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MSY Discharge/Transition Planning Requirements and Guidance

Discharge Planning Requirements

MSY program requirements regarding discharge/transition planning can be found in the application, and are outlined here:

- The attestation signature page of the MSY application, initialed/signed by the requestor, states, "*If funding is authorized to support out-of-home treatment, the requestor commits to immediately facilitate detailed discharge planning upon admission to an out-of-home treatment setting; if the child/youth is already receiving out-of-home treatment at the time of application, discharge planning must have started prior to application and the requestor commits to continue this work for the duration of funding..*"
- The attestation signature page of the MSY application, initialed/signed by the legal guardian, states, *"If funding is authorized to support out-of-home treatment, the legal guardian commits to immediately begin working toward reintegrating the youth into the family setting, to fully participate in discharge planning, and to allow the child/youth to return to their home as soon as deemed clinically appropriate."*

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With these requirements in mind, and knowing it takes time and resources to ensure a child/youth's successful transition back into a home/community environment, FCFCs and CMEs need to take an active role in leading development of a detailed written discharge/transition plan for all children and youth receiving MSY funding who are receiving residential treatment.

Please also note: all Qualified Residential Treatment Programs (QRTPs) that provide residential treatment and group home services and are licensed by the Ohio Departments of Job and Family Services (JFS) and Mental Health and Addiction Services (MHAS) are required to develop aftercare plans for each young person receiving treatment services at the QRTP. These facilities should be ready to be partners to FCFCs and CMEs as their service/care coordinators work with each young person's team to develop discharge/transition plans.

Developing Proactive and Detailed Discharge Plans

Discharge plans should include:

1. Where that young person will live after discharge from the residential facility.

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2. Specific types of services and supports that will help facilitate a young person's transition into a home/community environment.
    - In some cases, these services and supports should start being provided prior to the young person's discharge from out of home care.
    - The names of potential providers of services and supports should be included in the plan. These providers should be contacted as soon as possible to ensure they have availability and are lined up to provide care well before discharge takes place, and some services may need to start prior to discharge.
    - Consideration should be given to which payer(s) will cover/fund the services and supports. Funding for the service should be in place prior to discharge/transition so there is no gap in care.

3. Services and support that the young person's family and caregivers need to help make the child/youth's transition possible and successful.
    - In many cases, these services and supports should be provided while the young person is still receiving out of

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home care; they may need to continue once the young person discharges/transitions.

- Any assessments / referrals that need to take place to set up services should begin as soon as possible – ex: complete a DD board assessment while the young person is receiving residential care so specific I/DD services and providers can be part of the transition plan.
- The names of potential providers of services and supports should be included in the plan. These providers should be contacted as soon as possible to ensure they have availability and are lined up to provide care well before discharge takes place, and some services may need to start prior to discharge.
- Consideration should be given to which payer(s) will cover/fund the services and supports. Funding for the service should be in place prior to discharge/transition so there is no gap in care.

4. Discharge / transition plans should include crisis plans, as well as safety plans when appropriate for the youth/family circumstances. Services and supports referenced in #1 and #2 above should span formal / treatment services and natural / wraparound supports.

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5. The team should consider the young person's educational needs, if educational professionals and/or services need to be arranged, incorporate local school and education staff and resources in the planning process.

6. Expectations/responsibilities for individual members of the child and family team (including local organizations) as preparations are being made.

A sample written tentative discharge plan is included below for your reference. This is not a template that must be used, but instead should serve as guidance as you and your organization develop the best practices for creating high-quality discharge/transition plans.

Child and family teams should update these and evolve their detailed discharge/transition plans at each meeting to ensure they match the current young person and caregiver needs and progress, as well as include up-to-date referrals and acceptances from local providers of care.

Again, to satisfy the requirements of the MSY program, a detailed discharge/transition plan should be created as soon as a young person is admitted to residential treatment or as soon as MSY funding is authorized, whichever comes first.

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Sample MSY Tentative Discharge Plan

Youth's Name:
DOB:
Child and Family Team Members: Youth, Parents, Residential Provider, County FCFC care coordinators or Aetna OhioRISE care coordinator to facilitate access to OhioRISE services, any other team members.

Discharge Date: Include estimated / targeted discharge date. Setting and working toward a date is an important part of the planning process.

Step 1 – current phase: Team – including the youth – is actively meeting to review mental health/behavioral/educational progress for [youth] and the strengths/needs of caregivers.

- [Youth name] and [caregivers] are currently engaging in family therapy and part of that work consists of the following: identify triggers, coping strategies for both youth and [caregivers], attention seeking by [youth name] and sharing the attention with [sibling names] who have high needs and healthy communication.

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- [Caregivers] commit to at least two family visits per month, monthly family therapy, and weekly phone calls.
- [Sibling names] have been linked to therapy to assure their readiness for when [youth] comes home.

Step 2: Team – including the youth – will continue actively meeting to review mental health/behavioral/educational progress for [youth] and the strengths/needs of caregivers and evaluate progress toward meeting goals that will assure a successful transition home.

- Community visits will begin. The team thinks these should start at [insert location/activity].
- After 2 successful community visits, home visits will begin to provide opportunities for the youth and family to transfer skills into the community and home environments.
- Family therapy will continue, and [sibling names] will be fully engaged in therapy and making clinical progress to prepare for the transition.

Step 3: The team will establish in-home and community support services, including the following types of care, to be provided during transition and after discharge:

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- Individual sessions with an outpatient therapist from [name of provider], which will begin one month prior to discharge to ensure careful transition of care between clinicians.
    - Following discharge, individual sessions will take place twice per week for at least a few weeks to ensure the young person and their family have the intensity of services they need. Sessions may be reduced to once per week, every other week, or once a month, depending on progress and needs.
- Medication management services will be secured from [name of provider], and the team will ensure the new medication management provider has an opportunity to discuss [youth name] with the residential facility's medical director to plan for the transition and continuity of care / prescriptions.
- Identification of pro-social activities for the youth to engage in and working with the residential provider to get some of these in place while the youth is still in residential so they can help with transition.
    - The team will work with the school to enroll [youth] in [school-based activity].

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- The team will work with [caregiver's name] to help them identify and join a support group.
    - Given the youths interest in [insert interest] the team will explore using OhioRISE flex funds to enable access to additional support services, including [A], [B], and/or [C].
- Respite services – the team will explore setting up respite with local foster care providers and [family member] and will engage the OhioRISE plan to assist with ensuring these providers and family member receive assistance with enrolling as a Medicaid provider so they can bill for their services.

The team will continue to support the young person and their family as they engage in family therapy and home visits.

Step 4: Transition home, aftercare, and crisis supports.

- The service/care coordinator will convene the child and family team twice a month.
    - The discharging residential provider, as part of their QRTP aftercare support requirements, will be invited to and can be expected to join these meetings.

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- Meetings will be used to ensure services and supports are sufficient and helpful, as well as to develop additional plans for the young person and their caregivers.

- Upon discharge, [youth name] and [caregivers] will have access to MRSS, the Aetna OhioRISE crisis line, 24/7 response from our CME, and on-call supports from the mental health agency providing their discharging therapy services.

11/1/2024