TRANSITIONAL CARE MANAGEMENT:

Partnering with hospitals to support safe, coordinated discharges for NH Healthy Families members

nh healthy families

The Transitional Care Management (TCM) team supports and collaborates with our network facilities to effectively manage members in acute inpatient care facilities through discharge to home or other alternative setting. The TCM care navigation program allows NH Healthy Families to partner with our providers to assist patients achieve their discharge goals.

OUR TEAM

The Transitional Care Management (TCM) team includes Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Behavioral Health Clinicians, Social Workers, and care coordination professionals. The team works closely with NH Healthy Families clinical, utilization management, and community support teams to help members transition safely between care settings.

PROGRAM GOALS

- Promote safe, timely transitions across care settings
- Reduce avoidable hospital readmissions and emergency department visits
- Address barriers that may delay discharge or impact recovery
- Improve understanding of discharge plans, medications, follow-up care, and available resources

HOW TCM SUPPORTS DISCHARGE PLANNING

- Engages with hospitals after admission and throughout extended stays
- Participates in discharge planning and transition meetings, as appropriate
- Identifies and addresses barriers such as housing, transportation, food insecurity, caregiver support, and communication needs
- Coordinates services including home health, durable medical equipment, medication access, meals, behavioral health supports, waiver services, and community resources
- Facilitates expedited review of prior authorizations for covered outpatient services
- Schedules follow-up appointments with primary care, specialists, and behavioral health providers
- Supports transitions to home, residential treatment, skilled nursing facilities, long-term care, hospice, and other appropriate settings
- Coordinates behavioral health transitions with inpatient and community providers
- Shares discharge information with outpatient care teams, as appropriate
- Conducts post-discharge outreach to review care plans, assess needs, and offer ongoing care management services

INFORMATION HOSPITALS CAN SHARE WITH TCM

- Anticipated discharge date and destination
- Discharge barriers or complex care needs
- Hospital case manager or social worker contact information
- Follow-up appointments and aftercare needs
- Home services, equipment, medication, transportation, or community resource needs
- Member or caregiver communication preferences
- Changes in clinical status, discharge plans, or transfer location



CONTACT INFORMATION

NHHFTCMteam@CENTENE.COM

NHhealthyfamilies.com

1-866-769-3085
TDD/TTY: 1-855-742-0123

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