

Transition Planning

Transition planning involves ongoing collaboration between the individual, their guardian and family, staff from the Developmental Center, Managed Care Organizations (MCO), care coordinators, transition coordinators, NC START (adults only), and both residential and community service providers.

MCOs, in particular, can support individuals returning to communities of their choice from developmental centers by assessing the community need and residential provider capacity to address the needs of individuals with intellectual and developmental disabilities (IDD). This includes individuals with complex behavioral and/or mental health challenges, identifying gaps in service, and planning to address those service gaps.

This document should be used as a guide during the transition planning process.

Transition planning shall include the following:

Developmental Center Responsibilities:

- Provide a list to the MCO each quarter that identifies individuals or their guardians who have expressed interest in exploring community living, have a current Memorandum of Agreement (MOA), or are in a time-limited specialized program and have an identified discharge date within six months.
- For the Money Follows the Person (MFP) program, the Developmental Center transition coordinator will notify the respective MCO IDD Clinical Director if an individual/guardian wants to participate in the MFP project.
- Facilitate transition planning meetings at the Developmental Centers on a quarterly basis, or more often if indicated, between the individual and guardian, MCO care coordinator or other identified person, NC START team (when the individual has behavioral challenges and the guardian has given consent), and identified staff of the center for the transition population.
- Collaborate with the MCO care coordinator or other identified person to explore potential residential settings and other appropriate services and supports.
- Provide all necessary clinical, habilitative and other relevant information, including preferences of the individual. This information may be used to incorporate into the transition plan as appropriate.
- Provide a recommendation regarding the individual's staffing needs and preferences (ratios, training, adaptations, etc.).
- Complete a Community Care of North Carolina (CCNC) I/DD Medical Home Linkage Referral Form once a residential provider has been identified and if the individual needs assistance in linking to a primary medical home.
- Collaborate with the NC START teams and the MCO care coordinator or other identified person in the development of crisis plans. Crisis plan will include behavior guidelines recommended by the Developmental Center for those individuals with behavioral challenges.
- Arrange for the Developmental Center psychologist, in collaboration with the MCO care coordinator or other identified person, to contact the identified community psychologist, to discuss behavioral challenges and planning as needed.
- Work with MCO care coordinator or other identified person, and the community-based support staff to develop a residential staff training plan specific to the individual that is inclusive of strategies for addressing the needs of the individual in the context of a less structured community environment. The staff training plan shall be included as a component of the Transition Plan.
- Coordinate with the identified residential provider for their staff to spend time getting to know the individual and shadowing Developmental Center staff prior to discharge.
- Provide center-based and community-based (if appropriate) staff training specific to the individual and based on the training needs of the residential and other appropriate community staff prior to discharge. Training should be done in collaboration with the NC START team, if involved.
- Coordinate with the MCO care coordinator or other identified person, identified provider(s) and the guardian for transition visits by the individual to the residential and other community settings, The individual will be

accompanied by the center staff during these transition visits For individuals with behavioral challenges NC START staff will be included in the planning process.

- Provide staff to accompany the person on the first day in the community, if the transition planning process determines this staffing is needed.
- Provide ongoing training, consultation, and support for a minimum of 30 days or as agreed upon during the transition planning process.
- Participate in post-discharge meetings with the MCO care coordinator or other identified person, residential provider, guardian, and NC START team as appropriate. At a minimum, these post-discharge meetings must occur within 30 days, three months and six months post-discharge.

MCO Care Coordinator or Transition Coordinator:

- Identify or develop potential residential settings based on the individual's and guardian's needs and preferences.
- Participate in transition planning meetings on a quarterly basis, or more often if indicated, for those at the developmental centers who have expressed interest in exploring community options, have a current MOA, or who are in a time-limited specialty program.
- Ensure that services are available to adequately support the needs of the individual in the community per the Memorandum of Agreement signed by the MCO.
- **Develop a transition plan** in collaboration with the residential provider, Developmental Center, NC START team, and other individuals who know the person well. The Transition plan will **include timelines** for the transition process. A potential date for identifying a residential provider should be included in the initial transition plan timeline. **Provide a copy of the transition plan to all parties involved in the transition process. It is strongly recommended by the Division of State Operated Healthcare Facilities (DSOHF), the Division of Medical Assistance (DMA), and DMH/DD/SAS that the NC Transitions to Community Living: Transition Planning Tool format is used to document the transition plan.**
- In collaboration with the individual, guardian and treatment team explore, identify or develop a residential setting and provider agency that exhibits the skills, abilities, and commitment to meet both the needs and preferences of the individual.
- Identify and work with the identified community providers to develop, based on information shared during planning meetings, a meaningful day for the person. This is to insure that services and supports address the person's choices are in place when the person moves to the community.
- Arrange on site evaluations as needed, including Occupation and Physical Therapy, to assess and provide recommendations regarding environmental safety when a residential provider is identified, prior to discharge, and to ensure health and safety.
- Ensure that community medical services providers, and other professional services such as psychiatric and psychological are identified and all necessary appointments are arranged prior to discharge.
- For individuals moving to the community with waiver funding/slot, ensure that the waiver Person Centered Plan/Individual Support Plan (ISP) is completed within the required timeframe and **is both authorized and ready for implementation on the day of discharge.** Provide a copy of the approved PCP/ISP to all parties involved prior to the transition.
- For individuals moving to a community ICF-IID facility, the ICF-IID Qualified Developmental Disability Professional (QDDP) will coordinate and facilitate post-discharge meetings with developmental center staff, provider agency, guardian, the NC START team (if appropriate), and MCO as determined during the transition planning process and identified in the transition plan.
- Coordinate and facilitate post-discharge meetings with Developmental Center staff, MCO care coordinator or transition coordinator, provider agency, guardian and NC START team (if appropriate) when appropriate or at a minimum of within 30 days, three months and six months post-discharge.

Provider Responsibilities:

- Participate in all transition planning meetings when identified as the service provider.
- Accept recommendations of the treatment team, MCO Care Coordinator or other identified person, and guardian regarding staffing and support needs.
- Arrange for staff who will be working with the individual to attend training specific to the individual that is conducted at the Developmental Center and in the community.

- Coordinate with the Developmental Center, MCO Care Coordinator or other identified person, and the guardian for transition visits by the individual to the residential setting and/or other community service settings. The individual will be accompanied by the center staff during these transition visits. For individuals with behavioral challenges, the visits may also include the attendance of the NC START team.
- Contact the Developmental Center or the NC START team, MCO Care Coordinator or other identified person if behavioral challenges arise, as agreed upon during transition planning meetings. **When considering medication changes for the individual within the first six months, contact the Developmental Center for consultation.**
- Participate in post-discharge meetings with Developmental Center staff, MCO Care Coordinator or other identified person, the guardian, and the NC START team (if appropriate) as appropriate or at a minimum of within 30 days, three months and six months post-discharge.

NC START Responsibilities:

- Participate in the final quarterly transition planning meeting, to the extent possible, for those for whom a residential setting has been identified and a transition plan developed.
- Collaborate with the Developmental Center clinical staff for the exchange of medical, psychological, and psychiatric information to support the development of crisis plans that include behavior guidelines recommended by the Developmental Center. **Provide a copy of the crisis plan to all parties involved in the transition process.**
- Participate in transition visits to the residential and other community settings to the extent possible, accompanied by the Center staff.
- Provide staff to accompany the person on the first day in the community, if determined to be needed during the transition planning process.
- Arrange for visits to the NC START respite home if appropriate and determined to be needed by the transition planning team.
- Participate in post-discharge meetings with Developmental Center staff, provider agency(s), MCO Care Coordinator or transition coordinator, and guardian as appropriate or at a minimum of within 30 days, three months and six months post-discharge.

Family/Guardian Responsibilities:

- Participate in transition planning meetings on a quarterly basis or more often if indicated.
- Collaborate with the MCO care coordinator or other identified person to explore potential residential settings and other appropriate services and supports, including visitation to the residential setting if appropriate.
- Participate in development of a transition plan in collaboration with the residential provider, Developmental Center, NC START team, and others as appropriate.
- Assist the transition planning team in identifying what constitutes a meaningful day for the person.
- Participate in transition visits to the residential setting as appropriate.
- Participate in post-discharge meetings when appropriate but at a minimum of within 30 days, three months and six months post-discharge.