Department: Health Services Dept	**Number:** HS-021
Title: Discharge Planning and Transition of Care	
Original Effective Date: 1/1/2021	**Latest Revision Date:** 6/3/2025

PURPOSE:

This policy outlines the discharge planning and transition of care process within Sonder Health Plans ("SHP") Health Services Department ("HSD"), ensuring that members receive safe, effective, and timely transitions between care settings. It includes the role of HSD staff in facilitating discharge planning, coordinating transitions, and conducting post-discharge follow-up to ensure adherence to CMS regulations and standards of care. This policy applies to all SHP members, network providers, HSD Staff (including Utilization Management Nurses, Case Managers, and Support Staff) involved in the discharge and transition of care processes.

DEFINITIONS:

- **Beneficiary and Family Centered Care Quality Improvement Organization ("BFCC-QIO") -** Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review enrollee complaints about the quality of care provided by physicians, facilities, Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.
- **Care Management (CM):** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet an individual's health needs.
- **Discharge Planning:** A process that ensures a smooth transition of care from one level of care to another, based on the member's clinical status and post-discharge needs.
- **Enrollee:** For the purpose of this document, enrollee, member and beneficiary may be used interchangeably and refers to a Medicare Advantage eligible individual who has elected Sonder Health Plans to receive coverage and benefits.
- **Independent Review Entity (IRE):** An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.
- **Transition of Care (TOC):** The coordination and continuity of care as a member moves between different healthcare settings (e.g. from hospital to home or skilled nursing facility).
- **Post-Discharge Follow-up:** A process for assessing a member's condition and needs after leaving an inpatient or other care setting to prevent complications, readmissions, or care gaps.
- **Utilization Management (UM):** The process of reviewing and authorizing the medical necessity, appropriateness, and efficiency of healthcare services and treatments.

POLICY STATEMENT:

Sonder Health Plan ensures that all members receive coordinated and appropriate discharge planning services as part of its Utilization Management ("UM") and Care Management ("CM") programs. Discharge planning is initiated early in the continuum to support a smooth transition between levels of care and ensure the member's needs are met post-discharge. Transition of care protocols will be followed when moving

members between different care settings (e.g., from inpatient to outpatient care or to skilled nursing facilities). As required and/or determined necessary the HSD team will provide follow-up post-discharge to promote recovery, prevent readmissions, and ensure continuity of care.

PROCEDURES:

I. Initiation of Discharge Planning

A. **Early Initiation:**

i. Attending/Treating physicians and UM staff are encouraged to initiate discharge planning at the time of admission to any inpatient facility (e.g., hospital, skilled nursing facility). UM and/or CM staff, in collaboration with the facility's care team, will assess the member's expected discharge needs, including home health services, medications, equipment, or transportation.

B. **Daily Review:**

i. The UM staff will conduct reviews of the member's clinical status to ensure that care is progressing appropriately, and that discharge planning is on track.

C. **Collaboration with Multidisciplinary Teams:**

i. Discharge planning is coordinated with a multidisciplinary team, which may include physicians, nurses, case managers, social workers, physical therapists, and others as appropriate.

II. Discharge Planning:

A. Prior to any scheduled discharge, a UM or CM Nurse or designee will confirm the date and time of discharge with the facility liaison, facility case manager, or discharge planner to coordinate post-discharge services.

B. A UM and/or CM Nurse or designee will coordinate any placement in any other necessary facility (SNF, rehabilitation facility, etc.) with the member, family, primary care physician, admitting physician, facility case manager and/or the discharge planning staff.

III. Transition of Care Between Levels of Care

A. **Transition from Hospital to Home:**

i. The UM and/or CM staff will work closely with hospital staff to coordinate a safe discharge home. This includes assessing the member's ability to care for themselves, whether they have adequate support at home, and ensuring appropriate home health services, medical equipment, and medical access.

B. **Transition from Hospital to Skilled Nursing Facility (SNF) or rehabilitation:**

i. As required, if a member requires a transition to a SNF or rehabilitation facility, the UM and/or CM staff will ensure that all necessary clinical information is communicated to the receiving facility. This includes the member's care plan, medications, and any special needs. The CM and/or UM staff will also confirm that the receiving facility is within the SHP network and that prior authorization, if required, is obtained.

C. **Transition to a Lower Level of Care (e.g., Inpatient to Outpatient):**

i. For members moving from inpatient to outpatient services, such as therapy or follow-up visits, the CM and/or UM staff ensure the scheduling of post-discharge appointments, coordination of outpatient services, and that the necessary prior authorizations are in place as required.

IV. Member's Right of Appeal: (Refer to Related Policy Section below for SHP's process for handling these types of appeals)

A. **Hospital Discharges:**

i. A member has the right to request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization ("BFCC-QIO") when SHP or a hospital (acting directly or through its utilization committee), with physician

concurrence determines that inpatient care is no longer necessary.

ii. To request a BFCC-QIO review (immediate review), the enrollee must follow the steps listed on the standardized form, CMS Form R-193, An Important Message from Medicare ("IM").

iii. If the enrollee does not make a timely request to the BFCC-QIO, the enrollee may contact SHP to request an expedited reconsideration as indicated on the IM.

B. **SNF, HHA, CORF:**

i. An enrollee has the right to request an immediate review by the BFCC-QIO when a SNF, Home Health Agency (HHA), or Comprehensive Rehabilitation Facility (CORF) decides to terminate previously approved coverage (which includes an MA plan or contracted provider directing an enrollee to seek care from a non-contracted provider/facility).

ii. All enrollees receiving covered services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC), delivered by the facility or provider, before their services end.

V. Post-Discharge Follow-up Activities:

A. **24 to 48 Hours Post-Discharge Contact:**

i. As needed or if required, within 24 to 48 hours post-discharge, an SHP case manager and/or support staff will contact the member to:

1. Confirm they have received discharge instructions.
2. Assess any immediate needs, including medication reconciliation.
3. Address any concerns about their recovery process.

B. **7-Day Follow-up:**

i. Within 7 days post-discharge, the CM team will reassess the member's status and ensure they have attended any scheduled follow-up visits.

ii. If a follow-up visit has not been scheduled, the CM staff will assist the member in arranging the necessary appointment with their primary care provider or specialist.

C. **Chronic Care Management (if applicable):**

i. For SNP members with chronic conditions or high-risk profiles, CM staff will develop post-discharge care plan that includes ongoing case management or disease management services to prevent complications and readmissions.

VI. Coordination with Providers and Members:

A. **Communication with the Provider Team:**

i. The CM Staff will maintain regular communication with the member's primary care physician and other treating providers to ensure smooth coordination of care across transitions.

B. **Member and Caregiver Education:**

i. The CM team will provide applicable education to members and caregivers on discharge instructions, medication adherence, follow-up appointments, and symptom management. This includes ensuring they understand when and how to seek additional medical help if needed.

VII. Documentation and Reporting:

A. All transition of care activities, discharge planning details, and follow-up contacts must be documented in the member's medical record and if requested or required will be shared with the relevant providers. The CM team will report any issues, gaps in care, or member readmissions to HSD Leadership. Any issues to include compliance or quality concerns, to include but not limited to; Quality of Care, provider issues, gaps in care and member readmissions will be tracked, trended and reported as appropriate based upon current SHP policies and procedures, CMS requirements, and SNP Models of Care.

VIII. Readmission Prevention:

A. **Identification of High-Risk Members:**

i. The UM team will identify high-risk members who are more likely to be readmitted,

such as those with complex conditions or inadequate support systems at home. These members may be referred to SHP Care Management and enrolled in enhanced case management programs that provide closer monitoring and additional support post-discharge.

B. **Readmission Alerts:**
   i. If a member is readmitted to the hospital within 20 days of discharge, the UM team will review the case to determine the causes and ensure proper coordination of care to avoid future admissions.

IX. Monitoring and Reporting:

A. The CM team will track and monitor all discharge planning activities, including the timeliness of follow-up contacts, adherence to transition of care protocols, and rates of member readmissions.
B. Reports will be generated and reviewed monthly by SHP HSD Leadership and periodically by the SHP Health Services Committee to identify trends, gaps in care, or opportunities for improvement in the discharge planning and transition of care process.

X. SHP Staff Responsibilities:

A. SHP's UM Nurses and Case Managers are key resources for members (and their representatives and/or family members), providers, and the overall discharge planning process. At a high level, the following resources are also critical in supporting this process.
B. **Nurse Case Managers:**
   i. Conduct post-discharge phone calls to assess patient status and address any concerns.
   ii. Provide education on medication management, symptom monitoring, and follow-up care instructions.
C. **Care Coordinators:**
   i. Ensure that discharge plans are communicated to patients and their caregivers.
   ii. Schedule follow-up appointments with primary care providers (PCPs) or specialists as required.
   iii. Facilitate any necessary home health services, durable medical equipment (DME), or other post-discharge needs.
D. **Primary Care Providers:**
   i. Review discharge summaries and integrate them into the member's care plan.
   ii. Follow up with members in accordance with the scheduled appointments.
   iii. Complete medication reconciliation with the member at the initial follow-up visit post-discharge and document the reconciliation in the member's record.
E. **Quality Assurance Team:**
   i. Monitor compliance with the policy and review outcomes to identify areas for improvement.
   ii. Report on follow-up care metrics to internal and external stakeholders as required.

Attachment(s):

N/A

Statutory Reference(s):

Federal:

- 42 CFR § 422.112 – Access to Services
- 42 CFR § 422.133 – Return to Home Skilled Nursing Facility
- 42 CFR § 422.622 - Requesting immediate QIO review of the decision to discharge from the inpatient hospital.
- 42 CFR § 482.43 – Discharge Planning (Hospitals)
- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective July 19, 2024) – Sections 100.1 and 100.2

Contract Reference(s):

- Medicare Advantage D-SNP Health Plan Agreement Between Georgia Department of Community Health and Sonder Health Plans, Inc.

Element Reference(s):

N/A

Related Policy(s): (will update with policy id # once finalized):

- Appeals and Grievances Policy on QIO Appeals of Hospital Discharges