Connections for Better Care:

Inpatient Psychiatric Episode Care Coordination Initiative

FINAL

Expectations Framework

March 2022

Contact List will be developed to support activities detailed below. Outpatient providers will identify primary point of contact for Hospitals to be able to gather information in a timely manner. This list will be maintained regularly to ensure its accuracy. CMHCs to identify clinical liaisons to MCPs for clinical questions/ concerns.

Note: A recommended best practice is that the HOSPITAL, MCP and Outpatient Providers identify a single point of contact/email distribution group. Formally documenting and providing additional specification to the expectations above would be advisable as well. Additionally, at all stages of the inpatient episode MCP representatives, Community BH Provider treatment staff, and actively involved Family Caregivers need to be allowed on-site at the inpatient facility to engage with the patient and staff of the facility.

Stage in Episode of Care

PRE-ADMISSION

Hospital Psych Inpatient Facility	Outpatient Provider Organization-Tx Relationship with Client at Time of Admission	Outpatient Provider Organization-No Tx Relationship with Client at Time of Admission	MCP	Actively Engaged Family Caregiver
Contact Outpatient Provider using Contact List to obtain current meds, inpatient and treatment history- if no outpatient provider reported, MCP can be contacted for treatment history.	Provide Hospital snapshot of last admission, current meds, upcoming appointments, treatment team members and contact information.		When notified, MCP notifies Hospital of current providers in the community.	Family may provide information to Hospital including treatment providers, treatment and diagnosis history, etc.

Stage in Episode of Care

ADMISSION

Hospital Psych Inpatient Facility	Outpatient Provider Organization-Tx Relationship with Client at Time of Admission	Outpatient Provider Organization-No Tx Relationship with Client at Time of Admission	MCP	Actively Engaged Family Caregiver
Contact Outpatient Provider using Contact List to notify of admission. Notify MCP within 48 hours of admission (if admission is over the weekend, this notification may be pushed to the next business day) Identifies outpatient providers per patient report Initiate contact with family and gather collateral information. If patient does not have outpatient provider MCP requests consultation in order to make sure provider being referred to is within network.	Notify internal Treatment Team that patient has been admitted within 24 hours Provide Hospital snapshot of last admission, current meds, upcoming appointments, treatment team members and contact information.	N/A	Identify utilization manager from MCP for the Hospital and care manager if engaged in care management Identify members who require assistance transitioning between settings and notify the member's CCE, if assigned, through the care coordination portal Develop a method for evaluating risk of readmission or deterioration in order to determine the intensity of follow up required for the member after the date of discharge, and share this information with the CCE, OhioRISE Plan, and/or CME, as assigned	Communicate any special needs/concerns to the inpatient facility

Stage in Episode of Care

IN PATIENT TREATMENT

Hospital Psych Inpatient Facility	Outpatient Provider Organization-Tx Relationship with Client at Time of Admission	Outpatient Provider Organization-No Tx Relationship with Client at Time of Admission	MCP	Actively Engaged Family Caregiver
Gather input from Outpatient Provider Organization and Family Caregiver regarding history of treatment and request their participation in inpatient treatment team meetings as appropriate. Communicate and share course of treatment information with Outpatient Provider Organization and Family Caregiver Follow MCP specific PA processes for concurrent review Permit MCPs to come onsite to coordinate care/ enroll in care management If there is no outpatient treatment provider, the HOSPITAL will begin the process of linking patient to an outpatient provider early in the process based on patient choice, proximity to home, and treatment needs. Coordinate readmission care conference between outpatient provider, Hospital staff and other natural community supports to explore barriers and reasons for readmissions.	Provide information about prior treatment to the inpatient facility when requested Maintain contact and participate in critical inpatient treatment team meetings	N/A	When notified or referred from hospital staff, engage member in care management/ transition of care services while in the hospital UR process varies from plan to plan – usually 6-8 days up front, and then days are managed from that point on. If per diem fewer days up front and then UR more frequently. When requested, communicate with the discharging facility of the designated contacts of the member's care team, including all care coordinators and providers of services currently received by the member Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between MCO departments and with the CCE, OhioRISE Plan/CME, care settings, and the member's PCP, as appropriate through the care coordination portal	Provide information about the person's circumstances prior to admission. Maintain contact and participate where possible in critical inpatient treatment team meetings

Stage in Episode of Care

Discharge Planning

Hospital Psych Inpatient Facility	Outpatient Provider Organization-Tx Relationship with Client at Time of Admission	Outpatient Provider Organization-No Tx Relationship with Client at Time of Admission	MCP	Actively Engaged Family Caregiver
Work with Outpatient Provider Organization and Family Caregiver early on in the discharge planning process to ensure all necessary needs and resources have been addressed including follow up appointments, medications, referrals to PCP, specialists, and housing. Outpatient case managers could participate via Zoom, GoTo, etc. Notify MCPs of discharge plan during initial and concurrent reviews - MCP request notification within prior 24 hours, and avoiding same day notification.	Work with inpatient facility and Family Caregiver to ensure all necessary resources are lined up for discharge, including follow up appointment, medications, and housing	Patient leaves with appointment date and time on discharge papers. (therapist, psych, psych)	Collaborate in discharge planning activity with the facility, including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCO and/or CCE;	Work with inpatient facility and Outpatient Provider Treatment Team to ensure whatever resources the Family Caregiver is able and willing to provide are factored into discharge planning

Stage in Episode of Care

Discharge

Hospital Psych Inpatient Facility	Outpatient Provider Organization-Tx Relationship with Client at Time of Admission	Outpatient Provider Organization-No Tx Relationship with Client at Time of Admission	MCP	Actively Engaged Family Caregiver
Engage Family Caregiver early on in the discharge process Notify MCPs of discharge completion and provide discharge plan/ instructions Provide discharge summary to Outpatient Provider Organization at the time of discharge Ensure needed prescriptions are timely sent to pharmacy.	Ensure that the internal Treatment Team receives discharge summary	N/A	Obtain a copy of the discharge/ transition plan and share the plan with the member's care team through the care coordination portal[LP1] Arrange and confirm services are authorized and delivered in accordance with the discharge/ transition plan [LP1]Can plans share hospital discharge plans with other entities	Engage in discharge process when possible and necessary

Stage in Episode of Care

Post Discharge

Hospital Psych Inpatient Facility	Outpatient Provider Organization-Tx Relationship with Client at Time of Admission	Outpatient Provider Organization-No Tx Relationship with Client at Time of Admission	MCP	Actively Engaged Family Caregiver
Be reasonably available for clarification regarding treatment or referral while the patient was in their care.	Engage client to improve chances of successfully completing follow up appointments, facilitate patient in filling prescriptions and follow up on linkage and referral efforts that began while the patient was in the Hospital. At the time of follow up prescriber visit, if discharge summary has not been received, outpatient provider will reach out to Hospital for this information.	At the time of intake, if Discharge Summary has not been received outpatient provider will reach out to Hospital for this information. Engage client to improve chances of successfully completing follow up appointments, facilitate patient in filling prescriptions and follow up on linkage and referral efforts that began while the patient was in the Hospital.	Ensure that providers are able to obtain copies of the member's medical records as appropriate and consistent with federal and state requirements Conduct timely follow up with the member and the member’s primary provider to ensure post discharge services have been provided Follows up with patient and provider patient is scheduled with for follow to identify barriers	