Psychcare’s Aftercare / HEDIS Initiative Training
Topics

- Discharge Planning
- 10 Steps to Effective Discharge Planning
- How Psychcare supports your Discharge Planners
- The HEDIS measure
- 7 and 30 day appointment requirements
- Exclusions
- The Bridge Visit
- Preventing Readmissions
- Performance Scorecards
Effective Discharge Planning could make the difference between compliance and readmission.

- Effective discharge planning is crucial to care continuity. The fundamental principles of discharge planning have not changed over many years. However, the process has changed considerably. Research indicates that the increasingly ageing population and the complex needs of today’s patients, make discharge planning more difficult.

- There is a huge breadth of alternative services to hospital admissions aimed at increasing the pace of a safe discharge or transfer. These include: outreach services, rapid-access treatment centers, in-home services (contingent on benefit), mobile crisis units, and coordination of care programs.
10 Steps to Effective Discharge Planning

1. Start planning on admission
2. Identify whether the patient has simple or complex needs
3. Develop a Clinical Management Plan within 24 hours of admission
4. Coordinate the discharge or transfer process
5. Set an expected date of discharge within 48 hours of admission
6. Review Clinical Management Plan daily
7. Involve Patients and Caretakers
8. Revisit Discharge and/or Transfer Plan every day, to address needed modifications
9. Use a Discharge Checklist prior to discharge
10. Ensure that discharges are occurring each day (including holidays and weekends)
How Psychcare Supports Your Discharge Clinicians

Psychcare’s Discharge Clinician(s):

• Works with clinical staff and other departments within Psychcare to ensure Psychcare members’ discharge information is received timely from our participating providers and entered timely within our systems.
• Will engage with providers to ensure proper member information for aftercare follow up is given.
• Will identify training needs at facilities and regularly works to help educate providers on the importance of appropriate discharge planning.
• Identifies aftercare trends at treatment facilities and finds opportunities to increase provider awareness and education.
• Provides regular telephonic support to treatment providers and assists with questions/concerns about treatment follow up options.
• Analyzes specific discharge problems, plans and implements solutions that directly influence quality of care and discharge planning.
• Interacts with physicians and other members of the provider clinical team for discharge planning/discharge information.
• May provide information to members and providers regarding mental health and substance abuse benefits, and community treatment resources.
• Interacts with providers and facilities in a professional, respectful manner that facilitates the discharge process.
The HEDIS Measure

- HEDIS is the Healthcare Effectiveness Data and Information Set.
- It is a tool used by more than 90% of America’s health plans to measure performance on important dimensions of care and service.
- All in all, HEDIS consists of 81 measures across 5 domains.
- Because of its widespread use by Health Plans across the country, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans effectively.
- Psychcare’s Health Plan Partners look to us as behavioral health experts to ensure that their HEDIS outcomes scores are above the set benchmarks.
- Health Plans falling below designated percentages can face sanctions/fines and Medicare Advantage Plans may see diminished STAR ratings.
7 & 30 Day Appointment Requirements

- Providers discharging patients to community practitioners or programs for intermediate and/or outpatient levels of care, are required to schedule a follow-up visit within 7 calendar days of discharge date.
- These appointments need to be scheduled for the actual service; not a walk-in appointment or a wellness check.
- The appointments have to be with a licensed behavioral health practitioner and/or a program (i.e. Intensive Outpatient Program, Psychosocial Rehabilitation, or Partial Hospitalization Program)
- While Targeted Case Management services are valuable services covered for Medicaid recipients, they do not meet the standard for the HEDIS measure. Therefore, an additional appointment must be made for the member within the 7 calendar days.
- The 7 day appointment does not have to be scheduled with a psychiatrist, it can be for therapy, IOP, PHP, etc. However, if the patient is discharged with a prescription, the member should also be scheduled for a visit with a psychiatrist for continuity of care within 30 days.
Exclusions

The HEDIS measure excludes the following:

- Readmissions within 7 days of discharge
- Discharges to Skilled Nursing Facilities
- Discharges to Residential Treatment Facilities
- Discharges to the Corrections Department / Jail
- Discharges to a Medical floor
- Discharged to State Hospital
- Discharged to alternate acute care unit
- Discharged to Certified Group Home
# The Bridge Visit

## AMBULATORY FOLLOW UP PROGRESS NOTE

Please fax completed form to **Ambulatory Follow Up Program** at Fax No.: **305.279.4344**. Thank you.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>□ Medicaid</th>
<th>□ Medicare</th>
<th>□ Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan:</td>
<td>Member ID #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
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</tr>
</tbody>
</table>

### Appearance

- [ ] Normal dress, appropriate grooming, and appropriate hygiene
- [ ] Other (describe)

### Attitude

- [ ] Calm / cooperative
- [ ] Other (describe)

### Behavior

- [ ] No unusual movements or psychomotor changes
- [ ] Other (describe)

### Speech

- [ ] Normal rate / tone / volume (not pressured)
- [ ] Other (describe)
The Bridge Visit

- Psychcare has contracted with Facilities to provide a post-discharge, ambulatory follow-up visit.
- A specific form was developed for this visit.
- When the member is discharged from the inpatient psychiatric unit, and escorted off the unit to an outpatient setting, a licensed practitioner completes the form during the Bridge visit.
- Upon completion of the form, the member’s signature and the practitioner’s signature are provided.
- The form is faxed to 800-370-1116.
- Upon receipt of the form, an authorization for the Bridge Visit is generated.
- If the member consents for the release of information included in the Ambulatory Follow-Up form to his/her primary care physician, Psychcare’s Aftercare Coordinator will forward the information to the physician.
- The authorization number is provided to the facility / practitioner for claims submission and reimbursement.

**PLEASE NOTE:** Submit the Ambulatory Follow-up progress note at the time of completion. Do not keep and send in a bundled request for multiple visits.
- The bridge visit does NOT take the place of the 7 / 30 day follow-up visits. It is in addition to the follow-up visits.
# Preventing Readmissions

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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<tbody>
<tr>
<td>Identify patients at high-risk for readmission</td>
<td>Use a risk of readmission assessment tool and validate it using your own data</td>
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<td>✓ Develop a method to stratify patients at higher risk of readmission</td>
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<td>✓ Adopt an enhanced admission assessment</td>
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<td>✓ Assess the patient’s engagement and assertiveness in managing their own care</td>
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<tr>
<td>Self-management skills</td>
<td>✓ Assign clear accountability for medication reconciliation</td>
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<tr>
<td></td>
<td>✓ Educate patient regarding medication, need for medication, method of obtaining</td>
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<tr>
<td></td>
<td>and taking medication once discharged</td>
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<tr>
<td></td>
<td>✓ Educate patient on their condition, symptoms and what to do if symptoms worsen</td>
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<td></td>
<td>✓ Provide clearly written medication instructions using health literacy concepts</td>
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<td>Coordination of care across the continuum</td>
<td>✓ Obtain accurate information about primary care physician at the time of admission</td>
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<td></td>
<td>and create a patient centered record</td>
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<tr>
<td></td>
<td>✓ Ensure effective communication to non-hospital based care team members</td>
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<td></td>
<td>✓ Medication reconciliation at each transition of care</td>
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<td></td>
<td>✓ Send discharge summary to primary care physician with 48 hours of discharge</td>
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<td>Adequate follow-up and community resources</td>
<td>✓ Prior to leaving the hospital, determine what after-hospital resources and</td>
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<tr>
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<td>appointments are needed and ensure appropriate planning</td>
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<td>✓ Work with patient and care provider to identify and address any barriers to</td>
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<td>making and attending follow-up appointment(s) and other follow-up needs such as</td>
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<td>medications, special diet, etc.</td>
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Facility Performance Scorecards

As part of the HEDIS initiative, Psychcare monitors and tracks the following:

1. Facilities that are contracted for and complete the Bridge Visit
2. Rates, by facility, of effective coordination of 7 and 30 day appointment
3. Readmission rates by facility
4. Delay in discharge notification
5. Delay in submission of completed Bridge Visit
6. Percentage of scheduled appointments that are walk-ins, wellness checks, or false appointments that are not confirmed by the receiving outpatient practitioner

Facility Performance Scorecards will be sent out quarterly to all network facilities.
Working together, we can have an impact on the lives and success of our members.
Thank You