HEALTH PLAN POLICY	
Title: Follow-up after Hospitalization for Behavioral Health Services	**Number:** MCM12 **Revision:** F
Department: Medical Management	**Sub-Department:** Care Management
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☒ Medicare ☐ Commercial Insured ☐ Non-Insured Business ☒ Health Insurance Exchange ☒ USFHP ☐ Medicaid	
Effective Date: 09/28/2017	
Revision Date(s): 09/20/2018, 01/16/2020, 12/21/2020, 12/14/2021, 12/20/2022, 04/04/2024	

PURPOSE:

The purpose of this Transition of Care Policy for Behavioral Health (Mental Health and Substance Abuse) members identified for Care Management services is to establish a structured framework that ensures the seamless and collaborative transition of care for members with a primary diagnosis of Behavioral Health, including those with Severe and Persistent Mental Illness (SPMI). By emphasizing coordination between medical care and behavioral healthcare, this policy aims to optimize comprehensive care management services, facilitating a smooth transition from acute care settings to community-based care.

DEFINITIONS AND ACRONYMS:

- **Care Management (CM)** – A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
- **Behavioral Health (BH)**
- **Behavioral Health Social Worker (BHSW)**
- **Durable Medical Equipment (DME)** – Products ordered or prescribed by a health care provider for every day or extended use by a patient. The equipment is intended to last for more than one use and can help aid in a better quality of living.
- **Severe and Persistent Mental Illness (SPMI)**

POLICY:

This policy outlines the systematic approach to the transition of care for members with a primary diagnosis of Behavioral Health, emphasizing collaboration between medical care and behavioral healthcare. The focus is on providing comprehensive care management services to ensure a smooth transition from acute care settings to the community.

I. Disease Process: Transition of Care with Behavioral Health Focus

Members who have been discharged with a primary diagnosis of Behavioral Health will be identified for care management services.

II. Care Manager/Behavioral Health Social Worker Core Functions

1. **Behavioral Health Emergency Room and Behavioral Health Inpatient Discharge Workflow:**

- Care Management Nurse or Behavioral Health Social Worker will review discharge notifications in the EMR, triggering a comprehensive review of discharge plans.
    - Care Management Nurse or Behavioral Health Social Worker will outreach to member within 24-48 hours after discharge.
- Utilize Motivational Interviewing Tools, emphasizing the Person-Centered Counseling approach.
- Conduct a Transition of Care (TOC) Assessment, including medication reconciliation, readiness for change assessment, and identification of educational opportunities.
- Document all touchpoints with members in the electronic medical record.

2. **Care Management Behavioral Health Assessment Process:**
    - Assess health and pharmacy literacy.
    - Assist in scheduling follow-up appointments/referrals to a Behavioral Health provider and educate on compliance.
    - Identify and address barriers to treatment adherence/physiotherapy.
    - Assess the need for referral to community resources.
    - Educate members on preventive and healthy lifestyle changes.
    - Complete medication reconciliation.
    - Develop a Care Plan with mutually agreed upon short term and long-term goals. Document barriers to goals, if any.
    - Establish a follow-up call schedule, including specific post-discharge intervals.

III. Annual Data Collection Documentation: Collaboration Between Medical Care and Behavioral Healthcare

1. **Collaboration Initiatives:**
    - All members with a Severe and Persistent Mental Illness (SPMI) who have been admitted to an inpatient facility for a behavioral health crisis will be referred to the BHSW for care coordination support and transitions in care activities. The BHSW will refer the member to the CM Care Manager if, upon assessment, the BHSW determines that the member has medical issues better suited for the expertise of the Registered Nurse (RN).
    - Document and quantify collaborative initiatives between medical and behavioral healthcare, such as joint care planning sessions, interdisciplinary meetings, and shared decision-making processes.
    - Capture the frequency and nature of collaboration, including the integration of behavioral health into primary care settings and vice versa.
    - Collect data on the coordination of treatment plans between medical and behavioral health professionals.
    - Document joint assessments, treatment plan reviews, and modifications based on both medical and behavioral health considerations.

2. **Access to Care:**
    - Document the accessibility of behavioral healthcare for members, including wait times for appointments, availability of crisis intervention, and the integration of behavioral health into telehealth services.
    - Assess the ease of referrals between medical and behavioral health providers.
3. **Follow-Up Procedures:**
    - Document the processes in place for follow-up care after medical or behavioral health interventions.
        1. The outpatient treatment goal is to ensure the member discharging from the emergency room, has a BH provider appointment within 7 days of discharge.
        2. The outpatient treatment goal is to ensure the member discharging from an inpatient facility, has a follow up appointment with a BH provider within 30 days of discharge.
    - The purpose of the follow-up appointment is to ensure member stabilization, to promote medication adherence, and to prevent re-hospitalization.
4. **Outcome Measurement:**
    - Establish key performance indicators (KPIs) to measure the outcomes of collaborative efforts.
    - Analyze clinical outcomes, such as improvements in mental health symptoms, medication adherence, and overall health status.
    - Assess healthcare utilization outcomes, including a reduction in emergency room visits and hospital readmissions.
5. **Member Satisfaction:**
    - Collect feedback from members regarding their satisfaction with the integrated care approach.
    - Utilize surveys and interviews to gather qualitative data on members' experiences with collaborative care.

IV. Data Sources:

1. **Electronic Health Records (EHR):**
    - Extract relevant data from EHR systems to analyze treatment plans, medication adherence, and clinical outcomes.
2. **Claims and Utilization Data:**
    - Analyze claims data to assess healthcare utilization patterns, including emergency room visits, hospitalizations, and outpatient services.
3. **Member Surveys:**

- Administer surveys to collect member feedback on their experiences with collaborative care, focusing on perceived improvements in their health and overall satisfaction.

4. **Provider Interviews and Surveys:**
    - Collaborate with the Quality team to engage healthcare providers in structured interviews or surveys to gather insights into their experiences with collaboration, perceived barriers, and recommendations for improvement.

V. Data Analysis and Reporting:

1. **Quantitative Analysis:**
    - Conduct analyses to quantify the impact of collaborative efforts on treatment outcomes and healthcare utilization.
2. **Qualitative Analysis:**
    - Analyze qualitative data from member and provider interviews to identify themes related to collaboration effectiveness and areas for improvement.
3. **Annual Report:**
    - Compile all data findings into an annual report highlighting key achievements, challenges, and recommendations for enhancing collaboration between medical care and behavioral healthcare.
        1. Metrics to collect annually:
            - Readmission Rates: Compare readmission rates before and after implementing TOC process.
            - Patient Satisfaction Surveys: Assess patient experiences during transitions.
            - Treatment Outcomes: Evaluate health improvements post-transition.

VI. Continuous Improvement: This documentation will serve as a foundation for continuous improvement, with regular reviews and updates to enhance the effectiveness of collaborative efforts between medical care and behavioral healthcare.

REFERENCES:

- National Committee for Quality Assurance (NCQA) Standards 2022 UM 6 Clinical Information, Element B Relevant Information for Behavioral Healthcare Decisions.

RELATED DOCUMENTS:

- Behavioral Health Care and Physical Health Care Coordination Policy (MCM03)

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REVISION HISTORY:

Revision	Date	Description of Change	Approval 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
C	12/21/2020	Annual review. No change to policy content.	Executive Leadership
D	12/14/2021	Annual review. Moved from Utilization Management, MUM21. Updated References	Executive Leadership
E	12/20/2022	Annual review. No changes to policy content.	Executive Leadership
F	04/04/2024	Annual review. Policy was entirely re-written to incorporate NCQA standards and provide information on transition of care with behavioral health focus, staff core functions, annual data collection documentation, data sources, data reporting, and continuous improvement in relation to behavioral health.	Executive Leadership