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Owner:	Harriett Siddiqui
Policy Area:	Integrated Health Care
References:	NCQA CC3

Integrated Health Care Initiatives Care Coordination: Transitions in Care from Psychiatric Inpatient Settings

POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) to promote care coordination services to link individuals to needed outpatient behavioral and/or medical health care as they discharge from inpatient psychiatric settings.

PURPOSE

The purpose of this policy is to ensure that individuals are linked to needed outpatient behavioral, substance use disorders (SUD) and/or medical care as well as engaged in community resources that will support them in preventing readmissions, improve quality of life, and promote the delivery of cost-effective outpatient services.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWMHA Board, DWMHA Staff, Contractual Staff, Access Center, MCPN Staff, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, Autism
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. Case Manager
2. Consent to Share Information
3. Care Coordination
4. Community Outreach for Psychiatric Emergencies (COPE)
5. Integrated Care Organization (ICO)
6. Integrated Health Care

7. Manager of Comprehensive Provider Networks (MCPN)
8. Pre-Paid Inpatient Health Plan
9. Recidivism

STANDARDS

1. All individuals within the DWMHA network will have Care Coordination services available as they begin to transition back into the community from an inpatient psychiatric setting.
 - a. Focus will be on individuals who are not linked to services or who have a high recidivism rate – though the services are available to everyone.
2. DWMHA's Utilization Management (UM) and Care Coordination (CC) as well as MCPNs, their contractors and subcontractors will review psychiatric inpatient admissions or other acute care activity documented in respective electronic records.
3. Care Coordinators will contact the appropriate hospital, intensive crisis residential, SUD, legal, and/or CMH facilities to begin discharge planning.
4. Individuals involved in Care Coordination are active participants in the discharge planning as are their guardians and/or identified advocates.
 - a. Care Coordinators may meet with individuals while they are inpatient to initiate the engagement process and identify needs.
5. Care Coordination can assist with linkage to behavioral and/or medical health care services as well as housing, community inclusion, etc.
6. Care Coordination services will be discontinued once individuals are linked to services and are under the appropriate behavioral and/or medical care.
7. Care Coordination activities must be identified in the Individual Plan of Service (IPOS) and must include the amount, scope and duration that services will be provided. Frequency of contact by the Care Coordinator will be as clinically appropriate.
8. Care Coordinators must be appropriately credentialed and privileged; and are not to deliver services outside their scope of practice as defined in applicable policies and statutes, such as MDHHS Medicaid Provider Manual and the most recent version of the accompanying Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes.
9. Care Coordinators will gather data monthly to measure outcomes – including face-to-face meetings, phone contact with facility staff, final disposition, etc. and make adjustments to the Care Coordination process as needed based on the data.

QUALITY ASSURANCE/IMPROVEMENT

DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, MCPNs, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. MDHHS contract attachment P.9.3.1 and P.13.O/B
2. Michigan Mental Health Code, section 330.1209a
3. Individual MI Health Link contracts with the Integrated Care Organizations (ICOs)

RELATED POLICIES

1. Referral, Integration and Coordination of Care
2. Individual Plan of Service/Person Centered Plan

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Integrated Health Care
5. Managed Care Operations
6. Quality Improvement
7. Recipient Rights
8. Substance Use Disorders
9. Utilization Management

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

[Transitions in Care Procedure - 02232017.pdf](#)

Approval Signatures

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Dana Lasenby: Deputy Chief Operating Officer	05/2017

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	Procedure Title: Care Coordination: Transitions in Care from Inpatient Psychiatric Settings
	Procedure Origination Date: 01/30/2017
	Procedure Revision Date:
	Procedure Owner: Harriet Siddiqui/Julia Kyle
	Department: Integrated Health Initiatives
	Line of Business: DWMHA – Integrated Health Care Initiatives – Transitions in Care
	Regulatory Requirements: NCQA
	Associated Policy: Integrated Health Care Initiatives: Transitions in Care from Inpatient Psychiatric Settings

PROCEDURE PURPOSE

To provide guidelines for the delivery of care coordination services to individuals admitted to a psychiatric inpatient setting, intensive crisis residential facility, and/or SUD treatment facility.

EXPECTED OUTCOME

Delivery of Care Coordination services:

- To ensure individuals are linked to needed behavioral, SUD and/or medical health care services
- To encourage use of outpatient medical and behavioral health services in an effort to reduce overuse of unnecessary or preventable urgent or emergent services.
- To improve quality of life and overall functioning

PROCEDURE

- A. DWMHA’s Utilization Management (UM) and Care Coordination (CC) will review psychiatric inpatient admissions or other acute care activity documented in DWMHA’s electronic record on a daily basis. The information is typically in the Pre-Screening Assessment completed by the Community Outreach for Psychiatric Emergencies (COPE).
- B. CC will contact the hospital or other facility to obtain verbal information regarding the individual’s potential needs at discharge
- C. CC will notify the appropriate Community Mental Health (CMH) agency, medical health plan (MHP)/Integrated Care Organization (ICO) of the admission via email or other electronic means.

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- a. The CC will ensure that hospital staff contact WellPlace (1-800-241-4949) – DWMHA’s Access Center – to schedule an aftercare appointment that is within 7 days of discharge.

- D. CC identifies if the individual requires specialized residential services
 - a. If no, continue to step E
 - b. If yes, the CC will proceed as follows:
 - i. CC will identify the individual’s assigned MCPN and share the information with hospital social worker
 - ii. The hospital social worker faxes a clinical packet to the MCPN; this packet includes a psychosocial assessment, psychiatric evaluation, history and physical, nursing assessment, and current medication list
 - iii. CC explores potential transitional/pre-placement opportunities with the MCPN should the individual need to discharge from the acute care facility prior to location of placement
 - iv. A level of care assessment is completed by the MCPN to determine appropriateness for specialized residential placement
 - v. CC and MCPN will remain in direct contact throughout the placement process to ensure the individual’s needs are met and concerns considered
 - vi. MCPN will notify CC and hospital staff of the outcome of their placement efforts as well as an address, phone number, and contact person at the specialized residential facility
 - vii. CC will keep MHP/ICO and CMH service provider case manager/supports coordinator apprised of MCPN’s placement efforts

- E. Hospital social worker will provide discharge information to DWMHA UM or the appropriate MCPN for each enrollee (via fax or by secure scan). Discharge information will include the following:
 - a. Individual’s aftercare appointment – scheduled with an outpatient provider of individual’s choice – within 7 days of discharge
 - b. List of discharge medications – with appropriate sample size and scripts given to the individual
 - c. Referrals for medical follow-up and/or any recommended labs or screening evaluations
 - d. Address where the individual is being discharged to as well as contact phone number
 - i. Individuals should not be discharged to a shelter
 - e. If the individual has a guardian, the guardian’s name and phone number should be provided

- F. The hospital social worker will fax the discharge information to the identified service provider to avoid any gaps in service
 - a. CC will follow-up with hospital social worker and/or outpatient service provider to ensure that the discharge information has been faxed to and/or received by the appropriate outpatient service provider

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- G. CC notifies MHP/ICO of discharge information via follow-up email
- H. CC follows up with the outpatient service provider as appropriate to ensure that the individual's needs are met and to determine whether CC services are still needed. If not, CC services are discontinued; they will be re-instated as needed or if the individual is readmitted.

Procedure Monitoring & Steps

Who monitors this procedure: Name/Title of person

Department: _____

Frequency of monitoring: _____

Reporting provided to: _____

Comments: _____