Policy Title: Discharge Planning		POLICY #: 70.2.14 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 12/97	**Effective Date** 5/19	**Revision Date** 12/18, 9/21
Department Head: Sr. Director, UM		**Date: 12/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 12/21**	

PURPOSE

To identify, evaluate, coordinate, and implement discharge planning needs by the Utilization Management (UM) Department for Blue Shield of California Promise Health Plan (Blue Shield Promise) Members when hospitalized.

POLICY

The UM Case Managers will perform concurrent review weekdays on a daily basis for all scheduled and non-scheduled inpatient admission. The review process includes chart review, data collection, review of care plan with the attending physician and other members of the healthcare team, as well as discharge planning. Discharge planning will begin on the day of admission for unscheduled inpatient stays. For elective inpatient stays, these needs may be identified prior to the hospitalization and coordinated through the Prior Authorization process. The UM Case Managers will follow members through the continuum of levels of care until the member is returned to his/her previous living condition prior to hospitalization when possible. When applicable, UM Case Manager will coordinate care with the member's Complex Case Manager to assist in discharge planning per policy 70.4.3. This approach is to ensure continuity of care and optimum outcomes for Blue Shield Promise members.

PROCEDURE

Multiple modalities are utilized to evaluate the member's clinical and psychosocial status for discharge needs:

Physician Plan of Care: This involves the active problem, clinical findings the patients past medical history and treatment plan.

Surgical Procedures: Indication of a complex outcome of surgery, co-morbidity's, unexpected complications, wound management, tubes, equipment etc.

Respiratory Management: O2 therapy, respiratory treatments, O2 saturation's etc.

Medication Regime: Pain management, ABT therapy, anticoagulation therapy, associated labs adverse reactions, insulin management, or medication teaching.

Therapies: Physical Therapy, Occupational Therapy, Speech Therapy.

Level of Care Required: SNF, Acute Rehab, Sub Acute, TCU, Home Health.

Teaching/Patient Goals: Patient's/family skill level regarding needs for self-care at home. Are treatment goals realistic for patient? What is patient's current potential? What was patient's activity prior to hospitalization?

Social Needs: Environmental considerations, patients support system, transportation access and other current living circumstances.

Discharge Planning:

1. Evidence of an evaluation by discharge planning/social services note should be on the patient's chart within 24hours. If not, a call will be placed requesting it.
2. Is there identification of discharge needs?
3. If identified, are the needs short term or long term?
4. Have patient needs been clearly communicated to all involved parties (physician, family members, direct care givers)?
5. If patient is going home, is there a need for home safety check?
6. Is there a need for additional resources (linked services, delivery of meals, transportation to physician appointments)?
7. All necessary DME supplies home health care and follow up appointments will be made prior to the patient leaving the hospital.
8. Transportation and placement arrangements will be made utilizing contracted providers.
9. If the Primary Care Physician (PCP) was not the attending physician of the patient while hospitalized, all effects will be made to notify him/her of any arrangements made for the patient. This may be done by one of the following mechanisms:
    a. Dictated hospital summary note from the attending physician
    b. Phone call from the attending
    c. Phone call from the Blue Shield Promise UM Case Manager
    d. Inpatient Hospital Notification Form faxed by the Case Manager (see attachment)

REFERENCES