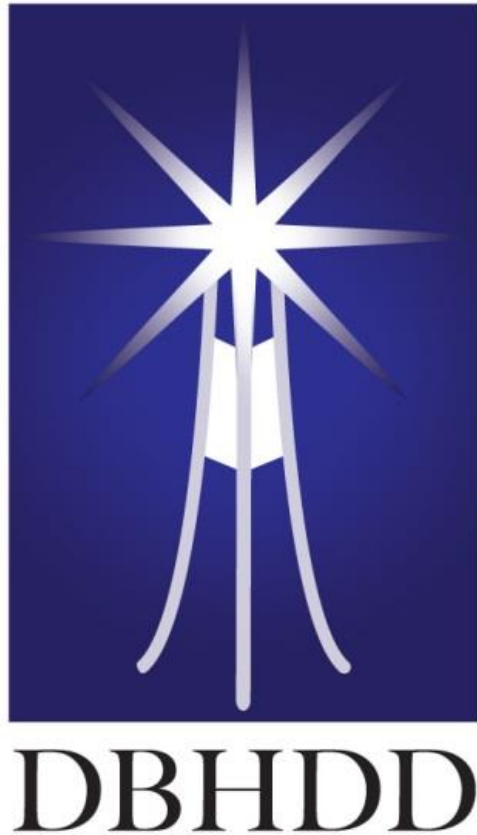


Community Transitions From State Hospitals Manual



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Division of Intellectual and Developmental Disabilities

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Introduction:

This “*Community Transitions from State Hospitals*” manual serves as the Department of Behavioral Health and Developmental Disabilities’ (DBHDD) source document for how the transition of individuals with intellectual and developmental disabilities (I/DD) from a state hospital to a community-based settings should occur. Included in this manual are documents, appendices, and related policies intended to clarify details that individuals transitioning, families, Support Coordinators, hospitals, providers and others should find helpful. The Division of Developmental Disabilities, Office of Transition Services, is the owner of this manual and possesses shared responsibility in the execution and oversight of both these transitions and fidelity to this process. For involved stakeholders, particularly hospitals, Field Offices, and Support Coordination agencies, this manual should be viewed as a supportive, informative, and educational guide, contributing to a greater understanding of the enhanced process to facilitate successful transitions – as defined operationally below – and positive outcomes and meaningful lives for the most important of all stakeholders, the individual.

The “Guide to Community Transitions¹” is intended to provide information, designate accountability, and facilitate understanding of what is required and expected of those responsible for supporting the individual throughout this process. This manual is intended to serve as a “how-to guide” before, during, and after transition. While the aforementioned “Guide for Community Transitions” outlines the required steps, this manual serves to further explain how to achieve the outcomes associated with each. The “Transition Process Map²” depicts the process flow of major outcomes to be achieved during the Transition Process.

1. Philosophy, Vision, and Mission of DBHDD:

DBHDD’s vision and mission statements follow:

Vision: “Easy access to high quality care that leads to a life of recovery and independence.”

Mission: “Leading an accountable and effective continuum of care to support Georgians with behavioral health challenges and intellectual and developmental disabilities in a dynamic healthcare environment.”

This process is further informed by the use of a recovery-oriented, community-based, and person-centered system of care. Recovery – and, by extension, independence – are individual constructs, shaped by experience and access to necessary supports and services. DBHDD posits that recovery is “nurtured by relationships and environments that provide hope, empowerment, choice, and opportunity.” The transition process is an illustration of this definition, as each step seeks to promote a high degree of individualization and self-determination.

¹ Guide to Community Transitions from State Hospitals, Appendix A.1

² Transition Process Map, Appendix A.2

2. Definition of Successful Transition:

A “successful transition “ . . . is realized when an individual is receiving necessary and appropriate supports and services in the most integrated setting within the greater community. These efforts assure that the individual is effectively and competently supported in making life choices that optimize safety and wellness, autonomy, and independence. The services and supports also clearly address those things which are important to the individual, including active membership in their community.” This definition³ in its entirety, included as Appendix A.2, offers measurable indicators of success, further endorsing the importance of person-centered planning and protection of the individual’s health and well-being.

3. Format of Manual:

This manual is primarily divided into three chapters, each summarizing the steps to occur before, during, and after transition. The chapters will reference the “Guide for Community Transitions” but will not list related steps; instead, users should review the “Guide for Community Transitions” carefully as each step reflects a domain outlined in this manual.

³ Successful Transitions – Operational Definition, Appendix A.3

Definitions

1. Burial Resources - An asset (resource) that is designated to be used for burial. This may include but not limited to a designated burial savings account, cemetery plot, burial prepaid/preneed, burial CD, and/or life insurance policy
2. Case Expeditor (CE) - Field Office staff member who specializes in planning and coordinating transitions for individuals moving from hospitals to the community
3. Care Plans - Specific protocols developed by the provider to address medical and/or behavioral needs of the individual, as identified in the nursing and behavioral enhanced supports review assessments
4. Community of preference – The community in which an Individual selects to live upon discharge from a state institution, as identified by the Individual, his/her legal guardian or their authorized supporter
5. Conditional Release Plan - A plan agreed upon by a court to release an individual from custody under defined conditions. These conditions often include participation in treatment and may include restrictions in certain activities
6. Conditions of Bond - Conditions under which an individual is released from court authority. Violation of the conditions may result in apprehension and incarceration
7. Early Engagement – A support model whereby a service entity such as Support Coordination or the Integrated Clinical Support Team engages with an individual to establish relationships and assist with transition planning prior to an individual's transition from a State Hospital to a community-based setting.
8. Enhanced Support Coordination – Service provided to an individual post-transition, whereby a Support Coordinator may monitor, assess, and evaluate the implementation of transition plans and coordinate additional services as needed.
9. Exceptional Rate – A rate paid for a waiver service that exceeds the maximum reimbursement rates established by Medicaid. An exceptional rate may be authorized by DBHDD under extraordinary circumstances related to an individual transitioning from an institution or to prevent imminent institutionalization
10. Forensic Review Committee (FRC) - A multidisciplinary hospital committee appointed by the hospital Clinical Director, in consultation with the hospital's Forensic Program Director. The FRC provides external review of Comprehensive Review Meeting decisions made by forensic Recovery Planning Teams. The FRC also provides external review, feedback, and guidance to forensic Recovery Planning Teams in certain circumstances, as dictated by policy
11. Health Risk Screening Tool (HRST) – The HRST is a nationally recognized screening tool that is used to identify and track health risks in vulnerable populations
12. Healthcare Facility Regulation (HFR) – “A division of the Department of Community Health (DCH) [which] is responsible for health care planning, licensing, certification and oversight of various health care facilities and services in Georgia”
13. Hospital Treatment Team – In state hospital services, an interdisciplinary team comprised of the Individual and his or her doctor, nurse, social worker, psychologist, and other staff members who work closely with the individual to identify, acquire or provide supports and services needed to assist the individual

in meeting personal goals. In hospital Intellectual and Developmental Disability and Skilled Nursing Facility service areas the hospital treatment team is often referred to as the Interdisciplinary Treatment team, while in hospital Adult Mental Health and Forensic service areas the hospital treatment team is often referred to as the Recovery Planning Team

14. Individual Support Plan (ISP) - An ISP is a written comprehensive plan that identifies in measurable terms the expected outcomes of all services to be provided to the participant. The ISP is directed toward achieving self-sufficiency and community integration.
15. Individual Support Plan Narrative (ISPN) - The ISPN synthesizes information from current assessments and makes recommendations for services and supports based upon assessment information. The ISPN is used by the Transition Team and Support Coordination to guide transition planning and ISP development
16. Integrated Clinical Support Team (ICST) - An ICST is a community-based team of clinical professionals that provides specialty services to individuals who have recently transitioned from institutions, as well as training and support to providers caring for the individuals. Members of the team include, but are not limited to, Nurses, Positive Behavior Support Specialists, Registered Dietitians, Occupational Therapists, Physical Therapists, Speech and Language Pathologists, and Psychiatrists
17. Money Follows the Person (MFP) Program - MFP is a demonstration grant entered into by states that helps to remove barriers to individuals moving from long-term care facilities to the community. The MFP program can provide funds to purchase items needed to establish a household, including basic household furnishings, goods and supplies and home modifications. MFP will also cover medical supplies and equipment and assistive technologies not covered by Medicaid. MFP funds are available to individuals for up to 365 days after transitioning from an institution to the community
18. Office of Transition Services – Within DBHDD’s Division of Developmental Disabilities, for all eligible individuals who elect to be served by a community-based Medicaid Waiver, this office is responsible for oversight of the transition process as an individual transitions from a state hospital to a community based setting
19. Patient Accounts Office – The office within hospital financial services which handles patient accounts
20. Prior Authorization (PA) - As a condition of reimbursement, NOW/COMP services must be approved prior to the time they are received and the individual must be Medicaid-eligible at the time the service is received - this process is called Prior Authorization (PA)
21. Quality of Life (QOL) Survey – “Sponsored by the Centers for Medicare & Medicaid Services (CMS) and the state of Georgia, [the QOL survey] is an essential part of an evaluation of the Money Follows the Person Program...[spanning domains of] housing, access to care, community involvement, and [the individual’s] health and well-being”
22. Recognize and Refer Model - Support Coordination monitoring and follow-up activities will follow a model identified as “Recognize and Refer.” If the Support Coordinator identifies unmet issues, concerns, or needs the Support Coordinator

- will be responsible for making a referral to the Integrated Clinical Support Team and/or the Field Office and for continued oversight to follow the unmet issues, concerns or needs until they are resolved
23. Regional Quality Review Team - Monitors the quality of services as well as providers' performance in meeting quality expectations for individuals with I/DD who transition out of state hospitals, to ensure individuals receive high quality services and achieve life goals in the community
 24. Regional Services Administrator-DD - Supervisor of the Developmental Disabilities services section of a Regional Field Office
 25. Service Types:
 - a. Developmental Disability Services - Services administered by DBHDD for individuals with intellectual and developmental disabilities, such as, community residential alternative, community living supports, supported employment, family support, and mobile crisis
 - b. Adult Mental Health Services - Services administered by DBHDD for individuals with mental illness and substance abuse disorders, including psychiatric care, case management, Assertive Community Treatment, individual and group therapy, and residential supports
 - c. Forensic Services - Services administered by DBHDD for individuals referred by the criminal justice system, including pre-trial evaluation, competency restoration, stabilization and inpatient treatment
 26. Support Coordination - A Medicaid funded waiver service for all NOW and COMP participants that is a set of interrelated activities that identify, coordinate and review the delivery of appropriate services with the objective of protecting the health and safety of participants while ensuring access to services
 27. Supports Intensity Scale (SIS) – The SIS is an assessment tool designed for individuals with intellectual disabilities that measures support needs in the areas of home living, community living, employment, health and safety, social activities, protection and advocacy, and lifelong learning and ranks each area according to the frequency and type of support required
 28. Transition Fidelity Committee - Serves as a final review body for individuals in the ADA Settlement population transitioning from state hospitals to community-based services.
 29. Transition Funds – Funding provided to facilitate an adequate and safe placement for individuals who transition from a State Hospital to community-based services
 30. Transition Team - Membership of the Individual's Transition Team
 - Individual
 - Individual's support network including Guardian or Representative and other persons of the Individual's choice
 - Hospital Treatment Team
 - Forensic Community Coordinator, if applicable
 - Field Case Expeditor
 - Support Coordinator
 - Integrated Clinical Support Team
 - Residential and any other Community Service Providers as selected by the Individual

31. Waiver Programs – Waivers are a source of funding for services that help Medicaid-eligible individuals who are elderly or who have disabilities to live in their own homes instead of an institution, such as a nursing home or Intermediate Care Facility for individuals diagnosed with an intellectual or developmental disability
- a. Comprehensive Supports Waiver (COMP) Program – A waiver program that serves individuals with more intensive needs and primarily provides residential service
 - b. New Options Waiver (NOW) Program – A waiver program that offers services and supports that help individuals live in their own homes or with family members and participate in their communities

Chapter 1: Pre-Transition Activities

The pre-transition phase extends from the time an individual is identified for transition and deemed eligible for services until the selection of community provider(s). This period is characterized by its focus on person-centered planning – carried throughout the transition by the individual’s assembled Transition Team. In this chapter, the following will be reviewed:

- Active List
- Waiver Eligibility & Financial Resources
- Person-Centered Planning
- Support Coordination Selection
- Integrated Clinical Support Team
- Budget Development/Creation of the Individual Support Plan Narrative
- Provider Selection
- Forensic Process

1. Active List:

1.a. Criteria for Inclusion:

DBHDD will support individuals with I/DD living in state hospitals to begin thinking about and planning for transition to lesser restrictive environments within their communities of preference with appropriate supports and services.

Criteria for inclusion on the Active List were developed to allow for thoughtful planning based on each individual’s needs and circumstances⁴:

1. All individuals in state hospitals, and their guardians, are offered information about community placement by both community and hospital staff together. As individuals and their families/representatives demonstrate agreement,
2. The individual’s needs are assessed to include medical, functional, behavioral, legal, personal interests and preferences, etc.
3. Individuals who were on the “Transition Master Planning List,” and whose previously identified provider, and individual/family/representative remain committed to community transition.
4. For individuals who are in state hospitals due to forensic issues, an assessment of their current legal status, including court orders or other legal requirements, will determine when or if they have community placement needs.

1.b. Inclusion: Responsibility: Office of Transition Services

All individuals residing in state hospitals are considered eligible for community-based services, a process that will be discussed in the “Financial Resources and Waiver Eligibility” section.

⁴ Criteria for Placement on Active List, Appendix B.1

The Office of Transition Services is responsible for the maintenance of the Active List. Individuals are added to the list through a collaborative process with hospital, Region, and Office of Transition Services' staff. Hospital and Field Office staff are responsible for notifying the Office of Transition Services, through the appropriate channels, of an individual or guardian's request for transition. For individuals residing on forensic units, the Office of Forensic Services determines inclusion on the Active List through reviews of the hospitals' Forensic Review Committees, Court approval, and mandates for discharge.

1.c. Reviews: Responsibility: Office of Transition Services

The Field Office – in collaboration with the Office of Transition Services – routinely review the transition progress of individuals on the Active List, primarily through the Transition Process Overview⁵ form, which provides an additional layer of oversight and reflects progress at the individual, provider, and residential levels.

1.d. Community of Preference: Responsibility: Case Expeditor

Once an individual has been placed on the Active List, the Case Expeditor engages the Individual and their Legal Guardian/Representative in discussion to determine the area within the state of Georgia where the Individual would like to live. This selection then guides the Selection of a Provider and other community services, in consideration of the geographic location in which the Individual would like to live.

1.e. Support Coordination and Integrated Clinical Support Team

Upon placement on the Active List, the Office of Transitions notifies the Integrated Clinical Support Team project lead of the individual's placement on the list so the ICST can begin a clinical review of the individual's documentation in the electronic database.

2. Waiver Eligibility and Financial Resources:

Prior to transition, DBHDD staff will review the individual's personal resources. As needs are identified, a plan will be developed to assist the individual with obtaining all eligible (or available) resources, benefits, and services. While the maintenance of Medicaid eligibility and financial resources begin during this phase, it is carried throughout transition.

2.a. Waiver Eligibility: Responsibility: State Hospital Social Work Staff

Upon inclusion on the Active List, the Case Expeditor will review the electronic database to determine if the waiver eligibility has been completed. To be eligible for the Developmental Disabilities NOW or COMP waivers, an individual must demonstrate:

1. DFCS determination of waiver eligibility (determines financial and Medicaid eligibility);
2. Documentation of intellectual disability since birth or before age 18, or another developmental disability since birth or before age 22, which requires similar services to those needed by people with intellectual disabilities;.

⁵ Transition Process Overview form, Appendix B.2

3. That he/she is at risk of institutionalization. (Substantial risk of harm to self or others; substantial inability to demonstrate community living skills at an age appropriate level; or substantial need for supports to augment or replace insufficient or unavailable natural resources.)

2.a.i. Waiver Application Process:

If eligibility has not been completed, CE will then request a waiver application packet from the individual's assigned social worker at the state hospital. The social worker utilizes DBHDD's Application for Developmental/Intellectual Disabilities Services⁶ to make a formal request for services and screening. In addition, the social worker should include: psychological evaluations with testing to include the following if known - IQ score, Adaptive Behavior Scores and age of onset; nursing assessment; Integrated Psychosocial Assessment (for individuals served in Adult Mental Health or Forensic hospital services) or Psychosocial Assessment for SNF and ICF/IID (for individuals served in Skilled Nursing Facility or Intermediate Care Facility hospital services); and a copy of legal guardianship papers, if applicable. Once the application is completed – with all required documentation – the social worker submits it to the Field Office.

Upon receipt, the Field Office Intake Coordinator should review the application and request any additional information needed to determine preliminary eligibility; once eligibility is determined, the Field Intake and Evaluation Office will send the individual a "Preliminary Eligibility Letter," which will also be uploaded to the electronic database. The hospital social worker will then work with the hospital's Patient Accounts Office to confirm the individual's current Medicaid code.

Prior to transition, the Field Intake and Evaluation Office will send the individual the "Waiver Award Letter," which will also be uploaded to the electronic database.

In the event, an individual has been found eligible in the past, but the eligibility is more than a year old, the Case Expeditor will request from the Field Intake and Evaluation Office for a Waiver State Funded Award consult to be completed.

2.b. Financial Resources:

Guided by available documentation from the hospital's Patient Accounts Office, the individual's social worker should review the individual's financial resources (i.e., benefits, income, burial resources) and document & submit findings to the CE for submittal to the I&E office using the Statement of Income form⁷. The Medicaid and Social Security Process Map⁸ is a helpful guide when reviewing an individual's financial resources and considering benefits an individual may need to apply for.

2.b.1. Burial Resources:

⁶ DBHDD Application for Intellectual/Developmental Disabilities Services, Appendix B.3

⁷ Statement of Income form, Appendix B.4

⁸ Medicaid and Social Security Process Map, Appendix B.5

Individuals can accumulate funds in their hospital burial accounts by transferring monies, in accordance with the policies of the hospital and Social Security Administration, from their personal accounts. In preparation for transition, it is necessary that these funds are transferred to community-based accounts through pre-paid funeral contracts or a bank of the individual/representative's choice.

Decisions about funeral planning should be made with the individual and his/her representative(s). The individual's social worker should facilitate the transfer of burial funds to community-based accounts, working closely with the Patient Accounts Office. A copy of the pre-paid burial contracts or accounts should be included in the individual's record and provided to the CE and community provider on the day of transition.

2.c. Vital Documents: In the Pre-Transition phase, the hospital social worker should assist the individual with obtaining his/her vital documents, specifically birth certificate, Georgia state ID card, Social Security card, and all applicable insurance cards. If vital documents cannot be secured, CE works with the Transition Team to develop a contingency plan.

2.c.i. Birth Certificates: The Georgia Department of Public Health, Office of Vital Records, maintains birth records of all individuals born in Georgia since 1919. Instructions on how to obtain a birth certificate can be found on their website: <http://dph.georgia.gov/birth-records>.

2.c.ii. Social Security Cards: To apply for a Social Security card, the Form SS-5 should be completed, with documentation supporting U.S. citizenship, age, and identity. More information can be found on their website: <http://www.ssa.gov/ssnumber/>, or by visiting a local Social Security Administration Office.

2.c.iii. Georgia State Identification Card: The Georgia Department of Drivers Services issues state identification cards. Any person able to sign his/her name – or make a mark – is eligible for an ID card, provided (s)he can produce “documentation showing identity, residential address, full social security number, and U.S. citizenship or proof of lawful presence in the United States.” For a complete list of required documents, refer to their website at: <http://www.dds.ga.gov/secureid/accepteddocs.aspx>.

3. Support Coordination Selection: Responsibility: CE and Hospital SW

Support Coordination is a service available to all individuals with I/DD deemed eligible for the DD waiver and “provides case management services designed to help identify, coordinate, secure, and monitor the person-centered supports and services which a person receives through the NOW/COMP Waiver (DD Waiver) funding.”

Using the Hospital Process for Education on Selection of Support Coordination Agency for Individuals who are Eligible for DD Services⁹, the hospital and Field Office staff are involved in both the dissemination of information about Support Coordination to individuals and representatives and education about agencies available within the community of preference. Support Coordination agencies serve geographic areas; therefore, the county in which an individual chooses to live will determine choice of Support Coordination agencies.

The individual's social worker begins education about Support Coordination by introducing the concept and sharing an informational pamphlet about Support Coordination Services¹⁰. Such pamphlets should also be placed on any hospital living unit where an individual with I/DD resides, along with pamphlets specific to all Georgia Support Coordination service providers. Education continues at the individual's person-centered planning meeting, at which time the community of preference should be identified. At this time, CE will review pamphlets describing the agencies serving the preferred geographic area with the individual and representatives and should answer any questions. Representatives are encouraged to participate in person-centered planning meetings, although there may be instances in which it is not possible. When this occurs, the CE will mail pamphlets to the representative, along with a Support Coordination Selection form¹¹ in a self-addressed, stamped envelope.

The selection of a Support Coordination agency is a time-sensitive matter. The CE will work closely with the individual or representative to make a selection. Selection is made within one week of educational efforts. If the CE does not receive a timely response, efforts will be initiated to further discuss this with the individual or representative, through preferred avenues of communication including face-to-face meetings as necessary. Initiation of Support Coordination will occur 60-90 days prior to the individual's anticipated transition. Tracking of the 60-90 days begins with the Support Coordinator's first face-to-face meeting with the individual.

Selection is considered official once the selection form is signed and returned to the CE. The CE uploads the form to the electronic database, assigns the Support Coordination agency to the individual in the electronic database, and notifies the Support Coordination agency of the selection. The assigned Support Coordinator is then responsible for engagement with the Individual, per Support Coordination standards.

4. Integrated Clinical Support Team (ICST): Responsibility: Office of Health and Wellness

⁹ Hospital Process for Education on Selection of Support Coordination Agency for Individuals Who Are Eligible for DD Services, Appendix B.6

¹⁰ Support Coordination Services pamphlet, Appendix B.7

¹¹ Support Coordination Selection form, Appendix B.8

The ICST identifies areas of risk for the person in an effort to assist the individual transitioning from the state hospitals into their community of choice by identifying and building needed supports.

The ICST is a four-member Core Team, comprised of but not limited to Project Director, Licensed Professional Counselor, Positive Behavior Specialist, and Registered Nurse. In the pre-transition phase, the Office of Transition Services will be the source of notification for the ICST to engage at the same time Support Coordination begins engaging with the individual. When a referral is needed for special ICST consult/assistance the Case Expeditor makes the referral to the ICST Project Director.

As the ICST assists with transition planning, they have specific responsibilities, to include, but are not limited to:

1. Participate in transition meetings;
2. Develop transition goals which address an individual's unique support needs;
3. Conduct at least three face-to-face contacts with the person prior to transition to build relationships;
4. Provide an assessment of provider readiness to serve an individual being transitioned, as requested;
5. Make contact with the individual within 24-hours of transition;
6. Make regular face-to-face visits for three months post-discharge; these visits can be increased or decreased based on identified needs.

5. Person-Centered Planning: Responsibility: Case Expeditor

Person-centered planning is a discovery process used to search out what is truly important to and about a person and what capacities and skills that individual embodies. It is values based with the knowledge that each and every individual has distinctive capacities and skills. It focuses on a positive vision for the future of the person based on his or her strengths, preferences, and capacities for acquiring novel skills and abilities. It concentrates on what a person can do versus what a person cannot do. A step-by-step process by a trained facilitator is utilized to help gather relevant information about a person. Each step contributes to learning a full picture of that person.

The individual is always at the center of the person centered planning process. He or she is as involved in the planning process as he or she wants to be or is able to be. The planning process is best achieved when it includes other people who also know the person well and believe in their vision. Each individual transitioning from a state hospital will have the opportunity to participate in a person-centered plan with the supporters of their choosing. This is accomplished by the Case Expeditor leading a meeting with the Individual, and their chosen supporters – this also includes members of the Transition Team. The person-centered planning document¹² is developed to identify what is important to the individual, his/her hopes and dreams, preferences for being supported,

¹² Person Centered Description form, Appendix B.9

and health and safety needs. It is used throughout the transition process to focus planning around the individual's preferences.

6. Individual Support Plan Narrative (ISPN) and Its Relationship to Budget Development: Responsibility: Coordinated through the Office of Transitions

The ISPN is a compilation of an individual's personal, behavioral, and clinical information, gathered from multiple source documents, then reviewed and summarized to identify an individual's comprehensive needs for transitioning from a state hospital.

The ISPN has five intended outcomes:

1. Informs the provider regarding types of services needed and personnel necessary to support the individual;
2. Informs Support Coordination goals and outcomes for the ISP;
3. Informs OLOD regarding the types of person-centered training necessary for the provider;
4. Informs post-transition follow-up; and
5. Informs the Budgeting Process

6.a. Required Documentation: Responsibility: Integrated Clinical Support Services

The ISPN is developed through record review. Upon direction from the Office of Transitions, a representative of Integrated Clinical Support Services contacts the Hospital Social Worker and Social Work Chief to request Clinical documentation from the state hospital as clinically indicated. This may include:

- Medical (History & Physical), Behavioral (Annual Psychiatric Evaluation), Current MAR, Physician Orders (to include standing orders), Nursing Assessment, Integrated Psychosocial Assessment or Comprehensive Psychosocial Assessment for SNF/ICF-IID, Behavior Support Plan (BSP) or Behavioral Guidelines, 24 Hour Support Plan, Occupational Therapy Assessment, Physical Therapy Assessment, Comprehensive Functional Assessment (CFA)/Individual Support Plan (ISP)/Individual Recovery Plan (IRP)/Plan of Care, Dietician/Nutrition Assessment, Dental records/evaluation, Speech/Language Evaluation and Diagnosis Sheet, but may request additional assessments as clinically indicated.

Once obtained, the CE will upload available required documentation to the electronic database using a standardized file name: *Type of Document (i.e., Psychosocial Assessment), Date Uploaded, Individual's Last Name.*

Information from the following, available from the Field Office, is also used for ISPN development:

- Enhanced Behavior Supports Review and Enhanced Medical Supports Review
- HRST (administered by trained HRST administrators)
- SIS (administered by trained SIS Assessment Specialists)
- Person-Centered Plan (must be current within 1 year at time of request, if not current must be updated before ISPN can be finalized)

6.b. Budget Planning Process: Responsibility: Office of Transition Services

The completed ISPN should reference appropriate Waiver Services and Codes for all recommendations. Upon completion, the ISPN will be forwarded by the Office of Transition Services to the Case Expeditor, DD RSA, and the Office of Community Services. The Office of Community Services develops a budget for waiver service supports. The Case Expeditor uploads the ISPN to the electronic database. The Transition Team can review it prior to initiating activities outlined in Chapter 2: Transition.

7. Provider Selection:

An individual or representative's selection of a community provider is a personal endeavor. With the support of the individual's Transition Team, information about prospective providers, and informed choice, the individual selects a community provider.

7.a. Provider Referral: Responsibility: Case Expeditor

The Case Expeditor will assist the individual and family/guardian to assess and identify one or multiple communities of preference. Based on geographical and other personal preferences the Case Expeditor will identify a pool of potential providers, and based on individual and family selection will proceed with scheduling meet-and-greets. The Case Expeditor should obtain written consent through [DBHDD's Authorization for the Release of Information, 23-110](#)¹³ to allow for sharing of information with prospective providers, serving as additional indication of the individual and/or guardian's agreement to proceed with meet-and-greets.

7.b. Meet-and-Greets: Responsibility: Case Expeditor

Upon consent from the individual and/or guardian, the CE should coordinate a meet-and-greet for the Individual with interested providers and other Transition Team members, to include the individual's hospital social worker and other hospital treatment team members, and Support Coordinator. These meetings will likely occur within the hospital to allow for ready access to the individual, review of hospital records in accordance with Health Information Management policy, and discussion with the individual's hospital treatment team. As this is an individualized process, there may be circumstances in which the meet-and-greet would more appropriately occur off-site and away from the hospital environment.

A meet-and-greet should be considered a dynamic encounter, wherein both the individual/guardian/family and provider have the opportunity to ask questions of one another. To prepare the individual/guardian, the CE may work with individuals and their family member(s) to create a list of questions to ask service providers during the meeting. At a minimum, the individual and/or guardian – or their designee - should facilitate a discussion about the provider's philosophy, approach, and experience working with individuals with similar needs and about the individual's preferences, aspirations, behavioral and medical support needs, housemate preferences, and house

¹³ DBHDD Authorization for Release of Information, Appendix B.10

'rules' or code of conduct. In addition, providers will have access to the individual's ISPN as additional documentation of support needs and required services.

The CE, Support Coordinator, and any other Transition Team members, as appropriate, should engage in separate, thoughtful dialogue with the individual and/or representatives and providers to review outcomes of the meet-and-greets and inquire about their willingness to continue with the transition process. As a result of these separate discussions, the individual and/or representative should express interest in continuing the process with particular providers. In addition, Providers who remain interested should commit to serving the individual at this time, and identify the home available for the individual. As available homes are identified, the Case Expeditor visits each home and completes the Initial Housing Checklist¹⁴.

7.c. Housemate Matching: Responsibility: Case Expeditor

It is necessary for the Transition Team to consider the compatibility of potential housemates and to be cognizant of the individual's right to choose their housemates (unless an individual decision is contraindicated based on their needs). But, more importantly, it is imperative that individuals and their supporters be central to decision-making and are active participants in the selection of prospective housemates. The Guide to Choosing a Housemate¹⁵ will be used to foster this process.

The Guide to Choosing a Housemate forms include open-ended questions to be first asked to the individuals, with assistance from supporters of choice as needed (Attachment A), and then with those who support them, such as their hospital treatment team members, direct care staff, families, friends, etc. (Attachment B). The CE will be responsible for facilitating this process and obtaining information, preferably prior to the Person-Centered Planning meeting and again as the individuals choose their providers and residences, in the most individualized manner. As housemates are proposed/identified, the Transition Team will review the completed forms to assess compatibility (Attachment C), to include their interests, preferences, likes/dislikes, etc., to help the individual and their supporters make an informed decision. For a more thorough review of the process, with associated timelines, refer to the Guide to Choosing a Housemate, Housemate Selection Process¹⁶, and Housemate Matching – Pre-Transition Activities¹⁷.

7.d. Home Visits: Responsibility: Case Expeditor

Once the individual and/or representatives express an interest in visiting specific providers in the community, the CE, Social Worker, Support Coordinator, and providers should collaborate to make arrangements for home visits. To the extent possible, individuals should be afforded the opportunity to tour prospective homes to aid in provider selection. Hospital staff will be primarily responsible for the arrangement of medication orders/administration, dietary considerations, equipment needs, and

¹⁴ Initial Housing Checklist, Appendix B.11

¹⁵ Guide to Choosing a Housemate, Appendix B.12

¹⁶ Housemate Selection Process, Appendix B.13

¹⁷ Housemate Matching – Pre-Transition Activities, Appendix B.14

transportation. There may be circumstances in which it is contraindicated for the individual to travel for this purpose; in this case, the representatives would serve as the individual's liaison to this process.

The CE, Support Coordinator, and hospital staff members should accompany the individual and/or representatives to these home visits. While the selection of a provider is the decision of the individual and/or representatives, it is beneficial to have additional support at the home visits to help determine if the home can accommodate the needs of the individual. In addition, this support can also help survey the surrounding community for medical services and supports, opportunities for community inclusion including employment if desired, and other community living needs. The providers can use this as an opportunity to highlight their willingness and proven ability to provide services that are person-centered and allow for the creation of meaningful lives as part of the broader community.

7.e. Selection: Individual and/or representatives

In consideration of all available information and opportunities to learn more about the providers, including outcomes of the Initial Housing Checklist and Housemate Matching, the individual and/or representatives should be supported in finalizing their selection of Provider and confirming agreement to proposed Housemates. Upon notifying the provider of their selection, the CE should work with them to determine if the identified home will require home modifications and should collaborate on a plan for renovations – with agreed-upon timelines for completion.

8. Forensic Process:

The Office of Forensic Services “provides forensic evaluation and treatment for individuals who are under the jurisdiction of the superior and state courts of Georgia,” as well as “inpatient treatment for individuals adjudicated incompetent to stand trial or not guilty by reason of insanity who meet the criteria for inpatient treatment by a superior or state court.”¹⁸

For individuals residing on forensic units, the transition process is guided by not only the values of DBHDD but also requirements of the Court and the following DBHDD policies:

- [Forensic Review Committees, 06-105,](#)
- [NGRI: Evaluation, Treatment and Release of Defendants Acquitted as Not Guilty By Reason of Insanity, 06-107,](#) and
- [Evaluation and Treatment of Defendants Adjudicated Incompetent to Stand Trial, 06-102.](#)

8.a. Forensic Review Committee: Responsibility: Hospital Forensic Director
Forensic-specific steps exist in all phases of the transition process and relevant elements will also be reviewed in chapters summarizing transition and post-transition activities. In the pre-transition phase, the individual's Recovery Planning Team (RPT) should present the individual's case to the Forensic Review Committee (FRC) to review

¹⁸ <http://dbhdd.georgia.gov/forensic-services>

readiness for transition, to include an increase in STEP privileges, as appropriate, to accommodate greater inclusion into an integrated environment through day and overnight passes. Upon approval from the FRC, the individual's psychologist should draft a letter to the Court requesting an increase in such privileges for the purpose of transition planning, which cannot be used until such time as the hospital receives a written Court order. Once the hospital is in receipt of the Court order, the individual's social worker should forward a copy to the Case Expeditor for awareness and filing.

8.b. Active List: Responsibility: Office of Forensic Services and Office of Transition Services

As referenced in the "Active List" section, the hospitals should coordinate with the Office of Forensic Services to identify individuals for inclusion on the Active List. There may be situations in which the hospital receives unanticipated notice from the Court to mandate transition planning efforts; in such instances, the individual's social worker should notify the Field Office to advise that the RPT is now seeking community placement in order to engage the Field Office in Pre-Transition activities. Individuals on forensic units must also proceed through the waiver eligibility process upon inclusion on the Active List.

Chapter 2: Transition Activities

In this phase, the Transition Team reviews clinical information to enact plans to address the individual's needed supports, services, and supervision to promote a successful transition. Such plans culminate in the approval of both the Field Office and the Transition Fidelity Committee to proceed with individual's transition. In this chapter, the following domains will be reviewed:

- Use of ISPNs: Transition Plan and Individual Support Plan
- Community Care Plan Development
- Home Readiness
- Comprehensive Transition Training
- Financial Resources: Money Follows the Person and Transition Funds
- Forensic Process
- Transition Fidelity Committee
- Day of Discharge

1. Use of Individual Support Plan Narratives:

As discussed in Chapter 1, the ISPN is a compilation of clinical assessments, along with the person-centered plan, and serves many purposes, including the identification of the types of supports, services, and supervision needed to support the individual. It informs Support Coordination of the types of goals and outcomes to be included in the ISP. As a result, the ISPN is a central focus of both the Transition Plan and the ISP.

1.a. Transition Meeting and Transition Plan Development: Responsibility: Case Expeditor

Once the individual and/or representatives select a provider, the Case Expeditor will schedule a Transition Meeting with the Individual's Social Worker. At this time the Case Expeditor should request of the hospital all applicable documents from the Transition Fidelity Committee (TFC) Clinical Records Documents for Transition and Discharge form (Part 1)¹⁹ to be made available at the ISP meeting, following the Process for Requesting Documents for Transition²⁰.

This serves as the first formal meeting between the Transition Team, Integrated Clinical Support Team (ICST), and provider to specifically discuss the individual's care needs and associated services and supports and outline a plan for attainment. The Transition Meeting utilizes DBHDD's Guidelines for Transitional Planning²¹ to provide a structure for both the facilitation of the meeting and the development of the Transition Plan. It centers on the individual's needs across many service areas: behavioral, health/nutrition, sensorimotor/mobility, communication, social/recreational, self-care, adaptive equipment, communication skills, employment, transportation, and legal issues.

¹⁹ Transition Fidelity Committee Clinical Records Documents for Transition and Discharge, Appendix C.1

²⁰ Process for Requesting Documents for Transition, Appendix C.2

²¹ Guidelines for Transitional Planning, Appendix C.3

The ISPN aligns with – and serves as a guide for – the Transition Team’s review of these areas. It outlines the recommended medical interventions (to include nursing services), mobility supports, psychiatric/mental health treatment, behavior support needs, communication supports, OT/sensory support, adaptive equipment/assistive technology, home/vehicle modifications, and vocational/active integrated community day support requirements. Given its many focus areas, the ISPN can also set forth training recommendations which form the basis of both individualized and foundational training for providers in preparation for transition. It also provides justification for an exceptional rate (behavioral), as appropriate.

Through the use of the ISPN, the Transition Team should engage in thoughtful dialogue about supports available in the identified community to which the individual will transition, to include physicians, opportunities for community integration & meaningful day activities, and proximity to and availability of specialty services, as well as the services that may need to be cultivated or sought elsewhere. In the development of the Transition Plan, the Transition Team identifies tasks to be accomplished by specific team members to continue the progress of the transition. The Transition Plan is documented by the Case Expeditor during the Transition Meeting.

The Transition Team and provider should also review the HRST, SIS and Enhanced Supports Review Assessments to identify the required Community Care Plans to be developed and sent to the Field Office and Office of Health and Wellness for review prior to the ISP meeting.

The Field offices should distribute a copy of the Transition Plan to all participants within one week of the meeting and should upload a copy to the electronic database. The Transition Plan should be updated as needed throughout the transition process but, at minimum, should be reviewed at the ISP meeting for accuracy of included information and status of assignments.

1.b. Individual Support Plan (ISP) Responsibility: Support Coordinator

The individual’s Support Coordinator convenes the Transition Team to develop the ISP, which should:

1. Be driven by the individual and focused on the outcomes the individual desires to achieve and reference the individual’s Person-Centered Plan
2. Fully be explained to the individual using language/communicate (s)he can understand and agreed to by the individual,
3. Provide information in order to identify social, educational, and other needs that are important to the individual
4. Include persons who:
 - a. Are significant in the life of the individual
 - b. Have historical perspective on the desire(s) of the individual
 - c. The individual consents to have input from their support network, if desired
 - d. Will deliver the specific services, supports, care, and treatment identified in the plan

The Support Coordinator should review the Community Care Plans, Person Centered Plan, Enhanced Supports Review Assessments, SIS, HRST Service Objectives, and ISPN recommendations for inclusion in the ISP. If the Transition Team determines that it is not in the individual's best interest to follow specific recommendations, it should be included in the ISP with justification.

With input from the individual, the Transition Team should develop achievable, measurable goals, with associated tracking requirements.

At the ISP meeting, the social worker will supply the previously requested documents required for the "Clinical Record Documents for Transition and Discharge Process – Part 1" to the Case Expeditor, as per the Process for Requesting Documents for Transition. Refer to Appendix B.10 for guidance regarding obtaining these documents if the Transition Meeting and Individual Support Plan meeting are combined.

2. Community Care Plan Development:

2.a. and 2.b.: Healthcare Plans and Behavioral Plans: Responsibility: Office of Health and Wellness

The Community Care Plans are specific protocols developed by the provider to address medical and/or behavioral needs, as identified in the nursing and behavioral enhanced supports reviews, respectively, and included in the ISPN. Provider staff are trained on implementation on Healthcare and Behavioral Plans.

2.c. Review and Approval: Responsibility: Office of Health and Wellness

The need for Community Care Plans is identified at the Transition Meeting. The Field Office can offer assistance in the development of these plans and, upon completion the Field Office should submit the draft plans to the Office of Health and Wellness for review, feedback, and final approval. These plans should then be submitted to the individual's Support Coordinator by the ISP meeting for inclusion in the ISP.

3. Home Readiness:

3.a. Healthcare Facilities Regulations (HFR): Responsibility: Case Expeditor and Provider

In the transition phase, the Case Expeditor should work closely with providers to ensure the necessary home modifications are completed in advance of the individual's discharge from the state hospital. If individuals receive Community Residential Access services in homes owned or leased by providers, the home is subject to HFR's licensing standards²² and DBHDD reviews. In collaboration with the provider, the Field Office is primarily responsible for all required home readiness reviews, described hereto.

Upon the provider's identification of a particular home suited to meet the needs of the individual, the CE should verify the status of the provider number and HFR status of site

²² Healthcare Facilities Regulation's licensing standards, Appendix C.4

number. As appropriate, the CE should request an expedited process through the Office of Transition Services.

3.b. Home modifications: Responsibility: Case Expeditor

If home modifications are required, the CE follows up with the Provider to ensure all modifications were completed as required.

3.c. Field Office Reviews:

3.c.i. Pre-Placement Site Visits: Once the provider obtains a site number from HFR, and the home license from Provider Network Management, the CE should complete the Pre-Placement site visit using the Site Inspection Checklist²³ to identify any areas of correction and develop timelines for action, in agreement with the provider.

3.c.ii. Placement Readiness: The day prior to transition, the RSA-DD, with CE and Support Coordinator, should conduct a readiness visit and document outcome on the Placement Readiness form²⁴. During this visit, if any areas require correction/immediate action, the CE should work to address these areas and will notify – and maintain contact with – appropriate stakeholders until resolution.

4. Comprehensive Transition Training: Responsibility: Office of Learning and Organizational Development

In keeping with DBHDD's emphasis on person-centeredness and provider development, provider management and direct care staff will receive both foundational and individualized training relative to the identified needs of the individual. In addition, providers will maintain responsibility for training their staff who will provide care to the individual and will develop a plan to address on-going training.

The Office of Learning and Organizational Development (OLOD) is the owner of the Comprehensive Transition Training Process²⁵. An OLOD representative will participate in conversations with the Transition Team, as necessary, to identify both foundational and individualized training areas and will develop necessary training tools.

5. Financial Resources: Money Follows the Person (MFP) and Transition Funds

5.a. Money Follows the Person: Responsibility: Case Expeditor and Provider

In the transition phase, the provider can access funds to assist in paying for approved expenses to promote a successful transition from the state hospital to community-based services. The implementation of the MFP initiative – a collaboration between DBHDD and the Department of Community Health – further illustrates DBHDD's commitment to

²³ Site Inspection Checklist, Appendix C.5

²⁴ Placement Readiness form, Appendix C.6

²⁵ Comprehensive Transition Training Process, Appendix C.7

recovery-based services as MFP's aim is to assist individuals in their transitions from institutional settings to their homes and communities²⁶. In order for individuals to be eligible for MFP services, they must meet basic criteria:

1. Must reside in an inpatient setting for at least 90 consecutive days prior to transition
2. Maintain Medicaid eligibility for at least one day prior to transition
3. Meet institutional level of care
4. Move into a qualified residence

5.a.i. Transition Funds Request: To aid in paying for expenses associated with relocation, providers can utilize Transition Funds, in keeping with criteria set forth in the DCH MFP Transition Protocols Appendix B: MFP Services Table²⁷. At the Transition Meeting, the Transition Team and provider should identify any areas in which Transition Funds will be needed. At this time the MFP Transition Agreement²⁸, MFP Release of Health Information²⁹ and MFP Informed Consent³⁰ documents are completed. The provider is responsible for submitting the Transition Funds Request³¹ to the CE in a timely manner in accordance with the Transition Fund Workflow Process.³² The CE submits the request to the Office of Transitions who will review and approve the request.

As transition for eligible individuals nears, the CE should notify the Office of Transition MFP Coordinator to complete the Quality of Life Survey within 14-30 days of anticipated discharge. The Case Expeditor should be cognizant of their responsibility to also complete the MFP Post-Renovation Inspection within the specified timeframes. The tracking of expenses and use of funds will be explored in Chapter 3: Post-Transition.

6. Forensic Process:

6.a. Court Approval: Responsibility: Hospital Forensic Director

The RPT – and the Transition Team as a whole – should collaborate in the development of a draft Conditional Release Plan (CRP) or Conditions of Bond (COB), per the individual's legal status, upon the development of the Transition Plan and ISP as both outline the services, supports, and supervision to be enacted upon discharge. The RPT is responsible for obtaining all required signatures from service providers, including the residential and behavioral health providers. Once the draft is complete (with signatures), the RPT should present it to FRC for review and approval. Upon approval, the Forensic

²⁶ MFP Fact Sheet:

https://dch.georgia.gov/sites/dch.georgia.gov/files/MoneyFollowsThePerson_FY14_Final_0.pdf

²⁷ MFP Services Table, Appendix C.8

²⁸ MFP Transition Agreement, Appendix C.9

²⁹ MFP Release of Health Information, Appendix C.10

³⁰ MFP Informed Consent, Appendix C.11

³¹ Transition Funds Request form, Appendix C.12

³² Transition Funds Request Workflow Process, Appendix C.13

Director, or designee, will submit the draft CRP or COB to the court of authority as the official request to grant transition to community-based services.

If the court requests changes to the proposed plan, the RPT and Transition Team should reconvene to make necessary adjustments – and consider the impact the adjustments will have on the ISP.

When the court officially approves the CRP or COB, the hospital will receive an order permitting transition, which should be filed in the individual’s medical record with a copy sent to the CE.

7. Transition Fidelity Committee (TFC):

The TFC serves as a final review body for individuals in the ADA Settlement population transitioning from state hospitals on a DD Waiver to community-based services. As reflected in the TFC Process³³, the focus of the TFC is to have standardized processes, protocols, and procedures from transitions that:

1. Reflect DBHDD’s goals and values
2. Demonstrate an application of knowledge of the individual’s needs and goals
3. Are likely to result in a safe, healthy, and successful life in the community

7.a. Documentation: Responsibility: Office of Transition Services

The TFC reviews a number of documents, to include the signed Clinical Records Checklist and Transitional Field Review Form³⁴ or, if applicable the Forensic Transitional Field Review Form³⁵. Both forms are completed by the CE. The latter includes details about scheduled medical appointments (i.e., physician, dentist, psychiatrist, etc.), provider competency training, environmental site inspection, ISP review(s), equipment plans, Community Care Plans, and monitoring schedule. The former is a detailed list of all clinical assessments and tracking forms obtained from the hospital and given to the provider for their files. The RSA-DD is responsible for reviewing the forms with the CE and signing off when it is deemed a complete package. The Field Office keeps copies of all documents that were given to the provider.

7.b. Reviews: Responsibility: Field Office and Office of Transition Services

A Field Office staff member, often the Case Expeditor or DD-RSA, conducts a “walk through” of the home to review individual-specific information, confirm all equipment is in place or planned for, complete staff interviews, and assess the progress of any areas identified for correction in previous visits.

³³ Transition Fidelity Committee Frequently Asked Questions and Process, Appendix C.14

³⁴ Transitional Field Review Form, Appendix C.15

³⁵ Forensic Transitional Field Review Form, Appendix C.16

Upon receipt of all aforementioned documentation, a TFC representative visits the identified home with Field Office leadership and conducts a review. During this visit, the TFC representative's purpose is to assure:

1. The provider has all necessary protocols and processes in place to support the individual
2. Competency-based training has occurred, with documentation to support this effort
3. All necessary plans of correction have actually occurred or identify other corrections that need to occur prior to the transition

This TFC representative will then submit findings and recommendations to the TFC to approve the home as ready to move forward, outline corrections that must occur prior to transition with a plan for reviewing said corrections, or deny transition request because the home is inappropriate with suggestions to the Field Office for a more appropriate plan outlining the individual's needs.

7.c. Approval: Responsibility: Transition Fidelity Committee

Within two business days of submission, the TFC will review all available documentation, schedule a conversation with the Field Office as appropriate, and reach a decision about the transition. Once approved, a TFC representative will sign the Transitional Regional Review form. An individual cannot discharge from the hospital through the Division of I/DD transition process without written approval from the TFC.

8. Day of Discharge:

8.a. Preparation: Responsibility: Hospital Social Worker and Case Expeditor

In the week prior to the scheduled transition, the CE and hospital should work collaboratively to gather documents required at discharge and as a part of the TFC Clinical Records Checklist (Part 2). Such documents include the individual's vital records, physician's orders, inventory lists, discharge summaries, and personal funds. The hospital should prepare two copies of all documents, with one copy each given to the provider and the Case Expeditor at the discharge meeting.

As the individual nears transition, the Treatment Team and provider should work collaboratively to determine the best approach for the individual to say good-bye to friends, other peers, and staff. In keeping with a person-centered process, it is important for individuals to have the opportunity to adjust to changing relationships and strategize methods to maintain contact with friends and others.

8.b. Hospital Discharge Meeting: Responsibility: Hospital Social Worker and Case Expeditor

On the day of discharge, the Transition Team convenes for the final discharge meeting, which serves as a final review and confirmation of all transition supports and required arrangements for the individual. The Transition Team should consider the individual's level of involvement at this meeting, as it generally lasts for an extended period of time and primarily involves records review.

At the discharge meeting, hospital staff should inform the provider of the individual's current health status with any issues occurring since their most recent interaction or home visit. In addition, the hospital and Field Office nurse should count all medications to be given to the provider and confirm accuracy of physician's orders. The Case Expeditor will then confirm follow-up medical appointments and will review all available documentation, as required by the Clinical Records Checklist, for completeness. The provider is given the originals of all vital documents and copies of all other documentation for filing and proof of discharge for the Social Security Administration. The Field Office provides copies of the signed and approved DMA-6³⁶ and MAO Communicator³⁷ (if residing on a unit that bills Medicaid) to the provider and designated hospital staff member.

Following the meeting the individual is transported to their new home, along with their personal belongings and any adaptive equipment. Ensuring the individual's belongings and equipment arrive to the home on the day of transition is a collaborative effort between the Provider, Hospital, and

8.c. Post-Discharge Meeting Activities: Responsibility: designated Hospital staff member
The designated hospital staff member should submit the following documents to the Level of Care email box (LevelofCare-Administration@dbhdd.ga.gov):

1. Physical address of the home the individual is transitioning to
2. Approved DMA-6
3. DMA-59³⁸ if applicable
4. MAO Communicator, with provider address for annual recertification written in remarks if applicable
5. Statement of Income updated per current hospital records

8.d. Financial Resources: Social Security: Responsibility: Provider

On the day of transition – but no later than three business days thereafter – the provider should either submit the Change of Payee form online or make arrangements to visit the local Social Security Administration to request the change.

Forensic individuals must be escorted by the provider to the Social Security Administration on the day of discharge and should provide copies of the Discharge Summary and court order to activate benefits.

³⁶ DMA-6, Appendix C.17

³⁷ MAO Communicator, Appendix C.18

³⁸ DMA-59, Appendix C.19

Chapter 3: Post-Transition Activities

In the Post-Transition phase, the community team, to include the individual, support network, provider(s), Support Coordination, and Field Office staff, routinely review, evaluate, and, as needed, modify the plans developed to support the individual to both establish a meaningful life in the community and to maintain health and well-being. Monitoring and service reviews from Support Coordination and Field staff, respectively, should also promote provider development and consider the measurable indicators of a “successful transition,” as reflected Appendix A.2. In this chapter, the following domains will be reviewed:

- DBHDD Transition Documentation
- Service Review and Technical Assistance
- Enhanced Support Coordination: ISP Reviews and Monitoring
- Financial Resources
- Forensic Process

1. DBHDD Transition Documentation:

1.a. Guide to Community Transitions: Responsibility: Case Expeditor

The CE is responsible for uploading the final “Guide to Community Transitions from State Hospitals” form to the electronic database as documentation of all activities occurring throughout the individual’s transition. The Pre-Transition and Transition section must be uploaded within 7 days of transition; then, upon completion of the Post-Transition section, the CE must upload the form in its entirety to the electronic database within 95 days of transition.

1.b. Transition Fidelity Committee Documents: Responsibility: Case Expeditor

Within three business days of transition, the CE must obtain the required signatures from the Office of Transition Services and upload the second part of the “Clinical Records Document Checklist” (items 42-61) to the electronic database and to the TFC for signature.

1.c. Transition Activities: Responsibility: Case Expeditor

All transition activities must be documented in the Hospital Tracking section of the electronic database following discharge from the hospital. The Transition Plan must be updated within five business days after transition and uploaded to the electronic database.

2. Service Review and Monitoring: Responsibility: DBHDD Clinical staff

2.a. Frequency:

At regular intervals post-transition, DBHDD clinical staff – primarily nurses and Behavior Specialists from the Field Office’s Intake & Evaluation Office and Regional Quality Review (RQR) Team – use the “Service Review and Technical Assistance” form³⁹ to assess services and evaluate fidelity to required Community Care Plans across a

³⁹ Service Review and Technical Assistance form, Appendix D.1

variety of areas, to include health & safety, environmental, medical, and behavioral supports. In addition, the staff interviews the individual to obtain his/her perspective on their transition, care, and support from the provider. These reviews occur on the day of transition, 48 hours, then on days 9, 16, 23, 30, 60, 90, and 120, and again at 6 months, 12 months, 18 months, and 24 months post-transition. Reviews could occur more frequently based on the individual's clinical need and level of needed provider support.

2.b. Reliability:

To assure reliability of assessment by staff and consistency in approach, interpretive guidelines⁴⁰ were developed to further explain the context of each question and to prompt the consideration of additional factors.

To foster provider support, staff should approach these reviews using a strengths-based approach, while not compromising the care to the individual. In addition, to the extent possible, DBHDD staff and Support Coordination should make joint visits. In doing so, providers are encouraged to utilize a team approach to problem-solving, wherein the Field Office and DBHDD staff not only instruct but also assist. To aid the provider in successfully supporting the individual, staff should exercise transparency in their reviews by presenting the outcome of their "Service Review and Technical Assistance" form to the provider immediately. Then, as staff provides recommendations, to include interventions, training, and technical assistance, the provider can obtain real-time responses to questions and/or concerns about any feedback. In instances in which the individual's health, safety, and well-being are in jeopardy, staff must intervene with necessary action, consult Field Office leadership, and coordinate subsequent visits to ensure standards are being met.

2.c. Documentation:

Upon completion, the "Service Review and Technical Assistance" form will be uploaded to the electronic database.

3. Enhanced Support Coordination: Monitoring and ISP Reviews: Responsibility:
Support Coordination

Enhanced Support Coordination is initiated upon an individual's discharge from a state hospital. Following discharge, plays a critical role in monitoring, assessing, and evaluating the implementation of such plans and coordinating additional services as needed. Responsibilities of Support Coordinators assigned to Enhanced Support Coordination include on-site monitoring, with coaching and referrals as indicated, and coordination of ISP meetings.

3.a. Monitoring:

Support Coordinators are responsible for monthly "monitoring participants in their community residence and all other areas where services are provided, identifying that the participant's needs are being addressed, recognizing any emerging or emergency

⁴⁰ Service Review and Technical Assistance Interpretive Guidelines, Appendix D.2

needs that the participant has developed, and making appropriate referrals to the appropriate team members, either on a state, field, local, and/or provider level.”⁴¹

The “Support Coordination Monitoring Tool”⁴² documents findings across seven focus areas: environment; appearance/health; supports and services; behavioral/emotional; community; financial; and satisfaction. Support Coordinators will utilize the “Recognize and Refer” model during all monitoring visits. In this model, the Support Coordinator can make “clinical” or “non-clinical” referrals to the Field Office and ICST to address unmet needs, issues, and/or concerns.

As outlined in the Support Coordination and the Transition Process training manual, *clinical referrals* include emergent and emergency medical situations, health and safety risks, and behavioral concerns. *Non-clinical referrals* include environmental concerns, lack of services as described in the ISP, other deficits in ISP implementation, and identification of the need for non-emergency additional support, services, and/or resources.

Support Coordinators will utilize the “coaching” technique, as appropriate, with provider staff when monitoring. As defined in the training manual, coaching is the provision of “positive and/or negative feedback to a direct service provider and/or provider, during on-site monitoring visits, when an issue(s) is identified that can be resolved during the monitoring visit, or the issue is a one-time concern.” Coaching items include “those supports and/or tasks that do not indicate the need for a clinical or non-clinical referral.”

3.a.i. Documentation:

Monitoring tools should be uploaded to the electronic database within 48-hours of completion, except when clinical referrals are made in which case the tool must be uploaded within 24-hours.

3.b. ISP Reviews:

In addition to routine monitoring, the individual’s Support Coordinator is responsible for the coordination of ISP reviews at 30 days, 90 days, and 180 days post-transition. The Support Coordinator will convene the individual’s community team to review and discuss all available relevant documentation, to include clinical assessments and recommendations following medical appointments; the individual’s satisfaction with services, goals, and objectives; and implementation and appropriateness of Community Care Plans.

3.b.i. Documentation:

After the ISP review, the Support Coordinator should finalize the ISP addendum within 7 days and upload to the electronic database.

4. Financial Resources:

⁴¹ Support Coordination and the Transition Process training manual, November 2014

⁴² Support Coordination Monitoring Tool, Appendix D.3

4.a Prior Authorizations: Responsibility: Field Office Operations Analyst

The Department of Community Health is responsible for the reimbursement of Medicaid providers, and, as a result, all waiver services require prior authorization. The prior authorization dictates the amount paid to providers for specific services. The Field Office Operations Analyst (OA) reviews the individual's ISP and budget to develop the prior authorization accordingly.

The OA also checks the "Georgia Medicaid Medicare Information System" (GAMMIS) weekly to ensure that the individual's Medicaid code has been converted to the correct community Medicaid code. If the OA encounters any delays in the processing of the prior authorization that may result in lapsed funding to providers, (s)he should notify the CE as soon as possible. The CE will communicate this information to the Office of Transition Services, who can assist with transition funds as needed, to pay for associated costs and offer help to provider and CE to resolve Medicaid issues.

4.b. Money Follows the Person: Responsibility: Case Expeditor

Following the transition, the CE must submit the "MFP Day of Discharge Checklist"⁴³ to the MFP Administration electronic mailbox (CC MFP Coordinator) to ensure that funding is secured and all required documentation is in place. The MFP Coordinator also communicates with the provider to obtain the vendor payment form and copies of all receipts related to approved transition expenditures. The CE is responsible for educating the provider about MFP resources available to the individual for the 12-months following transition.

4.c. Monitoring of Medicaid Eligibility: Responsibility: Support Coordinator

The Support Coordinator is primarily responsible for monitoring the individual's continued Medicaid eligibility upon transition, in collaboration with the provider. The Support Coordinator will document findings monthly; if the individual is not Medicaid eligible, (s)he will work to resolve any issues impacting eligibility with the provider and designated representatives.

5. Forensic Process:

5.a. Forensic Community Coordinators: Responsibility: Office of Forensic Services

Forensic Community Coordinators are assigned to individuals adjudicated either Not Guilty by Reason of Insanity (NGRI) and conditionally released or have been adjudicated Not Competent to Stand Trial and Not Restorable (IST-NR) and released on civil outpatient commitment/bond with mental health monitoring. Their responsibilities include:

- Regular contact with individuals to monitor clinical status and assess progress in community integration
- Monthly contact with community agencies to verify attendance and participation and ascertain status
- Documentation of all client contacts and community agency contacts

⁴³ Money Follows the Person Day of Discharge Checklist, Appendix D.4

- Provide monthly reports to the respective Hospital/Community Forensic Director(s) regarding an individual's progress in relation to their Recovery Plan
- Provide to Forensic Program Associate at the hospital(s) all monthly contact notes for accurate entry into AVATAR
- Track and schedule dates for Court updates. Coordinate with forensic psychologist to complete status update reports for the Court
- Attend court hearings as needed

As reflected above, the Forensic Community Coordinator will make routine contact with the individuals and their providers.

Appendices

This list reflects all of the referenced forms, policies, processes, etc., included in the manual.

A. Introduction:

1. Guide to Community Transitions from State Hospitals
2. Transition Process Map
3. Definition of successful transition

B. Chapter 1:

1. Criteria for Placement on Active List
2. Transition Process Overview form
3. DBHDD Application for Intellectual/Developmental Disabilities Services
4. Medicaid and Social Security Process Map – Attachment A, Statement of Income form
5. Medicaid and Social Security Process Map
6. Hospital Process for Education on Selection of Support Coordination Agency for Individuals Who Are Eligible for DD Services
7. Support Coordination Services pamphlet
8. Support Coordination Selection form
9. Person Centered Description form

10. DBHDD Authorization for Release of Information
11. Initial Housing Checklist
12. Guide to Choosing a Housemate
13. Housemate Selection Process
14. Housemate Matching - Pre-Transition Activities

C. Chapter 2:

1. Transition Fidelity Committee Clinical Records Documents for Transition and Discharge
2. Process for Requesting Documents for Transition
3. Guidelines for Transitional Planning
4. Health Facilities Regulation's licensing standards
5. Site Inspection Checklist
6. Placement Readiness Form
7. *Comprehensive Transition Training Process*
8. Department of Community Health – Money Follows the Person Transition Protocols, Appendix B – MFP Services Table
9. MFP Transition Agreement
10. MFP Release of Health Information
11. MFP Informed Consent
12. Transition Funds Request form
13. Transition Funds Request Work Flow Process
14. Transition Fidelity Committee Frequently Asked Questions and Process
15. Transitional Field Review form
16. Forensic Transitional Field Review form
17. DMA-6
18. MAO Communicator

19.DMA-59

D. Chapter 3:

1. Service Review and Technical Assistance form
2. Service Review and Technical Assistance Interpretive Guidelines
3. Support Coordination Monitoring Tool
4. Money Follows the Person Day of Discharge Checklist