blue california
Promise Health Plan

Policy Title: Discharge Planning		POLICY #: 10.2.100.20 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 4/11	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 321**	

PURPOSE

To identify, evaluate, coordinate, and implement discharge planning needs by the Utilization Management Department for Seniors and Persons with Disabilities (SPD) members when hospitalized.

POLICY

The Utilization Management (UM) Case Managers will perform concurrent review weekdays on a daily basis for all scheduled and non-scheduled inpatient admissions. The review process includes chart review, data collection, review of the care plan with the attending physician and other members of the healthcare team, as well as discharge planning. Discharge planning will begin on the day of admission for unscheduled inpatient stays. For elective inpatient stays, these needs may be identified prior to the hospitalization and coordinated through the continuum of levels of care until the member is returned to his/her previous living condition prior to hospitalization when possible. This approach is to ensure continuity of care and optimum outcomes for Blue Shield of California Promise (Blue Shield Promise) members.

PROCEDURE

A. Multiple modalities are utilized to evaluate the member's clinical and psychosocial status for discharge needs:
    1. Physician Plan of Care – this involves the active problem, clinical findings the patients past medical history and treatment plan.
    2. Surgical procedures – indication of a complex outcome of the surgery, co morbidities, unexpected complications, wound management, drains, tubes, equipment, etc.
    3. Respiratory Management
    4. Medication Regime – Pain management, ABT therapy, anticoagulation therapy, associated labs, adverse reactions, insulin management, or medication teaching.
    5. Therapies
    6. Physical Therapy, Occupational Therapy, Speech Therapy
    7. Level of Care Required – SNF, Acute Rehab, Sub-Acute, TCU, Home Health
    8. Teaching/Patient Goals
    9. Patient's/family skill level regarding needs for self-care at home
    10. Realistic treatment goals for the patient
    11. Patient's current potential
    12. Patient's activity prior to hospitalization

13. Social Needs – environmental considerations, patients support system, transportation access and other current living circumstances

B. Blue Shield Promise shall ensure the provision of discharge planning when an SPD member is admitted to a hospital or institution and continuation into the post-discharge period.

C. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD members once they are discharged from a hospital or institution, including an outpatient appointment and/or conducting follow-up with the patient and/or caregiver.

D. Minimum criteria for a discharge planning checklist:
   1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
   2. Documentation of pre-discharge factors, including an understanding of the medical condition by member or a member representative as applicable, physical and mental function, financial resources, and social supports.
   3. Services needed after discharge, type of placement preferred by the member/member representative, and pre-discharge counseling recommended.
   4. Summary of the nature and outcome of member/member representative involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

E. Assessment of Discharge Planning Needs – Evidence of an evaluation by discharge planning/social services notes should be on the patient's chart within 24 hours. If not, a call will be placed requesting it.
   1. Identification of discharge needs
   2. Identified short- or long-term needs
   3. Communication of patient's needs to all involved parties (physician, family members, direct care givers)
   4. Home safety check, if patient is going home
   5. Need for additional resources (linked services, delivery of meals, transportation to physician appointments)
   6. Need for necessary DME supplies and home health care
   7. Need for follow up appointments
   8. Transportation and placement arrangements utilizing contracted providers

F. If the Primary Care Physician (PCP) was not the attending physician of the patient while hospitalized, all efforts will be made to notify him/her of any arrangements made for the patient. This may be done by one of the following mechanisms:
   1. Dictated hospital summary note from the attending physician
   2. Phone call from the attending
   3. Phone call from the Blue Shield Promise UM Case Manager
   4. Inpatient Hospital Notification Form faxed by the Case Manager (see attachment)

REFERENCES