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Division: Care Management	
Department: Utilization Management	
Title: PHC-CA Transition of Care	
Effective Date: 1/8/2016	
Supersedes Policy No: 93022, UM 2.0, UM 2.1, UM 2.2, UM 2.3, UM 2.4, UM 2.5, UM 2.6 UM 2.7, UM 2.9	
Reviewed/Revised by: Tiffany Smith	**Review/Revision Date: 12/15/2025**
Approving Committee: Utilization Management Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/17/2025	

Purpose:

To describe how PHC California (the Health Plan) ensures effective transitions of care from one level of care to another and identifies member care transition needs to ensure the quality of care and reduce risk to patient safety; and to establish written protocols for discharge planning and care transitions for facilities including general acute care hospitals, long-term acute care hospitals and skilled nursing facilities.

Policy:

1. The Health Plan coordinates hospital/institutional discharge planning and post-discharge care, including:

    a. Conducting an assessment of enrollee and family caregiver needs

    b. Coordinating the patient's discharge plan with the family and hospital provider team

    c. Collaborating with the hospital or institution's care coordinators/case manager to implement the discharge plan in the patient's primary residence or primary care setting

    d. Facilitating communication and the transition to community providers and services.

2. The Health Plan assigns each enrollee an RN Care Team Manager (RNCTM) upon enrollment. Following a health risk assessment, the RNCTM, with input from the member and Primary Care Provider (PCP), establishes a plan of care that is shared with the enrollee's PCP and other care providers, reviewed during interaction with the enrollee and updated as often as necessary. The RNCTM communicates plan of care modifications to the other members of the care team, as necessary, to ensure that the clinical and psychosocial needs of the enrollee are met. Upon transition, initial change in level of care (admission to a hospital or Skilled Nursing Facility and upon discharge to Skilled Nursing Facility, Home Health, etc.) the care plan will be updated by the Utilization Management (UM) RN to reflect the initial discharge plan (admission) and the final discharge plan (discharge) and faxed to the receiving provider and PCP.

3. The Health Plan ensures that discharge planning documents are provided to enrollees or authorized representatives, as appropriate, when being discharged from a hospital, institution, or facility. The discharge planning documents include the following information, at a minimum:

    a. Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, Durable Medical Equipment (DME) uses, and other services

received prior to admission

b. Pre-discharge factors, including the enrollee's medical condition, physical and mental function, financial resources, and social supports at the time of discharge

c. The hospital, institution or facility to which the enrollee was admitted

d. Specific agency or home recommended by the hospital, institution or facility after the enrollee's discharge based upon enrollee needs and preferences; specific services needed after the enrollee's discharge

e. Specific description of the type of placement preferred by the enrollee, specific description of type of placement agreed to by the enrollee, specific description of agency or enrollee's return to home agreed to by the enrollee, and recommended pre-discharge counseling

f. Summary of the nature and outcome of participation of enrollee

g. Member's authorized representatives in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution, or facility to be included in the enrollee's medical record

h. Information regarding available care, services, and supports that are in the enrollee's community once the enrollee is discharged from a hospital, institution, or facility, including the scheduled outpatient appointment or follow-up with the enrollee.

4. The Health Plan requires facilities to notify and communicate with primary care and coordinate continuity of care with prior primary care providers (PCPs) and enhanced care management (ECM) providers, including sharing of discharge summaries, care plans, and medication lists.

5. The Health Plan will seek to establish periodic joint operating meetings (JOM) with facilities serving the largest proportion of the plan's enrollees.

Procedure:

A. Planned Transitions:

1. Planned member admissions to an acute hospital or skilled nursing facility are communicated by the Provider to the health plan via authorization request.

   The approved authorization triggers a notice by the Utilization Management RN (UMRN) to the RNCTM regarding the impending admission and the need for member education, care plan adjustment and follow-up.

   a. The UMRN is to obtain the date of admission and reason for the elective admission from the Admitting Physician and enter the pending admission date into the designated electronic documentation systems. The UMRN is to notify the member's RNCTM of the planned admission date.
   b. The RNCTM contacts member and provides the appropriate education for the upcoming admission. The education and understanding of the member is documented in the care management session notes.

2. Notification of admission is received from admitting hospitals or skilled nursing facilities within one (1) business day of admission/change in level of care.

    a. If the planned day of admission passes without the hospital notifying the UMRN or designee of the admission, the UMRN or designee is to contact the hospital the day after the planned admission to confirm the admission and begin the admission transition process as well as the discharge planning-transition process.

3. The UMRN/RNCTM verifies clinical information in the electronic medical record (EMR), the care plan with the PCP or specialist, as necessary, and contacts the member to assess member needs, expectations and provides education and instructions facilitating a smooth transition to the acute or skilled nursing facility setting.

4. The RNCTM updates the Care Plan and sends/faxes to the member's PCP and the receiving setting within one (1) business day of scheduled admission.

5. Upon admission, the UMRN documents the communication of the care plan and plan for discharge in Transition of Care assessment in the designated electronic documentation systems.

6. The UMRN and RNCTM follows-up with the member during the stay, as appropriate, and works with the facility Case Management/Discharge Planning staff to ensure an appropriate discharge plan is established.

7. The RNCTM communicates with the Health Plan's UMRN regarding admission status, clinical updates, and discharge status.

8. Discharge Planning is updated during hospitalization and upon discharge from an inpatient facility by the hospital Case Manager/Discharge Planner, Plan UMRN and RNCTM.

9. The member is contacted by the RNCTM prior to discharge to assure discharge education has been completed or to educate the member and/or caregiver on their discharge plan, what to expect at the discharge location (e.g., home, home health, nursing facility, etc.), assure there has been a follow up appointment with the member's provider or schedule one, and reconcile medication.

10. In preparation for discharge the RNCTM updates the Care Plan and sends the care plan to the receiving setting and/or PCP within one (1) business day of notification discharge/change in level of care from the hospital.

11. Within twenty-four (24) to seventy-two (72) hours of the day of notification of discharge, the RNCTM visits or contacts the patient or care provider to ensure the discharge plan has been implemented, e.g. home health care needs are met, equipment has arrived, the member understands diet, activity, medication regimen, and has a follow-up medical appointment.

12. The RNCTM ensures the member, family and agency/facility, as appropriate, have the contact phone number of the vendor used for home discharge plan and that the vendor triage nurse/call center is available after hours to answer questions, in addition to the twenty-four (24) hour nurse advice line.

13. RNCTM sends the care plan to PCPs within three (3) business days of notification of discharge/change in level of care.

14. RNCTM conducts post discharge follow-up to include Health Reassessment to assess level of care needs, Comprehensive Medication Review and care plan update within 1-3 business day of discharge.

15. The RNCTM updates the Transition of Care Assessment in the designated electronic documentation systems and makes sure the member has a seven (7) day post facility PCP follow up visit

16. If the member requires in home supportive services (i.e. homemaker or attendant care services), the contact information for the Department of Social Services (DPSS), In Home Support Services Program (IHHSP) will be provided to the client or his/her caregiver. The member or caregiver must then contact the IHSSP to determine eligibility and need for in-home services. The contact phone numbers are: (888) 944-4477 or (213) 744-4477.

17. When appropriate, the RNCTM refers the member to the Community Supports Coordinator and/or to the Enhanced Care Management or MCWP programs.

18. The member will be monitored by the RNCTM and/or the Community Health Worker (CHW) for thirty (30) days following the inpatient discharge from the facility to ensure compliance with care plan, progress toward Transition of Care goal, no complicating issues being encountered, and discharge instructions are clear, as well as the PCP or specialists' visits have been scheduled and completed.

B. Unplanned Transitions:

1. Unplanned member admissions to an acute hospital are communicated according to contract requirements to the Health Plan by the facility within one (1) business day of admission/change in level of care.

2. The authorization for the emergent admission triggers a notice from UMRN to the RNCTM regarding the admission and the member's current acute condition.

3. The UMRN verifies clinical information in the electronic medical record (EMR), care plan or directly with the PCP or specialist, as necessary, and documents discharge planning needs.

4. The RNCTM updates the Care Plan. The UMRN sends/faxes to the receiving setting within one (1) business day of notification of admission and notifies the RNCTM of the admission.

5. The UMRN opens the Transition of Care Assessment and documents the clinical information and the plan for discharge in the designated electronic documentation systems.

6. The UMRN/RNCTM follows up with the member during the stay, as appropriate, and works with the facility staff to ensure an appropriate discharge plan is established.

7. The RNCTM communicates with the Health Plan's UMRN regarding admission status, clinical updates, and discharge status.

8. Discharge Planning is documented for patients during hospitalization and upon discharge from an inpatient facility (includes acute hospitals and skilled nursing facilities).

9. Upon preparation for discharge the RNCTM updates the Care Plan and sends the care plan to the receiving setting and the PCP within one (1) business day of notification of discharge/change in level of care.

10. RNCTM conducts post discharge follow-up to include Health Reassessment to assess level of care needs, Comprehensive Medication Review and care plan update within seven (7) business days of discharge.

11. The RNCTM updates the Transition of Care Assessment in the designated electronic documentation systems. Making sure the member has a post outpatient follow visit with the PCP/attending surgeon targeted to occur within seven (7) days.

12. The member will be monitored by the RNCTM and/or the Community Health Worker (CHW) for thirty (30) days following the inpatient discharge from the facility to ensure compliance with care plan, progress toward Transition of Care goal, no complicating issues being encountered, and discharge instructions are clear, as well as the PCP or specialists' visits have been scheduled and completed.

13. The UMRN/RNCTM ensures the member, family, and agency/facility, as appropriate, has the contact phone number of the vendor used for home discharge plan and that a vendor triage nurse/call center is available after hours to answer questions, in addition to the twenty-four (24) hour nurse advice line.

14. The RNCTM sends the AHF PCP notification in the electronic documentation system regarding the discharge and sends/faxes non-AHF PCP discharge information notices.

15. The RNCTM sends/faxes the Transition of Care, Care Plan to PCPs within three (3) business days of discharge/change in level of care.

16. The RNCTM/CHW conducts post discharge follow-up to include Health reassessment to assess level of care needs, Comprehensive Medication Review, and care plan review within one (1) business day of discharge.

17. The RNCTM updates the Transition of Care Assessment in the designated electronic documentation system.

C. Joint Operating Meetings

1. The National Director of Contracting and Provider Relations or designee selects contracted facilities for Joint Operating Meeting outreach. He or she ranks each of three types of contracted facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) by the number of enrollees served over the prior year and identifies the top three facilities for each facility type. If the Health Plan does not have contracts with nine facilities (three for each type), the National Director of Contracting and Provider Relations or designee selects 50 percent of contracted facilities in the Health Plan's service area.

2. The National Director of Contracting and Provider Relations, or designee conducts outreach to facilities identified above with the goal of establishing periodic Joint Operating Meeting.

Definitions:

1. Care Plan: Information about the member that fosters communication, collaboration, and continuity of care across care settings. It is tailored to each member and includes health status information, current problems, medication regimen, member goals and other information important to the medical management of the member.

2. Care Setting: Place in which the member receives health care services and includes a designated practitioner who has responsibility for the member's medical care. Care settings include:

    a. Home

    b. Home health care

    c. Acute care

    d. Skilled nursing facility (SNF)

    e. Custodial nursing facility

    f. Rehabilitation facility

    g. Emergency Department

3. Clinical Team Rounds: weekly clinical rounds held by the Care Coordination department to generate, review, and consult on patients and address transitions.

4. Community Health Worker: The CHW is assigned to specific patients per the Care Team and follows up with patients according to Care Plan interventions, addresses patient barriers, observes for signs of distress and reports to RNCTM and/or PCP any issues observed or not in compliance with the overall Care Plan.

5. ICT: Interdisciplinary discussions that occur between the RNCTM and the PCP, specialist, UR Nurse, Hospital Staff, Mental Health Provider, Social Worker, or other interdisciplinary engagement for contribution to the member's plan of care.

6. Primary Care Provider (PCP): means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

7. Primary Setting: Location where the member normally receives care.

8. Receiving Setting: The setting responsible for the member's care after a transition.

9. RNCTM: RN Care Team Manager is assigned to a group of patients, completes a Health Risk Assessment, assigns an acuity level and establishes with the patient, the care plan goals, coaches the patient to become more involved in their care, reconciles medications and coordinates community resources to assist the patient in living with their condition. RNCTMs work in conjunction with Medical Social Workers, Care Coordinators and the Utilization team to meet patient needs.

10. Transition: Changes in a member's care setting due to a change in health status.

11. Transition Process: Includes the time from identification of a member who is at risk for care transition through the completion of a transition. It includes planning, coordination, communication, preparation, and follow-up to ensure transition was achieved successfully and safely.

12. UM RN: Utilization Management RN responsible for obtaining or coordinating medical services needed for the treatment of an episode of care or acute need.

Monitoring:

Documentation and Quality Review:

- Analyze TOC data and identify areas where avoidable, unplanned transitions can be reduced (member admissions to in-network and out of network hospitals and emergency departments)

Identification of High-Risk Members:

- The Utilization Management Department reviews all high-risk transition cases weekly during case rounds.

- Transitions of Care Assessments are loaded for all cases in the designated electronic documentation system by the UM RN and RNCTM.

- Assessment activity is reviewed weekly in Clinical Rounds

- High risk members receive care coordination from Plan CHWs/MSWs/Care Coordinators and additional telephone education by their RNCTM on how to better manage their condition and other options available to them in place of using the emergency rooms for non-critical conditions

This policy is updated as often as necessary and reviewed and approved annually by the Utilization Management Committee.

References:

DHCS Managed Care Contract

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response
8/29/2023	2.3	Department of Health Care Services (DHCS)	2024 Operational Readiness (O/R) R.0131	Approved
12/12/2023	2.4	DHCS	O/R R.0128	Approved
12/12/2023	2.4	DHCS	O/R R.0129	AIR1
12/29/2023	2.6	DHCS	O/R R.0129 AIR1	Approved
1/8/2024	2.4	DHCS	O/R R.0127	Approved
1/9/2024	2.4	DHCS	O/R R.0132	Approved
1/10/2024	2.4	DHCS	O/R R.0143	Approved