Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	DISCHARGE PROCESS	18.03

Authority:	Chapter 71.34 RCW	Behavioral Health Services for Minors
	42 C.F.R. 441.155	Individual plan of care.
	Chapter 246-337 WAC	Residential Treatment Facility
Reference:	State Operations Manual	Appendix N—Psychiatric Residential Treatment Facilities Interpretive Guidance

PURPOSE

This policy establishes the discharge planning process for a youth exiting a Youth Transitional Care Facility.

SCOPE

DDA field staff and facility staff responsible for discharge planning when a youth is determined ready for transition to a community-based setting.

DEFINITIONS

Cross-systems crisis plan means a plan that helps service providers deliver a coordinated and collaborative response to a person experiencing, or at risk of experiencing, a crisis involving multiple systems of care and agencies (e.g., law enforcement, mental health agencies).

Discharge planning means the result of ongoing collaboration between the multidisciplinary team, youth, parent or legal representative, field staff, managed care organization (MCO) and other members of the youth's community support system.

Discharge summary means a document used to communicate discharge instructions such as follow-up appointments, facility points of contact, discharge diagnosis, medication reconciliations, and medical plan of care to the next level of care provider(s).

Individualized treatment plan means a detailed plan that documents treatment activities that utilizes the youth's strengths and protective factors to support treatment activities, therapies, training, and future planning customized to address the youth's needs as a whole person. The individualized treatment plan is continuously reassessed and changed based on the youth's treatment progress and evolving needs.

Legal representative means a parent of a client if the client is under age eighteen and parental rights have not been terminated or revoked, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

Managed care organization (MCO) means an organization that delivers prepaid health care services to eligible Medicaid MCO enrollees.

MCO care coordinator means an MCO professional who coordinates physical health, mental health, and substance use disorder treatment services to MCO enrolled individuals.

Multidisciplinary team or MDT means a group of people who collaborate to develop the youth's individualized treatment plan.

Receiving entity means the place where the youth is moving to, which may be the youth's family home or some other community setting.

Transition framework means the process to facilitate a client's timely and stable transition from one setting to another.

Transitional Care Unit means the teams, which include Roads to Community Living (RCL) and Transition case managers, who have a caseload that solely supports clients transitioning from one setting to another.

Youth transitional care facility means a staff-secure and voluntary facility offering specialized treatment for suitable youth.

POLICY

A. The facility staff must initiate planning for discharge at admission.

B. The facility staff must conduct a thorough transition process to ensure a safe and successful discharge.

C. The facility staff must maintain a process for determining when a youth no longer requires active treatment at this level of care and is ready for active discharge planning.

D. All MDT staff members must document ongoing changes and progress towards the youth's discharge in individualized treatment plan reviews, social work monthly progress notes, physician rounds, and other progress notes.

E. The facility staff must document in the youth's electronic health record their readiness for the discharge.

F. At least 30 days before a youth's planned discharge date, the facility staff must notify in writing the youth and their parent or legal representative.

G. The facility staff must offer youth and their parent or legal representative therapeutic leave to assist caregivers with preparing for transition to a community-based setting.

PROCEDURES

A. Transition Planning

1. Before a youth is discharged, the facility:

   a. Must sufficiently prepare the youth and the receiving entity to ensure a safe and orderly transition; and

   b. May allow the receiving entity to shadow facility employees who work with the youth.

2. Before a youth is discharged, the receiving entity must, when possible, complete an orientation with the youth at the facility in a manner the youth can understand. The orientation may include tools like pictures and social stories.

B. Transition Meetings

1. Upon determination of a youth's potential discharge, the facility must schedule a transition meeting with the MDT, the youth and parent or legal representative, and their CRM.

2. The CRM must use DSHS 10-574A, *Transitional Care Planning and Tracking A. Transition Preparation,* to document the transition preparation steps, which includes:

   a. A person-centered discussion on the youth and parent or legal representative's goals for discharge;

b. Explanation of person-centered planning tools such as a facilitated person-centered plan, the MyPage profile or other person-centered planning tool that highlights the holistic goals of the youth and their support team;

c. Identify the youth's preferred discharge setting. If they request community-based residential services, the CRM must complete DSHS 10-232, *Provider Referral Letter for Residential Services*; and

d. Explain the transition process to the youth and parent or legal representative and what they can expect from DDA to support them to navigate their move back to the community.

3. Transition meetings must occur regularly until the youth is scheduled to leave and, when possible, a final meeting must occur at least one week before the discharge date.

4. Transition meetings may include but not limited to:

a. The youth;

b. The youth's parent or legal representative;

c. Advocates of the youth and parent or legal representative's choosing, if applicable;

d. The youth's CRM and other identified field services staff;

e. The youth's multidisciplinary team;

f. The MCO care coordinator;

g. Nursing care consultant support, if applicable; and

h. The receiving entity.

5. The purpose of the transition meetings is to:

a. Create a post-discharge plan of care;
b. Ensure all parties understand the discharge process;
c. Discuss the representative payee role in the youth's transition;
d. Determine if an assessment of the youth's new home is needed;
e. Determine if a Cross-Systems Crisis Plan is needed; and
f. Arrange for the youth's transportation to the receiving entity's care.

6. The CRM may document the transition meeting progress using DSHS 10-574B, *Transitional Care Planning and Tracking Part. B Active Coordination of Transition (ACT)*.

7. The post-discharge plan of care must indicate where the youth plans to reside, any arrangements that have been made for the youth's follow-up care, and any post discharge medical and non-medical services.

C. Sharing Client Information

Before the youth leaves the facility, the facility must give the receiving entity:

1. A list of the youth's preferences;

2. Instructions for assisting the youth with activities of daily living (when applicable);

3. The contact information of the youth's parent or legal representative, and medical providers;

4. The youth's adaptive equipment, instructions for using the equipment, proof of equipment lease or ownership, and whether or not the youth needs to purchase the equipment;

5. The youth's individualized treatment plan;

6. Assessments relevant to the youth's individualized treatment plan;

7. A discharge summary, which must include the youth's:

   a. Goals;
   b. Developmental status;
   c. Social status;
   d. Health status;
   e. Nutritional status;
   f. Current status of the objectives in the individualized treatment plan;
   g. Customary routine or active treatment schedule;
   h. Functional assessment, if applicable; and
   i. Positive behavior support plan, if applicable;

8. A medical summary of the youth's time at the facility, which must include:

   a. Current diagnoses and illnesses;
   b. A summary of lab, radiology, and consultations; and

c. Treatments and therapies implemented to address the youth's conditions;

9. Dates for follow-up appointments scheduled with the youth's community medical providers;

10. A pharmacy summary of the youth's time at the facility, which must include:

a. Medications currently taken by the youth and reasons for each medication's administration;

b. Medication administration instructions;

c. Known, pertinent medications taken by the youth in the past, reasons for each medication's administration, and reasons for each medication's discontinued use; and

d. Drug allergies, paradoxical effects, and adverse reactions; and

11. Education records such as a current individualized education program (IEP), behavior intervention plan (BIP), and any educational evaluations.

D. Day of Discharge

1. On the day the youth is discharged from the facility:

a. The facility must review the youth's discharge summary and post-discharge plan of care with the receiving entity.

b. The facility and receiving entity must review and sign the youth's personal property inventory.

c. The facility must give the receiving entity the youth's:

i. Insurance card or cards;
ii. Identification card;
iii. Social Security card;
iv. Birth certificate; and
v. Any legal documents, if applicable.

d. The facility medical provider must give the receiving entity:

i. The medical orders; and
ii. A prescription for a 30-day supply of the youth's medications.

e. The facility's clinical pharmacist must give the receiving entity at least a one-week supply of the youth's medication.

2. If the receiving entity asks the facility for a renewed prescription, the facility should discuss with the receiving entity ways to address the need and permanently transfer the prescriptions to a community provider.

EXCEPTION

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary or designee.

SUPERSESSION

None.

Approved: _____ Date: July 1, 2024
Deputy Assistant Secretary
Developmental Disabilities Administration