Kern Family Health Care™

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Enhanced Care Management Comprehensive Transitional Care				POLICY #: 18.26-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) will ensure timely management of care transitions from one care setting to another through defined processes and protocols in an effort to reduce avoidable Member admissions, and readmissions, across all Enhanced Care Management (ECM) Program functions.

Care transition management for ECM Members will be provided by the ECM Providers and the KHS ECM Care Team in collaboration with KHS inpatient nurses and the KHS complex case management team.

PROCEDURES:

A. For Members who are experiencing or are likely to experience a care transition, the ECM Provider or the ECM Care Team are responsible for:
    1. Development of a transition plan with regular updates
    2. Evaluation of a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges
    3. 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 care team Members
    4. Coordinating medication review/reconciliation
    5. Providing adherence support and referral to appropriate services

    The above activities will be achieved by the following processes:
    1. The care transitions process facilitates sharing of pertinent information between KHS, ECM Provider, ECM Care Team, Member and or Members family, caregiver(s), support person and Multidisciplinary Care Team. The KHS ECM Care Team and the KHS Transitional Care Management teams will collaborate with ECM Provider offices to assist in the coordination of ECM Member discharges
    2. The Utilization report is pulled daily and shared with the ECM Provider through 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
    3. KHS Utilization Management (UM)/Case Management 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 or the ECM Care Team
    4. ECM Provider and ECM Care Team transitional care services include, but are not limited to:
        a. Providing medication information and reconciliation
        b. Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
        c. Collaborating, communicating, and coordinating with all involved parties
        d. Easing the Member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
        e. Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
        f. Arranging transportation for transitional care, including to medical appointments
        g. Developing and facilitating the Member's transition plan
        h. Preventing and tracking avoidable admissions and readmissions
        i. Evaluating the need to revise the Member's Care Plan
        j. Providing transition support to permanent housing

    5. A Member Profile is available to the ECM Provider and accessible at any time utilizing the KHS Provider Portal. The Member Profile includes:
        a. Demographic Member updates
        b. Medical Diagnoses
        c. Medication activity through the Pharmacy Benefit Manager (PBM) system
        d. Lab and radiology testing results

e. Institutional encounters
f. Specialty and ancillary authorized services
g. Unused authorized services that have lapsed beyond 90 days
h. Preventive health screening services
i. 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 reports
   a. Readmit Report
   b. Utilization Report
   c. Member Specific Paid Claims Data File Record
   d. Member discharge report

2. The ECM Care Team receives data through KHS's internal care management platform. The ECM Care Team care manager receives alerts that trigger based on integrated data within the system. The care manager also has access to the above reports

3. The ECM Providers and ECM Care Team is responsible for:
   a. Developing and regularly updating a transition plan for the Member
   b. Evaluating a Member's medical 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

4. ECM Providers document information related transitional care within their EMR (Electronic Medical Record). The ECM Care Team documents information related to transitional care within the care management platform. The ECM Provider's EMR captures critical housing and other social determinants of health including changes such as loss of job or housing. For Members receiving services through KHS ECM Care Team model, KHS staff will document Member's changes in the medical management system.

Other reports, tools, and services utilized include:
   a. For non-contracted 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. The

Members care plan and other applicable care transition information will be included with the medical record information

c. Member care plan and care transitions information is retrievable by hospital case managers via the KHS and hospital portal. The information is delivered by hospital case manager to the Member or Member's family while the Member is in the hospital. This also applies to the discharge information such as any authorized services arranged for the Member. The authorization notification information will be included with the discharge instructions at the time of the Member's discharge
d. ECM Providers and ECM Care Team receives a formatted PBM report with the Member's medication history and utilization activities. This report is utilized during medication reconciliation activities are performed during care transition encounters

REFERENCE:

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