Approved by ICNF Board 7/21/2020

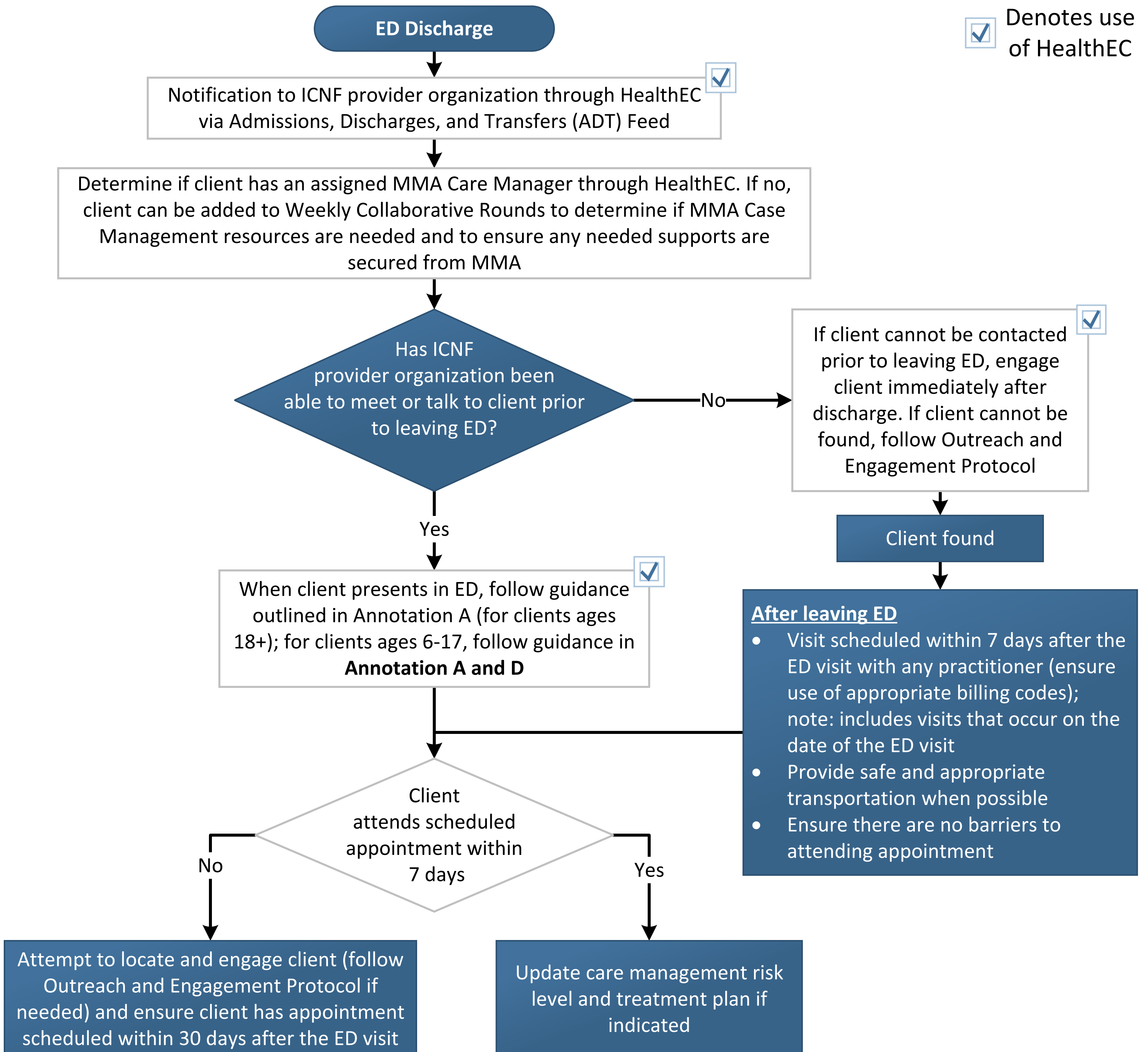
ICNF Transitions of Care Workflow

Follow-Up After Emergency Department Visit for Mental Illness (FUM) and for Alcohol and Other Drug Dependence Treatment (FUA)

FUM: This metric measures the percentage of emergency department (ED) visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness with any practitioner within 7 and 30 days of ED visit.

FUA: This metric measures the percentage of emergency department (ED) visits for beneficiaries age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD with any practitioner within 7 and 30 days of ED visit.

Note: *If you meet the 7-day measure, you automatically meet the 30-day measure. See ICNF provider manual and HealthEC for metric specifications regarding ICNF metric set.*



Workflow Annotations

Annotation A – Expectations in ER

- Outreach to ED/unit discharge planner (up to 3 attempts recommended) prior to discharge (**complete TOC Checklist**)
- Verify if client needs education, referral, or higher level of treatment
- Talk to client about reasons for ED/hospitalization and triggers/warning signs for future
- Complete a Medication Review if possible (**Annotation B**). When discrepancies are discovered follow medication discrepancy resolution process (**Annotation B**).
- Link client to appropriate level of care as soon as possible (appointment scheduled within 7 days)
- Have regular and robust communication with MMA Care Manager (if applicable) to effectively leverage and reduce duplicative efforts of both the MMA Care Manager and ICNF provider organization. Contact MMA Care Manager for coordination with physical health needs if indicated (**Annotation C**).

Annotation B – Medication Review Process

- Obtain and review the client's current medication list
- Compare that list to what is documented in the medical record
- Complete the medication review worksheet with client
- Communicate any duplications/omissions/red flags to a licensed staff to reconcile and complete medication reconciliation
- Document all actions taken in HealthEC
- Follow up on any outstanding issues

Note: best practice is to complete a Medication Reconciliation if possible (must be conducted by an RN, APRN, PA, Psychiatrist, or PCP)

Risk factors to consider when completing a medication review:

- Multiple medications
- Recent diagnosis (physical and behavioral health)
- Recent hospitalization
- Multiple specialists
- Cognitive/memory issues
- Low health literacy
- Language barriers
- Over the counter or herbal treatments that may conflict with prescribed medications

Red flags:

- Medication inconsistencies/discrepancies (e.g., variances between what client is taking versus what record shows)
- Multiple medications of the same type prescribed by different providers
- Not knowing how to take medicine correctly
- Not knowing warning signs that the medicine is not working effectively
- Not being motivated to take medicine because they are unsure of whether the medicine will work and unclear about whether it is needed; or feel they can stop taking when feeling better

Medication Discrepancy Resolution Process:

- If ICNF provider organization sees any red flags while completing the Medication Review, ICNF provider organization will send results of Medication Review and request a Medication Reconciliation with:
- Appropriate BH clinical within organization (RN, APRN, PA, Psychiatrist, PCP)
- Client's PCP
- Sunshine CM (either to conduct medication reconciliation or facilitate completion)

Annotation C – Primary Care and Specialist Follow-Up Best Practices

- Make connection to primary care for formal medication reconciliation (if no one on care team can complete) and record update
- Schedule with PCP/specialist for follow up for any medical concerns and/or open referrals
- Schedule care conference/case review for complex patient concerns (BH and/or secondary PH issues)
- Connect to Sunshine CM as appropriate

Depending on risk level, conduct routine outreach and follow-up:

- Review meds and side effects
- Goal setting/action planning
- Brief interventions/behavioral activation

Annotation D – For Children and Adolescents

- Contact parent/guardian (if required) and ensure required consent to treatment and releases of information are in place.
- After leaving ED, ensure client is referred to services which will address continued stabilization of acute clinical presentation.