

Children's Mental Health
Hospital Discharge/Transition to the Community
Action Plan

In 2013, the Children's Mental Health Division in the Department of Human Services sponsored a workgroup focusing on combating the issues surrounding successful hospital discharges as children are transitioning to the next level of care. The workgroup is a result of several departmental reports indicating that there are gaps within the system of care for children with mental health disorders. The [Mental Health Acute Care Needs Report](#) (2009), [Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services](#) (2010) and the [Report on Care Coordination for children with High-Cost Mental Health Conditions](#) (2012) all discuss, in detail, the difficulties within Minnesota's system of care that arise when children have unsuccessful discharges from inpatient levels of care. For the past five years, recommendations for system enhancement surrounding children with complex needs utilizing inpatient beds have included:

- Improve Discharge and Transition Planning when leaving one level of care to the next
- Increase coordination with Mobile Crisis Teams
- Create intensive services for specific population groups/intermediate levels of care
- Analyze the Child and Adolescent Behavioral Health Services (CABHS) program

The recommendations have been fairly consistent over the years. Through the Money Follows the Person Federal Demonstration project the CMH Division was able to allocate staff time (as recommended in the Report on Care Coordination for children with High-Cost Mental Health Conditions) to attend to the persistent system issues when children are leaving inpatient care.

The Hospital Discharge/Transition to the Community Workgroup came together on March 25, 2013 with the stated purpose to come up with solutions to common and systemic issues that thwart successful discharges from inpatient levels of care to the community or residential treatment children's mental health services. The workgroup comprised of over 75 individuals from the metro and Greater Minnesota who represent parents, consumers, advocacy organizations, county case management providers, hospitals, health plans, county based purchasing organizations, crisis service providers, community-based mental health providers, residential treatment providers, and state agencies (DHS and the Department of Education). Prior to the meeting, stakeholders sent in their perspectives on roadblocks to successful transitions to inpatient to the next level of care for children experiencing mental illness. There was wide consensus of the issues which were ranked by workgroup members in priority:

- Communication and Coordination Issues
 - Lack of role clarification and lead responsibility

- Lack of communication between case managers/care managers and hospitals
- Lack of knowledge of best practices for successful transitions
- Financial barriers (placement opportunities, funding for next level of service)
- Lack of communication with families and community providers
- Misunderstanding of each other's systems (hospital not understanding county case management and vice versa)
- Need to enhance the State's infrastructure of intensive "step-down" services:
 - Intensive in-home stabilization supports
 - Partial Hospitalization Services
 - Crisis stabilization Services
 - Psychiatric Residential Treatment Facilities
 - Crisis Residential Services
 - Therapeutic Respite Care
- Increase Family Involvement in the hospital process:
 - Regular and consistent communication with the family
 - Earlier discharge planning
 - Family friendly language
 - Need to attend to long-distance issues for families when children are in the hospital
- Training needs for the system:
 - Sharing philosophy on roles and treatment needs between systems
 - Information on community based services and recommendation needs for the hospital
 - Level of care/medical necessity and stabilization rules for each system
 - Documentation needs for outpatient and community based services
 - Permanency requirements for children in out of home placements
 - Child and Adolescent Services Intensity Instrument (CASII)

The larger workgroup created three smaller groups (Communication/Coordination, CMH Infrastructure and Family Partnership) that met over the summer to identify, research and create solutions the problems that were identified in the initial meeting.

On September 30, 2013, the Workgroup reconvened to look at the full list of recommended strategies for addressing issues when children and adolescents leave inpatient levels of care. Workgroup members took the list of recommendations to their stakeholder groups to get feedback and prioritize the strategies. The smaller groups met to reconfigure and rank the strategies based on the feedback. The strategies listed below were finalized and approved by the workgroup on January 13, 2014.

Recommended Strategies for Enhancing Transitions to the Community from Inpatient Levels of Care:

Creating Standardized Processes

1. All members of the child's care team need to have a standardized list of tasks to assist the child and family through the discharge and transition.
 - a. DHS CMH Division will create a template for the standardized list, seek feedback from members of the Communication/Coordination committee and publish on the DHS website by March 1, 2014
 - i. Having a parent/family meeting within 24 hours of admission, explain the purpose of hospitalization, expected date of discharge, expectations during the hospital stay, solidify a communication plan and sign all relevant releases
 - ii. Calling all authorized mental and physical health providers, school staff, case managers and care coordinators and inviting all providers to participate in or relay feedback for a care or discharge planning meeting. Items to communicate by phone or fax:
 1. Case manager/care coordinator: history of treatment interventions; things that have been successful; placement history; current service information
 2. Mental health provider (therapist/skills trainer/psychiatrist): current treatment focus; recent changes (personal or medication); recommendations; things that are not recommended; reasons why symptoms could be exacerbated; current individualized treatment plan; history of interventions; effective treatment history
 3. School staff: history of school placements and needs, current service information
 - iii. Creation of a standardized recommendation letter that outlines the child's level of care determination description (either through a CASII/ECSII score or similar description) and describes what are the necessary service components that are required for this child rather than just listing service types (i.e. hours or type of supervision required not "residential or group home")
 - iv. Making appropriate referrals
 - v. Mental health follow up appointment scheduled within 7 days of discharge
 - vi. Verify medications are covered by patient's insurance and there is sufficient supply until follow up medication appointment
 - vii. Completing and/or contributing to the emergency plan if the child does not already have one and connect the family with local children's crisis response services
 - viii. Notification to the school concerning the child's hospitalization, anticipated return to school, and educational support needs.

- ix. Documenting clear instruction to the child and family of aftercare instruction and who to call when particular symptoms or behaviors occur
 - x. Documentation of family's concerns at the time of discharge and resources to address them
 - xi. A plan for who on the team (hospital, community provider, case manager) will call family within 72 hours of discharge to ask questions (based on RARE):
 - 1. How have you been doing since you have been home?
 - 2. Do you have any questions or concerns about the instructions you were given when you were discharged, or about how to care for yourself now that you are home?
 - 3. Were you scheduled a follow up appointment? Are you able to make it?
 - 4. Were you discharged on medication? If so, are you clear on your medication instructions?
 - 5. Do you have any suggestions for what we could have done to provide you with better care while you were here? Do you have any additional comments/suggestions/concerns?
 - b. DHS will promote the use of the standardized list in connection with the Minnesota Hospital Association, Minnesota Association of County Social Service Agencies, MN Council of Health Plans, Minnesota Association of Children's Mental Health, Minnesota Association of Child Caring Agencies and NAMI.
 - c. DHS will utilize the list in the on-line training to promote consistency of practice and utilization.
2. Families need to have an Emergency Plan available that is up-to-date and has history of service utilization, provider contact information, which interventions have been successful, crisis intervention/prevention plan and information on what the family should do if experiencing a relapse of symptoms. This plan will develop over time and should be added to before discharge from the hospital.
- a. DHS CMH Division will create a template for the Emergency Plan, seek feedback from members of the Communication/Coordination committee and publish on the DHS website by April 1, 2014.
 - b. DHS will promote the use of the Emergency Plan in connection with the Minnesota Hospital Association, Minnesota Association of County Social Service Agencies, MN Council of Health Plans, Minnesota Association of Children's Mental Health, Minnesota Association of Child Caring Agencies and NAMI.
 - c. DHS will utilize the list in the on-line training to promote consistency of practice and utilization.
3. Parents, providers, hospitals, case managers, care coordinators, and school staff need to be educated on roles and responsibilities throughout the system, criteria for

hospitalization, and best practices for collaboration (including discussions of safety precautions) when a child is leaving inpatient care.

- a. DHS CMH Division will create an on-line training which will be accessible on TrainLink and free for parents, outpatient and community providers, case managers, care coordinators, social workers, probation agents, hospital and school staff.
 - i. Information for community providers on how to talk to families “pre-hospital”. This unit will discuss crisis prevention planning, having all of community providers names and needed information in one handy place, how to connect families to informal supports and advocacy organizations, what the emergency department experience is like, and what to expect from a hospital stay—Hospital 101.
 - ii. Training on how to develop Emergency Plans and navigate the standardized list of items during a hospital discharge.
 - iii. Information for all providers on roles and responsibilities of key players (hospital discharge workers, CMH-TCM, the new “in-reach” benefit, managed care/health plan care coordinators and outpatient/community providers). In this section each provider type would discuss what they view their role is, what they can do during the transition process and what kind of information they need to do their job well (like what is helpful in discharge summaries, teaming between systems during screening teams or releases of information rules).
 - iv. Optimal teaming examples. In this section we will highlight some experiences that demonstrate when best practices are utilized and all systems work well together.
 - v. Other items to incorporate in the training are: releases of information and education on how to navigate insurance plans (employer, self-insured and MHCP)
 - b. DHS will promote the use of the training in connection with the Minnesota Hospital Association, Minnesota Association of County Social Service Agencies, MN Council of Health Plans, Minnesota Association of Children’s Mental Health, Minnesota Association of Child Caring Agencies and NAMI.
 - c. DHS will track utilization of the training through TrainLink. Expected participation will be 200 people a year for 5 years. Outreach will be done to maintain that level of utilization.
4. Counties and Pre-Paid Medical Assistance Plans should have the same timeline when screening for Children’s Residential Treatment.
- a. Change the expected timelines for out of home placement reviews for Children’s Residential Treatment so that managed care and county screening teams are the same—10 days maximum with an expectation of 3 days under special circumstances.
 - i. MN Statutes 260C.157 Subd. 3. Juvenile treatment screening team.(a) The responsible social services agency shall establish a juvenile

treatment screening team to conduct screenings and prepare case plans under this chapter, chapter 260D, and section 245.487, subdivision 3. Screenings shall be conducted within ~~45~~ 10 days of a request for a screening. The team, which may be the team constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile justice professionals, persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability, and the child's parent, guardian, or permanent legal custodian under Minnesota Statutes 2010, section 260C.201, subdivision 11, or section 260C.515, subdivision 4. The team may be the same team as defined in section 260B.157, subdivision 3.

- b. Children's Mental Health Division will prepare a proposal for possible inclusion in DHS' department 2015 bill.

Infrastructure Development

1. Crisis services should be utilized to help children and families stabilize after a hospitalization.
 - a. Propose to make alterations to the Children's Mental Health Crisis Response Services (MN Statutes 256B.0944) policy and the State Plan to allow:
 - i. Amend the state plan to include inpatient or urgent care services as a "crisis intervention" so that crisis stabilization services could follow an ER assessment or sub-acute stay
 - ii. Extend crisis stabilization services from two weeks to 30 to 45 days
 - iii. Allow crisis teams to provide services within a hospital facility (at discharge meetings or to help with emergency department assessments)
 - iv. Add Family Peer Specialists (as defined in the recently passed MN Statutes 256B.0943) to a crisis team
 - b. Children's Mental Health Division will prepare a proposal to amend the state plan and make appropriate modifications to policies within the MHCP provider manual and training material.
 - c. The CMH Division will work with crisis teams to create standardized definitions for crisis intervention and stabilization admission and discharge criteria.
2. Intensive in-home family therapy services need to be available throughout the state to stabilize a child's mental health and prevent further hospitalizations.
 - a. CMH Division will address the discrepancies within Children's Therapeutic Services and Supports benefit and create rate reform to increase therapy services in conjunction with skills training for high needs children and family.
 - b. CMH Division will prepare a proposal for possible inclusion in the department's 2015 legislative bill.

Supporting Initiatives with Others

1. There needs to be a family friendly and clear process when parents report they do not have the resources to maintain their child safely within the community during the hospital discharge process.
 - a. Partner with Minnesota’s delegation working with the Casey Family Policy Group to create practice guidelines development for out of home placement (MN Statutes 260C and 260D) during moments when there are issues related to hospital discharges and a family’s ability to have child back to the home
2. Families would like more involvement in hospital processes and treatment decisions such as:
 - Incorporate family-based decision making (giving choices of treatment options and participating in rounds)
 - Have family friendly/strengths based language in reports and discharge summaries
 - Create multiple ways to include parents, from the beginning of initiatives, in feedback process
 - Add parents to the staff training program—include parent/family member experience to new employee training
 - a. Partner with the Minnesota Hospital Association to inform children’s hospitals and the Mental Health Task force of recommendations
 - b. CMH Division will present at the MHA Mental Health Task Force to assess for current family involvement strategies and assist in the development of family partnership strategies
 - c. CMH Division will provide ongoing consultation to the MHA Mental Health Task Force as needed.
3. Increasing the accessibility and performance of Children’s Mental Health Targeted Case Management.
 - Having a children’s mental health Child and Family Service Review process that is specifically focused on CMH guidelines and criteria
 - Utilizing the “presumptive eligibility guidelines” on a consistent basis to increase access for county based services
 - Update the eligibility determination process to be more consistent with current modes of communication.
 - Having case management providers target a particular person or phone line for triage—so that when hospitals call they can get an immediate response regardless if the identified worker is on vacation or unavailable.
 - a. Partner with the Mental Health Case Management reform committee

4. Increase the residential treatment facility and step down service options by creating Psychiatric Residential Treatment Facilities under the “psych under 21” benefit.
 - a. Partner with the Child and Adolescent Behavioral Health Services workgroup which is addressing MN Session Laws 2013, section 108, article 4 section 29 through discussions and recommendations for Psychiatric Residential Treatment Facility development within the state.