Universal Hospital Discharge Planning Protocol
for Youth with Intensive Needs
December 16, 2020

Protocol for Hospital Personnel:

1. Youth comes to a hospital emergency department for behavioral health needs or is admitted to the hospital and has an assessment that determines residential care is the most appropriate plan, and one or more of the criteria below applies to the youth:
    a. Has multiple emergency department visits for behavioral health needs;
    b. Has two or more hospital admissions in the past 90 days;
    c. Has a hospital emergency department stay of 5+ days without an inpatient admission;
    d. Is responsible for/suspected of firesetting;
    e. Is/was suspected of being a human trafficking victim;
    f. Has diagnosed developmental disabilities and/or Autism with psychiatric features;
    g. Demonstrates sexually-reactive behaviors;
    h. Has complex medical needs with or without psychiatric features; and/or,
    i. Has unique placement challenges.
2. Discharge planning should begin on the date of admission.
    a. If a youth is in the custody of the Department of Human Services (DHS) or Department of Juvenile Services (DJS), the agency should be involved on the date of admission as well as resource (pre-adoptive, foster, kinship) parents as applicable.
        i. DHS recommends that all discharge planning start with the local Department of Social Services (DSS) case worker, if the youth is receiving services from DSS. If there are concerns, the first point of escalation should be to the local DSS Director.
    b. If a youth is not in the custody of DHS or DJS, then the youth's family and/or guardian(s) should be assessed to determine what services, if any, are needed to support the youth at home, including coordinating services from any other public agency with whom the youth and family are involved.
3. Hospitals acknowledge the Local Care Team (LCT) as the first point of contact if the above protocol conditions are met.
4. If above conditions are met, the hospital discharge planner or designee completes the LCT referral form and sends it electronically to the LCT coordinator in the youth's county of residence. The referral will also contain the hospital discharge recommendations and the psychosocial summary. The LCT coordinator will respond to the referral in accordance with the Children's Cabinet directive.
5. The hospital discharge planner or designee will participate in the LCT meeting.

Factors Impacting a Smooth Discharge Planning Process:

- There are bed capacity and staffing limitations that will impact any established process.
- Communication and accountability between hospital personnel, participating agencies, and the youth and family is the key to success.
- As part of the communication effort, all parties should be informed of placement outreach efforts (group homes, foster care placements, etc.) and responses in a timely manner. This coordination will build trust and eliminate duplicate placement related efforts.