Children's Mental Health Waiver

Provider Procedure for: *Transition Planning for Waiver Discharge*

Implementation Date: 7/1/06

Revision Date: 9/1/07

Overview

Successful outcomes for the youth and family served by the waiver are the program's number one goal. To achieve those outcomes and provide the youth and family with as many opportunities to enhance their skills and abilities to realize their own goals, it is important to keep in mind the concept of family sustainability. That is why transition planning discussions begin as part of the second quarterly Individual Service Plan development meeting. It sets the course for the youth and family to identify their goals beyond waiver services, while using those resources to build their capacity for independence.

"Youth focused" transition planning may begin for youth at age 14 but is required for all youth age 16 and older who are receiving waiver services. This transition process identifies specific goals to support increased skills development that will allow the youth to become as self-sufficient as possible. Referrals will be made to applicable programs and services and these identified services and supports will be in place before discharge is considered.

Waiver Provider Roles and Responsibilities

Family Care Coordinator will:

- Initiate discussion of discharge planning as part of 2nd quarterly ISP development (WP-1).
  - Outline transition plan in Team Meeting Minutes section of the ISP document.
  - Identify transition plan goals and service outcome objectives (FCT-1) as such in the ISP document.
  - How this will all be accomplished will be negotiated with the youth and family and clearly identified and reported through quarterly ISPs and monthly reports (FCC-1).

- Connect the youth and family with services identified to accomplish the goals of the transition plan.
  - Consideration may be given to inviting an adult Mental Health service provider or case manager of the adolescent's choosing to participate in the Family Care Team processes during the adolescent's time on the waiver.
  - Consideration should be given to identification of other natural supports to further support the plan.

- Monitor and document status of transition plan as part of Family Care Team Monthly Service Plan Reviews (FCC-1) and subsequent quarterly ISPs.
  - When stable success has been demonstrated for a period of time determined by the youth and family and Family Care Team, waiver discharge should be discussed and a proposed discharge date should be identified.
    - Follow provider procedure for Waiver Discharge.

Waiver Service Provider will:

- Design and implement assigned services to address the youth and family's discharge planning goals as outlined in the ISP and/or service plan modifications.
  - As the process continues, there should be a demonstrated increase in the youth and family's use of community and natural supports and a documented decrease in utilization of waiver services.

- Monitor service provision to ensure timely and proactive response to changing needs.
  - Frequency and duration of service provision may change, as will monitoring and follow-up as the youth and family assume more responsibility for community based service coordination.

- Report on status of transition plan as part of Family Care Team Monthly Service Plan reviews (FCC-1) and subsequent quarterly ISPs.