Kaiser Permanente Southern California
Transitional Care Navigator, Woodland Hills

Position Overview and Intent:
The *Transitional Care Navigator* is an evolved RN case manager position, designed to better support geriatric patients' transition from hospital to the home setting. Woodland Hills identified a current gap in care for patients who do not qualify for home health and were discharged without supporting resources or contacts. This care navigator will act as an advocate for the patient and caregiver from the onset of hospital admissions, until their follow-up, post discharge ambulatory care appointment to ensure patients are effectively supported between care settings.

The Transitional Care Navigator will be the main point of contact for the patient within the interdisciplinary team. The navigator will work with patients to identify their social/non-medical needs and then connect patients to community resources to address these barriers.

Position Core Duties:
- Provides customized roadmap with specific resources and touch points
- Coordinates with interdisciplinary team
- Identify social determinants of health
- Educates and connects patients to resources
- Advocates for patient to receive coordinated care across continuum

Targeted Outcomes:
Short-term
- Increased patient control and confidence
- Follow KP plan of care and discharge instructions
- Decreased anxiety for patient and family (greater family engagement)
- Safe, informed members
- Enough knowledge and resources to follow through with discharge plan

Long-term
- Empowered patient and family
- Decreased utilization (hospital, ER)
- Decreased cost of care
- Healthier patients and improved health outcomes

For more information, contact SCAL WFPD Co-leads:
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