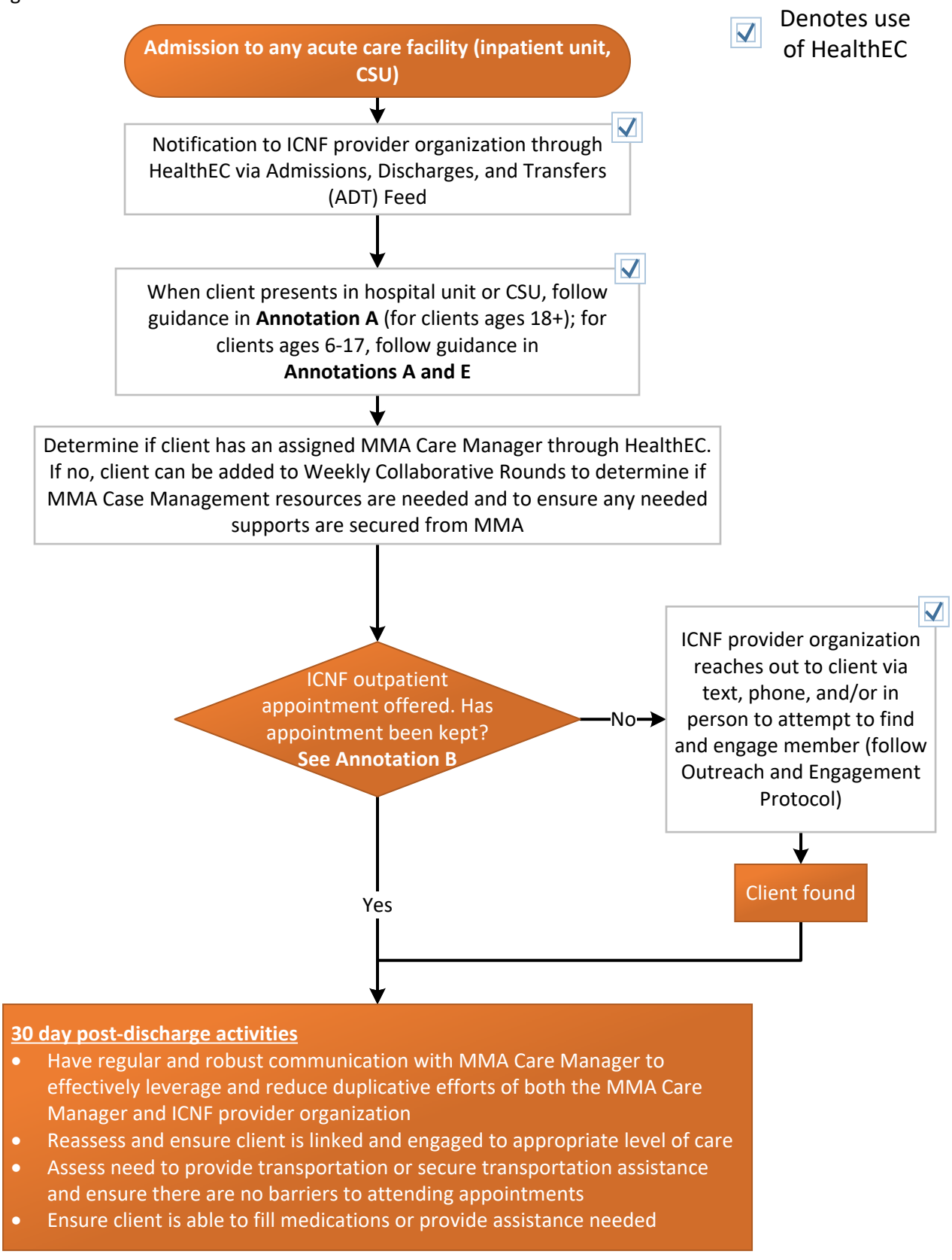
Approved by ICNF Board 7/21/2020

ICNF Transitions of Care Workflow
Mental Health Readmission Rate (RER)

The RER metric measures the percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis within 30 days (any mental health diagnosis at any facility). This metric applies to adults and children ages 6 and older. See ICNF provider manual and HealthEC for metric specifications regarding ICNF metric set.



Workflow Annotations

Annotation A – Expectations while Member is in Hospital Unit or CSU*

Goals: ICNF provider organization establishes a working relationship with local hospitals where members frequent. ICNF provider organization meets with client and discharge staff as early in the stay as possible, preferably in person. At minimum, ICNF provider organization makes contact via phone to attempt best practices outlined below.

- ICNF provider organization follows up with client *prior* to discharge from unit (face-to-face preferable).
    - Review discharge summary/plan and verify understanding with client (**complete TOC Checklist**).
    - Complete a Medication Review if possible. When discrepancies are discovered follow medication discrepancy resolution process (**Annotation C**).
    - Update treatment plan/care plan as appropriate with client, identified provider(s), unit staff, and coordinate with MMA Care Manager. Determine if an alternative level of outpatient care is required (e.g., intensive case management, peer support services, ACT).
    - Secure outpatient behavioral health appointment within 7 days of discharge (completion of appointment meets FUH performance metric).
    - Ensure client understands importance of attending scheduled appointments with ICNF provider organization, PCP and any medical specialist appointments (coordinate with MMA Care Manager for physical health needs as noted below).
- Have regular and robust communication with MMA Care Manager 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. (Note: If client does not have an MMA Care Manager, ICNF provider organization completes below best practices as much as possible.)
- Work with MMA Care Manager to secure primary care appointment within 7 days of discharge when physical health symptoms or discharge plan indicate (**Annotation D**).
- Work with MMA Care Manager to secure any medical specialist appointments needed, especially for clients with primary/ secondary conditions of vital importance to readmission risk (e.g., Sickle Cell, COPD, HF, Septicemia, Polypharmacy, Diabetes, Renal failure, UTI).
- Monitor and assess need for ongoing support related to transportation to appointments, completion of medication updates and refills, management of medication adherence at home, and assist client in preparing to report symptoms to providers or report to providers if client is unable.

**Although the RER measure does not include readmissions to an ED, ICNF provider organizations with clients readmitting to an ED should complete the TOC workflow process for those clients as part of the follow-up after ED visit for mental illness (FUM) metric or for alcohol and other drug dependence treatment (FUA) metric.*

Annotation B – Post Discharge Activities

- ICNF provider organization contacts client within 24 to 48 hours *after* discharge (face-to-face preferable).
    - Confirm intent to attend follow up appointments and transportation support to travel to appointments.
    - If possible, assess client living arrangement and determine if available supports meet the needs of the client (e.g., assure food/housing security, safety, medications are filled, and client is clear on medication instructions).
    - Ensure client understands warnings signs and symptoms of health deterioration and if/when they see warning signs to follow up with ICNF provider organization, PCP, or specialist to prevent ED visit or admission. Coordinate with MMA Care Manager as appropriate.

Annotation C – 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
- MMA Care Manager (either to conduct medication reconciliation or facilitate completion)

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

- Connect to MMA Care Manager as appropriate
- 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 client concerns (BH and/or secondary PH issues)

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

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

Annotation E – 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.