

HEALTH PLAN POLICY	
Policy Title: Follow-up after Hospitalization for Behavioral Health Services	Policy Number: MUM21 Revision: B
Department: Medical Management	Sub-Department: Utilization Management
Applies to Product Lines:	
<input type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> USFHP
<input type="checkbox"/> Children's Health Insurance Plan	<input checked="" type="checkbox"/> Commercial Insured
<input checked="" type="checkbox"/> Health Insurance Exchange	<input checked="" type="checkbox"/> Non Insured Business
<input checked="" type="checkbox"/> Medicare	
Origination/Effective Date: 09/28/2017	
Reviewed Date(s):	Revision Date(s): 09/20/2018, 01/16/2020

SCOPE:

To outline the continuity of care activities conducted by CHRISTUS Health Plan and its Behavioral Health provider network to enhance the services provided to members and to support and maintain medical and behavioral health treatment gains after a hospitalization.

DEFINITIONS AND ACRONYMS:

None

POLICY:

CHRISTUS Health Plan requires that all contracted Providers schedule a follow-up appointment for and/or continuing treatment for all Members receiving inpatient psychiatric services treatment prior to discharge. The outpatient treatment goal for follow-up appointments must occur within seven (7) days from the date of discharge.

The purpose of the follow-up appointments is to ensure member stabilization, medication adherence and to avoid re-hospitalization.

CHRISTUS Health Plan will monitor Members that have been hospitalized for psychiatric services to ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule their appointments. The goal is to maintain member engagement in their individualized treatment plan.

I. Discharge Planning Process

- A. During the initial contact with the treating clinician, the CHRISTUS Health Plan Concurrent Review nurse discusses the anticipated discharge and follow-up plan for the member.
- B. CHRISTUS Health Plan's UM and Case Management teams actively collaborates with the treating provider throughout the medical admission or behavioral health treatment episode to develop a follow-up plan appropriate to the member's bio-psychosocial needs. Core aspects of discharge planning are:
 - 1. Identifying medical care needs and services required to support discharge to the appropriate level of care, home health, Durable Medical Equipment (DME), specialist appointments, dressing changes, diabetes education, etc.

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2. Assist with coordinating the scheduling of the follow-up inpatient admission or ambulatory service appointment so that it is within seven (7) days of the discharge date of an acute behavioral health inpatient stay;
 3. Confirm follow-up behavioral health treatment service has been established (date, time and provider) prior to discharge; and
 4. Assure that the member has been informed of the follow-up service scheduled.
 5. Offer the member resources that are community-based to support a successful transition.
 6. If the Case Manager team member is unable to obtain this information, he or she will follow-up with the member's behavioral health specialist to assure that an appointment has been made and/or the patient has been seen within seven days of discharge.
- B. All CHRISTUS Health Plan members with a serious mental illness (SMI) who have been admitted to an inpatient facility for a behavioral health crisis will be referred to the Case Management team for care coordination support and transitions in care activities.
- C. Once the follow-up plan has been finalized, the CM team member enters any appropriate authorizations for the scheduled follow-up service(s). The actual discharge date, disposition, living arrangements, prescribed medications, and medical and behavioral health treatment plan including established follow-up services scheduled is also documented in the case management system.
- If aftercare services are not scheduled prior to discharge despite interventions by the CHRISTUS case management team, the CM documents the reason in the case management system.
- II. Welcome Home Calls
- A. To support members during the critical post-discharge period, the Case Management team will conduct a Welcome Home call within three days of notification of discharge to all members. The Welcome Home call will focus on the following:
1. Assess member's understanding on their short term treatment plan;
 2. Medication reconciliation as needed with assistance from the Behavioral Health Care Provider
 3. Updating member's case management plan to facilitate communication across providers; and
 4. Assuring member understands the importance of following up with their primary care provider and behavioral health medical provider.
- III. Follow-up Treatment Adherence Tracking
- A. Within one (1) business day following the scheduled follow-up services the CM or Associate is responsible for confirming with the follow-up provider that the member did adhere to the follow-up treatment plan.
- B. The following documentation elements are required in the care management system for follow-up service verification:
1. Actual date seen by the provider;
 2. Name and credential of the servicing provider;

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3. Name and title of CHRISTUS Health Plan staff that verified the kept visit (i.e., provider, provider representative, case management, or utilization management review (UM) staff, office staff);
 4. Disorder type being treated by provider (mental health (MH), alcohol or drug (AOD) or medical); and
 5. Setting/type of service (e.g., office, intensive outpatient program, partial hospitalization, residential treatment facility, non-acute/rehab hospital unit/bed.)
- C. Barriers to follow-up adherence are trended and identified for interventions.
1. The UM Nurse or Case Management team member will begin discharge planning within 24 business hours of notification of admission.
 2. Concurrent Review discharge planning seeks to meet the member's needs while at the lowest level of care.
 3. The concurrent review staff coordinate discharge planning with the facility case manager (CM).
 4. Discharge planning will be discussed regularly with the Medical Director during rounds.
 5. The concurrent review Nurse or Case Management team member will discuss any complex discharge plans with the Medical Director or Director of Medical Management for appropriateness.
 6. Discharge planning disposition will be documented by concurrent review RN or Case Management team member in the Concurrent Review Template and includes discharge disposition:
 - a. Home
 - b. Sub-Acute Rehabilitation
 - c. Hospital/HHC
 - d. Hospice
 - e. Skilled Nursing Facility
 - f. Other possible settings.
 7. In the CM system, document, "D/C date verified with xxxxxx".
 8. Place discharge in the assigned Case Manager's work queue for transitions in care/welcome home follow-up calls.

REFERENCES:

None

RELATED DOCUMENTS:

None

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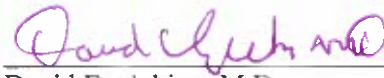
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Nancy Horstmann
Chief Executive Officer Health Plans

1/27/20

Date



David Engleking, M.D.
Medical Director Health Plans

1/27/20

Date

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	09/28/2017	Initial release.	Board of Directors
A	09/20/2018	Annual review - lines of business updated.	Executive Leadership
B	01/16/2020	Annual review. Updated References and miscellaneous verbiage throughout policy.	Executive Leadership