DEPARTMENT:	Case Management
SUBJECT:	Transitional Care Program
PRODUCT LINE:	All
POLICY NUMBER:	HM116
ORIGINAL POLICY EFFECTIVE DATE:	12/22/2020
LAST REVISED DATE:	4/11/2025
LAST REVIEWED DATE:	4/11/2026

Scope of Program:

Hospital discharge is a complex process representing a time of vulnerability for members. Ineffective care transition processes lead to adverse events which leads to high hospital readmission rates and increased cost. Eighty percent of adverse events during transitions of care are a result of miscommunications between facilities. The Transitional Care Program ensures that transitions of care from the hospital setting to any lower level of care occur effectively and safely and ensure the member's needs are met to improve outcomes.

Program Overview:

1. The health management team is responsible for completing the components of the Transitional Care Program.
2. The goals of the program are to:
    a. Reduce the PPR rate for the Medicaid population
    b. Reduce the 30-day readmission rate for the commercial population
3. Target population: All inpatient admissions

Program Components:

1. Hospital admission notification goes to inpatient utilization management case manager.
2. The admission is reviewed for medical necessity using InterQual criteria and a LOS is assigned based on the clinical review and concurrent review occurs.
3. Discharge Assessment is completed by GHC staff with the member after discharge to review and identify the following discharge needs:
    a. Assess cultural and linguistic needs of the member
    b. Evaluate any member education needs related to their condition and ensure education is completed
    c. Medication reconciliation including addressing new medications and process for obtaining new medications
    d. Evaluate understanding of their plan of care and reinforce plan of care including follow up care after discharge
    e. Determine what resources (services or supports) are needed upon discharge and ensure these are in place
    f. Ensure member understands warning signs that their condition is worsening
    g. Educate member on who to contact in case of an emergency
4. Any identified needs are documented in the care plan or electronic care management system along with interventions.
5. The Discharge Assessment is completed telephonically within 5 days of hospital discharge to ensure member's needs are being met.
6. The discharge assessment is completed by the outpatient case manager for members that are in case management. The discharge assessment is completed by the inpatient case manager for members who are not in case management.

7. If member is not in case management but meets criteria for case management, the member is referred to the outpatient case management team for enrollment in the complex case management program

APPROVED: Michele Bauer MD. DATE 4/11/2026

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
12/21/21	Michele Bauer, MD, CMO	Reviewed. No changes.
5/12/2022	Michele Bauer, MD, CMO	Updated name of program and removed Medicare Advantage items.
5/10/2023	Michele Bauer, MD, CMO	Reviewed no changes.
4/11/2024	Michele Bauer, MD, CMO	Updated program name and discharge assessment process.
4/11/2025	Michele Bauer, MD, CMO	Reviewed. No changes.
4/11/2026	Michele Bauer, MD, CMO	Reviewed. No changes.