

**Discharge Checklist for TennCare members for Inpatient Psychiatric Hospitalization
and Residential Treatment Facility**

1. HAS MEMBER MET TREATMENT MILESTONES?			
☐	Yes	☐	No
	If yes, go to question #2		If no, continue to treat member.
2. IS DCS INVOLVED OR IS THE CHILD "AT RISK"? OR DOES THE MEMBER HAVE AN IDD DIAGNOSIS?			
☐	Yes	☐	No
	Member will be referred to a discharge planner/IDD Care coordinator at the Managed Care Organization (MCO) to assist and develop a solid plan for discharge. Please notify the member's MCO.		If no, go to question #3
3. HAVE YOU ENGAGED THE PARENT/GUARDIAN IN DISCHARGE DISCUSSIONS?			
☐	Yes	☐	No
	If yes, go to question #4.		If no, engage parents/guardians in discharge discussions
4. DO PARENTS/GUARDIANS AGREE WITH THE DISCHARGE PLAN?			
☐	Yes	☐	No
	IF YES, GO TO QUESTION #5.		CALL THE MEMBER'S MCO. MCO WILL ASSIST THE FACILITY WITH DISCHARGE PLANNING FOR DISCHARGE RESOLUTION. - MCO will engage TennCare - MCO will engage DCS/CPS
5. DISCHARGE SUMMARY & MEMBER NOTICE WITH APPEAL RIGHTS DELIVERED TO MEMBER?			
☐	Yes	☐	No
	Member is ready for discharge.		

- MCO UM teams are available to engage with facility during the discharge planning period. Please escalate difficult cases to the MCO for discharge planning resolution to ensure that DCS/CPS and/or TennCare are engaged early.
- If there is no appropriate discharge plan, the provider will continue to provide care until an appropriate plan is in place. If there are any barriers to discharge, please engage the MCO immediately for assistance.
- Notices are separate from discharge planning. Notices are meant to provide appeal rights. Discharge plans must be secured prior to the notice being generated.
- If there is any DCS involvement with the member or the member is at risk for DCS custody, the provider shall notify the MCO immediately. The MCO will engage DCS early to assist in discharge planning.
- If member has an Intellectual or Developmental Disorder (IDD) diagnosis, please contact the MCO care coordinator for appropriate discharge planning, potential Employment and Community First (ECF) referral, collaboration with DIDD, etc.

Protocols for discharge planning

1. Discharge planning starts at Admission. The expectation is that the provider consistently assesses and immediately escalates any barriers to discharge. Some examples below:
 - a. Parents are not involved in therapy
 - b. DCS/Juvenile Court involvement
 - c. IDD Diagnosis; barriers finding appropriate aftercare appointments
 - d. Child refuses to go home or regresses when mentioning going home (i.e., suicidal thoughts)
 - e. Parent doesn't think the child's needs are being met in current facility, or wants a transfer to another facility
 - f. There have been no home passes during the child's stay at the RTC
 - g. Barriers to getting aftercare appointments in rural areas
 - h. Family refuses outpatient providers or aftercare appointments
 - i. Child is 6 months from 18th birthday at time of admission
 - j. COVID 19 (Family is positive and can't discharge child home; OR child is positive and family is negative)
2. If barriers are identified during admission, the provider will make a referral for care coordination to the member's MCO.
3. The MCO will assist the provider with the following steps:
 - a. Contact Facility for information on the case
 - b. Contact Family to facilitate discussion between facility and family.
 - c. Coordinate with outside systems (DCS, DIDD, BA, etc) as appropriate, to work on treatment needs.
 - d. Escalate issues of permanency to TennCare, when all medical needs were met, but there are still barriers to discharge.
 - e. Flesh out inconsistencies between facility and family. Help bridge the gap in communication.
 - f. Collaboration with provider for solutions and follow up.
4. MCO will escalate any patterns or trends to TennCare where the member is medically stable, discharge plan and community alternatives are provided, but the family refuses the care or where DCS is asking for continued stay.