



CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_CG1003

Effective Date: 1/2010

Guideline Subject: Ambulatory Management for Follow Up of Behavioral Health Admissions

Revision Date: 1/2011

Pages: 1 of 1

Obsoletes: 12/02, 10/04, 1/06, 1/07, 01/08


Medical Management Committee Chair

1-14-10
Date

I. PURPOSE:

To define the expected standards of care for DHMP members to ensure timely ambulatory follow-up after hospital admission for behavioral health treatment.

II. POPULATION:

All DHMP members including CHP+ and Medicare Managed Care members

III. GUIDELINE:

All patients who are admitted to a hospital for care of a Behavioral Health problem need to be followed-up after discharge within 30 days, ideally within 7 days, with an appropriate Behavioral Health Specialist in an out-patient setting.

1. The DHMP case manager and the attending psychiatrist or their designated representative identifies all patients with Behavioral Health admissions.
2. In the discharge planning stage, the attending physician or his or her designee will be responsible for coordinating that the patient has a scheduled appointment time with the appropriate Behavioral Health specialist (s) before the patient leaves the hospital.
3. The outpatient Team Leader or assigned therapist will receive written notification with discharge instructions from the inpatient treatment coordinator or social worker to achieve transition of care to the ambulatory setting. A documented telephone contact with the outpatient therapist can be substituted when necessary.
4. If the patient fails to keep the scheduled appointment, the out-patient Team Leader or assigned therapist will be responsible for calling the patient to assess the patient's status and re-schedule the appointment at earliest possible time.
5. Outreach efforts and clinical contact will be documented in the Behavioral Health record.
6. All Behavioral Health admissions are identified and tracked on a quarterly basis to identify any adverse trends in achieving follow-up.

IV. ATTACHMENT:

1. NCQA Standard QI 11: 2010 (Continuity and Coordination of Care Between Medical and Behavioral Health Care)

Note: This guideline is designed to assist providers by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinician's judgement or to establish a protocol for all patients with a particular condition.

QI 10: Continuity and Coordination of Medical Care

1.10 points

The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.

Intent

The organization uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

Summary of Changes

Clarifications

- Removed "documented process" as a data source (Element B)
- Clarified documentation to include date of termination and notification (Element B)
- Added "documented process" as a data source (Element C)
- Added "materials" as a data source (Element D)

Element A: Opportunities for Improvement

0.30 points

At least annually, the organization identifies and acts on opportunities to improve coordination of medical care by:

1. Collecting data
2. Conducting quantitative and causal analysis of data to identify improvement opportunities
3. Identifying and selecting one opportunity for improvement
4. Identifying and selecting a second opportunity for improvement
5. Taking action on the first opportunity
6. Taking action on the second opportunity.

Scoring

| 100% | 80% | 50% | 20% | 0% |
|--------------------------------------|----------------------------------|------------------------------------|----------------------------------|------------------------------------|
| The organization meets all 6 factors | The organization meets 5 factors | The organization meets 3-4 factors | The organization meets 2 factors | The organization meets 0-1 factors |

Data source Reports

Scope of review

NCQA reviews and scores this element once for all product lines/products brought forward for accreditation that are administered the same. If HMO and POS products are administered differently, NCQA reviews each product using one Survey Tool, and the score for the element is based on the average of the scores for each product.

If PPO products are administered differently from HMO or POS products, NCQA uses a separate Survey Tool to review and score the PPO products.

If product lines are administered differently in any product (e.g., HMO, POS, PPO), NCQA reviews each product line, and the score for the element is based on the average of the scores for each product line.

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 12 months prior to the survey date.
For Renewal Surveys: NCQA looks for evidence of completion of the required activities during the 24 months prior to the survey date.

Explanation **Data collection and analysis**

The organization must collect and analyze data to identify opportunities to improve coordination of medical care. Data collection methodology must be sound enough to produce valid and reliable results. NCQA does not require the methodology to be as rigorous as that required for HEDIS, nor does it require the organization to perform statistical analysis.

The organization collects data to assess coordination of care across settings or transitions in care. The organization may use information collected in *QI 7: Complex Case Management* and *QI 8: Disease Management* to identify continuity of care issues.

Settings

Different settings include inpatient, residential, ambulatory and other types of location where care may be rendered. An organization that collects data by setting must collect continuity and coordination of care data from a minimum of two different settings where these issues are likely to exist.

Transitions

Transitions in care include changes in management of care between practitioners, changes in settings or other changes in which different practitioners become active or inactive in providing ongoing care for a patient.

Patient safety

Activities related to patient safety, as required by *QI 1: Program Structure*, satisfy this element if they involve monitoring coordination of care across settings or transitions in care.

Activities used to demonstrate performance with *UM 13: Pharmaceutical Safety Issues* may not be used to demonstrate performance with this element.

Selecting opportunities to improve coordination

The organization uses quantitative and qualitative analysis to prioritize and select opportunities for improvement. The organization may identify multiple areas in need of improvement (where there is a lack of continuity and coordination of care throughout the system); it must take action to address at least two opportunities. NCQA evaluates whether the organization has begun to address issues where they exist. For this element, NCQA does not accept activities related to:

- Coordination between medical and behavioral health care, as required in *QI 11: Continuity and Coordination Between Medical and Behavioral Healthcare*
- Clinical quality not directly related to continuity/coordination of care.

NCQA assumes the existence of at least two opportunities for improvement of continuity and coordination of care across settings or transitions of care. Opportunities may be different each time the organization analyzes the data.

Examples

Data collection

- Combine lab results with claims or pharmacy data
- Sentinel events data
- Discharge planning data
- Practitioner survey about communication and coordination issues
- Case management data
- Data from electronic medical records (EMR) that integrate information from several sources
- Data from programs that steer practitioners and patients to centers of excellence

Taking action

- Prompt patients to return to primary care after a visit or episode of care from a specialist
- Prompt specialists to send summaries of recommendations to practitioners who provide primary care services
- Educate inpatient discharge planners or home health agencies on the use of discharge instructions
- Use incentives to promote rapid communication of discharge notes to practitioners providing primary care
- Notify practitioners about patients with prescriptions from multiple practitioners