



Child and Adolescent Inpatient

Performance Standards

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Child and Adolescent Inpatient Hospitalization Performance Standards

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Child and Adolescent Inpatient Performance Standards

I. PURPOSE

The Child and Adolescent Inpatient (CAIP) Services Performance Standards describe expectations for quality in service delivery for children and adolescents whose services are funded through Community Behavioral Health (CBH) or Philadelphia County. They are intended as a guide for providers to design and monitor their inpatient programs and for CBH to evaluate these services. The Standards support resilience through comprehensive assessment, individualized treatment planning, mobilization of supports, and comprehensive discharge planning.

The CAIP Performance Standards reflect the core values and principles of the City of Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) Practice Guidelines, the Mayor's Blue Ribbon Commission on Children's Behavioral Health¹, and the Commonwealth of Pennsylvania Code Title 55 Chapter 1151 Inpatient Psychiatric Services. The Standards aim to describe foundational standards, promote continuous quality improvement and best practices, increase the consistency in service delivery, and improve outcomes for children and their families.

CBH developed these Standards in collaboration with CAIP providers through a process guided by best practice research, consensus, and state regulation.

II. SCOPE OF SERVICES

Inpatient hospitalization is the most intensive treatment setting in the CBH service continuum. The DBHIDS Practice Guidelines emphasize resilience through community-based, least restrictive care whenever possible; inpatient hospitalization is intended for children and adolescents exhibiting acute symptoms that cannot be managed outside of a 24-hour secure setting. It provides comprehensive, intensive, short-term, resolution-focused treatment, including psychotherapeutic and psychotropic medication interventions, for children and adolescents in a secure/ locked facility. This intensive level of care requires coordination among families and caregivers, educational providers, and other treatment and community-based providers for the child/ adolescent to successfully return to and remain in the community.

¹ Blue Ribbon Commission on Children's Behavioral Health. (2007). *Mayor's Blue Ribbon Commission on Children's Behavioral Health Final Report*. Retrieved from <http://dbhids.org/wp-content/uploads/2015/01/BlueRibbonCommission1.pdf>

III. ADMISSION

The DBHIDS Practice Guidelines describe the admission process as the earliest opportunity to identify resilience capital embedded in the individual, family, and community. Admissions processes should maximize the involvement of family members and other supports in the child's treatment, thereby increasing capacity for successful return to home, school, and community settings.

A. Informed Consent

Psychoeducation and informed consent are critical components of inpatient hospital services. The informed consent process should be viewed as an opportunity to engage family members, provide education about the goals of inpatient treatment, and emphasize their involvement as a predictor of the child/ adolescent's success in treatment. Inpatient providers should utilize partnerships with outside agencies whose staff may have contact with guardians, including the Crisis Response Center (CRC) and CBH, to keep guardians involved in the admission process.

A staff member who is knowledgeable about the consent forms and processes should assist guardians with review and signing of consent documentation. Consent forms should be culturally and linguistically appropriate, and all releases of information must include names of individual/ agency, what information will be shared, and the date the consent was signed. Signatures on consent forms for treatment and releases of information should be obtained no later than 48 hours following authorization for inpatient treatment. Additionally, once medication is recommended, medication informed consent should be pursued daily to ensure the child begins receiving necessary treatment as soon as possible (see Medication Management section).

Consent should be obtained in accordance with state policy for age and guardian consent. Verification of legal guardianship (e.g., court order) should be obtained for children residing in out-of-home placements, for e.g., through the Philadelphia Department of Human Services/ Community Umbrella Agencies (DHS/CUA).

B. Assessment

An integrative assessment that addresses mental health, physical health, substance use, education, family, trauma, and the social determinants of health should be performed (required components are listed in 1-6 below). Assessment should emphasize wellness in addition to symptom reduction. The voice of the child/ adolescent and caregiver/ family and their respective perceptions of the presenting challenges must be included. Discharge planning should begin during admission; staff should identify and begin to address any barriers to the child/ adolescent successfully returning home.

An essential part of the CAIP assessment process is **Risk Assessment**. A Risk Assessment should be completed and documented as early in the admission process as possible, and should address aggression/ destruction of property, self-injurious behavior, bullying (whether victim or perpetrator), suicidality, homicidality, elopement risk, and sexual acting out. A structured tool to assess risk should be considered, such as the Columbia- Suicide

Severity Rating Scale (C-SSRS) (http://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf). A risk assessment can be completed by any combination of nurse, social worker, and/or psychiatrist. An accompanying **Safety Plan** should be completed and documented to address identified risk and guide treatment in the hospital; it should then be revised for discharge/ aftercare (see Disposition).

Another critical component of the assessment is completion and documentation of **The Certificate of Need**. PA regulations regarding Certification of Need for admission state, “an independent team shall certify at the time of admission the need for inpatient psychiatric treatment and document this in the medical record. The team shall (1) include a physician (2) have competence in diagnosis and treatment of mental illness, preferably in child psychiatry and (3) have knowledge of an individual’s situation” (55 PA Code § 1151.62(b) relating to Certification of Need for Admission). The Certificate of Need provides an opportunity for providers to ensure, in addition to the CRC’s determination, the child meets inpatient criteria.

1. Nursing

The nursing assessment is a face-to-face assessment completed within the first 12 hours by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN), either of whom must have specialized training or one year of experience in psychiatric care (55 PA Code § 1151.66(c2) relating to Team developing plan of care). A RN must co-sign an assessment completed by a LPN. During this assessment, the nurse should greet the child/ adolescent at admission, conduct a body scan and document any injuries or bruising sustained during crisis, provide any pertinent education / handouts about mental health topics and hospital protocol, check vital signs, obtain health history, identify complex medical needs and determine whether they are within the threshold of hospital criteria, conduct a risk assessment (unless conducted by another qualified staff person), screen for substance use, complete nutrition inventory, begin discharge planning, and ensure continuity of care with psychiatry.

2. Psychiatric

The psychiatric admission evaluation is a face-to-face evaluation with a psychiatrist completed within the first 24 hours of admission that results in DSM diagnosis and prescription of inpatient treatment as the most appropriate, least restrictive service to meet the mental health needs of the child. The psychiatrist should consider the need for or potential benefit of psychotropic medication interventions at this time (see Medication Management).

3. History and Physical (H&P)

The H&P examination is completed by a physician within the first 24 hours of admission. This should include collaboration with the primary care physician. The H&P is an opportunity to order consultations and tests as indicated. Providers are encouraged to maintain contacts and/ or ongoing relationships with local pediatricians to ensure daily access to physicians and to maintain the 24-hour standard.

4. Allied Health

The Allied Health Assessment is completed by a master's level clinician. This assessment determines developmentally appropriate therapeutic activities, based on the child's interests, to add to course of treatment, including but not limited to art, dance movement, athletics, pet therapy, music, relaxation, horticulture, or occupational therapy. The Allied Health assessment is an opportunity to conceptualize a case, tailor a treatment plan to the unique needs and strengths of each child, and reinforce patterns of healthy play in preparation for returning home.

5. Psychosocial Assessment

The psychosocial assessment should begin upon authorization and be completed within 48 hours via collateral contacts and a face-to-face interview by a master's level clinician. Outreach to guardians, if not present at admission, should begin immediately, with a minimum of 24-hour follow-up for unreturned calls. Outreach to other involved parties should also begin at admission, with attempts documented and letters filed (see Collaboration). The assessor should gather and synthesize all relevant information to produce a comprehensive clinical formulation that addresses functioning across domains. Efficient staffing strategies are needed, particularly for evening and weekend social work, to ensure the psychosocial assessment process can begin as soon as possible for children and adolescents regardless of the time or day of admission.

The psychosocial assessor should obtain information about the viability a child's return to the previous placement, identifying cases of caregiver submission of 30-day notice, or DHS/CUA agencies closing a child's case due to extended hospital stay, as early as possible. Close collaboration with caregivers of children in child welfare placements, which can positively impact the caregiver/child relationship, should begin during the assessment. Every effort should be made to preserve viable placements and relationships; alternate placements should concurrently be pursued when the team and family agree this is needed.

6. Structured Tools

CBH requires the administering of at least two evidence-supported structured tools, one trauma screening/assessment tool and one diagnostic tool selected by the provider. Tools should be developmentally appropriate and relevant to the child's symptoms. Structured tools will assist in refining the diagnostic assessment, thus reducing the incidence of the child being discharged without confirmed, specific diagnoses (i.e. to reduce "rule-out" and "not otherwise specified" diagnoses). Structured tools can also promote individualized and trauma-informed assessment, preventing misdiagnosis and inappropriate interventions. Structured tools must be completed, scored, and shared with the team and incorporated into treatment within one week of admission.

The tools used should be selected by the provider. Suggested tools for trauma are:

Trauma Screening

Yale Childhood Violent Trauma Center, 2013. *Trauma History Questionnaire (child and caregiver versions)*. Retrieved from http://medicine.yale.edu/childstudycenter/cvtc/redcap/THQ_Child%20revised_5-29-14_225300_22527.pdf

PTSD and Other Trauma Related Symptomatology

Foa, et al., 1997: Child Posttraumatic Stress Scale 5 (DSM 5). Retrieved from <https://webcache.googleusercontent.com/search?q=cache:fk2FfYoWu1AJ:https://www.div12.org/wp-content/uploads/2014/11/CPSS-I-5-Manual.doc+&cd=5&hl=en&ct=clnk&gl=us> (in the public domain)

IV. COURSE OF TREATMENT

Inpatient treatment should be comprehensive, trauma-informed, youth/ family-driven, and tailored to individual needs and preferences. Wellness should be emphasized in addition to symptom reduction, with an aim for timely discharge to the most appropriate, least restrictive setting. Evidence-based practices should be utilized across treatment modalities.

A. Treatment Modalities

1. Family Therapy

Family treatment is a critical component of inpatient treatment. Family treatment sessions allow for skill practice and acquisition through real-life enactments, increasing the likelihood of a positive and sustained discharge. In addition, family treatment sessions provide opportunities for family members to voice their desire for next level of care/ service, and for providers and families to consider and tackle any anticipated barriers to a successful return home.

Family sessions must be prioritized in treatment planning and delivery, with any barriers to consistent meetings addressed. Providers are encouraged to accommodate the schedules of family members, including maintaining weekend and evening slots, providing supportive and consistent outreach via phone calls/ letters, and offering transportation assistance. Face-to-face sessions are preferred family treatment modalities. However, telephonic or video sessions should be offered when needed. Family sessions are conducted primarily by social workers; however, other treatment team members including psychiatrists are encouraged to join family sessions, particularly when families request their participation.

The frequency of family sessions should be determined based on the individual needs of each child/ adolescent. Some cases will benefit from several family sessions per week to expedite a return home, particularly for those children who present with less acuity and only require a short stay. Family sessions must occur at a minimum of once per week, and all outreach efforts and missed appointments must be documented.

2. Individual Therapy

Children and adolescents will receive individual support from the inpatient team throughout their hospitalization. Individual therapy is particularly essential for children who struggle with group treatment modalities or whose needs are best addressed through individual modalities; in these cases, individual therapy should occur in higher frequency than occurs in outpatient treatment. Providers should also maintain capacity to provide specialized individual therapy to address trauma, risk behaviors, or other challenges that surpass what can be addressed by the traditional inpatient milieu approaches. Evidence-based treatments are particularly encouraged in the course of individual treatment.

3. Milieu Therapy

Milieu therapy comprises many of the activities of a treatment environment that provide structure, predictability, consistency, and stability during inpatient stays. Examples of milieu therapy include management and layout of the inpatient environment, efforts to maintain safety and security, and the daily program schedule. Emerging data supports moving away from non-evidence based approaches, such as points and level systems, toward approaches that are patient-centered, trauma-informed, and based on collaborative problem solving; evidence demonstrates that such strategies improve child and adult self-efficacy and reduce negative outcomes such as restraints and seclusions.

4. Group/ Allied Therapy

Allied and group therapies include activities tailored to a child's interests and strengths, including but not limited to art, dance movement, athletics, pet therapy, music, relaxation, horticulture, or occupational therapy. Providers should regularly evaluate and update programming and staff to provide children with a variety of outlets for play and healing. Group therapy should include evidence-based or empirically-supported programming tailored to the treatment needs of children on the unit. Groups may address challenges related to communication, anger/affect regulation, trauma, and social skills. Family psychoeducation and support groups are also encouraged.

5. Psychiatric Treatment

Psychiatric treatment indicates activities unique to the team psychiatrist. Psychiatric leadership of the treatment team/milieu and active involvement in psychosocial therapies, activities expected of the psychiatrist, are not covered in this section.

a) Medication Management

Psychiatrists should assess a child's medication needs during the first contact to ensure necessary treatment begins as soon as possible. As noted above, medication consent should be sought daily once medication is recommended and should be accomplished through informed consent. When indicated, medication administration should begin as soon as possible and generally within three to five days of admission.

In extenuating circumstances when this is not possible, providers should contact CBH

to discuss barriers.

If a child was being treated by an outside psychiatrist at the time of admission, the inpatient psychiatrist must contact the outside physician. PCPs should be consulted for medically complex children and/ or when medical input is required to make an appropriate and safe medication recommendation (psychiatrist can consult H&P for this information, if sufficient). Outreach attempts and collaboration should be documented.

Family member participation in medication appointments helps to ensure that they understand the risks/benefits of medication options and follow through on the medication plan after hospitalization. Psychiatrists must meet family members in person or by phone in cases when face-to-face meetings are not possible. Outreach efforts should be documented, and providers should request CBH support as needed to engage family members.

When medication is being considered as part of treatment, there should be an interactive, well-documented* discussion with the child/ adolescent (as appropriate given age) and caregiver/ guardian regarding:

- The rationale for an initial prescription of medication, including the condition or targeted symptoms
- The risks specifically associated with proposed use
- If the selected medication is off-label, the nature of off-label use and the reasons for choosing the non-FDA approved medication
- As applicable, the nature of any black box warnings as well as the regulatory requirements and monitoring schedules set forth by the FDA for these uses
- Proposed strategy for tapering and/ or discontinuing the prescribed medication²

*Documentation should clearly describe the details and rational from the above list, as well as indicate that they were discussed with the child/ adolescent and caregiver/ guardian.

Literature and guidelines regarding pharmacotherapy best practices must be consulted and documented. In particular, this should include all recommendations in the American Academy of Child and Adolescent Psychiatry Practice Parameters for the Use of Atypical Antipsychotic Medications in Children and Adolescents.³

Metabolic monitoring to screen for weight gain, diabetes, and hyperlipidemia should be conducted and documented according to the following table⁴:

² Provider Bulletin #10-03: Community Behavioral Health: Use of Psychotropic Medications in Children and Adolescents (FDA-approved and Off-label). January 11, 2010

³ R. L.Findling, S. S.Drury, & P. S. Jensen. Practice Parameter for the use of Atypical Antipsychotic Medications in Children and Adolescents. American Academy of Child and Adolescent Psychiatry. Accessed on March 7, 2012.

⁴ Provider Bulletin #07-07: Community Behavioral Health: policy regarding the Screening for and Treatment of the Components of Metabolic Syndrome. November 1, 2007.

Screening Guidelines obtained from ADA, APA & AACAP Recommendations ^{3,5}							
	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 years
Personal & Family History ^B	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting Plasma Glucose	X			X		X	
Fasting lipid profile (HDL, LDL, TG, TC)	X			X			X
^A More frequent assessments may be warranted based on clinical status ^B Personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease							

b) Daily Assessment and Psychiatric Notes

The hospital psychiatrist should complete daily assessments for every child/adolescent and document these in the daily psychiatric progress note with a complete MSE. The MSE should describe the clinical presentation of the child. MSEs should reflect specificity for each child/ adolescent through elaboration of endorsed symptoms. A daily assessment with detailed MSE eases the approval process when CBH reviews level of care recommendations.

The attending physician must complete the daily face-to-face assessment and progress note. Notes should address treatment planning, progress, medication, and any changes in medication with a clear rationale in addition to the MSE.

c) Psychiatric Evaluation

A psychiatric evaluation must be completed for every child or adolescent who requires a pre-approved next level of care or a child welfare placement. The written evaluation with next level of care recommendations must be submitted to CBH no more than five days after the recommendations are made. An essential aspect of discharge planning, the evaluation is closely reviewed by receiving treatment providers and child welfare placement providers. It should be thorough, comprehensive, and strengths-based, providing reasons for hospitalization, a summary of the hospitalization/hospital course, a strong biopsychosocial formulation, diagnoses, and rationale for recommendations. A formulation is a narrative that encompasses and expands on predisposing, precipitating, perpetuating, and protective factors. Treatment history, including past and current services, medication trials, and responses must be included. Recommendations to intensive levels of care, such as residential treatment facility (RTF), must be substantiated by a depiction of previous interventions and their impact and the anticipated goals of residential treatment.

B. Collaboration

Strong collaboration with collateral providers/supports is essential to tailoring inpatient treatment and discharge recommendations to the individual child/ adolescent. All outreach to collateral contacts should begin at admission and be documented; CBH Member

Services, Provider Relations, and/ or Clinical Care Management should be consulted when contacts do not respond to outreach.

1. Current and Past Treatment Providers

Contact with other treatment providers is critical to providing effective treatment. Providers should consult current and past providers to determine previous interventions and their impact. Collaboration among providers helps the inpatient team to continue effective interventions or introduce new ones when needed, thus increasing the likelihood of engagement from a child/ family who may otherwise be experiencing “treatment fatigue” or discouragement. Partnering with a provider who will resume treatment after discharge helps to ensure consistency in treatment approaches.

2. Schools

As a majority of inpatient hospitalizations are with school-aged children and many are prompted by school referrals, CBH expects that collaboration with schools will be a significant part of assessment, treatment, and discharge planning. School staff can provide perspective on a child’s needs and behaviors, thus facilitating more targeted treatment and discharge planning (see Plan to Transition to School). Additionally, schools must be consulted when planning academic portions of milieu care.

3. Other Involved Systems (e.g. Child Welfare)

CBH expects providers to identify any other significant collaborators in a child’s life. For many children, this will include DHS/ CUA case managers. Inpatient providers should maintain communication with DHS/ CUA beyond the initial consent process. DHS/ CUA should be consulted for perspectives on the child and family, including placement histories and settings where the child has experienced the most success. DHS/ CUA collaboration is particularly critical if any changes in a placement setting will occur as part of the discharge process (group home, new foster home, etc.). System partners are better able to contribute to a successful and sustained discharge when inpatient providers have educated them about a child/ adolescent’s needs.

C. Interagency Service Planning Team (ISPT)

The ISPT is a requisite step in the inpatient course of treatment. The Guidelines for Best Practices for Children’s Mental Health⁵ should be referenced to plan and facilitate effective ISPT meetings. When BHRS or RTF is recommended, the ISPT signature sheet will be submitted as part of the packet to authorize those services. The ISPT is a mechanism for child-driven, family-focused treatment and an opportunity to engage community-based treatment providers and CBH care managers in treatment planning. Providers should orient families to the purpose of ISPT meetings and encourage them to invite stakeholders and natural supports to participate. The purpose of ISPT meetings is to discuss presenting issues, current needs of child and family, service recommendations, and review continuum of care available, treatment interventions, child’s functioning in all domains, areas of need, and barriers to success. The outcomes of structured tools should be discussed as a means of

⁵ Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services Bureau of Children’s Behavioral Health Services. (2001, 2007). Retrieved from *The Guidelines for Best Practices for Children’s Mental Health*. Retrieved from http://www.dhs.pa.gov/cs/groups/public/documents/manual/s_001583.pdf.

educating attendees about the child/ adolescent's diagnoses and related needs. The following participants should be involved in ISPT meetings: inpatient clinician, inpatient psychiatrist, child*, legal guardian, caregiver, family members, school team, provider(s), clinical care manager (CBH), and other key parties (i.e. DHS, CUA).

*The child's age and developmental capabilities should guide the decision to include the child in the ISPT meeting.

D. Treatment Planning

PA state regulations indicate that treatment plans should be based on the diagnostic evaluation of the child/ adolescent that includes the medical, psychological, social, behavioral, and developmental aspects of the presenting condition and the medical need for inpatient psychiatric care. The plan should be developed by an interdisciplinary team of professionals, and the child and family members must drive the treatment plan and clearly understand the goals as they are documented.

Goals should be measurable, achievable, developmentally appropriate, and related to all areas of the child's life. Goals should include objectives and an integrated program of therapies, activities, and experiences designed to meet objectives. The treatment plan should evolve and change as it tracks progress, rather than simply mark time intervals. The initial treatment plan must be completed within 72 hours and updated every seven days. Goals should be modified for attainability if not met after 30 days.

The plan should be designed to achieve discharge from inpatient status at the earliest possible time. The discharge plan should be included, comprising coordination of inpatient services with partial discharge plans and/or related community services to ensure continuity of care with the child/ adolescent, family, school, and community upon discharge.

CBH requires that the treatment plan is signed by the psychiatrist, one additional member of the treatment team, and the guardian, or child if age 14 or over, at a minimum.

E. Psychological Testing

Providers should ensure access to psychological testing for children who demonstrate such a need. Testing should be used to gain understanding of the child's cognitive, emotional, and behavioral functioning and the impact this may have on behaviors and coping, particularly in the school setting. Psychological testing can facilitate diagnostic clarity and individualized recommendations. All efforts in program planning and staffing should be geared toward timely return of test results to allow for appropriate treatment.

V. DISCHARGE/ AFTERCARE

A. Disposition

As noted in the Psychosocial Assessment section, providers should begin to investigate return home options at admission. Providers should engage family members, DHS/ CUA, other treatment providers, schools, and CBH to facilitate an appropriate disposition plan. If barriers are encountered, providers should request assistance from CBH and/ or schedule an inter-agency meeting.

Safety planning to address risk for re-traumatization should be included in the disposition plan, particularly for children who have experienced trauma in the setting where they are returning. Safety planning should anticipate triggers for harm of self and others that may arise following discharge, with a clear support plan for managing these triggers. Since the risk for re-hospitalization is highest during the two weeks following discharge, providers should educate families about this risk and help them identify supports to prevent the need for returning to the CRC. Providers should also guide families in considering scenarios that will require a CRC visit versus scenarios in which other supports may be successful.

B. Services

The full continuum of services, including evidence-based practices, should be considered when planning next services. Partial hospitalization should be utilized when a child needs continued intensive care. Outpatient therapy should be considered in less intense cases or when specific evidence-based treatment practices such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT) are indicated. Inter-agency meetings are used to facilitate consensus about recommendations. Providers must engage family members to include their voice in recommendations and to ensure they understand the rationale for services. National and CBH data highlight the two weeks following discharge as a critical risk period for recidivism, thus the first appointment with the next provider must be scheduled for a date no more than seven days after discharge. Discharge plans should be given to family members and all other relevant parties, including PCP, DHS/ CUA, and next treatment provider.

C. Prescriptions/ Prior Authorizations

Providers should have working knowledge of each insurer's policies and procedures regarding prior authorizations. Providers' internal policies and resources must address external authorization challenges to prevent access issues following discharge. Efforts to obtain prior authorization should begin at a minimum of three days prior to the planned discharge, and families and/ or next providers should be given labs to facilitate authorizations as needed. Children/ adolescents must be discharged with a prescription to last until their next medication appointment, which should be scheduled for a date no more than 30 days following discharge.

D. Plan to Transition to School

Coordination with schools is an essential component of discharge planning. Providers must relay discharge recommendations to school counselors, particularly sharing interventions that should be used in the school setting to keep the child/ adolescent stable and to prevent re-hospitalization. Providers should make every effort to include schools in discharge planning meetings, documenting outreach efforts and contacting CBH regarding barriers to communication. Providers should be aware that schools cannot refuse a child's readmission, and CBH and other liaisons should be contacted in these cases.

E. Discharge Plan

The discharge plan should be individualized and strengths-based, building on supports and capacity for resilience. The plan will include diagnoses, outcomes of structured tools, medications, and recommendations as previously noted. The plan should be reviewed with the child and family/caregiver at the time of discharge, along with treatment providers, and other key people as identified by the individual. The discharge plan should be sent to the next treatment provider, PCP, and any other relevant parties as determined with the individual. Recipients of the discharge plan should be documented.

IV. FOLLOW-UP/ OUTCOME

The 30-day period following inpatient discharge is a critical time for successful acclimation or re-acclimation to placement and next level of care. The inpatient provider must maintain an active role in preventing re-admission. This can be accomplished through phone calls to assess the child's adjustment and remind of initial appointments. Providers are encouraged to adopt post-discharge monitoring strategies. CBH will facilitate readmission interviews for children that re-present for acute inpatient admission within 30 days of discharge.