

## Kentucky ICF/IID Facility Transition Planning and Process Overview

The Cabinet for Health Services believes that all individuals should have the opportunity to live in an environment that offers them opportunities for choice and self-direction.

Focus of transition process:

- provide training in preparation for a move to an alternative environment that provides individuals with increased choices
- the practice will be complete in nature
- transition will begin at the time of admission and will continue through a process of ongoing assessment and planning for each individual throughout their residence at the ICF/IID facility
- be a key component for treatment planning and will include training and building of skills to enable individual's to move into a community placement, education of the family/guardian regarding community alternatives and appropriate transitional planning and supports to ensure the success of the move.

### ADMISSION TO ICF/IID FACILITY:

- No ICF to ICF transition will occur without express written consent of the Secretary of the Cabinet for Health and Family Services.
- The Department for Behavioral Health, Developmental and Intellectual Disabilities, Division of Developmental and Intellectual Disabilities (DDID) will make necessary referrals for facility admission as needed. Final admission to the ICF/IID will be approved in writing by the Commissioner of Department for Behavioral Health, Developmental and Intellectual Disabilities and the Director of Division of Developmental and Intellectual Disabilities.

### TRANSITION PROCESS

#### **Provider Selection**

- The family/guardian will review the list of community providers.
- Referral packets are sent out to all providers as identified/requested by the family
- Transition staff follow up with providers regarding their willingness/capacity to support the individuals referred
- Pre-choice visits are scheduled to assist in the selection process
- Pre-selection meetings are scheduled as needed to assist in the provider selection process.
- Transition Facilitator submits the written request for allocation of SCL funding to DDID. The request packet shall include a completed MAP-620 form, treatment team recommendation for community placement, and supporting documentation (i.e., Psychological or other treatment documentation supporting the diagnosis)

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### **Planning Meeting:**

- Upon selection of a community provider and subsequent acceptance by the community provider, the facilitator will schedule the *Planning Meeting*.
- The planning meeting will be scheduled within seven (7) business after the selection of the community provider.
- Planning meeting will be to identify the supports that will be necessary to support the individual in the community.
- The Transition Plan will begin to be drafted following the initial planning meeting.
- The team will decide the number of planning meetings needed to insure a safe and successful transition. This will vary on an individual basis.

### **Plan Development and Review:**

- Draft Transition plan will be developed within 3-10 business days of the planning meeting.
- Director of Transition Services or their designee will review and provide feedback to the facilitator within 1-3 business days.
- All needed additions and/or corrections made within 1-3 business days.
- Transition team members provide feedback within 10 business days.
- Staff cross training dates and times are scheduled. Community provider comes to the facility to work with the staff and individual and receive cross training to safely support the individual.
- Day visit is scheduled (number of visits is dependent on how the individual does/adjusts)
- Overnight visit is scheduled after the staff cross training has occurred. (number of visits is dependent on how the individual does/adjusts)
- Throughout the planning process, activities critical to the success of the transition will be identified.

**Planning/Discharge Meeting** is scheduled to ensure that the transition process is on track for the move. The meeting will include a discussion about:

- 1) Cross-training of staff has been completed.
- 2) Visits have occurred and feedback is received and utilized to make any needed revisions to the transition plan.
- 3) Adaptive equipment that has been identified for purchase has been prior authorized through the MAP 95 process.
- 4) The final Transition Plan has been distributed and is accurate.
- 5) Move date has been confirmed
- 6) Date for closure call has been identified (the *closure call* is completed prior to the move. The purpose of this call is to finalize any details that are still outstanding and to ensure that all plans are in process.)
- 7) After the closure call, the facilitator will be responsible for confirming with the team leader the scheduled date and time for the move.

### **Day of the Move:**

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- Staff from the facility will ensure that the items on the checklist are confirmed for transfer and are packed for the move.
- Upon arrival at the community home, the community staff will verify that all items have arrived and will sign off on the checklist indicating receipt.
- The transfer of supports must take place at the individual's new home in the community. The facility staff will remain at the home long enough to ensure that the individual has settled into their home. The facility staff should remain sensitive to the individual's specific needs and should judge the length of time they stay upon the individual's adjustment.

### **After the Move:**

- In an effort to provide an opportunity for a successful transition to community life, the transition will not be considered complete for one year after the move. Monitoring activities include:
  - ✓ Facility transition facilitator will make phone contact with the Support Coordinator the day after the move to obtain feedback on the move and how the individual seems to be adjusting.
  - ✓ The facility transition and other appropriate facility staff in conjunction with the DDID field staff will complete pre-arranged visits. At a minimum these visits should occur at 30, 60 and 90 days, then 6 months and 12 months to monitor adjustment and ongoing supports .
  - ✓ The staff from the facility will complete the appropriate questionnaire related to the visit, have it signed by all participants
- Issues identified during the follow up visits will be addressed by the appropriate Facility staff or DDID field staff, whichever is appropriate.
- The transition staff and other appropriate facility staff will provided needed technical assistance to the community provider to assist in addressing any issues that have been identified related to the transition.
- Follow up information will be tracked in a database with routine reports being reviewed through the ongoing Quality Assurance process for continual improvement in the process.
- The DDID field staff will provide technical assistance to address any provider issues identified during the follow up visits.
- **Monitoring activity should an individual move from the community to a psychiatric setting during the first year of transition:**
  - Onsite visits shall occur as identified above unless otherwise contraindicated.
  - Should visits be contraindicated, telephone follow up by the Transition Facilitator and DDID field staff will occur every 30 days for the first 90 days.
  - Follow up information will be shared with the appropriate facility staff. Any needed technical assistance will be provided to assist with stabilization and return to the community setting.
  - Telephone follow up will continue to be made by the DDID field staff on a monthly basis to check the status of the individual and anticipated timeframe for return to the community.

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- When appropriate, transition planning will commence to assist the individual to return to the community or return to Facility if appropriate to implement treatment and strategies for the individual's return to the community.
- Monitoring will continue according to the above
  
- **Monitoring activity should an individual need to move from the community back to the ICF/IID setting:**
- Facility transition staff will be involved from the date of readmission to ensure that transition planning is incorporated into the individual planning process.
- Issues will be identified that resulted in the previous failed community placement and strategies put into place to address these issues and other identified barriers to community placement. These strategies will be incorporated into the ILP for the individual.
- The transition process will be followed to ensure a smooth and successful transition.
- Monitoring will be initiated as outlined above immediately upon the new transition to the community.
- One year after the move, the transition is considered to be complete.
- Thereafter, the monitoring will continue under the normal waiver ongoing monitoring and Quality Assurance process.