Instructions for Reporting a Discharge

This document is for informational purposes only. Do not mail or fax back to Tufts Health Plan.

1. Go to Home page to login to the secure Provider website using your Facility ID.
2. Click the Mental Health Facility Online Discharge link.
3. Enter the patients Tufts Health Plan Member ID number (include suffix without "-"or space)
4. Date of Birth: Enter on calendar.
5. Admission Date: Enter on calendar.
6. Submit.
   A success message will display with the Member ID, Name, and Member’s age.

For Tufts Medicare Preferred HMO member Only

8. Indicate where the patient resided prior to this admission:
   - Home
   - Assisted Living
   - Nursing Facility

9. Discharge Date: Enter on calendar
10. Indicate from where the Member is being discharged:
    - Inpatient Care
    - Acute Residential
    - Partial Hospital
    - Intensive Outpatient

If discharged from ART, partial hospital or intensive outpatient care:

11. Enter the number of days the member attended: 
12. Indicate where the member was discharged to:
    - Residential or Acute Residential (not a covered level of care for Medicare Preferred)
    - Partial Hospital
    - Intensive Outpatient
    - Skilled Nursing Facility
    - Another Inpatient Facility
    - Home with VNA Services
    - Home
    - Other

13. Indicate admission class:
    - Mental Health
    - Substance abuse

14. Enter any primary, secondary, medical conditions and psychosocial and environment problems. Enter NA for fields that are not applicable:
    - Primary Diagnosis Code:
    - Secondary Diagnosis Code:
Medical Conditions:
Psychosocial and Environmental Problems:

15. Does the patient have comorbid substance abuse and psychiatric conditions? □ Yes □ No
   If yes, please specify: ____________________________________________________________

16. Was the PCP notified of this admission? □ Yes □ No, if not, why: □ Member refused □ No PCP
   □ Other

For Tufts Medicare Preferred HMO members discharged from inpatient to home:

17. Was a post discharge appointment scheduled for the member with their PCP? □ Yes □ No
   Enter the date of the PCP appointment: Enter on calendar

18. Was an aftercare review session held with the patient on the day of discharge: □ Yes □ No
   • Enter the Date of the aftercare review session: Enter on Calendar
   • Name and credentials of person conducting the aftercare review session:

19. Was a post discharge aftercare appointment scheduled for the patient with a mental health or
    substance abuse provider within 7 days: □ Yes □ No

20. Was the patient given the name, appointment date, time and phone number of the outpatient
    provider they will see following discharge? □ Yes □ No

21. Was there a conversation with the patient’s outpatient provider during admission? □ Yes □ No
    □ NA

22. Was medication reconciliation completed with patient or the patient’s caregiver as part of the
    discharge? □ Yes □ No □ Not Discharged on Medication
   • Was the patient given the name, appointment date, time and phone number for MD/RNCS
     who will follow their medication?: □ Yes □ No
   • Discussed when and how to take medication: □ Yes □ No
   • Discussed when and how the patient will refill medication: □ Yes □ No

23. Is the patient or caregiver able to explain why the member was hospitalized? □ Yes □ No

24. Were barriers identified to the patient successfully following their discharge plan? □ Yes □ No
   • Were strategies discussed with the patient to deal with any identified barriers? □ Yes □ No

25. Is the patient or caregiver able to explain why the member was hospitalized? □ Yes □ No

26. Does the patient or caregiver understand what they need to do to prevent another hospitalization?
    □ Yes □ No

27. Was this a readmission (within 30 days of a previous admission)? □ Yes □ No
   If yes:
   • Did communication with the patient’s outpatient providers (PCP, MH/SA treatment team) occur
     during prior admission? □ Yes □ No □ Unknown
   • Was an outpatient follow-up appointment scheduled within seven days of the prior discharge?
     □ Yes □ No □ Unknown
   • Did the patient attend their outpatient appointment? □ Yes □ No □ Unknown
   • Following their prior discharge was the patient medication compliant? □ Yes □ No □ Unknown
   • Did the patient experience significant decline in their cognitive status since last admission?
     □ Yes □ No
   • Prior to these last two admissions was the patient hospitalized for MH/SA in the last six
     months at any facility? □ Yes □ No □ Unknown
28. Submit.

*An option to print the completed form with a confirmation number is available.*