



Hospital to School Transition Protocol

This protocol was developed by the Behavioral health Integrated Resources for Children Project (BIRCh), representing a collaboration between the University of Massachusetts Boston and the University of Massachusetts Amherst and funded by Boston Children's Hospital.

The mission of the BIRCh Project is to provide professional development and resources for schools and strengthen the coordination of behavioral health supports provided by school and community agencies. More information is available at www.umb.edu/birch, or contact us at [Birch.project@umb.edu](mailto: Birch.project@umb.edu).



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Behavioral Health Integrated Resources for Children Project

➤ Procedural Checklist

Hospital to School Transition Protocol 7-11

The Hospital to School Transition Protocol is a 4-page document that is to be filled out upon student transition from hospitalization. Stakeholders needed to collaboratively complete this document include the school-based multidisciplinary team, hospital staff, community-based behavioral health providers, student, and family/guardians. Information recorded on this protocol include:

- **Team Contacts** - log for multidisciplinary team contacts & confidentiality considerations.
- **Student Demographics** - name, pronoun, gender identity, language preferences, etc.
- **504 Plan** - considerations for 504 plan eligibility or documentation of existing Individualized Education Plan & 504 plans.
- **Hospital to School Transition Information** - date of Hospital to School Transition meeting, length of absence, date of return to school, planning details to support the student in the areas of school community transition and management of academics, mental health, and behavior.
- **Collaboration with Families** - communication preferences and support services for the student's caregivers.

Hospital to School Transition Protocol Supplemental Documents12-17

These four supplemental documents can be used to inform the Hospital to School Transition Protocol.

Family Handout: Hospital to School Transition Plan12

The Family Handout: Hospital to School Transition Plan is a one page document that summarizes the key details of the transition plan. The purpose of this document is to make the Hospital to School Transition plan easily accessible for the student's caregivers on the team. Information recorded in this document includes: team contacts, planned student return date, next meeting date, family support services, academic support plan overview, behavior support plan overview, and mental health support plan overview.

Hospital to School Accommodations Checklist13-14

The Hospital to School Accommodations Checklist is a staff-oriented tool that is referred to in the Hospital to School Transition Protocol. Stakeholders needed to collaboratively complete this document and include the school-based multidisciplinary team and hospital staff. The purpose of this checklist is to transition accommodations from the hospital setting to the school setting. Information recorded in this document includes: behavioral health and instructional supports.

Youth Action Plan 15-16

The Youth Action Plan is a **student-oriented tool** that is referred to in the Hospital to School Transition Protocol. Stakeholders needed to collaboratively complete this document are the student and the primary school-based behavioral health staff member. The purpose of the Youth Action Plan is to uplift student voice during the initial phase of the hospital to school transition process. The student-oriented questions serve to record student input on navigating their physical space/environment in the school, preferences for communicating details of their absence with teachers and peers, identification of staff and peers that can serve as a support system, and areas in which the student feels they may need more supports (academic, social-emotional, behavior).

Phases of Hospital to School Transition 17-18

The Phases of Hospital to School Transition is a **staff-oriented tool** that is referred to in the Hospital to School Transition Protocol. Stakeholders, including the school-based multidisciplinary team and hospital staff, should collaboratively complete this document. The purpose of this document is to collaboratively determine how the student will be supported through the hospital to school transition process. Information recorded in this document includes: phases of hospital to school transition (or intensity of supports needed).

Hospital to School Transition Team Action Plan..... 19-21

The Hospital to School Transition Team Action Plan is a **staff-oriented tool** that is referred to in the Hospital to School Transition Protocol and is informed by the Hospital to School Accommodations Checklist. Stakeholders need to collaboratively complete this document. The purpose of the Hospital to School Transition Team Action plan is to further specify school-based transitional supports. Information recorded in this document includes: coping, safety/crisis, and academic support.



Behavioral Health Integrated Resources for Children Project

► Introduction

An increasing number of students are hospitalized each year for psychiatric crises, such as suicidality, and eating disorders, as well as psychosis, substance abuse, and mood disorders. With limited follow-up care, students often return to school within 5 to 7 days of experiencing a crisis. Among these students, up to half are re-hospitalized within a year, and most often within the first month back to school. During their return to school, **high-quality and coordinated after-care services are one of the most powerful strategies for preventing further psychiatric challenges.** Together, hospital and school-based clinicians can help students, in collaboration with their families, transition back into the school community to achieve improved short and long-term health outcomes and experiences of success. The BIRCh protocol and accompanying webinar can be helpful resources to support the hospital to school transition process for schools beginning this work without additional financial resources to allocate to the process at this time. There are organizations who provide more intensive support to schools and districts around the hospital to school transition. We encourage schools and districts who are interested in more intensive supports to contact these organizations to learn more, such as Bridge for Resilient Youth in Transition (BRYT), a program of The Brookline Center for Community Mental Health in Massachusetts, as an example (<https://www.brooklinecenter.org/services/schoolbased-support/bryt-program/>).

► Development of Hospital to School Transition Protocol

To address this need, the BIRCh team engaged in a collaborative process to develop a comprehensive tool to help guide the transition process for students returning to school following a psychiatric hospitalization. Beginning with a review of the research literature, the team identified the essential needs of students, families, schools, and hospitals throughout various phases of this transition. In the next stage of protocol development, a series of transition protocols and procedures from districts across the country were collected and reviewed using a comprehensive vetting tool that evaluated the following areas: applicability to K-12 settings, approval by a school district, legal defensibility, integration into a multi-tiered framework, promotion of equitable access to services, cultural responsiveness, comprehensiveness, clarity/simplicity, and recency of tool. This same vetting tool was utilized to evaluate the current Hospital to School Transition Protocol. This protocol drew upon the areas of strength identified from the collection of diverse resources reviewed and from the best practices identified in the literature base. Lastly, a team of school-based providers were asked to review, critique, and provide feedback to further inform the refinement of this tool and improve its feasibility and usability in school settings. Components of the Hospital to School Transition Protocol were drawn from exemplar models such as that of the Loudoun County Public Schools Return to Learn Guidelines. If teams are interested in learning more and accessing the resources that informed the development of the current Hospital to School Transition Protocol, please refer to the resource list at the end of this document (p. 21-23).

► Important Considerations

This protocol integrates multiple elements of recommended practice guidelines for school transition post-hospitalization. It should be noted that many students in need of hospitalization do not have access to higher levels of care, and for those who do, “hospitalization” can take many forms (i.e., hours or nights in the Emergency Room, Partial Hospitalization, acute residential, CBAT, etc.). We also acknowledge that various stakeholders will come to this process with different viewpoints about where to start the conversations, the aspects of the process that should be prioritized, and what supports should look like over time. This is challenging and important work, which will require collaboration from all team members, a commitment to valuing all perspectives and all voices, and a willingness to monitor progress, revisit plans, and make modifications or adjustments to ensure student success. This process should be considered within your

existing Multi-Tiered Systems of Support framework. This tool should be utilized in the manner that is most **responsive, relevant, and feasible** for your school community. The BIRCh team recognizes the limitations of and the negative impact language can have on perpetuating inequitable systems. Please feel free to rename the titles of the documents and make other adjustments in language throughout the protocol if you team feels it would be more culturally responsive to the needs of your school community. We acknowledge that this is hard work, but know that student outcomes will be enhanced through our efforts to work through this process together.

► Helpful Tips

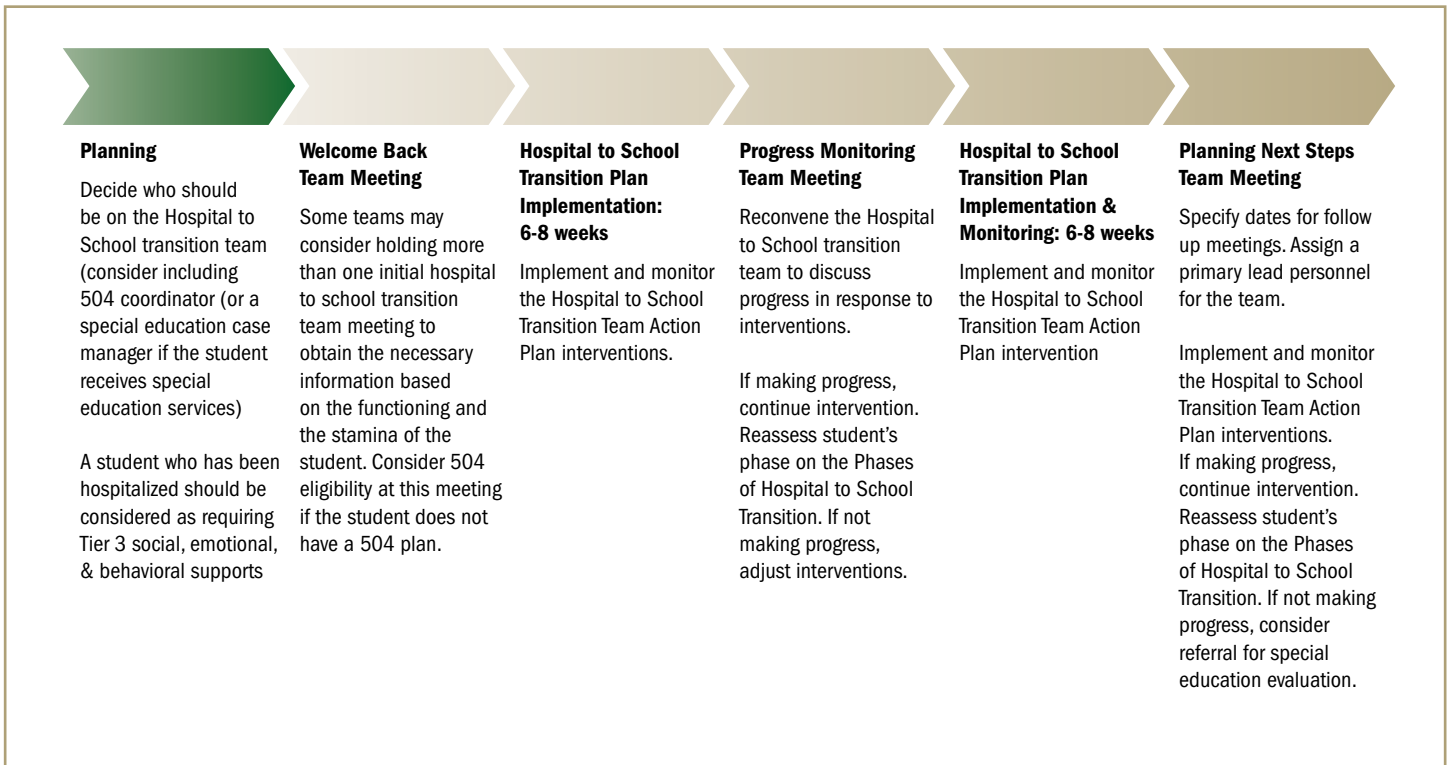
- Please engage in an ongoing discussion regarding confidentiality to ensure that all sensitive information is kept private, shared in a student and family-centered manner, and is HIPPA and FERPA compliant. Feel free to make use of your district's existing guidelines and tools for releases of information.
- It may be helpful to review the Hospital to School Transition Webinar and Training Module to inform implementation of these tools.
- Keep in mind that behavioral health crises and “hospitalization” take many forms. The case studies presented in the Webinar and Training Module, address the complexity and necessity of caring for students struggling in school due to a mental health crisis, regardless of their access to higher levels of care.
- Consider translating or using alternative formats of this protocol to ensure accessibility. These considerations will be dependent on student and family needs (i.e. translation, large print, etc.).
- This protocol is intended to be utilized flexibly within your current school systems and processes to support successful hospital to school transition for students following psychiatric hospitalization (i.e. district crisis plan, emergency management system, etc.). Please consider your local context and access to local resources throughout implementation.
- This is not intended to be a solely linear process. Hospital to school transition planning should be based on each student and family's individual transition needs and in collaboration with your schools' team.
- Teaming is an integral part of supportive student hospital to school transitions. It may be useful to keep your teams to a reasonable number of participating stakeholders, to enhance efficient and effective decision making.
- It may be helpful to refer to the *Considerations for Teaming and Planning Timeline* and *Suggested Use of Hospital to Transition Protocol Tools* throughout this transition process, to orient your team to the best ways to complete the protocol and supplementary documents.
- Teams should continuously monitor data to evaluate the overall effectiveness of its effort, as well as to determine individual student level responses to the hospital to school transition plan. Such data sources may include both overall group data and individual student level data such as the number of re-hospitalizations, number of crisis calls, number of school counselor/school psychologist visits, number of nurse visits, discipline referrals/data, school attendance records, academic/assignment records, time on task/school assignment completion, family/team transition meeting attendance, Subjective Units of Distress Scale (SUDS) ratings, and Check-in Check-Out data.



Behavioral Health Integrated Resources for Children Project

► Considerations for Teaming and Planning

Please be advised that the following timeline is a suggested guideline for organizing your school’s multiple disciplinary team throughout the hospital-to-school transition process. This timeline may be used flexibly and/ or adapted to align with your school’s procedures, timelines, and systems for teaming, planning, monitoring, and evaluating student progress.



► Suggested Use of Hospital to School Transition Protocol Tools

Please be advised that the following recommendations for completing the Hospital to School Transition Protocol and supplementary documents are meant to serve as one example of the way this tool can be used. It is up to your team to decide how to best collaborate and obtain the information in each section of the overall Hospital to School Transition Protocol. Please refer to this suggested sequence and adapt and align these procedures and documents with those currently in place in your school.



Planning & Initial Review of Hospital to School Transition Protocol

- Review Hospital to School Transition Protocol & Supplemental Documents
- Coordinate completion of protocol sections. Many sections require input from different individuals supporting the student.
- Ensure team has access to necessary data from the past 12 weeks for the student prior to hospitalization: attendance, discipline, assignment completion, academic assessment data, response to previous interventions attempted, etc.

Hospital to School Accommodations Checklist

- Collaborate with hospital to ensure this document is completed, preferably while the student is still hospitalized.
- (Obtain appropriate releases of information)

Youth Action Plan

- Complete Youth Action Plan with student.
- (The Youth Action Plan can be completed with or after the Phases of Hospital to School Transition & Hospital to School Transition Team Action Plan if necessary)

Phases of Hospital to School Transition & Hospital to School Transition Team Action Plan

- Complete Phases of Hospital to School Transition form with team.
- Complete Hospital to School Transition Team Action Plan with team.

Hospital to School Transition Protocol





- Review Hospital to School Transition Protocol to ensure that all sections are comprehensively completed to the best of the team's ability. (Please note that various sections of the Hospital to School Transition Protocol correspond to the Hospital to School Transition Supplemental Documents)



Hospital to School Transition Protocol

TEAM CONTACTS

Family, student, and school staff should collaboratively build the following team contact list (e.g. school nurse, school psychologist, teacher, principal/department head, etc.). Attention should be paid to the level of information needed to know by each member.

Name and Position	Phone #	Email	Release	What information should be shared?
 Signature			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Academic <input type="checkbox"/> Mental Health <input type="checkbox"/> 504 Plan <input type="checkbox"/> IEP
 Signature			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Academic <input type="checkbox"/> Mental Health <input type="checkbox"/> 504 Plan <input type="checkbox"/> IEP
 Signature			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Academic <input type="checkbox"/> Mental Health <input type="checkbox"/> 504 Plan <input type="checkbox"/> IEP
 Signature			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Academic <input type="checkbox"/> Mental Health <input type="checkbox"/> 504 Plan <input type="checkbox"/> IEP

STUDENT DEMOGRAPHICS

Student Legal Name:	Date of Birth:	Age:
Student Preferred Name:	Gender Identity:	Preferred Pronouns:
Language(s) Spoken:	Preferred Language:	Interpreter Needed:
School:	District:	Does the student have an IEP?

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504 PLAN

Any student returning to school following psychiatric hospitalization may be eligible for a 504 plan. A diagnosed mental health condition is no different than any other chronic health condition. Accommodations are frequently needed, and medications may need to be taken at school.

504 Planning Team members:

Attach 504 plan

HOSPITAL TO SCHOOL TRANSITION INFORMATION

School transition meeting date:	Length of absence from school:	Date returning to school:
Community Integration		
What communication plan is in place?	Specify communication plan: (or see Youth Action Plan attachment)	
What social support plan is in place for the student?	Specify social support plan: (or see Youth Action Plan & Hospital to School Transition Team Action Plan attachments):	
Academics		
Key Academic Personnel/Support Person	Personnel Assigned:	
What, if any, essential curricular content was missed?	Specify curricular content missed (or see Hospital to School Transition Team Action Plan attachment):	
What, if any, state/district testing did the student miss?	Specify testing missed:	
IEP, 504, or individualized academic support considerations	IEP or 504 Plan (attach IEP or 504 plan):	
Modifications or reduced course schedule considerations	Specify hospital to school transition schedule (see Phases of Hospital to School Transition):	
What plan has been developed for making up missed work/course modifications?	Make-up work plan (or see Hospital to School Transition Team Action Plan attachment):	
Additional Considerations	Specify:	

Mental Health	
Key Mental Health Personnel/Support Person	Personnel Assigned :
What plan is in place to assess the student's mental health needs? (school-based)	Specify MH Assessment Plan: (or see Hospital to School Transition Team Action Plan attachment)
In what ways is the student utilizing non-school based mental health/counseling services? If not, what plan is in place to link resources/provide support?	Specify non-school based MH supports:
What is the coping plan specified for the student?	Specify Coping Plan (or see Hospital to School Transition Team Action Plan attachment):
What is the crisis/safety plan specified for the student?	Specify Crisis/Safety Plan (or see Hospital to School Transition Team Action Plan):
Additional Considerations:	Specify:
Behavior	
Key Behavioral Personnel/Support Person	Personnel Assigned:
Functional Behavior Assessment (FBA) and a Behavior Intervention Plan (BIP) for the student	FBA and BIP (attach existing FBA and BIP):
In what ways is the student utilizing non-school based behavioral support services? If not, what plan is in place to link resources/provide support?	Non-school based behavioral supports:
Additional Considerations:	Specify:

COLLABORATION WITH FAMILIES

Communication with Families

Parent/Caregiver Names & Pronouns:	Preferred Language:	Language(s) Spoken:
Interpreter Needed:	Preferred Communication Method:	Best time of day to contact:
Name of school-based contact/point person for family:		
Name(s) of team members (refer to above contact list):		
Are there cultural, family, or other background factors to consider in supporting the hospital to school transition?		
What kind of information does the family find most helpful, and how often would the family/team like that information shared?		

Supporting Families

Were information and opportunities for caregiver support shared with the family?
Yes/No? If yes, specify below:

Have all service areas been addressed?

- Mental Health/Emotional Support
- Education
- Medical
- Behavioral
- Insurance
- Advocate/Advocacy services
- Subsequent family action steps/plan
- Transportation For Students
- Resources (Access to technology, books, learning materials)

Which support services have been requested by the family?

Specify additional considerations:

Date of Next Meeting:

Attachments:

1. Hospital to School Accommodations Checklist
2. Youth Action Plan
3. Phases of Hospital to School Transition
4. Hospital to School Transition Team Action Plan
5. Family Handout: Hospital to School Transition Plan
6. 504 Plan or IEP (if applicable)
7. Existing youth FBA and BIP (if applicable)
8. Medical information/discharge summary (if applicable)



Family Handout: Hospital to School Transition Plan

TEAM CONTACTS			
Support Personnel Role	Name	Phone Number	Email
School-Based Contact/ Point Person			
Key Academic Personnel/ Support Person			
Key Behavioral Personnel/ Support Person			
Key Mental Health Person- nel/Support Person			

HOSPITAL TO SCHOOL TRANSITION INFORMATION		
School transition meeting date:	Next meeting date:	Date returning to school:
Academics		
Behavior		
Mental Health		
Family Support Services		



Hospital to School Accommodations Checklist

Please discuss which accommodations will be most beneficial to the student upon their return to school. It is recommended that hospital and school staff have a phone conversation or meeting if possible to allow for a more detailed conversation around the rationale for accommodations selected by hospital staff and their feasibility in the school setting. Accommodations may need to be adapted depending on the school resources available. It is also important to note that students may need different accommodations at different points during the transition process. This checklist can be sent to hospital staff electronically to be completed if it is not possible for hospital and school staff to collaborate in the completion of this form. If completing electronically, hospital staff should write in the notes sections which of the accommodations are most essential for the student's success.

Any support recommended for the student in this checklist should supplement any accommodations already outlined in the student's Individualized Education Program (IEP; if the student is eligible under the Individuals with Disabilities Education Act) or 504 plan. Students returning to school following psychiatric hospitalization may be eligible for a 504 plan as a diagnosed mental impairment or psychological disorder that may substantially limit their functioning in school. Consider Attendance and Stamina (e.g. the student's capacity to participate in school and persist in various school-based environments), Academic and School-Based Engagement (e.g. the student's capacity to successfully complete work, engage in the classroom/school setting, and navigate the school environment), and Level of Support (e.g. necessary supports required by the student to increase attendance and improve stamina and engagement) in a variety of contexts pertinent to each individual student.

Copies of the Hospital to School Accommodations Checklist may also be shared with teachers and staff after the meeting.

*(*modeled from LCPBS Return to Learn Guidelines)*

Academic Stamina/Engagement Level of Support (check **one** option)

1 Minimal Supports

2 Moderate Supports

3 Maximum Supports

Academic Stamina/Engagement Support Examples (check which are **most beneficial**)

- No school (minimal homework, assignments, tests, quizzes; rest at home only)
- Shortened school days (e.g., 1/2 day or partial day) for gradual transition back into school routines
- Full time/Attends all classes

Academic Stamina/Engagement Supports Notes

(list **priority** accommodations to be implemented in **school-setting**):

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Behavioral Health Level of Support (circle **one** option):

1 Minimal Supports

2 Moderate Supports

3 Maximum Supports

Behavioral Health Supports Examples (check which are **most beneficial**):

- Case Management with treatment team (e.g., outpatient)
- Transition meeting with counselor on day of return to school
- Shortened school days (e.g., 1/2 day or partial day) for gradual transition back into school routines
- Built in breaks during a regular length school day
- Scheduled and regular check-ins with school counselor/ staff
- Modified environment (e.g., no hallways or cafeteria; or separate work space needed)
- Counseling (including coping skill instruction, please specify coping skills practiced in the hospital in the notes section)

Behavioral Health Supports Notes (list **priority** accommodations to be implemented in **school-setting**):

Instructional Supports Level of Support (circle **one** option):

1 Minimal Supports

2 Moderate Supports

3 Maximum Supports

Instructional Supports Examples (check which are **most beneficial**):

- No homework, assignments, tests, quizzes; rest at home only
- Short periods of sustained work in home-setting
- Limited homework
- Alternative grading strategies
- Extra time, assistance and/or modification of assignments as needed

Instructional Supports Notes (list **priority** accommodations to be implemented in **school-setting**):

Specify education program as well as additional accommodations provided in hospital setting and/or additional accommodations to be provided in school setting:



Youth Action Plan

In collaboration with the student, please complete the following questionnaire. This document can be filled out directly by the student or in an interview format. Please consider adapting questions to be developmentally appropriate for your student. Please consider that the student may not be able to answer all of the questions within the youth action plan document, however, their responses may be useful indicators for hospital to school transition team planning. Similarly, all of the students' requests may not be able to be accommodated within your school setting. Please consider how to incorporate student input into the hospital to school transition planning process as much as possible.

(A copy of the Youth Action Plan may be shared with the student after their meeting)

My space (Environment)

Where in the school building do I feel safest? (i.e. particular offices, library, etc.)	My safe spaces in the building:
Are there changes in my classroom environment that will help me to get through the school day? (i.e. which classes am I most comfortable in, changes in classroom seating, sitting with certain peer mentors, etc.)	My classroom space:
Are there changes in my lunchroom environment that will help me get through the school day? (i.e. changes in lunch seating, changes in what time I enter or exit the lunchroom, etc.)	My lunch space:
Are there any changes during my transitions between classes or when I arrive and leave school that can help me to get through the school day? (i.e. transitioning early between classes, using a different entry for school arrival and dismissal, etc.)	My transition space:
Are there any changes to my transportation to and from school that can help me to get through the school day? (i.e. bus pick-up/drop off, seating on the bus, etc.)	My transportation space:
Are there any changes to my free time during the day that can help me get through the school day? (i.e. different space for recess, different space for enrichment block, etc.)	My free time space:

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My communication and support	
What do I want to tell my peers/friends about my absence?	My message for friends:
What do I want to tell my teachers about my absence?	My message for teachers:
Is there anything important I want my support team to communicate to my peers/friends, teachers, or family?	My message for the team:
When I am not feeling my best, how will I communicate what I need to my peers/friends and my teachers?	Communicating what I need:
What kind of support do I have at school and home/community? (i.e. counseling, Big Brother/Big Sister program, after school program, sports, extracurricular activities, etc.)	My supports at home/community & at school:
At school, who can I go to for support? (i.e. which teachers and friends?)	Supportive people at my school:
Outside of school, who can I go to for support? (i.e. family, friends, mentor, counselor)	Supportive people at home and in my community:
My school work	
What school work/classes do I feel most confident in?	Strengths in school:
What school work/classes do I feel I need the most help in?	Challenges in school:
My thoughts, feelings and behaviors	
How do I know when I am starting to feel stressed? What do I notice in my body when I am starting to have big feelings? (i.e. sad, upset, angry, etc.)	My thoughts, feelings, & behaviors:
What can I do when I am having these feelings? (i.e. coping strategies: deep breathing, ask for a break, have lunch with a friend, talk to my teacher)	My coping strategies:
Date of Next Meeting:	



Phases of Hospital to School Transition

It is expected that many students will need the support of a transition plan for several weeks or more as they transition back into the school environment. Every student's progression through the phases of transition will be different-every student will start at a different point, progress at a different rate, and in a different order. Not all students will progress through each of the following phases outlined in this document.

An effective and developmentally appropriate student hospital to school transition plan can be utilized to increase attendance and participation in classrooms and various school settings, to improve student engagement broadly, and to decrease the necessity of accommodations/school-based supports as the student progresses in their school transition process, with respect to academic, behavioral, and social emotional functioning. This plan should consider **Attendance and Stamina** (e.g. the student's capacity to participate in school and persist in various school-based environments), **Academic and School-Based Engagement** (e.g. the student's capacity to successfully complete work, engage in the classroom/school setting, and navigate the school environment), and **Level of Support** (e.g. necessary supports required by the student to increase attendance and improve stamina and engagement) in a variety of contexts pertinent to each individual student.

The phases of hospital to school transition described below provide a framework for team planning around the hospital to school transition. Please select the phase that most accurately describes the level of support currently needed by the student and describe the signs the team will see when the student is ready to transition to the next phase. Consider student and family collaboration when completing this document when appropriate.

(The language used to describe student levels of functioning & the phases of the transition process were modeled from LCPBS Return to Learn Guidelines)

<p>No School or Work; Maximum School-Based Behavioral Health Supports</p> <ul style="list-style-type: none"> • No homework, assignments, tests, quizzes; rest at home only • Maximum/intensive counseling, check-ins, and case management 	<p><input type="checkbox"/> Student currently needs this level of support</p> <p>Signs the student is ready to move to the next phase:</p>
<p>No School; Minimal Work; Maximum School-Based Behavioral Health Supports</p> <ul style="list-style-type: none"> • Short periods of sustained work in home-setting • Maximum/intensive counseling, check-ins, and case management 	<p><input type="checkbox"/> Student currently needs this level of support</p> <p>Signs the student is ready to move to the next phase:</p>
<p>School Part-Time with Maximum Instructional Supports; Maximum School-Based Behavioral Health Supports</p> <ul style="list-style-type: none"> • Shortened days with built-in breaks • Modified environment (e.g., no hallways or cafeteria & work in library) • Exclusion from standardized and classroom testing • Extended time to complete assignments • Rest and recovery when out of school • Maximum/intensive counseling, check-ins, and case management 	<p><input type="checkbox"/> Student currently needs this level of support</p> <p>Signs the student is ready to move to the next phase:</p>

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<p>Full-Time School Attendance; Moderate Instructional Supports; Moderate School-Based Behavioral Health Supports</p> <ul style="list-style-type: none"> <input type="checkbox"/> Built-in breaks <input type="checkbox"/> Limited homework <input type="checkbox"/> Alternative grading strategies <input type="checkbox"/> Modified or limited classroom testing <input type="checkbox"/> Exclusion from standardized testing <input type="checkbox"/> Moderate level of extra time, assistance and/or modification of assignments as needed <input type="checkbox"/> Counseling, check-ins, and case management 	<p><input type="checkbox"/> Student currently needs this level of support Signs the student is ready to move to the next phase:</p>
<p>Full-Time School Attendance; Minimal Instructional Supports; Minimal School-Based Behavioral Health Supports</p> <ul style="list-style-type: none"> • Built-in breaks • Limited formative and summative testing • Exclusion from standardized testing • Minimal level of extra time, assistance and/or modification of assignments as needed • Continuation of instructional modification and supports academically • Limit on challenging subjects that require cognitive overexertion and stress • Weekly or twice per month counseling • Check-ins as needed 	<p><input type="checkbox"/> Student currently needs this level of support Signs the student is ready to move to the next phase:</p>
<p>Full-Time School Attendance; No Instructional Supports; Minimal School-Based Behavioral Health Supports</p> <ul style="list-style-type: none"> • Attends all classes • Maintains full academic load/homework • Check-ins and counseling as needed 	<p><input type="checkbox"/> Student currently needs this level of support Signs the student is ready to move to the next phase:</p>



Hospital to School Transition Team Action Plan

Based on the student’s phase in the **Phases of Hospital to School Transition** process and using accommodations identified in the **Hospital to School Accommodations Checklist** that are feasible for the school to implement and relevant for the student and family, develop the student’s Hospital to School Transition Team Action Plan. Any support provided to the student as part of the **Hospital to School Transition Team Action Plan** should supplement any accommodations already outlined in the student’s Individualized Education Program (IEP) or Section 504 Plan if the student is eligible under the Individuals with Disabilities Education Act or Section 504, respectively. The school team may need to consider further evaluation through the Student Support/Success Team if the student’s functioning in the school environment does not improve over time. *Consider student and family collaboration when completing this document when appropriate.*

COPING SUPPORT PLAN (ensure this is integrated with existing systems of tiered supports that exist in the school)	
What symptoms and triggers have been identified?	Specify:
What supports have been identified to put in place to help students through challenging social situations? (i.e. buddy, peer mentor, peer support group)	Specify:
What coping skills and strategies have been identified for the student? (breathing, music, breaks, etc.)	Specify:
Is social and communication skills development needed? If so, what types of school-based supports will be needed? (social skills group, counseling, etc.)	Specify:
SAFETY SUPPORT PLAN (ensure this is integrated with existing safety protocols/procedures that exist in the school)	
What school-based staff member and/or crisis team has been identified to support the student during crisis situations?	Specify Staff/Team:
What is the specified plan for how to best respond and support the student during crisis or challenging situations?	Specify response plan (de-escalation strategies):
What is the plan for a follow up risk assessment to ensure the safety of the student?	Specify follow-up/risk assessment plan:
What plan has been identified for following up with student’s home/community support following a crisis situation?	Specify contacts for home/community supports:

Disclaimer: This tool should be utilized in the manner that is **most responsive, relevant, and feasible** for your school community. The BIRCh team recognizes the limitations of and the negative impact language can have on perpetuating inequitable systems. Please feel free to rename the titles of the documents and make other adjustments in language throughout the protocol if you team feels it would be more culturally responsive to the needs of your school community.

ACADEMIC SUPPORT PLAN (ensure this is integrated with existing academic supports that exist in the school)

How much school missed? (total days, total for each course if rotating schedule)	Specify amount of school missed:
What was the student's education program while in treatment/hospitalized?	Specify education program received:
Is there any academic intervention or specific skill development needed to complete assignments? (generalization to all classes)	Specify academic intervention/skill development plan:
Were educational/cognitive abilities/psychological/psychiatric evaluations completed during treatment?	If yes, please provide a copy as an attachment
Does an evaluation seem appropriate? Re-evaluation? Review of education needs?	Specify:
Were there any major behavior management programs that should be considered/continued?	Specify:
How will student be provided with: (1) instruction on content missed, (2) support with assignments needed to check their understanding, and (3) modifications to required assignments to fit within students' phased hospital to school transition plan?	Specify Accommodations/Supports:

Date of Next Meeting:

Academic Subject (specify subjects below)	Key Instruction Missed



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