POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Behavioral Health Follow-Up After Hospitalization
PAGE: 1 of 4	**REFERENCE NUMBER:**
APPROVAL DATE:	**REPLACES DOCUMENT:** N/A
EFFECTIVE DATE:	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:**

SCOPE:
This policy applies to employees of Louisiana Healthcare Connections (Plan) Behavioral Health Department.

PURPOSE:
The purpose of this document is to outline the requirements for the Plan to provide Follow-Up after Hospitalization (FUH) services to enrollees.

The objective of this service is to coordinate the continuation of care as enrollees transition from acute care facilities into the community to ensure appropriate access to needed follow-up care and medications, with the goal of preventing secondary health conditions or complication, re-institutionalization, re-hospitalization, unnecessary emergency room visits, and decreasing health care expenditures.

POLICY:
The Plan must require, through provider contract provisions, that all enrollee's receiving inpatient psychiatric services are scheduled for outpatient follow-up or continuing treatment prior to discharge.

The Plan will ensure that for the behavioral health population, enrollees will receive aftercare planning prior to discharge from a 24 hour facility (6.30.2.15).

The Plan will maintain and operate a formalized hospital and/or institutional discharge planning program (6.30.2.10).

The plan will coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge (6.30.2.11).

The plan must have policies and procedures requiring and assuring that care managers follow-up with enrollees with a behavioral health-related diagnosis within 72 hours following discharge from an inpatient facility (6.30.2.11.2).

The plan must coordinate with LDH and other state agencies following an inpatient, PRTF, or other residential stay for enrollees with a primary behavioral health diagnosis occurs timely, when the enrollee is not to return home (6.30.2.11.3).

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The plan will collaborate with hospitals, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers (8.1.3.10).

The Plan will ensure that the enrollee receive reminder calls prior to their aftercare appointment to offer assistance removing barriers to attendance.

The Plan will make telephone calls and home visits only to enrollees for education and outreach for the purpose of educating them about services offered by or available by the plan (12.4.1.2).

PROCEDURES:

The Plan will utilize the daily Inpatient census to Identify enrollees who have been admitted to inpatient psychiatric facilities.

Community Health Workers (CHW's) will work face to face with enrollees and Inpatient psychiatric discharge planners, to establish preliminary discharge planning for the Plan's enrollee while inpatient. CHW's will assess the enrollees outpatient service needs and communicate with them about the types of covered services which are available to them.

In collaboration with discharge planners, CHW's will assist with determining what community-based services and other support needs are identified as the enrollee's choice. An aftercare appointment with a behavioral health provider should be scheduled within 7 days from the discharge date. The Plan's enrollees must attend an aftercare appointment within 30 days from their discharge date.

The CHW's will use the care form to update demographic information, and other relevant information during the visit.

If the enrollee has discharged prior to the visit, the CHW will secure the discharge documents, and review to ensure that an aftercare appointment has been scheduled. The discharge documents should be uploaded to the enrollee's record in TruCare.

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The CHW will create a task in TruCare to the behavioral health care coordinator (BHCC), to follow-up with the enrollee to confirm aftercare attendance. The task note should include the enrollees discharge date, and indicate that the discharge documentation has been uploaded to the document summary section of TruCare.

The BHCC will telephonically outreach all enrollees, who have been referred by CHW's, two days prior to their appointment to remind them of their appointment, complete the Post Discharge Outreach (PDO) assessment, assist with scheduling transportation, and to discuss any barriers to attendance.

The BHCC will contact the enrollee telephonically 1 day after their scheduled appointment to follow-up on successful attendance.

Enrollee missed their Appointment: If the enrollee has not attended the appointment, the BHCC will discuss the barrier to attendance and offer to reschedule the appointment. If the enrollee agrees, the BHCC will contact the provider and re-schedule the enrollee's appointment. The BHCC will repeat this process until the enrollee attends an appointment within 30 days of the discharge date (6.39.3.1).

The enrollee will be educated about Behavioral Health case management services and offer enrollment. If enrollee agrees, the case will be referred to BHCM services.
Thereafter, the BHCC will complete a note in TruCare, and document the outcomes on the HEDIS SharePoint site at https://cnet.centene.com/sites/LHCC/Med%20Mgnt/BehavioralHealthProgramSite/Lists/HEDIS%20FollowUp/AllItems.aspx
Enrollee attended their appointment: The BHCC will offer the Enrollee case management services and refer to the BHCM queue to be assigned to a case manager. BHCC will complete a note in TruCare, and document the outcomes on the HEDIS SharePoint site.

The enrollee has the right to decline case management services or CHW coordination of care.

The Program Manager will provide reporting to the Plan's Quality Department weekly and to HEDIS Steering committee monthly.

ATTACHMENTS:

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Life Coach Care
Form Revised 2.14.2(

REFERENCES:

DEFINITIONS:

REVISION LOG

REVISION	DATE
Policy creation and review with Plan policy meeting	4/20

APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.

Sr. VP, Population Health –Electronic Signature on File
Chief Medical Officer- Electronic Signature on File