DBHDS Community Transition Guide

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

August 2019

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Introduction

What is the *DBHDS Community Transition Guide* and how do I use it?

This *Handbook* was designed to provide practical information to children and their families, who are preparing to make decisions related to the type of care that best suits their support needs or are planning to transition from various facilities (Intermediate Care Facilities – ICFs, Nursing Facilities – NF) to new homes in the community. Getting ready to move to a new home can be exciting and scary at the same time. Don't worry; there are people available such as your Support Coordinator (SC) through your Community Service Board/Behavioral Health Agency (CSB/BHA) and the Department of Behavioral Health and Developmental Services' (DBHDS) Community Transition Team to assist you through this process. So let's get started!

What is the Department of Justice (DOJ) Settlement Agreement?

In 2008, the Department of Justice (DOJ) began an investigation of Central Virginia Training Center (CVTC) according to the Civil Rights of Institutionalized Persons Act (CRIPA). The investigation was expanded to cover Virginia's whole system of services for individuals with intellectual and developmental disabilities, including all five state training centers and community based services.

DOJ issued a findings letter to Governor McDonnell in 2011 concluding that Virginia is not providing services in the most integrated and appropriate setting, not developing a sufficient quantity of community services, and that Virginia has a flawed discharge process at training centers. Virginia then began good-faith negotiations to reach a settlement agreement with DOJ while not subjecting the Commonwealth to a costly and lengthy legal battle.

In 2012, Virginia and DOJ reached a settlement agreement. This agreement will ultimately provide the necessary services so more individuals with intellectual and developmental disabilities can live successfully in their home communities and it will lead to a more effective use of public funds.

In March of 2012, Judge John A. Gibney signed a temporary order for approval of the settlement agreement. In August 2012, Judge John A. Gibney signed the permanent order for approval of the settlement agreement.

How will the DOJ Settlement Agreement affect individuals living in facilities?

The settlement agreement focuses on individuals with a developmental disability who meet any of the following additional criteria: (1) currently live at any of the training centers, (2) meet the criteria for the Statewide Developmental Disability (DD) waiver wait lists, or (3) currently live in a nursing home or Intermediate Care Facility (ICF).

DBHDS will ensure that the personal support teams, working with the CSB case manager, provide individuals and their authorized representatives with specific options for types of community placements, services and supports based on the individual's needs and desires.

What do you mean by "community" and "children?"

Lots of people feel that their community is wherever they live. For the purposes of this *Handbook*, "community" will mean a place to live where there are only a few people in each house and there are places to go and things to do right near your home. "Children" refers to individuals under 22 years of age.

Can I choose where I want to live?

YES! Choice of where you live is the most important part of your transition. Support coordinators/case managers, transition coordinators, facility and other staff do not decide where you will live. They will provide you with information and help, but in the end it is YOUR decision.

What kind of homes can I choose from?

There are several options available for you to consider when looking for community homes. We will discuss in detail on the following pages the types of homes, how you can qualify to live there, and what a provider must do to support you in your new home.

<u>You are strongly encouraged</u> to research, visit, and evaluate any home you are considering before you make the decision to move there.

Office of Integrated Health (OIH)

What is the Office of Integrated Health (OIH)?

The Office of Integrated Health (OIH) was established by the Department of Behavioral Health and Developmental Services (DBHDS) to assess the needs and resources available for providing needed health services and supports to persons with Developmental Disabilities (DD) and serious mental illness (SMI) throughout the Commonwealth as they transition from Training Centers (TCs) to community living. The OIH currently oversees and is responsible for the Health Support Network, and Long Term Care Services: PASRR, OBRA, and the clinical operations of Hiram W. Davis Medical Center.

What is the Health Support Network (HSN)?

The Health Support Network (HSN) was created to assess the health service needs of individuals leaving Training Centers. The HSN's original design is outlined in the concept paper of 2014 and identified short term and long term concentrations of effort.

Short term: Identifying gaps in services and supports to immediately improve the quality of care and health

Long-term: Building the infrastructure of health professional knowledge through outreach and education

The HSN structure and implementation has evolved over time to accommodate the true needs of regional communities and the Commonwealth overall. Service based programs have been established as a result of identifying gaps in care. Across the Commonwealth, and within each of the five Health Planning Regions (HPR), dental care is not widely available for adults greater than 21 years old. Further, there is no payment source for basic dental care. Many individuals leaving Training Centers are mobility challenged. Within the TC, they were able to have routine maintenance for their mobility equipment in addition to onsite and on-time repair. There is no payment source in community for care of mobility equipment and technicians for repair are few and far between. Technical assistance for a wide variety of issues surrounding the health and wellbeing of individuals with DD was also limited and fragmented. Individuals discharged from TCs frequently required specific care involving nursing supervision or management. Community based nursing was identified to be sporadically available, and nursing roles within community related to the population were not always clear to the provider community. Programs were developed to support each of these issues consistent with meeting the short term goals identified.

Mobile Rehab Engineering (MRE)

MRE was designed to continue the safety assessments, repair, and sanitation services that were regularly scheduled in Training Centers. Throughout the Commonwealth, there are few community resources available to individuals needing such services. Additionally, there is no mechanism for routinely evaluating the physical changes of individuals that might necessitate wheelchair modifications, nor are there routine safety evaluations specific to mobility equipment by trained professionals.

This program ensures that individuals who rely on durable medical equipment (DME) such as wheelchairs, shower chairs or other mobility equipment have access to maintenance and repair services that do not already exist. Services provided by MRE include safety evaluations and education, repairs, maintenance, replacement of broken parts, custom/personalized adaptations to equipment, and power washing as needed. The MRE staff includes an Engineer, two technicians, an Occupational Therapist and Registered Nurse Care Consultant (RNCC). The team travels to group homes, nursing facilities, and individual residences providing these services.

Dental Program

Adult dental services are limited by the Medicaid state plan to medically necessary oral surgery and associated diagnostic services, such as X-rays and surgical extractions. Preventive, restorative, endodontic, and prosthetic services (e.g. cleanings, fillings, root canals and dentures) are not covered for adults over 21 years of age. The elimination of the dental services provided by the Virginia Department of Health (VDH), only serve to exacerbate the lack of regional access. The result has been inadequate dental services for all Virginians without dental insurance coverage, especially individuals with DD.

In response, the OIH developed the *Fixed Rate Dental* program that began as a pilot and has since been rolled out in several regions. This program replaced the segregated dental clinics

located at NVTC and SVTC by offering a single fixed rate for the provision of basic dental services over the course of one year. Using established community dental practices and clinics that serve everyone in a community, (free clinics, FQHCs) the program has expanded its reach not only individuals who were served at the Training Centers, but to those in the community with DD who have never received dental services. The program has two objectives: meeting the dental needs of the broader DD adult community, and demonstrating a cost effective and reasonable payment structure.

The HSN capitalized on an idea for sedation dentistry for those with developmental disabilities observed in the Tidewater area of Virginia. This innovative model utilized a Certified Registered Nurse Anesthetist (CRNA) and certified moderation sedation dentist to provide a wider variety of services within the community setting, omitting the need for additional medical professionals or the need for hospitalization for services. The OIH *Sedation Dentistry* program is designed to supplement, not replace Medicaid. It is available for individuals with fears, and behavioral or physical issues, which make a standard dental visit difficult. Because of the specific nature of this pilot requires sedation certified dentists and a CRNA, and the expectation that examinations and treatment are carried out on-site, program implementation has been challenging. An initial attempt was made in Northern Virginia between October 2016 and March 2017. The contract however did not yield the intended results and had to be terminated. Alternative arrangements for temporary care have been made until the new contract is fully implemented this summer.

Community Nursing

Around 1985, the concept of "person-centered planning" began to replace the 1960's "medical model" of care for individuals with DD. Person-centered planning is an approach to planning supports for an individual that recognizes them to be first and foremost a ***person***. The medical model, effectively treated individuals as patients in community, not as individuals living their lives at home, and thus was abandoned by community advocates and providers. However, as society embraces the inclusion of a more diverse populace (including individuals with developmental disabilities who are also medically vulnerable), a complete abandonment is not practical, nor is it person-centered.

An evaluation of the needs of the DD community highlighted the specific need to incorporate nursing support, and while not a part of the medical model, rarely existed for this population in community. It became part of the mission of the OIH to educate community providers about the importance and utility of nurses as an adjunct to care within the person-centered supports structure. In order to facilitate a more cohesive nursing structure in the state wide system, the Director of the OIH invited nurses to meet together regionally to share concerns, discuss solutions and receive education and updates from the department.

To ensure the development of a community nursing infrastructure and the subsequent education and technical assistance availability necessary to work on policy development, the first of eight planned Registered Nurse Care Consultants (RNCC) was hired in December 2014. Since that time four RNCCs have been hired and have coordinated or assisted in the development of regular monthly nursing meetings within all five regions of the Commonwealth.

Our current team provides community based health education, technical assistance including case review and guidance, and policy and procedure development internally and externally.

Long Term Care

Preadmission Screening and Resident Review (PASRR) and Omnibus Budget Reconciliation Act (OBRA)

Preadmission Screening and Resident Review (PASRR) is a federally mandated process for evaluating individuals with DD or SMI who are referred for nursing home placement, and ensure that individuals are served in the least restrictive environment appropriate and available. In February of 2017, the OIH assumed responsibility for the entire division. The PASRR team evaluates community based screenings of individuals and affirms that they meet standards of appropriateness for in facility medical management.

Once established, community based alternatives are explored with the referring body and the individual is diverted away from nursing facilities with community based wrap around services instead. Since 2015, admissions for individuals with DD have been reserved for those needing short-term rehab, respite, or hospice. The goal for individuals with SMI, is also one of least restrictive placement; however at this time, nursing facility placement is often least restrictive environment available. As community based services are developed however, the PASRR team will proactively work to facilitate community placement.

When nursing home placement is determined to be appropriate, the PASRR team follows the individual to ensure they are receiving the supports and specialized services needed as identified by their person-centered plan. This includes the use of OBRA funding to support the services needed that are outside the usual scope of the nursing homes.

In January 2015, the OIH developed a T*ransitions Team* directed at helping to move children currently living in nursing facilities to community. The Community Transitions Nurse in conjunction with the interdisciplinary teams at each of the two nursing facilities in the Commonwealth identifies barriers and possibilities for community placement. The PASRR team includes, the Registered Nurse Community Integration Consultant, OBRA specialist, the PASRR Mental Health Coordinator and the Community Transitions Nurse.

Hiram W. Davis Medical Center (HWDMC)

HWDMC is a state based long term care facility located in Petersburg, Virginia. This facility is dedicated to serving the long term care medical and rehabilitation needs of individuals with developmental disabilities and severe mental illness. The facility staffs also work with the Health Support Network to provide community based services and educate the community regarding population specific aspects of care.

Who should I contact for more information?

Dental Information/Questions
Casey Tupea, RDH
Office (804) 347-2039
Casey.tupea@DBHDS.Virginia.Gov

PASRR Questions
Mary Irvin, RN
Office (804) 658-6338
Mary.irvin@DBHDS.Virginia.Gov

MRE Information/Questions
Tammie Williams, RN
Office (804) 347-2919
Tammie.williams@DBHDS.Virginia.Gov

Community Nursing Questions
Christina Gleason, RN, BSN
Office (804) 573-8733
Christina.gleason@dbhds.virginia.gov

Nursing Facility Questions
Lisa Rogers, RN
Office (804) 347-5260
Lisa.rogers@DBHDS.Virginia.Gov

Nursing Rules and Regulations
Susan Moon, RN
Office (804) 629-8288
Susan.moon@DBHDS.Virginia.Gov

Waiver Options

What is a Medicaid Home and Community-Based Waiver?

A “waiver” is a way for the State Medicaid program to pay for your 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 enables states to waive the usual requirements that individuals must live in an institution in order to receive Medicaid funding for services. In this way, Medicaid funds certain community-based alternatives to institutional care.

Virginia’s Development Disabilities (DD) Waivers consist of the Building Independence (BI) Waiver, Family and Individual Supports (FIS) Waiver and the Community Living (CL) Waiver.

What is a Commonwealth Coordinated Care Plus Waiver?

The CCC Plus Waiver (also known as the Commonwealth Coordinated Care Plus Waiver), is a combination of the formerly known waivers titled: EDCD (Elderly or Disabled with Consumer Direction) waiver and the Technology Assisted (Tech) waiver. All of the waivers offer CD or 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 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 (NF) or other specialized care medical facility.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Program

What is the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program?

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, under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at 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

Who is eligible for EPSDT?

- Children under the age of 21 who receive Medicaid through Medicaid/FAMIS Plus or a MCO are eligible to receive the full scope of Medicaid/EPSDT services
- FAMIS children who are not enrolled with a Managed Care Organization
- MCO enrolled FAMIS children receive well child services through their MCO but are not eligible for the full scope of EPSDT treatment

Individual and Family Support Program (IFSP)

What is the Individual and Family Support Program (IFSP)?

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 (DD) Medicaid waivers. The goal of the program is to support continued community living. IFSP consists of four major components:
1) The IFSP Funding Program

2) The IFSP Community Coordination Program

3) A partnership with Virginia Commonwealth University's Center for Family Involvement

4) A partnership with Senior Navigator through Disability Navigator

Additional information on IFSP can be found at http://www.dbhds.virginia.gov/developmental-services/ifsp.

Community Services Options

DD Waiver Services

Employment and Day Options	Building Independence	Family & Individual	Community Living
Individual Supported Employment	✓	✓	✓
Group Supported Employment	✓	✓	✓
Workplace Assistance Services		✓	✓
Community Engagement	✓	✓	✓
Community Coaching	✓	✓	✓
Group Day Services	✓	✓	✓

- **Individual/Group Supported Employment-** Training and support in a competitive job where persons without disabilities are employed.
- **Workplace Assistance-** Includes support to individuals who have completed job development and job placement training (or near completed) but require more than typical follow-along services to maintain stabilization in their employment.
- **Community Engagement-** Provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual).
- **Community Coaching-** Designed for people who need 1:1 support to build a skill or set of skills to address a barrier to participating in Community Engagement. This service takes place solely in community settings.

- **Group Day Services-** At no more than 1:7 ratio, includes skill-building and support for the acquisition or retention of self-help, socialization, community integration, employability and adaptive skills.

Residential Options	Building Independence	Family & Individual	Community Living
Independent Living Supports	✓		
Shared Living	✓	✓	✓
Supported Living		✓	✓
In-Home Support Services		✓	✓
Sponsored Residential			✓
Group Home Residential			✓

- **Independent Living Supports**- A service provided to adults (18 and older) that offer skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.

- **Shared Living**- Medicaid payment for a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a person who has no legal responsibility to support the individual and resides in the same household as the individual. The live-in person cannot be a parent or spouse.

- **Supported Living**- Residential supports are provided in a licensed or DBHDS authorized apartment and enable the individuals to have access to round the clock support, a timely response when needed, and support to develop skills needed for daily life.

- **In-Home Support Services**- Residential services that take place in the individual's home, family home, or community settings and typically supplement the primary care provided by the individual, family or other unpaid caregiver.

- **Sponsored Residential**- Residential supports provided to no more than two individuals in a licensed or DBHDS authorized sponsored residential home and enable the individuals to improve or maintain his or her needs, live at home and use the community, improve abilities and acquire new skills, and be safe at home and in the community.

- **Group Home Residential**- Consists of skill-building, routine supports, general supports, and safety supports provided primarily in a licensed or approved residence that enables an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills needed to reside successfully in a home and community-based settings.

Medical & Behavioral Options	Building Independence	Family & Individual	Community Living
Skilled Nursing		✓	✓
Private Duty Nursing		✓	✓
Therapeutic Consultation		✓	✓
Personal Emergency Response System (PERS)	✓	✓	✓

- **Skilled Nursing**- Defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. Medical services that are ordered by a physician, nurse practitioner or physician assistant and that are not otherwise available under the State Plan for Medical Assistance.
- **Private Duty Nursing**- Individual and continuous care for individual with a medical condition and/or complex health care needs, certified by a physician, nurse practitioner, or physician assistant as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility, or ICF-IID.
- **Therapeutic Consultation**- Provide expertise, training, and technical assistance in the home or community, to assist family members, caregivers, and other service providers in supporting the individual and to facilitate the individual's desired outcomes as identified in the ISP
- **Personal Emergency Response System (PERS)** - Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. When appropriate, PERS may also include medication-monitoring.

Self-Directed Options	Building Independence	Family & Individual	Community Living
Consumer-Directed Services Facilitation		✓	✓
CD Personal Assistance Services*		✓	✓
CD Respite*		✓	✓
CD Companion*		✓	✓

- **Consumer-Directed Services Facilitation-** Supports individual or Employer of Record (EOR) to arrange, direct, and manage their own services. **Service can also be agency-directed.*

- **Consumer-Directed Personal Assistance Services-** Direct support with personal needs, typical daily tasks, community involvement, and health & safety. **Service can also be agency-directed.*

- **Consumer-Directed Respite-** Provides temporary supports during emergencies and at other times as needed by an unpaid caregiver. Can be in the individual's home, a provider's home, or other community locations. **Service can also be agency-directed.*

- **Consumer-Directed Companion-** Provides non-medical care, socialization, or support to adults. This service is provided in an individual's home or at various locations in the community. **Service can also be agency-directed.*

Crisis Support Options	Building Independence	Family & Individual	Community Living
Community-Based Crisis Supports	✓	✓	✓
Center-Based Crisis Supports	✓	✓	✓
Crisis Support Services	✓	✓	✓

- **Community-Based Crisis Supports-** Provides services to individuals experiencing crisis events which put them at risk for homelessness, incarceration, hospitalization, and/or danger to self or others.

- **Center-Based Crisis Supports-** Provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu.

- **Crisis Support Services-** Provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization. This service is designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

Additional Options	Building Independence	Family & Individual	Community Living
Assistive Technology	✓	✓	✓
Benefits Planning Services	✓	✓	✓
Community Guide	✓	✓	✓
Peer Mentoring	✓	✓	✓
Electronic Home-Based Services	✓	✓	✓
Environmental Modifications	✓	✓	✓
Non-Medical Transportation	✓	✓	✓
Transition Services	✓	✓	✓

- **Assistive Technology-** Specialized equipment that increased abilities in daily living or assists with enhancing communication. May also include items for life support.
- **Benefits Planning Services-** The development of documents or guidance that assist individuals receiving Social Security benefits (SSI, SSDI, SSI/SSDI) to better understand the impact of working on all benefits. This service will enable individuals to make informed choices about work and support working individuals to make a successful transition to financial independence. **Service pending approval.*
- **Community Guide-** Direct assistance to persons in brokering community resources. Community Guides provide information and assistance that help the person in problem solving and decision making and developing supportive community relationships and other resources that promote implementation of the person-centered plan. This service involves face to face contact with the individual to determine the interests of the individual. In addition to direct service, there is a component of supporting the individual that may occur without him/her present.
- **Peer Mentoring-** Person-centered services offered to individuals by specifically trained Peer Support Mentors, who are or have been service recipients and have a developmental disability. Peer support is meant to assist with empowering the individual to advocate for opportunities and experiences in community living, working, socializing, and staying healthy and safe.
- **Electronic Home-Based Services-** Goods and services based on Smart Home technology. This includes the purchase of electronic devices, software, services, and supplies that enables individuals to access technology that can be used in the individual's residence to support greater independence and self-determination.
- **Environmental Modifications-** Physical adaptions to a home, vehicle, and in some instances, a workplace which provide direct medical or remedial benefit to the individual.
- **Non-Medical Transportation-** Enables individuals to gain access to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan.
- **Transition Services-** Nonrecurring set-up expenses for individuals who are transitioning from an institution or certified provider-operated living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

CCC Plus Waiver Services

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	Transition Services
Assistive Technology (AT)	Environmental Modification (EM)
Transition Services	Adult Day Health Care

Monitoring and Oversight

I currently receive many supports and services at my facility. Will I receive the same supports and services in the community?

You and your family member or authorized representative (AR), along with your support coordinator/case manager will develop a person-centered service plan. This is a written plan of services addressing all life areas: physical and mental health; personal safety and behavior issues; financial, insurance, transportation, and other resources; home and daily living; education and vocation; leisure and recreation; relationships and social supports; legal issues and guardianship; and individual empowerment, advocacy, and volunteerism. Addressing all life areas, you, your family member or AR, and support coordinator/case manager will look at potential risks unique to you and determine what is needed to make sure you stay healthy, safe, and satisfied in the community, either through waiver services or through other sources. All of these services and supports will be specified in the plan and offered by the chosen providers. Each person-centered service plan will be updated and revised annually or when needed as things change in your life.

What is the Community Services Board/Behavioral Health Authority (CSB/BHA)?

The CSB/BHA is a local agency, established by a city or county or some combination of counties and/or cities that plans, provides, and evaluates behavioral health and developmental services in the area it serves. The CSB/BHA serves as the single point of entry for an individual, family member, or representative requesting support coordination and/or DD Waiver services. Individuals seeking waiver services for persons with any developmental disability will have diagnostic and functional eligibility confirmed by their local CSB and, as appropriate, be placed on the single statewide waiting list. Waiver wait lists will be maintained by the local CSB for all individuals under their jurisdiction, including those served by private CM agencies.

What is the Office of Licensing?

The DBHDS Office of Licensing licenses services providing treatment, training, support and habilitation to individuals who have mental illness, intellectual disability or substance abuse disorders. Licensing staff make at least one unannounced inspection of services per year and investigate complaints about licensed services.

What is the Office of Human Rights?

The DBHDS Office of Human Rights helps assure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed or funded by the Department.

What monitoring does DMAS provide?

DMAS is the single state authority responsible for supervising the administration of home and community-based waivers in Virginia. DMAS performs routine "quality management reviews" (QMRs) of all waiver services and providers. These include a review of the provision of services to ensure that services are being provided according to DMAS regulations, policies, and procedures.

DMAS conducts QMRs of waiver services provided by all providers to ensure your health, safety, welfare, and your satisfaction with services. The reviews focus on areas required by the federal government such as making sure your individual service plan, includes your preferences, services are being delivered according to your ISP, that risks to you are identified and that you are being included in the community. In addition to assessing your ongoing need for Medicaid-funded long-term care, another purpose of the reviews is to ensure your satisfaction with services and providers and that your choice of services and the results of your person-centered planning are being carried out. This may involve interviews with you and/or your family/caregiver as appropriate.

Providers are continually monitored to make sure that they follow Medicaid participation standards and program policies. Providers are assessed on their ability to deliver consistent, high-quality supports.

DMAS's Provider Review Unit and Medicaid Fraud Control Unit provide further oversight by checking for individual and provider fraud. DMAS considers fraud to be an intentional deception with the knowledge that the deception could result in some unauthorized benefit to that or some other person.

For more detailed information regarding DMAS monitoring please visit the website at www.dmas.virginia.gov.

Who will be responsible for monitoring my transition (post-move monitoring)?

The DBHDS Community Transition Team will coordinate post move monitoring visits with CSBs and other involved parties by the 7th, 30th, 60th and 90th day following a child's discharge from the facility. Your CSB Support Coordinator will also provide additional monitoring visits. Please inquire with your CSB SC for their schedule of visits. Additional visits may occur based on needs of the individual or community provider.

DBHDS Contact Information

Who can help me with Community Integration?

The Community Transition Team consists of a Community Integration Manager (CIM) and Family Resource Consultants (FRCs). CIMs and FRCs are responsible for assisting ICFs with coordinating your discharge process and ensuring that it occurs within a timely manner. They serve an integral part in assisting individuals and families with community transition.

Contact Information for Community Transition Team

Kimberly King
Community Integration Manager
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Provider Selection Guide

What is the Provider Selection Guide and how will it help in my transition?

DBHDS has assembled information from various sources to aid in the decision making process regarding residential supports for individuals transitioning to homes in the community. This shortened version has been created to use as a guide to discuss various topics or concerns that families/guardians will have while screening potential residential services providers. Please remember every individual will require their own set of supports so you may have to go into more detail with your questions or concerns. Feel free to modify this guide to meet the specific needs of your loved one as you begin your selection process.

What are some of the topics or issues I need to cover when screening potential residential services providers?

- **Section I – Provider Information:**

Local & corporate – name, address, telephone number, contact person & title

Licensure info – number of years in business, length of current certification, suspensions, revoked

Homes – number operated by organization & locations

Type of organization – for profit, not-for-profit, partnership, sole proprietorship, etc.

Philosophy – mission statement of organization, philosophy of supports

- **Section II – Residential & Individual Information:**

Appearance of home – well kept, clean, free of hazards, smell, adequate space, comfortable space, single level (if needed)

Safety – fenced yard, front & back, type of locks on doors, alarms, safety rails, ramps, plan to keep individuals safe, evacuation process, smoke alarms, entries & exits (easily accessible)

Individuals – number, age range, sex, special needs, appearance, cleanliness, interactions with individuals and staff, personal items, grievance policies

Kitchen – adequate equipment and safety precautions

Bedrooms/Baths – private or shared and number, individual/families decorate

Modifications - wheelchair accessible (if needed)

Laundry room – where located, easily accessible, persons responsible for laundry, individuals encouraged to participate

- **Section III – Program & Transportation Information:**

Visits & vacations – policies on visits & telephone calls from families/guardians, announced or unannounced, overnight trips to visit families/guardians, vacations away from residence, length of stays

Person centered practices – personal choice in development & implementation of support plan, age appropriate, unique needs identified

Oversight – management reviews, procedures for handling problems with staff, grievance policies, supervision, monitoring

Activities – planning for community involvement, access to desired house of worship, personal interests, daily/weekly schedules

Transportation – types, distance to day support and employment, safety, costs, arrangements, repairs

Disagreements – policies on handling problems between individuals and staff

- **Section IV – Financial Information:**

  Costs - services covered (food, cable, private phone), funding for program, resources, medical expenses, upkeep of specialized equipment, supplies, communication with families/guardians regarding finances

  Individual – policies on handling personal finances, incidental amounts, purchases for personal care items and clothing, payee for disability benefits

- **Section V – Staff Information:**

  Knowledge/Skills/Abilities – requirements for direct support professionals, initial and ongoing training, training to handle complex medical needs & positive behavior support plans, sign language, autism expertise, skilled nursing

  Staffing – individual/staff ratio per shift, average tenure of staff, policies for emergency coverage with open shifts, ability to provide proper supports, onsite supervision, overnight staffing

  Communication – types to relay changes & updates in medications & diets, info about individuals, schedule changes

  Work relationships – interactions with other individuals, co-workers, management

- **Section VI – Day Support, Employment & Education Information:**

  Day support – requirements, location, visit

  Employment – requirements if individuals are capable, number of individuals employed, job skills training

  Education – school requirements if applicable, location, class set up, ratio of teachers to students, related services (therapies), connections with local colleges or universities

- **Section VII – Medical Information:**

  Medicines – qualifications to administer, training, storage location, security, nurse monitoring

  Medical care – physical exams, dental care, psychiatric care, etc., locations, annuals

  Emergencies – policies, 911, communication with families/guardians, staff coverage, hospitals

- **Section VIII – Nutrition Information:**

  Food - accessibility, refrigerator/freezer adequately stocked, pantry/cabinets adequately stocked, favorite foods/beverages of individuals

Preparation – special diets, cooking, frozen vs. fresh foods, recipes, individual involvement

Menus – nutritious & well balanced, visibility of menus, planning, staff & individual input, weekly or monthly

Kitchen – adequate equipment & appliances, modifications, safety issues

Costs – allocation of funds for meals & snacks, food budgets, shopping, dietician or nutritionist services available

- **Section IX – Community/Social Events Information:**

  Community – neighborhood & community /social activities, interactions with neighbors

  Events – staff and individual input/choices for planning special events, parties, religious activities, independent or group events, activity calendars

- **Section X – Family/Guardian Involvement:**

  Communication – open lines of communication with families/guardians, sudden illnesses or problems

  Support plan – families/guardians involvement with support plan, level of support required, families/guardians involvement with major decisions such as medical care, behavioral issues

  Problem areas – policies on handling conflict with provider or staff, areas of concern, grievance policies

  Legal guardianship – assurance new residence is aware of legal guardianship roles in decision making

Additional Resources

Where can I find additional resources to help me transition to my new home in the community?

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