An Information Handbook for
Individuals and Families
Preparing to Transition to New Homes in the Community

April 2024

Introduction

Transitioning from facility-based care to community-based care can be overwhelming for the individual as well as for the parents/legal guardian. Change is not easy and can be intimidating when you do not know what to expect. Don't worry, you are not alone during this process. There are both state staff and community partners here to help you and answer all your questions. The Community Transition Guide was designed to provide practical information to families regarding the discharge process, available service options, and resources in the community. Additionally, your loved one will have a transition team that will include the facility's treatment team, a Community Services Board Support Coordinator, and a Department of Behavioral Health and Developmental Services (DBHDS) staff. This team will help guide you and your loved one as they begin the transition to more integrated options in the community.

DBHDS State Staff

Family Resource Consultant/Manager- The Family Resource Consultant (FRC) and Manager are responsible for screening individuals seeking placement in an ICF/IID. Additionally, the FRC provides information to families, community residential providers and other stakeholders regarding Medicaid Waiver Services and community resources available to support individuals with developmental disabilities and their families.

Community Integration Manager- The Community Integration Manager (CIM) is responsible for coordinating the implementation of policies, procedures, regulations, and other initiatives related to ensuring individuals residing in training centers are served in the most integrated setting appropriate to meet their needs. The CIM provides support and direction for all aspects of the individual's transition to the community, including the post-move monitoring process.

Community Transition Nurse- The Community Transition Nurse (CTN) is responsible for monitoring the screening process for individuals seeking placement in a nursing facility. Additionally, the CTN provides education, support, and guidance to facilities during the discharge process.

Community Partners

Community Services Board- The Community Services Board (CSB) plays an important role in the process of getting people connected to community supports and services. They are responsible for adding your loved one to the statewide Developmental Disabilities' waiver waitlist and completing required paperwork. These services are completed by either a Support Coordinator (SC) or Case Manager (CM).

Peer to Peer Program- The Arc of Virginia provides peer mentoring services to individuals who are 16 years of age or older, and are either on the DD waitlist or receiving DD waiver services.

Family to Family Program- The Family to Family Program is an initiative of the Center for Family Involvement at Virginia Commonwealth University's Partnership for People With Disabilities. This network of families provide assistance with answering questions and identifying community supports.

Children's Intermediate Care Facilities (ICFs/IID)

Preparing for discharge takes time and proper planning. There is no one size fits all approach to planning for your loved one's future. It is the goal of DBHDS to ensure that individuals transitioning to community-based services have a safe and nurturing environment to live and grow. To that end, several processes are in place to help ensure a successful transition for all individuals.

Family Outreach Plan

A Family Resource Consultant will contact the families of children residing in an ICF/IID to develop a Family Outreach Plan. The plan is intended to gather individualized information regarding the child's past experiences with receiving community services and to discuss any preferences, concerns, and questions the families may have regarding discharge. The plan is updated yearly and is used to help guide discharge planning efforts when the family and individual are ready. At any time, the family can request information regarding community options. Discharge planning always begins on the first day of admission. Our goal is to ensure that the discussion regarding discharge planning is ongoing and that each family is provided with the resources and information needed to make an informed decision regarding their child's care.

Discharge Ready/Aging Out

When a child is about to "age out" of a facility (meaning he/she will no longer qualify for services based on age), notification is sent to the local Community Services Board in which

based on the family's primary residence. The notification is sent approximately 120 days prior to the child's "age out" date.

When a child is not "aging out" but rather the family is ready to begin discharge planning, the notification will be sent immediately by the Family Resource Consultant.

After the notification is sent, the parent/legal guardian will be contacted by the Community Services Board to complete the intake process. Also, during this time, a Family Resource Consultant will contact the family to discuss discharge options.

The Family Resource Consultant will provide the family with a list of community options to explore. It is important that the families call the provider(s) to ask questions, learn about the services available, and where appropriate arrange tours of the programs to assist in making an informed decision. Once intake is completed by the Community Services Board, your Support Coordinator can further assist in this process.

Discharge Meeting

After the intake process has been completed, the facility will schedule a discharge meeting. This meeting is attended by the child's treatment team, the parents/legal guardian, the child's assigned Community Services Board's Support Coordinator, the new providers, and a Family Resource Consultant. During the meeting, the child's care will be discussed. The facility's social worker will review a list of equipment and supplies needed for the child's care. Routines and best practices performed by facility staff will be shared with the new provider. The meeting provides a great opportunity for the new providers to hear about the child's support needs and to ask questions. During the meeting, it is customary to schedule several day visits and occasionally an overnight visit for the child to spend time at the new residential provider's home. Additionally, the provider is invited to visit with the child at the facility to observe his/her care and supports for staff's training purposes, and to enable the provider to ask more questions. At the end of the discharge meeting, a tentative discharge date is scheduled.

What's Next

The next couple of weeks will consist of orders being signed and sent off to a Durable Medical Equipment provider where they will be subjected to Medicaid approval. Once approval is received, the orders for equipment and supplies will be filled by the Durable Medical Equipment provider. This process takes time and occasionally has resulted in a delayed discharge date. This is why it is so important not to wait until the last minute to begin discharge planning. Also, during this time, the Support Coordinator will meet with the new provider and your family to develop a person-centered plan. The plan will guide services for the child once discharged.

Unexpected Delays

During active discharge, it is common to experience minor hiccups. Those hiccups may range from a delay in receiving required equipment and supplies needed for your loved one to changes with the provider. Again, don't worry, your team is here to help. The transition team will work

quickly to address any issues that may arise so that your loved one has every opportunity to be successful in the community.

Post Move Monitoring

The Family Resource Consultant will coordinate post move monitoring contacts with the Community Services Board and other involved parties after your loved one has been discharged from the facility. The contacts are intended to check on the individual's well-being and to ensure that all essential supports are in place. Contacts occur at the 10th and 90th day mark. Additional contacts may occur if deemed appropriate by the Family Resource Consultant. Your Community Services Board's Support Coordinator will also provide additional monitoring visits. Please inquire with your Support Coordinator for their schedule of visits.

Adult Intermediate Care Facilities (ICFs/IID)- Privately Operated

The Family Resource Consultant and Manager are here to offer guidance and assistance when your loved one is ready to make the transition from the facility back to the community. Additionally, there are Community Resource Consultants in each region that can assist. Let us know if you have any questions.

DBHDS Contact Information- ICF/IIDs

Benita Holland, PhD
Family Resource Consultant Manager
DBHDS- Transition Network Supports
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Benita.Holland@DBHDS.Virginia.Gov

Josephine Harris
Family Resource Consultant
DBHDS-Transition Network Supports
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Southeastern Virginia Training Center- State Operated

DBHDS has established policies and procedures to ensure person-centered principles and practices are used to help individuals living in training centers consider more integrated residential and day activity options and make informed decisions for discharge planning. Upon

admission to Southeastern Virginia Training Center, the Personal Support Team, which includes the Legal Guardian/Substitute Decision Maker, Community Services Board's Support Coordinator, and training center staff, work collaboratively to identify the supports that are essential for maintaining the individual's health and safety. The Personal Support Team also identifies those things that are important to the individual and contribute to his/her happiness and general satisfaction with life. This information is critical in developing the discharge plan and is used to guide the evaluation of community options as well as the creation of goals for the Individual Support Plan.

Transition Planning

DBHDS is committed to supporting individuals to successfully transition from the training center to more integrated community homes. The steps required to achieve this have been broken down into a 12-week process which includes meetings, tours, visits, and staff trainings, as well as a robust post-move monitoring process. The individual's health, safety and wellbeing are closely monitored during each part of the transition process. Although the steps included in the 12-week process are mandatory, the order, timeframes, and manner in which they are accomplished may be altered to accommodate the needs of the individual or other circumstances that are unique to a particular service provider or transition. The process must be person-centered.

Post-Move Monitoring

Training Center and other designated DBHDS' community integration staff conduct post-move Monitoring visits and follow up for a minimum of one year for all individuals discharged from a training center to a community home. A minimum of four face-to-face visits with the individual are completed within the first 60 days to assess acclimation to the new home, ensure the provision of all identified essential supports and offer additional support or staff training as needed. Visits are also conducted by advocates with the Office of Human Rights and the Community Services Board's Support Coordinator.

DBHDS Contact Information- Training Center

Kimberly M. King, MS
Community Integration Manager
DBHDS Facility Programs and Discharge Planning
804-297-1208
Kimberly.M.King@dbhds.virginia.gov

Children's Nursing Facilities

When a child has begun the process of moving to the community from a Nursing Facility setting, DBHDS is notified of a "pending discharge." The Community Transition Nurse then

notifies the associated Community Services Board of the "pending discharge" of a child through an Action Letter which offers the Community Services Board’s support coordination Unit 120 days of funded case management/support coordination services to help involve the case manager in the discharge process sooner to increase collaboration and assure continuity of care.
In addition, a copy of the child's most recent Resident Review is attached to the Action Letter. The Resident Review is completed as part of the ongoing Preadmission Screening and Resident Review (PASRR) process and is attached to ensure the Community Services Board is aware of the child's basic individual support needs. As the discharge date nears, the Community Transition Nurse and the Omnibus Budget Reconciliation Act specialist work together to ensure any requests for specialized support(s) from the Community Services Board are completed.

Discharge Meeting

The actual discharge from the nursing facility is coordinated by the facility’s Social Worker who ensures there is continuity of care, which includes but is not limited to the transfer of durable equipment and assistive technology, orders for follow-up medical, therapy appointments, and coordination with educational services to achieve a safe transition to the community. The Community Transition Nurse remains available to provide support throughout the process.

Post Move Monitoring

Once the child discharges from a nursing facility, the Community Transition Nurse reaches out to the child's home Community Services Board within seven business days to ensure the discharge went smoothly and to offer assistance. After that, the Community Transition Nurse will again reach out to the home Community Services Board six months later to monitor progress and to offer assistance. If any needs are identified during the contact, the Community Transition Nurse will follow-up as needed.

DBHDS Contact Information- Children’s Nursing Facilities

Lisa Rogers, BSN/RN
Registered Nurse-Community Integration Consultant
DBHDS- Transition Network Supports
Office (804) 347-5260
Lisa.Rogers@DBHDS.Virginia.Gov

Christina Gleason, BSN/RN
Registered Nurse-Community Transition Nurse
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Funding Options

An individual does not require a Developmental Disability waiver to live in the community. Many of the services that you or your loved one may need can be accessed under the Commonwealth Coordinated Care (CCC) Plus Waiver and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). These programs usually do not have a waitlist and can be accessed without assistance from the Community Services Board.

Commonwealth Coordinated Care Plus Waiver

Commonwealth Coordinated Care Plus Waiver, also known as CCC Plus Waiver, is a combination of waivers formerly known as Elderly or Disabled with Consumer Direction waiver (EDCD) and the Technology Assisted (Tech) waiver. CCC Plus waiver offers Consumer Directed (CD) or Agency Directed (AD) services depending on individualized needs and program criteria met. CCC Plus waiver is an integrated delivery model that includes medical services, behavioral health services, and long-term services and supports. CCC Plus waiver offers care coordination and person-centered care with an interdisciplinary team approach. This waiver provides care in the home and community rather than in a nursing facility or other specialized care medical facility. Screenings for CCC Plus waiver are completed by the local health department and social services. To learn more about CCC Plus waiver, visit https://www.cccplusva.com.

Covered Services	
Respite Services (Agency and Consumer-Directed)	Personal Care Services (Agency and Consumer-Directed)
Personal Emergency Response System (PERS), includes Medication Monitoring	Skilled Private Duty Nursing (RN and LPN)
Services Facilitation	Adult Day Health Care
Assistive Technology (AT)	Environmental Modification (EM)
Transition Services	

Early Periodic Screening, Diagnosis, & Treatment

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) is a comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. In addition, states are required to provide any medically necessary health care services listed in section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under the state's Medicaid plan.

Virginia's EPSDT program goals are to keep children as healthy as possible by:

• Assuring that health and developmental concerns are diagnosed as early as possible,

• Assuring that treatment is provided before problems become complex, and

• Assuring that medically justified services are provided to treat or correct identified problems

To learn more about EPSDT, visit https://www.dmas.virginia.gov/media/1465/epsdt-fact-sheet.pdf

Some Covered Services
Skilled & Private Duty Nursing (RN and LPN)
Assistive Technology (AT)
Behavioral Therapy
Specialized Residential Behavioral Therapy & Residential Treatment
Substance Abuse Residential Treatment Services
Personal Assistance (Agency and Consumer Directed)

Waiver Options

A "waiver" is a way for the State Medicaid program to pay for an individual's services in the community. States make applications for Medicaid Waivers with the federal Medicaid agency, known as the Centers for Medicare and Medicaid Services (CMS). This allows states to waive the usual requirement that individuals must live in an institution to receive Medicaid funding for services. As a result, Medicaid can fund certain community-based alternatives to institutional care.

Developmental Disabilities Waivers

Virginia's Development Disabilities Waivers consist of the Building Independence Waiver, Family and Individual Supports Waiver, and the Community Living Waiver.

Building Independence Waiver	Family & Individual Supports Waiver	Community Living Waiver
For adults (18+) able to live independently in the community. Individuals own, lease, or control their own living arrangements and supports with the option of non-waiver-funded rent subsidies.	**For individuals living with their families, friends, or in their own homes**, including supports for those with some medical or behavioral needs. Available to both children and adults.	**24/7 services and supports for individuals with complex medical and/or behavioral support needs through licensed services.** Includes residential supports and a full array of medical, behavioral, and non-medical supports. Available to adults and some children.

Do I get to select which waiver I receive?

Families are not able to select which waiver they will receive. Assignment of waiver slots is based solely on need at the time of the assignment. For example, if the goal is for the individual

to return home with supports in place, a Family & Individual Supports Waiver is an appropriate option. On the other hand, if the individual is unable to return home and will require a 24/7 residential setting, a Community Living Waiver is the most appropriate option. Individuals can transition between waivers if their needs change and there is supporting documentation to support the request. The Community Services Board should be contacted assistance.

Where can I learn more?

Visit http://www.mylifemycommunityvirginia.org/ or scan below for more information on resources that will help in your transition to your new home in the community.

Additional Available Resources

Dental Program

The Office of Integrated Health has a Dental Team that creates and implements various community dental programs including comprehensive dentistry, sedation and remote dentistry through participating contracted dentists and a mobile/remote dental program. The Dental programs are gap services that are funded through the Commonwealth of VA/Health Support Network. For more information or assistance email: dentalteam@dbhds.virginia.gov

For assistance accessing dental care the referral form to submit can be find at this link: https://dbhds.virginia.gov/wp-content/uploads/2022/09/Dental-Referral-Form.2022.pdf

Mobile Rehab Engineering (MRE)

The Office of Integrated Health developed the Mobile Rehab Engineering Team. This team performs durable medical equipment-related services to include but not limited to pressure washing, safety assessments, repairs, custom adaptations, and assistive technology consultation. In addition, the Physical Therapist on the team can provide general technical assistance on specific issues around wound care and seating assessments. The Mobile Rehab Engineering Team is a gap service that is funded through the Commonwealth of VA/Health Support Network. Donations of equipment to be recycled or repurposed are accepted. For more information or assistance email: mreteam@dbhds.virginia.gov

For assistance with durable – medical equipment and assistive technology submit the request form found at this link: https://dbhds.virginia.gov/wp-content/uploads/2023/05/MRE-Form-101-DME-5.2023.pdf

For assistance with assistive technology, PT and wound care submit the request form found at this link:
https://dbhds.virginia.gov/wp-content/uploads/2023/04/MRE-Form-2023-PT-OT.pdf

Public Guardianship

Public Guardianship assists with the court ordered appointment of a public agency to make decisions on the behalf of a person with a diagnosis of intellectual or developmental disability meeting the following criteria: the diagnosis was documented prior to age 22, the individual is believed to be incapacitated, indigent, and in need of someone to make decisions for them. DBHDS in partnership with the Department for Aging and Rehabilitative Services (DARS), oversees and manages requests for guardianship. Requests are organized based on public guardianship program service areas and prioritized by the date the individual is referred to DBHDS. If you believe you or a member of your family would benefit from guardianship, please contact your local Community Services Board. For more information or assistance email: Public.guardianship@dbhds.virginia.gov

Housing

Independent housing resources are available to adults who want to live in their own homes (instead of with parents, grandparents, or guardians or in provider-operated settings). Eligible individuals must have a DD Medicaid Waiver or be on the Waitlist for a DD Medicaid Waiver. Resources include rent assistance, financial assistance for one-time costs to transition into housing, and priority to rent units in certain apartment properties. Individuals who live independently may decide to live alone, with a roommate, or live-in caregiver of their choosing. Supports in housing generally come from the Medicaid Waiver. If you meet the criteria and you are interested in applying, contact your Support Coordinator with the Community Services Board. For more information or assistance: http://wwwmylifemycommunityvirginia.org/taxonomy/mlmc-menu-zone/independent-housing

Special Olympics Virginia

Provides year-round athlete services to individuals regardless of ability or disability. For more information or assistance: https://www.specialolympicsva.org

The disAbility Law Center

Provides protection and advocacy to individuals with disabilities experiencing abuse, neglect, and discrimination. For more information or assistance: https://www.dlcv.org

Virginia Board for People with Disabilities

Provides protection and advocacy for the civil and human rights of individuals with developmental disabilities. For more information or assistance: https://www.vaboard.org

disAbility Navigator

A useful tool for searches regarding local services and helpful tips for individuals with developmental disabilities. For more information or assistance: https://www.disabilitynavigator.org

The Arc of Virginia

An advocacy group of people with developmental disabilities, their families, and their allies working to achieve "A Life Like Yours" for Virginians with developmental disabilities. For more information or assistance: https://www.thearcofva.org

Family to Family Network of Virginia

Program providing support to the families of children and adults with disabilities and special health care needs. For more information or assistance: https://www.centerforfamilyinvolvement.org

Supported Decision-Making

Supported Decision-Making is making a decision with the help of people you trust. The people you trust ensure that you have all of the information need to make an informed decision. Supported Decision-Making Agreements are a way to show in writing who you want to support (help) you, in what areas of life, and how you want to be supported. Supported Decision-Making and Supported Decision-Making Agreements are seen as a least restrictive way for someone to get help with making a decision, when needed, as they keep their legal rights and make the final decision. In Virginia, people with developmental and intellectual disabilities who are at least 18 years old and have legal competency can create Supported Decision-Making Agreements. For more information on Supported Decision-Making and Supported Decision-Making Agreements go to https://dbhds.virginia.gov/supported-decision-making-supported-decision-making-agreements/

Individual and Family Support Program

The Individual and Family Support Program (IFSP) assists individuals with developmental disabilities and their families with accessing person-centered and family-centered resources, supports, services and other assistance. The program's primary target population is individuals on the waiting list for Virginia's Developmental Disabilities' Medicaid Waivers and residing in the community. The goal of the program is to support continued community living.

- **Financial assistance**: Visit **our webpage** to learn more about eligibility and how to apply for IFSP Funding.
- **Education, information, and referrals**: Visit **My Life, My Community**, our one-stop online tool, to find what you need.
- **Family Mentoring**: Want guidance or support from someone who has been there? The

Family to Family Network at **the Center for Family Involvement** can help!

- **Peer Mentoring**: Connect with peers with disabilities through The Arc of Virginia's Peer Mentoring Program
- **Community coordination**: Ready to give back to your community and have your voice heard? Consider joining your **IFSP Regional Council**.

To get updates from IFSP, please sign up for our email list at **tinyurl.com/IFSP-list**. This is the best way to get the most up-to-date information from us.

To speak with a live operator, you can call My Life, My Community at **844-603-9248** (Monday through Friday, from 9 a.m. to 4 p.m.). Operators can help you find the Community Services Board or Behavioral Health Authority (CSB/BHA) that serves your area. They can also help you navigate the My Life, My Community website, and can share information about the resources named in this document.

Additional information on IFSP can be found at http://www.mylifemycommunityvirginia.org/.

To get the links, visit ***https://tinyurl.com/IFSP-FirstSteps****, or use your mobile device to scan this QR code.*