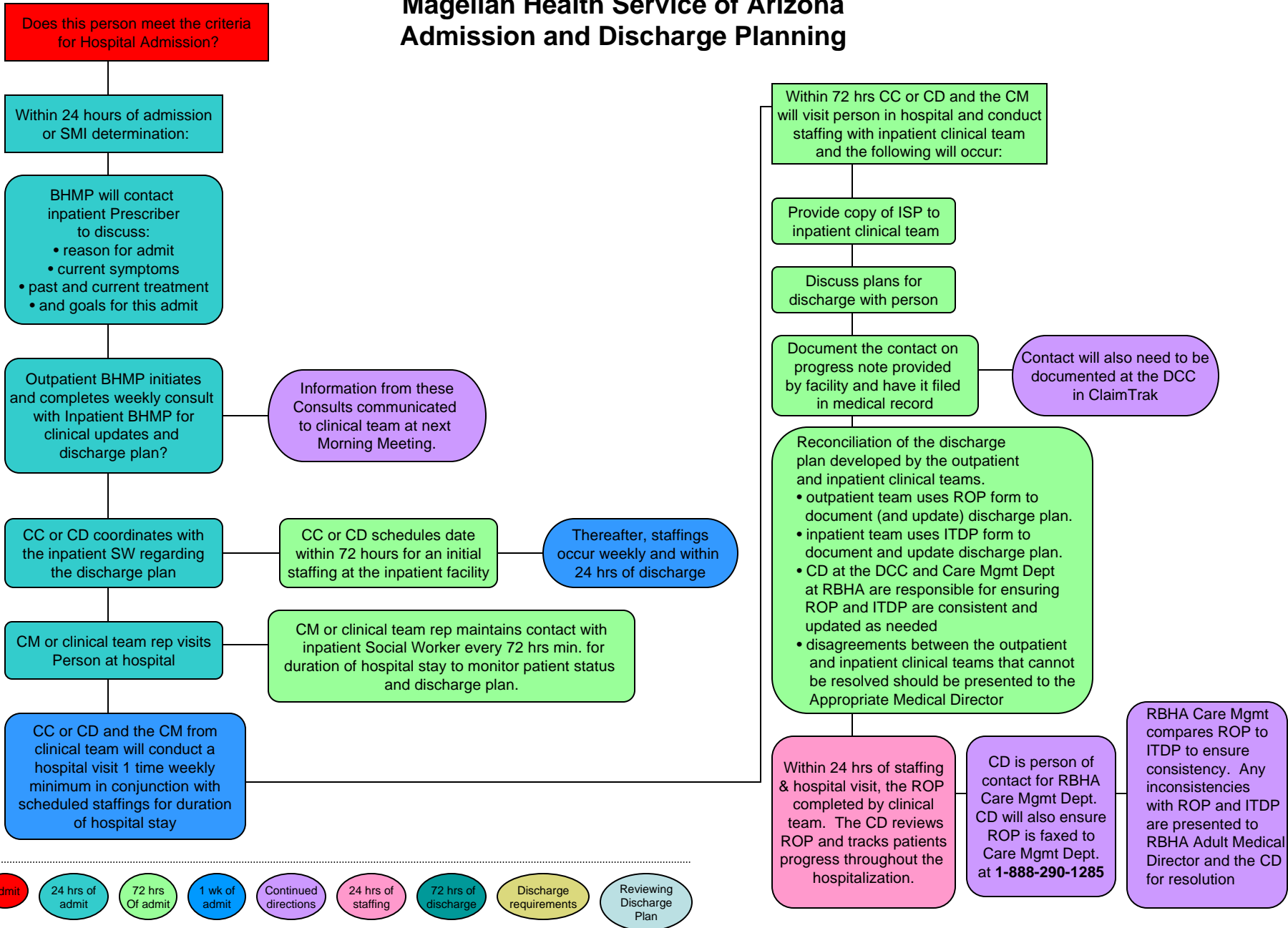


Magellan Health Service of Arizona Admission and Discharge Planning



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If person hospitalized for 7 days or longer, the CD will ensure a copy of the ITDP is obtained by the 10th day and placed in person's medical record.

CD will ensure the ITDP prepared by Inpatient team and the ROP prepared by the outpatient team are consistent.

CM/CL ensures ISP is updated within 7 days after discharge from the inpatient facility.

Prior to discharge, the CC or CD will ensure the Hospital Discharge Plan has been reviewed by person as evidenced by person signing the ROP

The person and clinical team must sign the revised ISP and give a copy to the person.

Within 72 hrs of discharge the person will be evaluated by the BHMP.

The following documents will be obtained from inpatient facility and provided to the BHMP prior to scheduled evaluation appointment:

- Hospital final discharge plan or ITDP
- ROP
- Copy of Psychiatric Evaluation
- Copy of Medical Physical Exam
- Copy of most recent lab results from inpatient facility
- List of final discharge meds provided by inpatient facility
- Copy of any Prior Authorizations obtained
- Copy of medical consults provided during hospitalization from the inpatient facility

Reviewing the Discharge Plan and Modification of the Treatment Plan

For persons who are either discharged or readmitted within the last 30 days, the following will occur within the next 7 days:

- 1) CC and CM will meet with the person for a clinical consult to review discharge plan and ISP. The review will include:
 - a) Determination of whether the discharge plan was successful in helping person return to community upon discharge
 - b) Determination of whether ISP requires additional revisions.

Requirements for Discharge from an inpatient facility:

A staffing scheduled by the inpatient Social Worker and Clinical Coordinator shall be held prior to discharge during which time the person and all members of the clinical team will review hospital discharge plan

A member of clinical team shall maintain daily contact with person via telephone and/or face-to-face contact during the first 5 working days following discharge

At Risk Crisis Plan updated to incorporate information included in hospital discharge plan, as appropriate.

The clinical team will ensure person's AHCCCS provider or other primary care provider is notified of the person's inpatient admission in accordance with the Continuity of Care: Coordination of Information to/from PCP policy.

Case Manager will ensure person has adequate transportation from facility to Their home.

If person is discharged from a Level I Acute facility during business hours, the Case Manager should provide transportation.

Case Manager and clinical team will assist person in obtaining medication In accordance with discharge plan upon discharge from facility

Prescriptions (and any related prior-authorizations) need to be obtained for a minimum of a 7 day supply for all discharge Medication

For persons considered to be at-risk for readmission, the Case Mgr will meet with clinical team weekly to discuss person's progress toward the goals identified in the discharge plan.