KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Enhanced Care Management Comprehensive Transitional Care	**Policy #**	18.26-P
Policy Owner	Enhanced Care Management	**Original Effective Date**	01/2022
Revision Effective Date	04/01/2025	**Approval Date**	6/2/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to establish comprehensive guidelines and procedures for the effective coordination among internal and external healthcare professionals involved in a patient's transition of care within the Enhanced Care Management (ECM) program. The transition of care policy for Kern Health System's ECM program serves as a vital framework aimed at ensuring seamless continuity and quality of care for its members as they move between various healthcare settings or providers.

II. POLICY

Kern Health Systems (KHS) is committed to the timely and effective management of care transitions across different care settings through clearly defined processes and protocols. This approach aims to minimize avoidable member admissions and readmissions, ensuring continuity and quality of care across all functions of the Enhanced Care Management (ECM) Program.

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. For Members who are experiencing or are likely to experience a care transition, the ECM Provider is responsible for but not limited to:

1. Tracking all transition of care eligible events through either internally/externally driven mechanisms and contacting member through appropriate modalities.
2. Documentation and development of an action plan reflecting care coordination efforts with regular updates.

3. Evaluation of a Member's medical and social care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.
4. Tracking each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, incarceration facility, or other treatment center and communicating with the appropriate ECM site staff.
5. Coordinating medication review/reconciliation as necessary.
6. Providing adherence support and referral to appropriate services
7. The above activities will be achieved by the following processes:

    a. The care transitions process facilitates sharing of pertinent information between KHS, ECM Provider, Member and or Members family, caregiver(s), support person and Multidisciplinary Care Team.
    b. The Utilization report is internally generated daily and shared with the ECM Provider through Secure File Transfer Protocol (SFTP) data sharing. The Utilization Report contains, listing each individual Member that has undergone a care transition to/from an emergency department, acute hospital, skilled nursing facility, or rehabilitation center. The Utilization Report is an automated report that integrates authorization and claims data.
    c. KHS Utilization Management (UM) and Population Health Management (PHM) team has established procedures for working with network facilities to identify Members who experience unplanned transitions such as hospitalizations through the Emergency Department or admissions to Long Term Care Facilities. When KHS staff receives this information from network facilities a notification is sent to the ECM Provider.
    d. ECM Provider transitional care services include, but are not limited to:

        i. Providing medication information and reconciliation as necessary.
        ii. Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners.
        iii. Collaborating, communicating, and coordinating with all parties involved in the member's transition of care.
        iv. Easing the Member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management.
        v. Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.
        vi. Together with the member, obtaining consent for, identifying, and facilitating relevant community resources needed as part of a transition of care.
        vii. Arranging transportation for transitional care, including to any covered service.
        viii. Developing and facilitating the Member's transition plan.
        ix. Preventing and tracking avoidable admissions and readmissions.
        x. Evaluating the need to revise the Member's Care Plan.

xi. Providing transition support to permanent housing and/or any community support needs.

e. A Member Profile is available to the ECM Provider and accessible at any time utilizing the KHS Provider Portal. The Member Profile includes:
   i. Demographic Member updates
   ii. Medical Diagnoses
   iii. Lab and radiology testing results
   iv. Institutional encounters
   v. Specialty and ancillary authorized services
   vi. Unused authorized services that have lapsed beyond 90 days.
   vii. Preventive health screening services
   viii. Member access history to carved out services (i.e., behavioral health or targeted case management services

B. Reducing Transitions:

1. KHS shares data with the ECM Provider through the following report:

   a. Utilization Report

2. The ECM Providers are responsible for:

   a. Developing and regularly updating a transition plan for the Member.
   b. Evaluating a Member's medical and social care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges
      i. Communication and collaboration with facility care managers and discharge planners.
      ii. Communication with the Member, family, caregiver(s), and support person(s) to assess transition needs.

   c. Tracking each Member's admission and discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team Members.
   d. Coordinating medication review and reconciliation.
   e. Provide adherence support and referral to appropriate services.

3. ECM Providers document information related transitional care within their EHR (Electronic Health Record) and is subject to audit per the quarterly KHS audit process.

4. Other reports, tools, and services utilized include:

a. For non-contracted Emergency Room (ER) encounters, KHS will extrapolate information for this activity through claims payment process.
b. For non-contracted institutional encounters, KHS will also use facsimile transactions contemporaneously to ECM Providers upon KHS receipt of the information.
c. Member care plan and care transitions information is retrievable by hospital case managers via relevant hospital portals if ECM site has appropriate HIE privileges.

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	01/2022	General approval for MOC Part 1-3 received by DHCS to implement ECM on January 1, 2022.	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)	MOC Part 1-3	12/2021

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		

KHS Policy & Procedure: 18.26-P Enhanced Care Management Comprehensive Transitional Care

Previous implemented version: 2024-04

Reason for revision: Annual policy review by the 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, Enhanced Care Management		

Date posted to public drive: _____

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