KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Enhanced Care Management Core Measures and Services	**Policy #**	18.23-P
Policy Owner	Enhanced Care Management	**Original Effective Date**	01/2022
Revision Effective Date	04/2025	**Approval Date**	5/12/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of the Enhanced Care Management Core Measures and Services policy is delineating the fundamental procedures governing the provision of comprehensive care to individuals requiring Enhanced Care Management (ECM) services. This policy acts as a guiding framework, outlining the essential components and standards of care delivery, including but not limited to assessment protocols, care coordination strategies, communication cadence guidelines, and interdisciplinary approach mechanisms.

II. POLICY

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

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. Comprehensive care management services include, but are not limited to:

1. Outreach and engagement 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.

2. Developing a comprehensive, individualized, and person-centered plan of care 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 but not limited 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 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 for all ECM members within ninety (90) days of notification of enrollment by the ECM provider.

2. ECM providers 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 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 three (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 six (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 twelve (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 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 weekly and/or more frequently if needed based on the member's health condition.

    ii. Visits will be every week with in-person interaction with the member preferred and the other via telehealth as necessary.

    iii. Contact every seven (7) 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 every two (2) weeks minimum, with in-person contact preferred and or more frequently based on the member's health condition.

    ii. Contact every fourteen (14) 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.

    i. Member contact will be every four (4) weeks minimum, with in-person contact preferred and or more frequently based on the member's health condition.

    ii. Contact every thirty (30) days or more frequently as needed.

5. Member contact will be primarily in person based on the member's health condition.
    a. Contact member per tiering level assigned by the lead care manager at the time of assessment with member and during course of member care management in the ECM program. .

    b. ECM providers must develop a comprehensive, individualized, and person-centered care plan for every member enrolled in ECM. The care plan must be reviewed and updated as necessary at each comprehensive and follow up assessment with the member.

c. ECM provider is responsible for sharing a copy of the Member's Care Plan with the member and Primary Care Provider (PCP) as well as, information about how to request updates.

d. ECM provider, ECM Lead Care Manager are responsible for communicating with the member and chosen family/support persons, including guardian(s) and caregivers(s) ensuring they are knowledgeable about the member's condition(s) and that they know the ECM Lead Care Manager is the primary point of contact as available.

e. ECM provider is responsible for providing appropriate education to the member, guardian(s), and caregiver(s) on care instructions for the member.

f. ECM provider 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 (CSS) (In Lieu of services).

h. Coordinating and referring members to available community resources and following up to ensure services were rendered.

C. ECM Provider Training

1. ECM providers will conduct 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 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 is appropriate for the member's individual progress or changes in needs and/or as identified in the care plan.

e. Conducting and documenting interdisciplinary care team meetings. Including requisite documentation standards as leveraged by the KHS audit and appropriate clinical and non-clinical attendees, as defined by the Department of Healthcare Services (DHCS).

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 Code of Federal Regulations (CFR) § 438.208; 42 CFR § 441.301(c)(1) and (2)) and ensure that DHCS's standardized LTSS referral questions (as referenced in the ECM Policy Guide) are included in the Comprehensive Assessment.

   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.

3. The assessment is also available to the PCP, mental health service providers, substance use disorder services providers, and the care coordinators for all ECM members within the given Electronic Health Record (EHR).

4. The ECM provider will assess for risk factors; this may include using standardized best practice screening tools, which include but are not limited to:

   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

5. 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 but are not limited to:

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. Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)

g. Long Term Support Services Assessment (LTSS)

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 ninety (90) days of enrollment in order to complete the care plan.

3. ICT's should occur at least annually and whenever there is a significant change in the member's health or care plan.

V. ATTACHMENTS

N/A

VI. REFERENCES

Reference Type	Specific Reference
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	04/2025	Annual review of Policy by ECM Department Leadership. Revisions made to update current processes to ensure proper alignment with operational processes.	D.D. Enhanced Care Management
Revised	04/2024	Annual review of Policy by ECM Department Leadership. Revisions made to update current processes to ensure proper alignment with operational processes.	D.D. Enhanced Care Management
Effective	06/2022	Policy revised to comply with ECM operational readiness. Policy received DHCS approval on 12/08/2022 per ECM MOC Addendum 1.	Enhanced Care Management

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)		12/08/2022

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 18.23-P Enhanced Care Management Core Measures and Services

Previously Implemented Version : 2022-06

Reason for revision: 04/2025 Annual review of policy by ECM Department Leadership. Revisions made to update current processes to ensure proper alignment with operational processes.

Director Approval		
Title	**Signature**	**Date Approved**
Amisha Pannu Senior Director of Provider Network		
Robin Dow-Morales Senior Director of Claims		
Loni Hill-Pirtle Director of Enhanced Care Management		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____