	# 825	POST HOSPITAL SCREENING AND FOLLOW-UP ☒ Workflow

Date of Inception:	09-02-2021	**_____ Approval:**	
Current Approval Date:	07-31-2023	**CMO Approval (If Required):**	

STEPS	WHAT	WHO
1.	Discharge/Transition Specialist monitors, alerts, and supports the scheduling of a follow up appointment with a Behavioral Health Medical Professional (BHMP) or Primary Care Physician (PCP) following a discharge from acute and sub-acute psychiatric facilities or Medical Hospital or Emergency Room. Members are scheduled with a BHMP on the day of discharge when clinically necessary. If a same day appointment is necessary, the Discharge/Transition Specialist will follow the process identified in Step 4. PCP visits for integrated members will be scheduled within 7 days. If the person is not integrated, the MA will notify the external PCP. 1.2 C	Discharge/ Transition Specialist BHMP PCP MA
2.	Discharge/Transition Specialist should acquire a working contact number for the member, or an alternate contact, and ensure all contact information including address is correct in the Electronic Health Record (EHR).	Discharge/ Transition Specialist
3.	***For members with repeated readmissions (one readmission within 90 days with a priority focus on readmission within 30 days)****:* Discharge/Transition Specialist will complete the Readmission Screening to identify the potential reasons for the readmission. The findings of the screening should be presented to the Clinical Team, and they should be used to update the Individual Service Plan (ISP) so that the factors are addressed to prevent or reduce readmissions. *Complete the screening again if the member readmits after another 90 days.*	Discharge/ Transition Specialist
4.	If a member is scheduled with the BHMP on the day of discharge, Discharge/Transition Specialist will inform the member that a Provider Health Behavioral Health Professional (BHP) Counselor will be calling them within 7 days to offer additional support. This should occur before they discharge, ideally. Additionally, if a member is not seen by a BHMP within 3 days of discharge (i.e., member no-shows, cancels appointment etc.), Discharge/Transition Specialist will also request BHP engagement.	Discharge/ Transition Specialist
5.	Discharge/Transition Specialist will notify the BHP via e-mail that the member needs to be contacted regarding a recent hospitalization. This notification will occur either prior to the discharge, on the day of discharge, or 3 days following the discharge if member was not seen by BHMP. Discharge/Transition Specialist should include the clinical team on the e- mail (e.g., Clinical Coordinator (CC), Case Manager (CM), Registered Nurse (RN)) so that all team members are aware of subsequent outreach efforts. Contact information for the member and discharge date will be included in the notification. Discharge/Transition Specialist will indicate when outreach can begin.	Discharge/ Transition Specialist

STEPS	WHAT	WHO
6.	BHP will call the member as soon as outreach can begin (as noted in #5) with the purpose of completing a screening for additional services/supports.	BHP
7.	**If the first attempt does not result in reaching the member**: • BHP will continue to outreach daily up to the 7th day from discharge. • BHP will communicate barriers in reaching the member to the Hospital Discharge/Transition Specialist and Clinical Team. • BHP will document all attempts to contact the member in the EHR. • BHP will notify the Discharge/Transition Specialist and Clinical Team when contact has been obtained.	BHP
8.	**Upon contacting the member**: • BHP will explain the reason for the outreach. • BHP will complete the Post Psychiatric Discharge screening in the EHR. • During the screening, BHP will look at the existing services in the ISP for reference.	BHP
9.	**When the screening is completed**: • The screening will be tasked to CC in the EHR to share identified needs or services not included in the existing ISP with the team. • BHP will communicate via email with the Discharge/Transition Specialist and Clinical Team that the screening was completed.	BHP
10.	Needs/services identified in the Post Psychiatric Discharge screening will be added to the ISP, and subsequent referrals will be completed by the CM and reviewed by the CC.	Clinical Coordinator/ Case Manager
11.	Discharge/Transition Specialist will update the hospital discharge spreadsheet (column "L") with the date the screening occurred. If the BHP was unsuccessful in contacting the member, the Discharge/Transition Specialist will make a note under the "Comments" section of the hospital discharge spreadsheet.	Discharge/ Transition Specialist