WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Post Discharge Member Outreach Calls
PAGE: 1 of 4	**REPLACES DOCUMENT:**
APPROVED DATE: 11/25/13	**RETIRED:**
EFFECTIVE DATE: 10/08/13	**REVIEWED/REVISED:** 11/13, 10/14, 9/15, 9/16, 8/17, 5/18, 2/19, 01/20**, 7/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.24.01

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management Department

PURPOSE:
The purpose of this document is to outline the process for post discharge outreach to members. Outreach calls will be made to identified members within 72 hours of discharge.

The goal of this outreach is coordination and continuity of care as members move from the acute care setting to ensure members have appropriate access to needed follow up care, home care services and medication with the goal of preventing secondary health conditions or complications, re-institutionalization, re-hospitalization or unnecessary emergency room use.

The Utilization Management (UM) Clinical Reviewer will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge. For members in care management, the UM Clinical Reviewer will engage the member's Care Manager to ensure appropriate discharge planning and follow-up.

WORK PROCESS:

A. Stratification and Identification of Members

1. The members discharged from an acute care facility with a ~~**readmission risk score ≥50**~~ **"PH Discharge Indicator" of "YES"** will receive a post discharge outreach within 72 hours of discharge**. All Behavioral Health discharges will receive post-discharge outreach regardless of "PH Discharge Indicator".**

2. Members discharged to home will be identified through the Inpatient Daily Census report and the Discharge Detail report, both located on the enterprise reporting platform.

3. To ensure continuity of care, the UM Clinical Reviewer is responsible for identifying the high risk members and may obtain necessary discharge documents to facilitate timely post discharge outreach.

4. Upon discharge, the designated staff member will conduct member outreach.

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- If the discharged member is currently in care management, a discharge follow up task may be created for the current Care Manager to complete the outreach call.

B. Management

1. Outreach

a. The initial post discharge outreach call will be made within the first 72 hours of discharge by a Care Manager or designated staff member. If the Care Manager is non-clinical, they will make the outreach in consultation with a staff RN.

i. Before making any attempts, the member's eligibility will be verified.

b. A minimum of three (3) attempts will be made to valid phone numbers available for the member no later than ten (10) calendar days of discharge.

i. Calls should be made on different days at different times of the day.

ii. If all available numbers are found to be invalid, the Member's PCP will be contacted for updated contact information.

c. Member contact information should be verified within the Member Demographic Screen in the clinical documentation system upon each contact.

i. If the address and/or phone number information obtained from the member is not the same as in the system, the information should be entered in the Contact Information section as the "Preferred" address and/or "Preferred" phone number. (This address information will be used for any health plan mailings when pulling from the clinical documentation system.)

ii. Members should have one "Preferred" address in the clinical documentation system. Any additional addresses listed must be opened to uncheck the "Preferred" box.

d. Any new address and/or phone number should be entered into OMNI.

2. Documentation of Outreach

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- All outreach efforts and information (successful or unsuccessful) should be documented within the "Post Discharge TOC Assessment V3".

3. Enrollment to Care Management
   - If the member is found to be a candidate for Physical or Behavioral Health care management or qualify for the Community Health Services Program, the Care Manager will enroll the member into case management and/or the member will be transferred to the appropriate staff member.

REFERENCES:
TruCare Training Manual Post Discharge Member Outreach - LA.UM.24 Disease Management Programs - CC.CM.11

ATTACHMENTS:

DEFINITIONS:

REVISION LOG

REVISION	**DATE**
Changed to meet process for Louisiana Healthcare Connections	11/13
Changed section A: Stratification and Identification of Members, back to match corporate policy.	10/14
No revisions	9/15
No revisions	9/16
Clarified outreach to occur in 72 hrs. irrespective of holiday and/or weekend. Readmission Risk Score, located on the IP Daily Census Report, is used to prioritize outreach. CCR nurse role added to obtain discharge documents to facilitate timely outreach. Post hospitalization note is no longer being used- currently replaced by the Post Discharge TOC Assessment.	8/17
Specified type of task used to notify care manager of member discharge, updated CRM to OMNI, changed Post Discharge TOC Assessment to Post Discharge TOC Assessment V2 note for	05/18

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documentation of outreaches, specified type of referrals for care management	
No revisions	2/19
Changed Concurrent Review Nurse to UM Clinical Reviewer Changed Post Discharge TOC Assessment V2 to V3 Changed process from entering a referral after outreach for CM to transferring the case to the appropriate staff member.	01/20
Updated PDO criteria to include Corporate's new requirement of using the "PH Discharge Indicator"	**07~~6~~/2020**

WORK PROCESS APPROVAL

The electronic approval retained in RSA Archer, ~~Centene's P&P management software,~~ is considered equivalent to an actual signature on paper.

~~Sr. VP, Population Health: Electronic Signature on File~~
~~Chief Medical Officer: Electronic Signature on File~~