Section: **Clinical Practices**	Procedure Name: **Discharge Planning, Care Transition, & Follow Up**	Procedure #: **MHL P12.08.01**
Overarching Policy: **MHL 12.08 – Discharge Planning, Care Transition, & Follow Up**		
Owner: **Manager of UM & Call Center**	Reviewed By: **Elizabeth Guisinger, LPC, CAADC** **Bangalore Ramesh, MD**	Total Pages: **4**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Elizabeth Guisinger Elizabeth Guisinger (Jun 4, 2020 10:39 EDT) B K Ramesh B K Ramesh (Jun 8, 2020 15:32 EDT)	Date Approved: Jun 4, 2020
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☐ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **5/20/2020**

Policy: It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) to provide/assure that discharge planning, care transition and follow up services meet the contractual and regulatory requirements of National Committee for Quality Assurance (NCQA), the Michigan Department of Health and Human Services (MDHHS) contract and Center for Medicare and Medicaid Services (CMS), Code of Federal Regulations (CFR) and the Public Health Code and advance the recovery and/or independence of SWMBH customers. This will be accomplished by establishing collaborative, planning relationships among CMHSP's, behavioral health, substance use disorder and medical health care providers and establishing procedures and protocols that support SWMBH principles.

Purpose: Transition and Discharge Planning is considered an integral part of treatment, particularly in higher/short-term levels of care. Consideration of the continuum of care and long-term recovery needs of the member will be considered at every step of treatment planning. Discharge planning, care transition and follow up intends to improve the quality of care, improve outcomes and control costs by assuring plan coordination in which primary and specialty mental health, substance use disorder and health providers inform each other regarding their treatment of an individual and collaboration regarding the needs of the patient/individual and acting together to develop an integrated health aftercare plan and implement ongoing aftercare in a manner that eliminates barriers to and duplication of services.

Scope: To describe a clear method for assuring member discharge and transition from inpatient psychiatric care occurs in a coordinated fashion with follow up outpatient care provided within specified timeframes.

Responsibilities: SWMBH staff will plan discharge aftercare upon member's admission, including but not limited to determining medically necessary level of outpatient care, complete level II if appropriate, make referrals and assist in securing follow-up appointments, and securing Release of Information for applicable parties.

Definitions: None

Procedure:

A. Southwest Michigan Behavioral Health (SWMBH) shall begin discharge planning upon a member's admission to an inpatient psychiatric facility. SWMBH staff shall work with the inpatient unit staff to establish a discharge/care transition follow up plan including:
   1. Determining medically necessary outpatient level of care
   2. Completing Level II Assessment
   3. Making referrals to outpatient care and securing follow up appointments
   4. Securing Release of Information to applicable parties

B. Upon discharge, SWMBH staff will provide follow up calls at specified intervals to both the member and the provider to track if follow appointments are kept and to assist with resolving barriers to making it to appointments.

C. Referrals for Community Mental Health Service Provider (CMHSP) specialty services shall be made when:
   1. The Level of Care Utilization System (LOCUS) score indicates a specialty services level of care according to the SWMBH Level of Care Guidelines; or
   2. The member meets medical necessity criteria for CMHSP specialty services; or
   3. The member meets the Medicaid Provider Manual criteria for a specific specialty service

D. SWMBH will make a referral for and the CMHSP shall provide at minimum targeted case management to facilitate and coordinate follow care when a member has been
   1. Hospitalized for 14 days or more; or
   2. If the member has been psychiatrically hospitalized twice in a 12-month period.

E. For persons meeting medical necessity criteria for Prepaid Inpatient Health Plan (PIHP) specialty services or those already involved in CMHSP services, the CMHSP shall be involved in inpatient discharge planning. The CMHSP staff shall work with SWMBH and inpatient staff to establish a discharge/care transition follow up plan including:
   1. Participating with the inpatient treatment team and in discharge planning when and as requested by SWMBH staff.
   2. Facilitating referrals for medically necessary services including securing safe housing upon discharge, psychiatric evaluation or medical review follow up and referral to primary care physician.

3. Providing a qualified follow-up service within 7 and 30 days of discharge (See Attachment P12.8.1A Follow-Up to Hospitalization Code List).
    a. 7-day qualified services include Medicare covered outpatient behavioral health assessment, individual or group therapy, or psychiatric evaluation or medication review services or Medicare covered physical health physician evaluation or office visits or those specified on the code list.
    b. 30-day qualified services only include Medicare covered outpatient behavioral health assessment, individual or group therapy, or psychiatric evaluation or medication review services or Medicare covered physical health physician evaluation or office visits or those specified on the code list.
4. Securing necessary Michigan Department of Health and Human Services (MDHHS) Standard Consent Form.

Effectiveness Criteria: Members will be discharged to the appropriate level of care and referred to medically necessary services that will adequately meet their needs.

References:

A. Michigan Mental Health Code.
B. MDHHS Plan Requirements and Technical Information.
C. MDHHS/PIHP Managed Specialty Supports and Services Contract
D. MDHHS Medicaid Provider Manual
E. 42 CFR 438.10(f) (5)
F. MHL Policy 12.08 Discharge, Planning, Care Transition & Follow-Up
G. SWMBH Policy 10.21 Use of MDHHS Standard Consent Form

Attachments: MHL P12.08.01A Follow-Up to Hospitalization for Mental Illness Code List

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	5/20/2020	Separated Procedure from Policy	Annual Review	E. Guisinger

MHL P12.08.01 Discharge Planning, Care Transition & Follow Up

Final Audit Report 2020-06-08

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