KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Complex Care Management				POLICY #: 19.17-P	
DEPARTMENT: Population Health Management					
Effective Date:	Review/Revised Date: 7/3/2023	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Compliance and Fraud Prevention Officer

_____ Date _____
Director of Population Health Management

PURPOSE:

To outline Kern Health System's (KHS) process in assisting LTC members with Complex Care Management support

POLICY:
Complex Care Management (CCM) Complex Care is an approach to comprehensive care management that meets differing needs of high and rising-risk Members through both ongoing chronic care coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. CCM is a voluntary program for members and members have the option to participate or to decline to participate in the KHS CCM Program.

KHS will offer Complex Care Management (CCM) Program as an option to provide support to members identified as high risk due to complex or chronic medical conditions or have undergone an event that has significantly impacted a change in their health status such as hospitalizations, multiple traumatic falls, new onset of a co-morbidity or diagnosis that impairs their usual state of health and requires complex care coordination such as cancer, heart failure, advanced dementia, and other like circumstances. The key goals to support members include:

A. Improve patients' functional health status, including adherence to treatment plans
B. Enhance coordination of care in the medical neighborhood and social environment
C. Eliminate duplication of services and increase alignment of services and goals
D. Reduce the need for expensive medical services

DEFINITIONS:

Complex Care Management (CCM)	CCM is a service for managed care Members who need extra support to avoid adverse outcomes but who are not in the highest risk group. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. Definition DHCS APL-22-018
Enhanced Care Management (ECM)	ECM is a whole-person, interdisciplinary approach to comprehensive care management for managed care Members who meet the Populations of Focus criteria. It is intended to address the clinical and non-clinical needs of high-cost, high-need Members through systematic coordination of services and it is community-based, interdisciplinary, high-touch, and person-centered. One of the ECM Populations of Focus is specifically intended for nursing facility residents transitioning to the community. For these Members, the ECM Lead Care Manager must identify all resources to address all needs of the Member to ensure they will be able to transition and reside continuously in the community. ***LTC members receiving ECM will not be able to receive CCM services as this would constitute duplication of services.***
Community Supports	Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social determinants of health, which are factors in people's lives that influence their health.
Care Plan	The Care Plan serves as a guide to address the full range of medical, social, and other issues pertaining to the member's circumstances. This is done by prioritizing member preferences and needs, establishing goals, and implementing interventions to assist in achieving the members goals through ongoing measurement of progress towards goals. Example of care plan elements may include:

	A. Diagnosis, symptoms, complaints, and complications, B. Social determinants of health C. Description of individual's functional level, D. Health Objectives E. Barriers to care F. Care Coordination activities G. Planned interventions H. Measuring progress towards goals
Interdisciplinary Team	Consists of different disciplines such as health professionals, community supports, LTC facility staff, along with the patient and/or patient care giver, working collaboratively as a team. The team members share responsibilities and promote role interdependence while respecting individual members' experience and autonomy. The member care plan is developed with the input of the interdisciplinary team.

PROCEDURE:

1. Identifying LTC Members for Complex Care Management (CCM)

A. As part of the CCM program LTC Members are identified through authorization requests, claims and encounter data, hospital inpatient notifications, or referrals from specialty or primary care providers and LTC facility referrals for assistance with CCM. The information is then vetted to confirm they meet CCM eligibility criteria or care coordination assistance depending on the acuity of the member's circumstances.

B. LTC Members who meet eligibility are contacted and enrolled in CCM. This may done via their health advocate or health care designated representative in the event the member cannot self-

C. Once a member is identified by the CCM program, a comprehensive psychosocial and medical assessment is completed, and a person-centered care plan is created.

D. Primary goals of a care plan include referrals and support for condition and disease self-management, health system and benefit navigation, addressing barriers to goals and other social determinants of health, and referrals to appropriate health plan and community services.

E. All CCM members have access to a multidisciplinary care team that consists of the KHS LTC Department RN case managers, MSW or LCSW licensed clinical social worker (LCSW), case management coordinators, and the LTC KHS Medical director. Other members of the multidisciplinary team include different disciplines such as health professionals, community supports, LTC facility staff, along with the patient and/or patient care giver. The Care Team

works in conjunction with the member's primary care provider and KHS network and community partners to achieve person-centered care plan goals.

F. KHS CCM is an opt-out program; all eligible members have the right to participate or to decline participation. The KHS CCM meets the requirements as outlined in National Association for Quality Assurance (NCQA) accreditation as well as the California Department of Health Care Services (DHCS) contractual requirements for a Complex Case Management (CCM) program.

2. CCM Program Outreach

A. Members who meet the CCM program criteria are contacted by a CCM Coordinator who explains the goals and objectives of the CCM Program. Program intake includes outreach to the primary care provider (PCP) and/or treating provider by the assigned CCM RN Case Manager in order to discuss the referral and gather additional clinical information. If the member is not affiliated with a specialist or appropriate provider to manage the member's onset of his /her complex circumstances. The care plan will include the goal of establishment of the patient/provider relationship.

3. CCM Initial Assessment

A. The initial assessment includes both a psychosocial and medical assessment as well as one or more condition-specific assessments that cover additional detail based on the member's medical conditions. The assigned CCM RN completes the assessments either in person at the LTC facility, or via conference calls over the phone. The initial CCM assessment is begun within 30 calendar days of identifying member eligibility for CCM and completed within 60 calendar days.

B. The assessments cover multiple domains including:
    1. Linguistic Needs and Consent
    2. Initial Assessment of Member Health Status, Including Condition-Specific Issues
    3. Memory and Understanding and Cognitive Functions
    4. Behavioral Health
    5. Psychosocial Overview
    6. Cultural Needs and End of Life Planning
    7. Caregiver Resources and Involvement
    8. Evaluation of Available Benefits
    9. Evaluation of Available Community Resources
    10. Goal Prioritization
    11. Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs)
    12. Visual and Hearing Needs, Preferences or Limitations

4. CCM Care Planning

A. Individualized care plans are developed in collaboration with the member, member's care-giver health advocate when appropriate, and member's health care team based on the answers provided in the initial assessment. The CCM team works with the member and caregivers-LTC designated staff (case manager, social workers, (as appropriate) to prioritize the identified goals. Priorities are identified as low, medium, or high and reflect the member's and caregivers' goals, preferences, and desired level of involvement.

B. Ongoing Care Management Activities Following completion of the initial assessment and care plan, the care management team works with the member to connect them to providers, community agencies and complete care plan goals. Care management interventions supporting progress toward goal completion may include:
    1. Development and communication of member self-management plans
    2. Member education on chronic conditions
    3. Follow-up after referral to a resource or other program, i.e. community placement, hospice, palliative care, etc.

C. Initial care plans and any care plan updates are shared amongst the member and his/her care team. The care plan serves as the source of goals, interventions and member's progress towards goals and when identified barriers to goals with adjustments made to meet the goals.

5. Risk Stratification

Member Acuity Status	**CCM Encounters-Communication**
High-Risk (3) High-risk members may require prompt attention to address crisis and/or to ensure health and safety. These members present with a combination of the following factors: • Recent or ongoing ED/IP utilization within the last month • Multiple poorly or unmanaged chronic conditions • Any specialty mental health and/or substance abuse diagnosis • Low self-efficacy (poor compliance, limited mobility multiple falls/traumas, very limited participation in own care • Low Health Literacy • Lack of social support/isolation/loss of health advocate or care giver • Requires a change in setting such as desire to re-enter the community, palliative care • Moderate to severe cognitive impairment	The minimum recommended contact is four (4) in-person, phone or email contacts per month.

Moderate (2) Moderate-risk members have chronic and ongoing needs— both medical and social. A member or the member's care giver is motivated to change and has the capacity to manage needs with moderate direction and assistance. Members are receptive to and welcomes health education coaching in regard to self-efficacy and self-advocacy. Member cooperative with appointments and requires moderate assistance with specialty/new providers. Most basic needs are met	The minimum recommended contact is two (2) in-person, phone, or conference contacts per month.
Low (Maintenance) (1) Member is high functioning (complies with medical system appropriately and has a system in place to manage medication), adequate social and medical support, informed of many community services, connected to appropriate services, and most basic needs are met. Client has fewer and more concrete goals and is moving toward "well managed" and maintenance.	The minimum recommended contact is one (1) in-person, phone, or email contacts per month.

6. CCM Continuation/Closure Criteria for Program

A. Continuation Ongoing CCM program enrollment is based on member's participation in the progress toward goals or development of any new goals. At any point, the assigned CCM RN in accord with the member's care team and KHS LTC Medical Director a reassessment will be conducted to determine if the case should remain open.

7. Criteria for Case Closure

A. The CCM RN submits cases close to the KHS care management system. Closure criteria include:
   1. Member completed care management goals.
   2. Member requests to withdraw from CCM
   3. Member refuses or does not engage in CCM services.
   4. Member is no longer eligible based on eligibility criteria.
   5. Member is referred to or enrolls in a program that provides comparable case management services that is considered duplication of services, i.e. Targeted Case Management (TCM) services
   6. Member is transferred to another setting, such as hospice and no longer requires case management.
   7. Member death.
   8. Member has attained maximum improvement.
   9. Member is dis-enrolled from health plan.

8. Documentation

A. All LTC CCM staff document CCM activities in the KHS case management system, which provides data integration for member care management. This system supports:
   1. Evidence-based clinical guidelines or algorithms to conduct assessment and management. Such as those from the Case Management Society of America (CMSA)
   2. Automatic documentation of the staff member's ID and date, and time of action on the case or when interaction with the member occurred.
   3. Automated prompts for follow-up, as required by the case management plan.
   4. Contact logs, including contact information and role of support persons and collaborating community providers.
   5. Assessments.
   6. Date/Time-stamped case progress notes, including details of referrals, need for coordination with other service providers and actual coordination of services that take place.
   7. Care Plan sharing to include Date and Time Stamped
   8. Releases signed by participants to facilitate communication with support persons and collaborating providers.

REFERENCE:

Revision 2023-01: Policy revised per APL 22-018 AIR. DHCS approval received per 22-018, LTC 8, on 1/11/2023.
Revision 2022-11: Policy developed to comply with DHCS APL 22-018.