POLICY AND PROCEDURE

DEPARTMENT: Population Health and Clinical Operations	**REFERENCE NUMBER: CC.UM.24**
EFFECTIVE DATE: 10/08/2013	**P&P NAME:**
REVIEWED/REVISED DATE: 08/16; 08/17; 08/18; 04/19; 05/20	**RETIRED DATE: NA**
BUSINESS UNIT:	**PRODUCT TYPE: Medicaid, Medicare, Marketplace**
REGULATOR MOST RECENT APPROVAL DATE(S): NA FL: 00/00/0000 GA: 00/00/0000 (etc.)	

SCOPE:
Population Health and Clinical Operations

PURPOSE:

The purpose of this document is to outline the process for post discharge outreach to members.

The goal of this outreach is to facilitate coordination and continuity of care for members moving from acute care settings or transitioning to home. Outreach calls help ensure members have appropriate access to needed follow up care, home care services, and medication, with the goal of preventing secondary health conditions or complications, re-institutionalization, re-hospitalization, or unnecessary emergency room use.

Timely and comprehensive discharge planning requires Plan staff to work collaboratively with a multidisciplinary team to initiate and execute the discharge planning process. This process begins at the time of admission and is complete only after the member is discharged to home and completes all aspects of their discharge planning. Concurrent Review staff should work closely with plan Care Management or Care Coordination staff who are conducting post-hospital outreach to ensure optimal discharge planning occurs.

Real time discharge notification, where possible, further enables the appropriate activities to support the member and aids in the prevention of readmission.

DEFINITIONS: NA

POLICY:

All members with a “PH Outreach Needed Indicator” of “YES” on the 079 Discharge Detail report should receive post discharge outreach within three calendar days of discharge. Additional members may be identified for outreach as necessary, based on plan processes and clinical judgement.

Members are flagged for outreach because they are at a high-risk for a potentially preventable readmission and for a limited number of other prioritized reasons, such as membership in an LTSS, DSNP, or MMP product line or engagement in active care management at the time of hospital discharge.

Upon discharge, the applicable staff member will conduct member outreach. The person conducting the outreach can vary per Plan’s process. However, if a non-clinical staff member completes the “Post Discharge TOC Assessment”, a clinician should be available to review clinical components of the assessment and perform medication reconciliation, as necessary.

Plan staff responsible for conducting post hospital outreach should foster communication with facilities to ensure discharge needs are met in a timely manner, including arrangements for durable medical equipment (DME), home health care (HHC), and follow up care. The initial three calendar days post-discharge are critical to successful transition and recovery.

All outreach attempts are documented utilizing the designated “Post Discharge TOC Assessment”.

PROCEDURE:

1. Refer to CC.UM.01.07 (Concurrent Review) for the appropriate concurrent review and discharge planning processes.
2. Each workday, in accordance with the Plan process, the daily discharge report (079) is reviewed. All members with a "PH Outreach Needed Indicator" of "YES" is assigned to a team member who is responsible for completing post hospital outreach. Telephonic attempts to contact members are made at varying times and days, to optimize successful contact. Outreach attempts and successful contact is documented in the "Post Discharge TOC Assessment."
    a. Neonates being discharged from the hospital are assessed using the "SSFB Post Discharge - NICU" assessment. The outreach window for neonate discharges is also three calendar days.
3. As part of completion of the "Post Discharge TOC Assessment", the Plan staff responsible for outreach reviews and addresses the following key elements:
    a. Receipt and understanding of discharge instructions
    b. Follow-up physician appointments arranged in appropriate timeframes with adequate and confirmed transportation
    c. Medication reconciliation and filling of prescription(s)
    d. Adequate home support, home care, and/or medical equipment
4. If, after initial discussion, a member is identified as being a candidate for care management (e.g., members with a high-priority flag on the CM Prioritization report), services should be offered in accordance with CC.CM.02 (Care Coordination/Care Management Services).
5. For members who are unable to be contacted through telephonic attempts, Member Connections/Community Health Services Representatives may also be utilized to assist in outreach. Representatives may go to the member's physical address and attempt to initiate contact, or outreach to local community agencies and provider offices in an effort to locate a member. All attempts must be documented within the "Post Discharge TOC Assessment" and when outreach is successful or attempts are completed, the assessment must be submitted, whether successful or not.
6. Data are monitored for outreach attempts and successful completion of the "Post Discharge TOC Assessment" as follows:
    a. The Discharge Detail Report (079) is available daily on the enterprise-reporting platform and allows management to monitor post discharge outreach entry and direct concentrated outreach efforts, as necessary.
    b. Metrics reflecting post hospital outreach attempts and post hospital outreach success are posted to the Clinical Initiatives Dashboard (CID) on a monthly basis. All members with a "PH Outreach Needed Indicator" of "YES" are included in these metrics.
    c. The goal for the initial outreach (within three and ten calendar days) is 90% (to allow for member eligibility loss).

REFERENCES: CC.UM.24.01 Post Discharge Member Outreach Calls

ATTACHMENTS: NA

SUPPORT/HELP:
NA

EXAMPLE:

If you need help with:	Contact:
Questions about ….	
Questions about ….	

REGULATORY REPORTING REQUIREMENTS:
NA.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document, Annual Review, or Ad Hoc Review	Annual review; no substantive changes.	08/17
	Annual review; removed revision history prior to 2015, no substantive changes	08/18

	Updated **PROCEDURE** section to clarify Outreach Staff.	04/19
	Annual review; removed revision history prior to 2017. Reformatted order and presentation of policy. Added section regarding using Member Connections to contact unable to reach members.	05/20

POLICY AND PROCEDURE APPROVAL

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

Manager, Population Health and Clinical Operations: Approval on File
Director, Population Health and Clinical Operations: Approval on File