistent use of substances impacting wellness
    d. Food and/or housing instabilities
    e. Health Promotion
6. Additional assessment tools will be utilized in conjunction with the KHS Assessment tool during the comprehensive assessment and as indicated during follow up assessments to effectively capture data related to specific conditions and circumstances. These tools include:
    a. Drug Abuse Screening Test-DAST 10
    b. Screening, Brief Intervention, and Referral to Treatment- SBIRT
    c. Patient Health Screening for Depression- PHQ-9
    d. General Anxiety Disorder- GAD7
    e. Audit-C
    f. PRAPARE

E. Interdisciplinary Care Team (ICT) meetings
    1. Lead Care Manager is responsible for coordinating and leading the meetings and inviting all the members from the care team including the PCP and Member.
    2. First ICT meeting should occur within 90 days of enrollment in order to complete the care plan.
    3. ICTs should occur at least annually and whenever there is a significant change in the Member's health or care plan.

REFERENCE:

Revision 2022-06: Policy revised to comply with ECM operational readiness. Policy received DHCS approval on 12/08/2022 per ECM MOC Addendum 1.