DIVISION OF CHILD AND FAMILY SERVICES

DESERT WILLOW TREATMENT CENTER

Individualized Treatment, Discharge, and Aftercare Planning

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	CLINICAL PROGRAM MANAGER II

I. POLICY

This policy outlines the Desert Willow Treatment Center guidelines concerning treatment planning, case management, discharge planning, and aftercare planning. Per Desert Willow Treatment Center's mission statement to "provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community, and other providers to ensure that children and families of Nevada may achieve their full human potential."

II. PURPOSE

To reflect the individual youth's clinical needs, condition, functional strengths, and limitations. Develop a comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services. To assess each individual's discharge planning needs and facilitate timely, appropriate, and continuous post-discharge care. To guide and define aftercare planning.

III. PROCEDURE

A. Treatment Planning

a. Presenting Problem List

i. Upon admission, a presenting problem list is formulated based on the intake assessment.
ii. Mental health and medical professionals are responsible for assessing, identifying, and modifying the presenting problems list.
iii. The presenting problems list becomes the framework for developing the individualized treatment plan, which is generated directly from the presenting problem list.
iv. Address presenting problems which are not being treated by noting as such or "deferred".
v. Identify presenting problem list dates of identification and resolution.
vi. Problems on the list must correspond with the Individualized Treatment Plan.

b. Preliminary Treatment Plan

i. focuses on youth safety and will be completed at the time of admission. The parent/legal custodian and youth shall sign and date the preliminary treatment plan.
ii. The parent/legal custodian and youth will participate in the treatment planning process and shall be informed that other identified problems for treatment will be included in the Individualized Treatment Plan.

c. Individualized Treatment Plan

Timelines
A comprehensive Individualized Treatment Plan must be developed by the clinician, with the assistance of the youth and input from the Parent/legal custodian within three business days for the acute unit and five business days for the RTC unit. The treatment plan must be signed by the parent/legal custodian and the youth.

The Individualized Treatment Plan is considered final when marked "Final" in Avatar.

Critical Elements
The following must be included in the plan.

i. Recipient's full name;
ii. Recipient's Medicaid/Nevada Check Up billing number;
iii. The intensity of Needs determination;
iv. Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) determination;
v. Date of determination for SED or SMI;
vi. The name and credentials of the provider who completed the determination;
vii. Goals and Objectives
    1. The individualized treatment plan must demonstrate an improvement of the recipient's medical, behavioral, social, and emotional well-being of the effectiveness of all requested Behavioral Health services that are recommended in meeting the plan's stated rehabilitative goals and objectives documenting the effectiveness at each reevaluation.
viii. Requested Services
    1. Services: Identify the specific behavioral health service(s) (i.e., family therapy, individual therapy, medication management, basic skills training, day treatment) to be provided;
    2. Scope of Services and Duration: Identify the daily amount, service duration and therapeutic area for each service to be provided;
    3. Providers: Identify the provider or providers who are responsible for the implementation of each of the plan's goals, interventions, and services;
    4. Rehabilitative Services: Document that the services have been determined to be rehabilitative services consistent with the regulatory definition;
    5. Care Coordination: When multiple providers are involved, the plan must identify and designate a primary care coordinator. The primary care coordinator develops the care coordination plan between the specified BH services and integration of other supportive services involved with a recipient's services;

6. Strength-Based Care: Collaboratively establish a treatment plan of care involving the strengths of the recipient and family (when applicable);
7. Declined Services: If the recipient declines recommended service(s), this act must be documented within the treatment plan

ix. The Discharge Plan must identify:
1. The planned duration of the overall services to be provided under the Treatment Plan;
2. Discharge criteria;
3. Recommended aftercare services for goals that were both achieved and not achieved during the duration of the Treatment Plan;
4. Identify available agency(ies) and independent provider(s) to provide aftercare services (i.e., community-based services, community organizations, nonprofit agencies, county organization(s) and other institutions) and the purpose of each for the recipient's identified needs under the Treatment Plan to ensure the recipient has access to supportive aftercare.

x. Required Signatures and Identified Credentials
1. The clinical supervisor and their credentials;
2. The recipient, recipient's family or their legal representative (in the case of legal minors and when appropriate for an adult);
3. The individual QMHP and their credentials responsible for developing and prescribing the plan within the scope of their licensure.

d. Quality of Treatment Plan

Presenting problems should be clearly specified. Goals must relate to the presenting problems and objectives, and reflect the plan for measurable improvement in functioning.

In the development of the treatment plan, the clinician shall review admission assessment/evaluations from nursing and medical staff in addition to referral sources (if applicable).

Once final, the treatment plan shall be made available and accessible on the chart and at the treatment team meeting and any DWTC disciplines identified in the plan as persons responsible for interventions shall sign the treatment plan.

e. Review of Treatment Plan

For youth receiving treatment on the RTC unit, the treatment plan must be reviewed with the youth and parent/legal custodian at least every 90 days after initial developments. The youth and the parent/legal custodian must re-sign the treatment plan. Reviews should be documented in the case file. Every attempt will be made to contact the parent/legal custodian for a review of the Treatment Plan. Contact attempts will be noted in the medical record. The Treatment Plan shall also be reviewed with the youth and parent/legal custodian upon revision.

f. Treatment Plan Revision

The Treatment Plan is reviewed weekly by a multidisciplinary team, and parents/guardians and revisions are made as needed based on the reassessment of the individual's current clinical problems, needs, and responses to treatment.

B. Discharge Planning

a. Desert Willow Treatment Center will provide discharge planning for each youth, and such planning will begin upon admission.

b. The Psychiatric Caseworker, clinician, or designee will develop the Aftercare Plan with input from the youth, parent/legal custodian, treatment team members, and psychiatrist. The plan will address placement, medication, counseling, school, referrals made to additional support services, and any medical appointments the youth may have.

c. The Aftercare plan will contain continuum of care appointment(s) date(s) and time(s) for psychiatry and psychotherapy. Ideally, psychiatry appointments are scheduled to occur within 30 days of discharge and psychotherapy appointments are scheduled to occur within seven days of discharge.

d. Discharge planning will consider unit performance, observation of behaviors, and results from therapies conducted by clinicians and will address the youth's ability to function in the family, community, and school settings to which he/she is to return. The psychiatrist must concur with the treatment team's recommendation concerning the youth's ability to function in a less restrictive setting.

e. A discharge planning progress note must be entered weekly in the youth's electronic medical record by the psychiatric caseworker.

f. The Psychiatric Caseworker shall meet with the youth's parent, legal guardian, foster parent, or group home parents prior to the youth's discharge from the program. They will also be expected to attend the last Treatment Team meeting. For youths under supervision of the court, the psychiatric caseworker will work directly with the youth's agency caseworker to ensure proper notification and/or filings are made with the court to provide notification of the intended discharge date.

g. Referral for services to DCFS, Children's Clinical Services will be made as needed for youths requiring this out patient service, but prior to discharge.

h. Referrals to other supportive services including but not limited to Wrap Around in Nevada (WIN), Mobile Crisis Intensive Stepdown Unit (MCRT-ISD), and Nevada PEP may be made at least 30 days prior to the intended discharge date as applicable. The assigned psychiatric caseworker will ensure such referrals are made and documented within the youth's electronic health record and on the Aftercare Plan.

i. For youths approaching the age of majority (18 years of age) a referral for ongoing services will be made to Southern Nevada Adult Mental Health Services (SNAMHS) as applicable.

j. Should a referral to SNAMHS be deemed necessary, such referral shall be submitted by the psychiatric caseworker at least 90 days prior to the youth's birthday (new youths who are within 90 days of their 18th birthday shall be referred immediately if ongoing services are needed). The

psychiatric caseworker shall do this in coordination of efforts with the youth's guardian and/or caseworker as applicable.

k. SNAMHS representatives will be invited to the youth's weekly multidisciplinary treatment team meetings to receive updates regarding youth progress and response to treatment. Any additional supporting documentation such as CUMHA's, treatment plans, and MARS will be provided upon request per the signed release of information approval by the guardian.

l. Coordinate intra-agency staffing to facilitate the referral and coordination of services.

m. SNAMHS will assess the referral from DWTC and determine the type and level of services needed.

n. SNAMHS will participate in inter-agency staffing to facilitate coordination of services.

o. If applicable, as a part of the transition planning, referral to a Bureau of Alcohol and Drug Abuse (BADA) certified out patient or residential program will be documented and communicated to the youth and family members.

C. Aftercare Plan

a. It is the policy of Desert Willow Treatment Center that all youths receive aftercare planning prior to discharge. The completed Aftercare Plan is reviewed with the guardian and youth at discharge. The psychiatric caseworker will ensure all signatures are obtained on the Aftercare Plan.

b. The Psychiatric Caseworker will facilitate the scheduling of aftercare resources as necessary in accordance with treatment team recommendations.

c. The clinician will complete the brief treatment summary and update the diagnosis made by the psychiatrist in Avatar.

d. The assigned Nurse will personally facilitate a review of the youths medications at discharge, administration of the medication, and a review of potential side effects with the guardian and youth during the discharge meeting.

e. The Psychiatric Caseworker will place the Aftercare Plan in the youth's chart and provide a copy to the youth and legal guardian upon discharge.

f. All disciplines will write a discharge note and include it in the youth's medical record.

g. A discharge note must be completed by a licensed nurse and shall include any specific doctor's orders and medication prescribed if any.

h. A discharge summary will be completed by the attending psychiatrist within thirty (30) days of youth discharge (for routine discharges) or 45 days after an administrative or AMA discharge.

REFERENCES:

The Joint Commission Rights and Responsibilities of the Individual (RI)
Care, Treatment, and Services (CTS)
Medicaid Services Manual 400