CHAPTER 13 - SERVICE AUTHORIZATION

13.4 DISCHARGE PLANNING

Health Choice Integrated Care developed and implemented a discharge planning process to address the post-discharge clinical and social needs of the member upon discharge. The process is initiated by a qualified health care professional as soon as possible before, upon or immediately after admission and updated periodically during the inpatient admission to ensure accurately determined continuing care needs. The discharge plan must be appropriately documented in the person’s medical record and must be completed before discharge occurs. Health Choice Integrated Care ensures that its subcontracted providers have a process that includes:

• Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post discharge bio-psychosocial and medical needs of the eligible person prior to discharge. This process shall include the involvement and participation of the eligible person and representative(s), as applicable.

• The person and representative(s), as applicable, must be provided with the written discharge plan with instructions and recommendations identifying resources, referrals and possible interventions to meet the person’s assessed and anticipated needs after discharge.

• The coordination and management of the care that the eligible member receives following discharge from an acute setting. This may include:
  o Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the person’s primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge;
  o Coordination of care involving effective communication of the eligible person’s treatment plan and medical history across the various outpatient providers to ensure that the member receives medically-necessary services that is both timely and safe after discharge. This includes access to nursing services and therapies;
  o Coordination with the member’s outpatient clinical team to explore interventions to address the member’s needs such as case management, disease management, placement options, and community support services.
  o Access to prescribed discharge medications;
  o Coordination of care with the acute care plan when applicable; and

• Post-discharge follow up contact to assess the progress of the discharge plan according to the member’s assessed clinical (physical health care) and social needs.

The discharge plan must be documented in the member’s medical record.

Behavioral Health Discharge Planning, Notifications and Appointments

- Discharge planning is the primary responsibility of the inpatient and chemical dependency (CD) residential facility treatment team with input and collaboration from HCIC Medical Management unit and the individual’s referring behavioral health home (BHH) clinical team.

- The inpatient and CD residential facility will notify the outpatient BHH clinical team of discharges 24 hours prior to discharge so that appropriate arrangements may be made.
The first post-discharge follow-up face-to-face behavioral health medical service is scheduled by the inpatient team prior to discharge at the outpatient provider as part of the discharge plan.

For follow up after inpatient hospitalization, the outpatient provider must provide this first post-discharge follow-up service in a timely fashion ideally within 7 days after discharge as per Section 2.3 Outreach, Engagement, Re-Engagement and Closure.

The outpatient provider must prioritize appointments within seven days of discharge with a medical practitioner, within a timeframe that ensures that the person does not run out of any needed psychotropic medications and within a timeframe indicated by clinical need, but no later than 7 days. [See HCIC 2.1 Appointment Standards and Timeliness of Service. See HCIC 2.3 Outreach, Engagement, Re-Engagement and Closure.]

Inpatient, Residential and HCTC Facilities Discharge Notifications

In order to identify members with longer than expected lengths of stays or unexpected readmissions to higher levels of care, to track length of stay accurately and to flag the member for a discharge follow up call by an HCIC Member Services Representative:

- Behavioral Health Inpatient Facilities, Behavioral Health Residential Facilities and HCTC providers must report all admissions, transfers and discharges by completing and submitting HCIC Notification of Admission, Discharge and Transfer Form for BHIF, BHRF, HCTC within 5 days of the occurrence to HCIC_MMReporting@iasishealthcare.com or fax 855-408-3401.
- Inpatient Psychiatric Hospitals and Sub-Acute Facilities submit a discharge notification or the member’s discharge summary within 1 business day of discharge to HCIC_MMReporting@iasishealthcare.com or fax 855-408-3401.
- CD residential facilities must report all admissions and discharges to HCIC Medical Management unit by entering the change into HCIC ICE portal “My CDR Placement” within 5 days of the occurrence.

ACCESS TO DURABLE MEDICAL EQUIPMENT (DME) FOR ARIZONA STATE HOSPITAL DISCHARGES

Individuals who are discharged from the Arizona State Hospital (AzSH) must be provided with the same brand and model of glucometer and supplies and the individual was trained on while in the hospital.

INTERVENTIONS

To ensure appropriate discharge needs of the member are met upon discharge from the inpatient setting and to provide services to promote continuity of care for the member, discharge planning needs are identified by the Medical Management Specialist upon review of the medical record, and communicating with the facility discharge planner and/or attending physician.

- Interventions include, but are not limited to:
  - Assigning a designated HCIC integrated Care Manager or Population Care Lead with specialized expertise, for example youth in transition services, developmental disabilities, medical conditions, Arizona State Hospital, nursing, etc.
  - Working with inpatient teams for proactive discharge planning
  - Coordinating care between providers, hospitals, government agencies, and other stakeholders
  - Locating and securing services for members with complex care needs, e.g. sexually maladaptive behaviors, eating disorders and severe aggression
  - Consulting with Health Homes (HHs), providers, hospitals, health plans and other entities in supporting members
  - Ensuring teams are using appropriate clinical practice guidelines and protocols
- Referring members to a DDD Community Collaborative Care Team or Assertive Community Team (ACT) or to HCIC’s Top Tier Care Management Program
- In cases where Health Choice is not the primary payor, HCIC Medical Management staff are available for discharge assistance.

**Post-Discharge Follow-Up Outreach**

An HCIC “Buddy” who is a Member Services Representative does outreach calls to members within 3 days of discharge from an inpatient facility. The outreach call is to check on the well-being of the member, identify any needs, ensure medications have been received if needed, answer questions about post-discharge services and DME, make sure member knows about post-discharge appointments and engage the member in ongoing care. If the member is in HCIC’s Top Tier Care Management Program, the HCIC Integrated Care Manager also ensures the member’s assigned HH case manager engages the member within a few days of discharge. The goal of this program is to assure team implementation of the discharge plan including any required follow-up care, and to assist in coordination of any needed care or service to prevent adverse outcomes or unnecessary re-admissions.