Steward Health Care Network

HEALTH CHOICE ARIZONA

Children's Discharge Planning Desktop Guide

Compiled by:

Victoria Tewa, LPC Director of
Children's Services

Jesse Sharber, MS Youth/Young Adult
Projects Coordinator

Kelly Lalan, MSW
DDD/ASD/CRS Liaison

Kim Sevier, MA
Clinical Care Coordinator/DCS Liaison

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This guide is designed to be a reference tool to help CFTs create effective discharge plans, as well as to provide information about key SHCA policies and processes related to children's out of home care. It is not intended to drive the discharge planning process, or provide a prescriptive discharge planning protocol.

Creating a Discharge Plan

The most important goal of out of home (OOH) treatment is to ensure the child and family are prepared for the child's return to their home/community setting. The discharge plan must reflect this goal, and be focused on helping the child to function successfully in their home/community.

The discharge planning process begins either before, or immediately after, the child's admission to a higher level of care.

Discharge planning can be complex and challenging, and should be discussed at each CFT while the child is OOH. This creates accountability for the team to carry out its goals and to ensure an effective transition to a lower level of care/least restrictive environment. During the child's stay in a higher level of care, the team will need to meet more frequently in order to evaluate the child's progress and make needed adjustments to the discharge plan.

Fundamentals of Discharge Planning

Comprehensiveness

The discharge plan must be comprehensive, and address all of the components below:

Identify Services: The discharge plan considers all aspects of the needs of the child and family. The discharge plan identifies services which will be implemented upon the child's return and the frequency/intensity of services (i.e. therapy 2x weekly, direct support 3x weekly, etc.). The plan also identifies what ancillary supports and services will be sought out, such as MMWIA services, respite, and/or parent support. Ideally, these support services will be set in place *before* the child is discharged, and will commence upon discharge.

Identify Other Needs/Coordination of Care: The plan identifies and addresses non-behavioral health needs, such as transportation to/from services, educational needs, and medical care needs, and addresses how care will be coordinated with other agencies/systems the child is involved with.

Coordination of Care for American Indian members may need to include Indian Health Facilities (I/T/U), Indian Health Service (IHS) Facility, Tribally Operated 638 Program or an Urban Indian Health Program. While recognizing that American Indian member may choose to receive their services from an IHS or a 638 tribal facility rather than a SHCA Health Home.

Develop a Crisis Plan & Safety Plan: Crisis planning is a key component of successfully transitioning a child to a lower level of care and preventing the child/family from experiencing a crisis, and consequences of crises, such as readmission to an inpatient facility or other crisis. The crisis plan needs to be completed before the child transitions to a lower level of care.

Crisis Prevention Plan: a plan created in collaboration with the member that helps to predict and plan for future crises. Includes development and use of crisis prevention skills and community supports to help avert a crisis as much as possible.

Safety Plan: a 24-hour plan created when there is a specific risk of harm. Safety plans should be discussed with the CFT to determine if a Safety Plan will be needed upon return to the home/community.

Risk Assessment: evaluates a person's risk for future suicidality. Team members should be aware and evaluating risk and mitigating factors at all times.

CASII: A CASII should be completed prior to the child's transition to a lower level of care, to assist the team in determining appropriate supports and service intensity.

For more information about Crisis & Safety Plans and Planning, please see CFT Module 2: Crisis and Safety Planning in Relias.

Ensure the plan is realistic: The CFT must ensure the discharge plan is practical, realistic and that the family is in agreement and are able to carry out the plan. *Note: changes of levels of care do not necessarily mean changes in the amount of support needed by a child or family. Get creative in your approach to treatment!*

For BHIF Level Discharges: SHCA's Medical Management Team will review the discharge plan. You may be asked to provide detailed information about the discharge plan to the Medical Management Specialist.

Family Engagement

Every child in OOH care must be treated within the context of their family system. Encourage the family to view the placement as a therapeutic intervention designed to support the entire family, not just the child who is received treatment.

There is an expectation that the guardian/family will be involved in discharge planning, and have consistent contact with the child including phone calls/visits and participate in treatment or shared parenting, as determined appropriate by the CFT and treatment team. Family therapy, if appropriate, should begin as soon as a child is placed in a higher level of care, and increase in frequency as the child approaches discharge. It is the responsibility of the case manager or person managing the child and family's care to coordinate outpatient services (psychiatric, individual/family therapy, family support, etc.) for the guardian/family prior to the child's return home.

The primary goal of family driven work is to partner with the child and family to assist the child and family in cultivating the best relationship that they can have. This may require repairing or strengthening the relationships they have, and it is imperative that the CFT collaborate with the OOH provider to ensure the child and family have opportunities to connect and bond while the child is receiving OOH treatment. For example, home visits can provide families the chance to practice skills they have learned, and family therapy can assist in addressing complex family dynamics.

Children who do not have a family/caregiver to return to must be assisted in developing ties to their community, including locating extended family, identifying healthy caregivers, adults and peers who can meet their needs.

Set Clear Responsibilities & Expectations

Each team member, including the family, needs to understands their role in the discharge planning process and their role(s) in continuing to support the child/family after discharge. It can be helpful to create a timeline for discharge at the first CFT after the child's admission, and determine what needs to be accomplished before discharge, and who will accomplish it. Revisit these tasks frequently to discuss

barriers, or determine if the needs of the child/family have changed. Although this timeline will likely change, having necessary tasks and goals outlined can help ensure the team will not experience disruptions or setbacks as the child approaches discharge.

Contingency Plans

Establish an expectation for the team that discharge planning and transition of care will likely be challenging, and agree upon how the team will address barriers and/or setbacks. Developing a contingency plan helps to ensure that in the event of adverse changes or the primary discharge plan fails, the child will not be in a restrictive setting longer than necessary.

For American Indian members who live on tribal lands, additional planning may need to include the involvement of the local Behavioral Health agency and Tribal Health Care staff.

Collaboration & Integration

Collaboration between the Health Home, OOH provider, family, system partners, primary care providers, and others involved in the child's care is essential to ensure the child and family have adequate support and ongoing needs will be met upon discharge.

Continually Addressing and Re-Assessing the Underlying Needs of the Child and Family

The needs and situations of the child and family will change over time. The needs of the child and family will be different and unique at different levels of care, and during transitions from levels of care. A function of the CFT is to assess and address ongoing needs, to ensure the child and family are receiving adequate services and support. *It is essentially for the family to receive support and treatment while the child is placed in a higher level of care so the child can return to a positive, healthy environment.*

***For additional information on OOH procedures, policies and expectations, please refer to the OOH CFT Module available on Relias, OR see SHCA's Provider Policy Manual, Chapter 18.12.4 (pg 46). Also see AHCCCS's** Out of Home Practice Protocol.*

General Resources

AHCCCS Covered Services Guide

SHCA Provider Policy Manual

SHCA Clinical Practice Guidelines

- AACAP Practice Parameters
- CFT Practice Protocol
- Out of Home Practice Protocol

SHCA on Eventbrite

Commonly Used Forms (including Prior Auth forms)

HIPAA Information

AHCCCS/DBHS Guides and Manuals

Crisis Lines:

- Mohave, Coconino, Apache, Navajo, Gila and Yavapai Counties: 1-877-756-4090
- Maricopa County – 1-800-631-1314 or 602-222-9444
- Pima and Pinal County – 1-866-49-6735

Contact Info for SHCA's Children's Team

Victoria Tewa, MS, LPC
Director of Children's Services
Victoria.Tewa@steward.org

Kelly Lalan, MSW
DDD Liaison
Kelly.lalan@steward.org

Kim Sevier, MA
Clinical Care Coordinator/DCS Liaison
Kimberly.Sevier@steward.org

Jesse Sharber, MS
Youth & Young Adult Projects Coordinator
Jesse.Sharber@steward.org

SHCA Switchboard
928-774-7128

SHCA Customer Service
1-800-640-2123

SHCA Crisis Line
1-877-756-4090