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# BHH Notification, Follow-up Care and Transitional Care Services for Admission and/or Discharge from a Facility or Service

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## I. Purpose

To outline protocol and procedures related to Behavioral Health Home (BHH) client notification, follow-up care and transitional care services for admission and/or discharge from local inpatient facilities, emergency department (ED), residential facilities, crisis services and corrections.

Aligns with Regulation: MaineCare Benefits Manual Section 92 Behavioral Health Home Services (92.02-1/Pages 5-6/Letter H & I/Page 18, Numbers 1-7).

## II. Policy

When a BHH client has an admission and/or planned discharge from a local inpatient facility, ED, residential facilities, crisis services and corrections there will be procedures and protocols in place for prompt notification, follow- up care, and transitional care services.

## III. Procedure

### A. Notification Protocol

1. All BHH clients/families will verbalize understanding of their role in notifying the appropriate Health Home Coordinator (HHC) of an admission and/or discharge from any entity listed in the above policy during development of the client's crisis plan.
2. The HHC will document that the client/family has verbalized understanding of their role in the notification process in the crisis plan.
3. HealthInfoNet (HIN) will be utilized to alert the appropriate HHC of any admission and or discharge from any Emergency Department or inpatient hospital admission.

### B. Follow-up Care

1. The HHC will follow-up with client/family within 24 hours during normal operating hours and 48 hours after a weekend to identify placement or discharge of client from facility or service to arrange appropriate follow-up care and alert treating clinicians if it may necessitate treatment changes.
2. The HHC will document all follow-up care in client's record.

**C. Transitional Care Services**

1. The HHC and/or Nurse Care Manager (NCM) will collaborate with facility discharge planners, the BHH client and family members or other support system, as appropriate, to ensure a coordinated, safe transition to the home/community setting, and to prevent avoidable readmission after discharge.
2. The HHC will assist the client/family with the discharge process, including outreach in order to assist them with returning to the home/community.
3. The HHC and/or NCM will follow-up with each client following a hospitalization, use of crisis service or out of home placement.
4. The HHC will collaborate with client/family, and facilities to ensure a coordinated, safe transition between different sites of care or transfer from the home/community setting into a facility.
5. The HHC will assist the client/family in exploration of less restrictive alternatives to hospitalization/institutionalization.
6. The HHC shall provide timely and appropriate follow-up communications on behalf of the transitioning client/family, which includes a clinical hand off, timely transmission and receipt of the transition/discharge plan, review of the discharge records, and coordination of medication reconciliation.
7. The HHC will facilitate, coordinate, and plan for the transition of members from children's services to the adult system.

Scott Tash, CEO

8-15-19
Date