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Reference Number:	502-10-DD
Title of Document:	Transition of Individuals from DDSN Regional Centers to Community
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Effective Date:	September 16, 2021 (**REVISED**)
Applicability:	DDSN Regional Centers, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Providers, and Residential Habilitation Providers

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I. PRINCIPLES AND PURPOSE

The South Carolina Department of Disabilities and Special Needs (DDSN) promotes the provision of services to individuals in a manner and setting which:

- Effectively meets the full array of the persons' needs;
- Individualizes services to meet the unique needs of the individual;
- Promotes individual choice and decision-making; and
- Is the least restrictive alternative.

This policy is intended to establish a procedure for persons being served in DDSN's Regional Centers to move to community settings in a fashion which is in keeping with DDSN's service principles.

II. LONG RANGE PLANNING

A. Annual Service Planning Meeting

1. At the annual Individual Support Plan, the DDSN Regional Center Qualified Intellectual Disability Professional (QIDP) will initiate a discussion about the service alternatives which are available to the person in the community (DDSN Directive 700-03-DD: Informed Choice in Living Preference (ICFs/IID)).

2. The DDSN Regional Center QIDP will offer both a written and pictorial example of the community services available to the individual and his/her family during this meeting.

3. A record will be made in the person's file of individual/family preferences regarding a move to the community.

B. Community Visits

1. The DDSN Regional Center QIDP will arrange for the individual/family to visit providers with available community services in the geographic areas preferred by the person/family when the individual/family expressed desire to move to the community.

2. The DDSN Regional Center QIDP will make a record of the outcome of these visits in the person's file.

C. Summary of Planned Transitions

1. A cumulative list of persons residing in DDSN Regional Centers desiring to live in the community will be maintained and shared with providers of community services on a quarterly basis (DDSN Directive 700-03-DD: Informed Choice in Living Preference (ICFs/IID)).

2. This list of persons desiring to live in the community will contain the initials of each person, a listing of the geographic preference of the individuals, and general information about the needs of the person.

III. TRANSITION SELECTIONS

A. New Services

1. When DSN Boards/Contracted Residential Habilitation Providers plan to develop additional residential services, they must identify specific persons to be served. These individuals must live at one of the DDSN Regional Centers or be on the DDSN Critical Needs List (DDSN Directive 502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Setting).

2. When planning to develop new residential services to serve specific individuals residing at a DDSN Regional Center, the DSN Board/Contracted Residential Habilitation Provider should focus on those persons who have expressed a desire to move to the community and every effort should be made to accommodate individual house-mate preferences and compatibility.

B. Vacancies

1. The DSN Board/Contracted Residential Habilitation Provider will make an effort to identify a pending vacancy prior to its occurrence (DDSN Directive 502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Setting).

2. The DSN Board/Contracted Residential Habilitation Provider will review persons on the DDSN Critical Needs List and the list of individuals living at a DDSN Regional Center who have expressed a desire to live in the community to determine who would be most compatible in the home with a pending vacancy.

IV. TRANSITION PLAN DEVELOPMENT

A. Within 30 days of the identification of the person to move to a specific community location, the DDSN Regional Center QIDP will arrange a meeting to develop a transition plan for the individual.

1. The transition plan will be developed by the DDSN Regional Center QIDP which will include the following:

a. A schedule for the person to make overnight visits to the new home;

b. A schedule for the DSN Board/Contracted Provider direct support staff to observe the individual being served at the DDSN Regional Center;

c. A projected date for the individual to move to the community;

d. Identification of any obstacles or prerequisites to the person’s successful move to the community to include review of previous unsuccessful community service experiences;

e. A list of “must have” conditions which are necessary for the individual to succeed in the community setting;

f. Identification of the primary coordinator for the DDSN Regional Center and the DSN Board/Contracted Provider to expedite the move; and

g. A schedule of residential, day and recreational activities that the individual will follow after moving to the community residence.

B. To assure the development of a comprehensive service plan the following persons should be in attendance at this meeting:

- Individual;
- Individual's family (unless the individual requests the family not to be present);
- Individual's invited friends; and
- The individual's selected case management provider in the community.

Regional Center Staff (unless the individual requests these staff not to be present)

- Qualified Intellectual Disability Professional (QIDP);
- Direct Contact Staff;
- Nurse (if health needs are present);
- Psychologist/Behavioral Specialist (if behavioral needs are present);
- Physical/Occupational/Speech/Assistive Technology Therapist (if therapy needs are present);
- Other Interdisciplinary Team members as appropriate; and
- District Office Personnel (i.e., Assistant District Director, Compliance Coordinator, Program Coordinator for Case Management).

DSN Board/Contracted Residential Habilitation Provider (unless the individual requests these staff not to be present)

- Case Manager;
- Direct Contact Staff;
- Nurse (if significant health needs are present);
- Psychologist/Behavioral Specialist (if significant behavioral needs are present).

V. TRANSITION PLAN IMPLEMENTATION

A. Community Transition Visits

1. The individual will make at least two (2) overnight visits to the community residence prior to moving unless the transition plan stipulates fewer visits would be in the best interest of the individual.

2. The individual should spend time in both the residence and the day support settings.

3. DDSN Regional Center staff familiar with the individual will transport the individual to the community residence and accompany the individual on a tour of the residence and anticipated setting for vocational/day supports.

4. DSN Board/Contracted Residential Habilitation Provider staff responsible for coordinating the transition will have a follow-up discussion with the DDSN Regional Center QIDP regarding the outcome of the visit.

B. DSN Board/Contracted Residential Habilitation Provider Staff Training

1. The DSN Board/Contracted Residential Habilitation Provider direct support staff who will be serving the individual in the community will directly arrange to receive training in meeting the unique needs of the individual from DDSN Regional Center direct support staff and will observe services being provided to the individual at the DDSN Regional Center (a minimum of two (2) staff must participate in this training).

2. As applicable, the DSN Board/Contracted Residential Habilitation Provider nurse/behavioral specialist/therapist/program manager will arrange to receive training in meeting the unique needs of the individual from the DDSN Regional Center nurse/behavioral specialist/therapist(s) prior to the individual moving if the individual has significant health, behavioral or therapeutic needs.

C. Specialty Community Supports (if significant health, behavioral, and or therapeutic needs exists)

1. The DSN Board/Contracted Residential Habilitation Provider will identify providers of specialty services (e.g., physician, neurologist, dentist, psychologist, physical therapist) necessary to meet the needs of the individual prior to the move.

2. The DSN Board/Contracted Residential Habilitation Provider will identify and arrange for any needed environmental modifications and or secure assistive technology to accommodate the individual prior to the individual's transition to the community residence. DDSN Regional Center staff will provide consultation and assist the DSN Board/Contracted Residential Habilitation Provider to determine necessary modifications. Requests for assistance with environmental modifications and or assistive technology should be routed to the respective DDSN District Director.

3. The DSN Board/Contracted Residential Habilitation Provider will identify and purchase within 30 days after the individual moves any adaptive equipment/devices needed by the individual that will not accompany the individual when he/she moves to the community.

4. The DSN Board/Contracted Residential Habilitation Provider will assure that arrangements have been made with a local physician and pharmacy to provide necessary prescription medications to the individual within seven days after move.

5. The DSN Board/Contracted Residential Habilitation Provider will evaluate available internal and external capacities to accommodate any behavioral or medical emergencies that the individual might experience.

6. The DSN Board/Contracted Residential Habilitation Provider will assure that arrangements have been made to accommodate the dietary needs of individual, to include consultation with a dietician or other medical practitioner with dysphagia expertise (if applicable).

D. Discharge Planning/Waiver Enrollment

The DSN Board/Contracted Residential Habilitation Provider, in coordination with the DDSN Regional Center QIDP, will complete all applicable activities detailed in DDSN Directive 738-01-DD: Discharge Planning for those leaving ICF/IIDs and Enrolling in the ID/RD Waiver, if the individual is moving to an ID/RD waiver funded setting.

E. Reimbursement

Payment for services provided by DSN Board/Contracted Residential Habilitation Provider will be made in accordance with applicable DDSN Directive 250-10-DD: Capitated Payment System for Services, or terms of applicable RFP solicitation (see Supply and Services Procurement section of DDSN website).

F. Final Preparations

1. Regional Center

a. The Psychologist will assure all behavior support plans and corresponding data are current and filed in the individual's permanent record prior to the scheduled move.

b. The Nurse Manager will assure all medical records (including the physician discharge summary) are current and filed in the individual's permanent record prior to the scheduled move.

c. The Nurse Manager will assure that at least a 14-day supply of all prescription medications, dietary supplements and medical supplies is provided to the DDSN Regional Center QIDP on the day of the scheduled move.

d. The Nurse Manager will assure that all medical evaluations and immunizations are current and recorded in the individual's chart prior to the scheduled move.

e. The Nurse Manager will assure that tuberculosis screening is completed in accordance with DDSN Directive 603-06-DD: Tuberculosis Screening.

f. The financial staff will assure that $50.00 (if available) from the individual's personal account is withdrawn and made available to the DDSN Regional Center QIDP on the day of the scheduled move.

g. The QIDP will assure that all the individual's clothing and personal possessions are recorded in a written inventory and packed on the day of the scheduled move.

h. The records management staff will provide a copy of the individual's discharge summary, to include the post discharge plan of care, to the Case Manager/QIDP on the day of the scheduled move.

i. The QIDP will complete a DDSN Regional Center Individual Transition Checklist (see ATTACHMENT) verifying that all preparations have been made for the individual to move to the community residence before the day of the scheduled move. The respective Facility Administrator will review the Transition Checklist and if all preparations have been made will approve the move and send to the DDSN Regional Representative for review/approval.

j. The QIDP will complete and assure all interdisciplinary team members sign a discharge plan.

k. Anyone who believes that there should be a delay in the individual's move to the community should immediately notify the QIDP. The QIDP will convene a meeting of the transition team to review the matter and if warranted the move will be delayed.

l. The QIDP (or other DDSN Regional Center staff designated by the Facility Administrator) will transport the individual and his/her clothing, possessions, medication and personal funds to the community residence, unless other arrangements have been approved by the individual/his/her family, and or the DSN Board/Contracted Residential Habilitation Provider. The QIDP will have the person/the legal guardian and the DSN Board/Contracted Residential Habilitation Provider staff sign for receipt of items in the person's possession.

2. DSN Board/Contracted Service Provider

a. The DSN Board/Contracted Residential Habilitation Provider will assure that sufficient furnishings are available at the residence to accommodate the individual prior to the scheduled move.

b. The DSN Board/Contracted Residential Habilitation Provider will review the Transition Checklist verifying all staff training and specialty

community supports have been secured at least three (3) days before the scheduled move.

c. The DSN Board/Contract Residential Habilitation Provider CEO will sign off on the DDSN Regional Center Transition Checklist and send to the DDSN Regional Representative for review/approval prior to the move.

VI. TRANSITION FOLLOW-UP

A. The DSN Board/Contracted Residential Habilitation Provider will file a request for payeeship for the individual's income (e.g., SSI) to be transferred from the DDSN Regional Center to the DSN Board/Contracted Residential Habilitation Provider/individual within 45 days after the individual moves (if the individual is moving to a non-ICF/IID).

B. The DDSN Regional Center financial staff will notify the Department of Health and Human Services-Medicaid Eligibility that the individual has moved to the community residence within ten (10) days after the individual moves. A copy of the DHHS Form 181 will also be sent to the DDSN Central Office staff responsible for Home and Community Based Medicaid waiver enrollment (if the person is moving to non-ICF/IID licensed home).

C. The DDSN Regional Center financial staff will transfer the balance of the individual's personal funds to the Social Security Administration within 60 days after the individual moves.

D. The DSN Board/Contracted Residential Habilitation Provider will assure that no abrupt change occurs in the individual's medication or diet.

E. The DDSN Regional Center will provide consultation to the DSN Board/Contracted Residential Habilitation Provider to respond to significant behavioral/medical challenges if the DSN Board/Contracted Residential Habilitation Provider has exhausted all internal resources.

F. The DDSN Regional Center will re-admit the individual in the event of a behavioral or medical crisis if all of the following conditions are met.

1. DSN Board/Contracted Residential Habilitation Provider has exhausted all internal resource; and

2. On-site DDSN Regional Center consultation has proven ineffective; and

3. The health and safety of the individual or others is at imminent risk of harm.

4. The DDSN Regional Representative must authorize the re-admission of the individual.

5. The DSN Board/Contracted Residential Habilitation Provider will transport the individual and their belongings to the DDSN Regional Center.

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Commissioner Barry Malphrus
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Barry D. Malphrus
Vice-Chairman

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Stephanie M. Rawlinson
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Stephanie M. Rawlinson
Chairman

To access the following attachments, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

ATTACHMENT: DDSN Regional Center Individual Transition Checklist

RELATED POLICIES:

250-10-DD: Funding for Services
502-01-DD: Admission/Discharge of Individuals to/from DDSN Funded Community Residential Setting
603-06-DD: Tuberculosis Screening
700-03-DD: Informed Choice in Living Preferences (ICF/IIDs)
738-01-DD: Discharge Planning for those leaving ICF/IIDs and Enrolling in the ID/RD Waiver DDSN Case Management Manual