Manual/Library Name: Case Management	**No:** CMT.103
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	Effective Date: 04/02/24
Policy Title: Hospital Case Management Transition Planning	**Previous Versions:** 03/05/21; 05/18/17; 05/12/16; 01/30/14; 02/07/13
	Approved By: Executive Leadership Team
	Approval Date: 03/04/24

I. Scope:

This policy applies to Tenet Healthcare Corporation, its wholly-owned subsidiaries and affiliates (each, an “Affiliate”), any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of greater than 50%, and any entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a “Tenet Entity”) (collectively, “Tenet”).

II. Purpose:

Transition Planning ensures optimal post-discharge health outcomes for patients admitted to Inpatient and Outpatient Observation status.

III. Definitions:

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

Inpatient: Any person at a Tenet Hospital occupying a bed in an Inpatient level of care status for purposes of receiving hospital services.

Observation Services or **Observation:** Assessment, short-term treatment, reassessment, and stabilization services provided before a decision to admit to Inpatient status or discharge from the hospital.

Outpatient Observation: An Outpatient level of care status describing a person registered on hospital records as an Outpatient, but who could potentially be moved to an Inpatient status at the hospital during the same stay.

TEMPO®: Team Engagement to Manage Patient Outcomes, which is a multi-disciplinary patient throughput visual management system to coordinate and sequence efficient and quality care planning.

Transition Planning: The process of assessing and reassessing patients for post-acute care hospital needs and then developing and implementing a plan to coordinate those services identified as necessary to ensure optimal outcomes for patient health post discharge.

IV. Policy:

Case Management Registered Nurses (RNCM) or Social Workers (SWCM) provide Transition Planning services to ensure optimal health outcomes for patients upon discharge from hospital Inpatient and Outpatient Observation status.

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The Transition Planning process includes mechanisms for a Case Management Registered Nurse or Social Worker to identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon Discharge or Transfer if there is inadequate planning.

V. Procedure

A. Case Management Registered Nurse or Social Worker will complete Discharge Planning Risk Assessment or Infant/Child Transition Evaluation and make his or her best efforts to complete the initial assessment within 24 hours, but no later than 48 hours after admission or registration.

B. Case Management Registered Nurse or Social Worker will develop an initial discharge plan for patients admitted to Inpatient or Outpatient Observation status based on the goals, preferences and needs for each applicable patient.

C. Case Management will complete an Adult Transition Evaluation on any adult patient identified as high risk form the Discharge Planning Risk Assessment.

D. Case Management will complete a complex Case Management Transition Assessment to evaluate patients identified as high risk for readmission or with complex discharge needs

E. The patient and/or patient's representative, family, hospital staff or physician may initiate a request for a discharge planning evaluation when there is an identified need.

F. Case Management will reassess the patient's discharge plan and update during the hospitalization as the patient's condition and goals or preferences change. The discharge planning process addresses all transitions between care levels emphasizing continuity of care. Care Management staff will complete the discharge plan in the patient's medical record before discharging or transferring the patient to another facility.

G. This policy does not apply to Labor and Delivery, Post-Partum and Normal Newborn patients because the nursing assessment routinely addresses their transition needs during their hospitalization as outlined in the Plan for Provision of Nursing Care.

H. Tenet may waive any requirements of this policy in accordance with the Centers for Medicare and Medicaid Services blanket waiver during the effective period of the national emergency (e.g., COVID-19 pandemic.

VI. Enforcement:

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be

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subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. References:

CMT.103.PR.01 Hospital Case Management Transition Planning (Procedure)

Hospital Conditions of Participation – Title 42: Public Health, Part 412 – Prospective Payment Systems for Inpatient Hospital Services; 42 CFR § 482.43 Discharge Planning

American Case Management Association (ACMA) Standards of Practice and Scope of Services, revised 2020

CMT.102 Requirements for Patient Choice for Post-Hospitalization Service (Policy)

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