COLORADO
Office of Children, Youth & Families
Division of Child Welfare

COLORADO
Department of Health Care Policy & Financing

HOSPITAL DISCHARGE ROLES & RESPONSIBILITIES

This document was created and reviewed by representatives from HCPF, CDHS, counties, and hospital staff out of the HRCC Forum.

Updated July 2022

	FOR KIDS IN COUNTY			FOR COMMUNITY KIDS -		
Hospital Discharge Tasks	**RAE**	**County**	**Hospital**	**RAE**	**County/ Parent**	**Hospital**
General/Universal Tasks						
Clarify and confirm who has custody/medical decision making			x			x
Confirm payer for services			x			x
What length of stay is the hospital recommending?			x			x
Communicate timeframes for authorization/reauthorization (daily, 72 hrs, 14 days, etc.).	x			x		
If there is not a RAE Care Manager assigned, make a referral.		x				x
Assess and communicate with the RAE Care Manager assigned to the member.			x			x
Confirm participants required/ expected to participate in D/C planning			x			x
Identify roles and responsibilities of team members on MDT and D/C planning team; as well as their contribution to the coordination of care.		x		x		
Collect relevant collateral contacts for input (parents, teachers, providers, etc.)	x	x	x	x	x	x
Complete necessary ROIs in order to create communication amongst all parties.			x			x
Educate family on concurrent planning required to manage long-term residential (LTR) waitlist or alternative plan if residential is not approved; i.e. request may be denied if the accepting facility cannot admit the member for 3+ weeks, need to develop interim plan, which may include returning home with intensive in-home supports.			x			x
Confirm/review disability/waiver eligibility		x		x		
Define what “stable” means			x			x
Complete safety planning			x			x
Have a clear medication management plan			x			x
Client discharge date determined - Medical Necessity Determination made or hospital has determined discharge date.			x			x
Confirm medical record is complete and accurate			x			x
Appeal Medical Necessity Determination as needed		x			x	

Inpatient Hospital to Home	RAE	County	Hospital	RAE	County/ Parent	Hospital
1. Schedule care conference with multi-disciplinary team (MDT) for resource collaboration at least once during member stay.			x			x
2. Complete relevant assessments while in the hospital so services can be put in place prior to discharge.		x		x		x
3. Assess family needs to support member transition home (i.e. peer support type services).		x		x		
4. Develop clear, timely and confirmed discharge plan to include but not limited to:						
a. Follow-up BH appointment scheduled prior to discharge (7 day therapy follow up and 30 day medication management appointment)			x			x
b. Follow-up medical appointments scheduled prior to discharge			x			x
c. In-home supports set up prior to discharge	x	x	x	x		x
d. IOP/PHP set up prior to discharge			x			x
e. Physical Health Supports (DME, Home Health, etc.)			x			x
f. Pediatric Behavioral Therapy or home health- provider must complete an assessment prior to requesting a prior auth. Those take time, and this will likely not be in place for discharge.	x		x	x		x
g. Assess/Submit referral to specialty programs (i.e. Momentum), if appropriate.	x		x	x		x
h. Assure a supportive school plan in place; including having had a conversation with CWEL/school personnel for recommendations.		x		x		
5. Assure member/caregiver receives discharge plan with contact information for provider.			x			x
6. Assure member has 30 day supply of medications, if appropriate; and/or appointment with prescriber.			x			x
Inpatient Hospital to PRTF, QRTP	**RAE**	**County**	**Hospital**	**RAE**	**County/ Parent**	**Hospital**
1. Clinical recommendation for residential treatment by hospital team or collateral voices/providers.			x			x
2. Schedule care conference with multi-disciplinary team (MDT) to address concurrent planning needs			x			x
3. Refer to Independent Assessment (IA) if seeking QRTP		x		x		
4. Search for residential treatment with all options known/available to the MDT.		x		x		
5. Generate referral information and referral to residential treatment facilities		x		x		x
a. If all in-state facilities deny, assess whether EPSDT will need to be utilized (for out of state placements)	x			x		
b. Complete the EPSDT process (including ICPC)	x	x		x		
c. Complete ICPC request if EPSDT not involved		x		x		
d. Initiate referral to Creative Solutions as needed	x			x		
6. Update MDT with clinical information to assist coordination efforts.		x		x		x
7. Secure placement		x		x		x

8. Arrange transportation to placement	x	x		x		
9. Collaborate with the CWEL/educational team for academic recommendations and/or financial support as needed.		x		x		
10. Inform accepting residential facility of ongoing care management needs and entities that will need ongoing communication.	x			x		
11. Provide orientation of placement to child/family	x			x		x
12. Assess/Submit referral to specialty programs (i.e. Momentum), if appropriate. [Momentum may be needed for transition planning and may have an extensive waitlist.]			x			x
ED to Home	**RAE**	**County**	**Hospital**	**RAE**	**County/ Parent**	**Hospital**
1. Schedule care conference with multi-disciplinary team (MDT).			x	x		x
2. Develop clear, timely and confirmed discharge plan to include but not limited to:						
a. Follow-up BH appointment scheduled prior to discharge (7 day therapy follow up and 30 day medication management appointment)			x			x
b. Follow-up medical appointments scheduled prior to discharge			x			x
c. In-home supports set up prior to discharge	x	x	x	x		x
d. IOP/PHP set up prior to discharge			x			x
e. Complete community-based provider assessments or assessments are scheduled prior to discharge			x			x
f. Physical Health Supports (DME, Home Health, etc.)			x			x
g. Assure supportive school plan in place; including having had a conversation with CWEL/school personnel for recommendations.		x		x		
h. Develop a safety plan for member and family.		x	x			x
3. Assure member/caregiver receives discharge plan with contact information for provider in place			x			x
4. Schedule coordination meeting within 30-45 days with member/caregiver to continue to address BH/PH needs after transition; confirm with member/caregiver.		x		x		
5. Assure member has 30 day supply of medications, if appropriate; and/or appointment with prescriber.			x			x
6. Notify RAE as needed, especially if guardians refuse to take member home. [Please note, the RAE does not know when people are in EDs unless they ask for prior auth.]			x			x
ED to PRTF, QRTP	**RAE**	**County**	**Hospital**	**RAE**	**County/ Parent**	**Hospital**
1. Clinical recommendation for residential placement by hospital team or collateral voices/providers.			x			x
2. Schedule care conference with multi-disciplinary team (MDT) to address concurrent planning needs			x			x
3. Refer to Independent Assessment (IA) if seeking QRTP		x		x		
4. Search for residential treatment facilities with all options known/available to the MDT.		x		x		
5. Generate referral information and referral to residential facilities.		x		x		x

a. If all in-state facilities deny, assess whether EPSDT will need to be utilized (for out of state placements)	x			x		
b. Complete the EPSDT process (including ICPC)			x	x		x
c. Complete ICPC request if EPSDT not involved		x			x	
d. Initiate referral to Creative Solutions as needed	x			x		
6. Update MDT with clinical information to assist coordination efforts.			x			x
7. Secure placement		x		x		
8. Arrange transportation to placement		x		x		
9. Collaborate with the CWEL/educational team for academic recommendations and/or financial support as needed.		x		x		
10. Inform accepting residential facility of ongoing care management needs and entities that will need ongoing communication.	x			x		
11. Provide orientation of placement to child/family		x				x
12. Assess/Submit referral to specialty programs (i.e. Momentum), if appropriate.	x		x	x		x