Transition of Care Requirements: Hospital Admission or Inpatient Discharge

Hospital Admission or Inpatient Discharge

This education sheet outlines Enhanced Care Management (ECM) provider responsibilities following a hospital admission or inpatient discharge. ECM providers must initiate Transitions of Care (TOC) activities promptly and within 2 business days of discharge notification to support safe transitions, continuity of care, and prevention of avoidable readmissions.

ECM members meet PHM's high-risk Transitional Care Services criteria because the PHM Policy Guide (p.54) defines "those in or entering ECM or CCM" as high-risk.

Although this document reflects ECM program expectations, the ECM Policy Guide (p.61) directs ECM providers to follow the Transitional Care Services (TCS) standards in the PHM Policy Guide, Section F (p. 47). Therefore, ECM Transitional Care responsibilities are grounded in both:

- **The ECM Policy Guide**, which outlines ECM-specific requirements, and
- **CalAIM: Population Health Management (PHM) Policy Guide,** which defines statewide TCS standards for Medi-Cal Managed Care Plans.

ECM Provider Responsibilities

Following notification of a hospital admission or discharge, ECM providers must:

1. Initiate outreach within 2 business days of notification.
2. Review the discharge summary and discharge instructions.
3. Assess changes in the member's condition, needs, and risk factors.
4. Complete post-discharge medication reconciliation.
5. Ensure timely Primary Care Provider (PCP) and specialist follow-up, within 7 days for high-risk members.
6. Assess for social or access barriers impacting recovery.
7. Update the ECM care plan to reflect post-discharge clinical, behavioral, and social needs.
8. Collaborate with discharging facility staff (e.g., discharge planners) to avoid duplicative discharge planning documents and to ensure a single, coordinated plan is shared.
9. Document all activities in the member's record.

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Required Post-Discharge Activities

The following activities must be completed and documented:

Post-Discharge Assessment

- ☐ Contact the member or caregiver.
- ☐ Ensure the first successful contact is in real time.
- ☐ Assess current health status and any changes in condition.
- ☐ Identify new symptoms, complications, or concerns.
- ☐ Evaluate risk for readmission.
- ☐ Identify unmet needs and barriers to recovery, including transportation, housing, food access, or caregiver support.
- ☐ Coordinate urgent follow-up if concerning symptoms are identified.

Primary Care and Specialist Follow-Up

- ☐ Confirm that a follow-up appointment with the Primary Care Provider has been scheduled within 7 days or when clinically appropriate in alignment with discharge instructions.
- ☐ Confirm that any specialist-ordered appointments have been scheduled.
- ☐ Assist with scheduling if appointments are not yet arranged.
- ☐ Address transportation or access barriers.
- ☐ Follow up on missed appointments when applicable.

Medication Reconciliation

Medication reconciliation must be completed and documented by:

- ☐ Reviewing the hospital discharge medication list.
- ☐ Comparing discharge medications to pre-admission medications.
- ☐ Identifying discrepancies, duplications, omissions, or interactions and notifying PCP.
- ☐ Confirming the member understands medication changes.
- ☐ Ensuring prescriptions were filled and medications are accessible.

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- ☐ Coordinating with the PCP or discharging provider if clarification is needed.

Care Plan Review and Updates

- ☐ Incorporate discharge recommendations into the ECM care plan.
- ☐ Update goals, interventions, and services to reflect all post-discharge needs.

Post-Acute and Ancillary Services

Confirm initiation of the services ordered, including but not limited to:

- ☐ Home health services
- ☐ Physical, occupational, or speech therapy
- ☐ Durable medical equipment
- ☐ Behavioral health services
- ☐ Other post-acute supports

Health Promotion and Safety Education

During post-discharge contact, ECM providers must:

- ☐ Review and Reinforce understanding of discharge instructions.
- ☐ Review and educate the member on warning signs and red flag symptoms.
- ☐ Instruct the member to call 911 or go to the nearest emergency room for life-threatening symptoms such as chest pain, difficulty breathing, severe bleeding, loss of consciousness, or other emergent conditions.
- ☐ Encourage contact with their PCP or specialist for non-emergent concerns.
- ☐ Provide information about the Alliance Nurse Advice Line for health questions that do not require emergency care: **844-971-8907**.
- ☐ Reinforce medication adherence and appointment attendance.
- ☐ Promote self-management strategies to support recovery.

Pregnant & Postpartum Transitional Care Requirements

ECM providers must follow additional Transitional Care expectations for any member who is pregnant or within 12 months post-partum, including:

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- ☐ Coordinate with perinatal providers and discharge planners to ensure a unified discharge plan and avoid duplicate documents.
- ☐ Review discharge summary, discharge instructions, and postpartum care requirements immediately upon receipt.
- ☐ Perform real-time post-discharge contact within 7 days, or sooner if clinically indicated.
- ☐ Ensure a postpartum visit is scheduled in alignment with ACOG recommendations.
- ☐ Ensure pediatric visits according to AAP Bright Futures schedule from newborn through 2-month well-child visit are coordinated.
- ☐ Assess for and coordinate the following as appropriate:
  - Lactation services
  - WIC and nutrition support
  - Behavioral health and SUD services
  - Doula services
  - Transportation
  - Community Supports

Outreach Requirements

Initial Outreach

- Begin within 2 business days of discharge notification.
- Two phone call attempts on consecutive days.
- One written outreach if phone contact is unsuccessful.

7-Day Follow-Up

If unable to reach the member during initial outreach:

- Continue attempts through day 7 post-discharge.
- One additional phone call attempt (1 written outreach is also recommended)

- If the member responds at any time between days 1 through 7, all required TOC activities must be completed during that interaction.

Unable to Contact or Member Refusal

- Document all outreach attempts, including date, time, method, and outcome.
- If the member declines services, document as Member Refused Services.
- Notify the Care Integration Unit if unable to contact the member by day 7 or if barriers arise that may impact recovery or timely follow-up care.
- Assess the need for additional internal case management and complete a warm handoff if appropriate.

Source Citation Table

Requirement	PHM Policy Guide Pages	ECM Policy Guide Pages:	Notes
ECM Provider Responsibilities	59–90 https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	55–62 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	ECM responsibilities incorporate PHM TCS ECM policy p.61 directs providers to PHM Policy "Providing PHM Program Services and Supports: c. Transitional Care Services."
Required Post-Discharge Activities	58–66 https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-	60–61 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge	Includes assessment, real-time contact, follow-ups, med rec, and risk review.

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	Plan-2023-Q1-2024-Q2.pdf	Requirements.docx&action=default&mobileredirect=true	
Primary Care & Specialist Follow-Up	60-62https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	60–61 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	DHCS high-risk standard; ECM must coordinate all follow-ups.
Medication Reconciliation	62https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	61 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	Prevents discrepancies; ECM builds on PHM requirements.
Care Plan Review & Updates	48	56–58, 60https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	ECM-specific requirement.
Post-Acute & Ancillary Services	60-67https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	58–61 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	Includes HH, therapies, DME, BH, and CS supports.
Health Promotion & Safety Education	https://calhps.com/wp-content/uploads/2025/01/ECM-by-	59 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?source	Education on red flags, instructions,

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	Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	doc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	self-management.
Pregnant & Postpartum TCS Requirements	24, 76https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	50–53 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	ECM adds perinatal-specific TOC tasks.
Outreach Requirements	62 https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	47, 55, 60–61 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	CCAH's 2-business-day outreach standard is an internal requirement, not PHM or ECM policy.
ECM Provider Responsibilities	47https://calhps.com/wp-content/uploads/2025/01/ECM-by-Population-of-Focus-by-Managed-Care-Plan-2023-Q1-2024-Q2.pdf	55–63 https://ccahallianceorg-my.sharepoint.com/personal/irobinson_ccah-alliance_org/_layouts/15/Doc.aspx?sourcedoc={5FAFD625-10A6-4DF0-8D58-500A51748F39}&file=ECM Hospital Admission_Inpatient Discharge Requirements.docx&action=default&mobileredirect=true	ECM responsibilities incorporate PHM TCS because ECM p.61 directs providers to the PHM TCS Overview.

Thank you for your continued partnership in supporting members during care transitions.

Care Integration Unit
Central California Alliance for Health