

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Discharge Planning
PAGE: 1 of 4	REPLACES:
APPROVED DATE: 8/2017	RETIRED:
EFFECTIVE DATE: 8/2017	REVIEWED/REVISED: 9/17, 1/18
PRODUCT TYPE: ALL	REFERENCE NUMBER: WA.UM.40

SCOPE:

Coordinated Care Medical Management Department

PURPOSE:

To outline the provisions of discharge planning with the goal of preventing secondary health conditions or complications, re-institutionalization or re-hospitalization.

POLICY:

Plan will ensure coordination and continuity of care as members' transition between different care settings with the goal of preventing secondary health conditions or complications, medically unnecessary ER visits, or medically unnecessary acute care readmissions.

PROCEDURE:

1. The Concurrent Review Utilization Nurses (CCR) will refer members to the Complex Discharge Planning Team when the following criteria are met
 - a. Diagnosis of: COPD, Substance Use Disorder, Asthma, Cancer (new diagnosis), CHF, End of Life, DKA or if the member was admitted due to significant trauma or end of life care *or*;
 - b. Member had an unplanned readmission less than 30 days since last admission *or*;
 - c. An inpatient behavioral health admission *or*;
 - d. Serious Mental Illness;
 1. Schizophrenia, Schizoaffective disorder, Major depression, Psychotic disorders, Anxiety disorders impacting function, Bipolar disorders, Eating disorders, Personality disorders impacting functioning *or*;
 - e. If the member is homeless ;
 - f. When the member has history of leaving inpatient settings AMA *or*;
 - g. If the CCR identifies the member is at risk for a readmission or has complex discharge needs.

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Discharge Planning
PAGE: 2 of 4	REPLACES:
APPROVED DATE: 8/2017	RETIRED:
EFFECTIVE DATE: 8/2017	REVIEWED/REVISED: 9/17, 1/18
PRODUCT TYPE: ALL	REFERENCE NUMBER: WA.UM.40

2. If member is discharged prior to first concurrent review, no discharge planning will be performed by either CCR or CDP nurses.
 - a. Transitional Care Unit (TCU) will make Post Hospital Outreach attempts within 3 business days of inpatient discharge to assess if member has DME, HH, and/or PCP appointments in place.
3. The Complex Discharge Planner (CDP) will work closely with the facility staff to ensure a transition plan is developed and in place within one business day of referral from CCR.
 - a. For members in Case Management, the CDP staff will engage the member's case manager to ensure appropriate discharge planning and follow-up. The UMDP is responsible for discharge planning during the inpatient admission.
 - b. For members not currently in Case Management a Case Manager will also be engaged for any member unexpectedly readmitted less than 30 days from last admission or meeting any criteria noted in Appendix A. The CDP is responsible for discharge planning during the inpatient admission.
4. The CDP, CM, and Facility DC planning team will work together on the member's established mutually agreed upon discharge goals and timeframes, ensuring that each individual member's plan includes measures for interventions to mitigate the risk for repetitive ER visits or hospital readmissions and to optimize function for the member.
5. The CDP will establish a schedule for follow up according to the intensity of needs and timeframe for discharge, at minimum the member's discharge plan will be reviewed every 3 business days.
6. Members in the post-acute setting will be reviewed according to the timeframe for discharge, at a minimum of every 5 business days.
7. The CDP will assess for the following when reviewing the discharge plan:
 - a. Limitations, barriers, or factors that would affect discharge follow up
 - b. Follow up with PCP/Specialty Care at an appropriate interval as indicated by acuity
 - c. Transportation to follow up care and pharmacy
 - d. Eligibility for SSI
 - e. Housing including Long Term Service Support assessments
 - f. Need for authorization of services including but not limited to home health, therapy, SUD treatment, Mental Health services, DME, and or hospice

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Discharge Planning
PAGE: 3 of 4	REPLACES:
APPROVED DATE: 8/2017	RETIRED:
EFFECTIVE DATE: 8/2017	REVIEWED/REVISED: 9/17, 1/18
PRODUCT TYPE: ALL	REFERENCE NUMBER: WA.UM.40

1. The CDP will coordinate with the Prior Authorization team to facilitate authorization of services needed for discharge
2. The CDP is responsible for authorization of Home Health services if identified during the discharge planning process
- g. Post-Acute Placement needs
 1. If member is discharging without PCP or specialty provider, a request will be made for a Visiting Physician Assistance (VPA) (as available and member consenting) for follow up within two weeks.
8. The CDP will document status of the discharge plan and all updates in the WA Complex Discharge Planning note
9. Upon discharge the member's Case Manager or the Transitional Care Nurse will conduct telephonic post-discharge follow-up calls within three days of discharge to provide:
 - Education on timely initiation of post-discharge home care,
 - Evaluate member's understanding of discharge instructions and medication regimen,
 - Verify member has PCP contact information and follow up appointment scheduled at appropriate timeframe for acuity
 - Verify ordered home services were initiated/delivered i.e. home health and/or DME, and
 - Ascertain that post-discharge needs are met
 - Review crises plan if applicable

Appendix A

- Three or more inpatient admissions within the last 6 months
- Three or more ER visits in the last 3 months
- Complex cases/ multiple co-morbidities, including but not limited to:
 - Chronic or non-healing wounds / Stage 3 burns that require extensive wound care or skin grafts
 - Requires life sustaining device – ventilator, tracheostomy, oxygen, CPAP/ BIPAP, tracheostomy care or suctioning
 - TPN or continuous tube feedings
 - Recent functional decline within 90 days
 - Private Duty Nursing
 - Skilled Nursing Visits > 3 visits / week

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Discharge Planning
PAGE: 4 of 4	REPLACES:
APPROVED DATE: 8/2017	RETIRED:
EFFECTIVE DATE: 8/2017	REVIEWED/REVISED: 9/17, 1/18
PRODUCT TYPE: ALL	REFERENCE NUMBER: WA.UM.40

- Multiple co-morbidities that require 4 or more specialists
- Diabetes with Lower Extremity (LEX) episode or HgbA1c > 8
- High risk pregnancy (including members on 17-P)
- Post-transplant within 6 months
- NICU with LOS > 7 days
- Catastrophic illness or injury, e.g. transplants, HIV/AIDS, cancer, serious motor vehicle accidents, etc.
- End Stage Renal Disease (ESRD)
- Co-occurring disorders – members with serious, chronic behavioral health and physical health diagnoses
- Palliative care needs

REFERENCES:

UM.02.01 – *Medical Necessity Review*

ATTACHMENTS: N/A

DEFINITIONS:

CDP- Complex Discharge Planners include Registered Nurses, Licensed Independent Social Workers, and Behavioral Health Specialists and reside within the Utilization Management Department

REVISION	DATE
Added additional referral criteria, clarified no dc planning occurs if member discharged before first review, added use of VPA for member with no PCP	9/19/17
Removed reference to use of the Readmission Risk Score. Deleted Preadmission Assessment and PAC concurrent review from CDP. Changed UMDP to CDP	1/23/18

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Coordinated Care Vice President of Medical Management: signature on file