

- DASHBOARD 2
- PATIENTS ▾
- PROGRAMS ▾
  - All
  - High Priority Programs
- CASES ▾
  - All
  - My Open Cases
- TASKS ▾
  - Active
  - My Open Tasks
  - Completed
- MESSAGES ▾
- EVENTS ▾
- SETTINGS ▾
- PROVIDERS

Programs >

## ER Discharge with Identified MH Issue

Program Lead: Pamela Wilson

When a patient is discharged from an Emergency Room or Inpatient Hospital for certain mental health conditions, a patient will need to have 2 follow up visits. One within 7 days of the discharge and the other within 30 days of the discharge. This program engages a Care Coordinator to work directly with the discharging facility, the patient and the patient's primary care physician to setup the follow up appointments and identify any potential barriers to post acute care including access to food, housing, transportation and medication. If barriers are identified, the Coordinator will help the patient to connect to local agencies and services including arranging transportation for the two follow visits if necessary.

[Download Report](#)

### PROGRAM OVERVIEW

10  
OPEN

8  
LATE

TASKS

TARGET DAYS TO CLOSE: 30

0  
AVERAGE DAYS  
TO CLOSE

GOALS

2  
OPEN

12.5  
/WEEK  
CLOSURE RATE

CASES

### STAFF & CASE LOAD

Beth Davidson

### OUTSTANDING TASKS

Case	Task	Assignee	Opened on	Due on	Status	Priority
Eric Roberts	Review SDOH Survey	Mark Taylor	5/20/2020	5/20/2020		<span style="color: red; font-weight: bold;">U</span>