Virginia Department of Behavioral Health & Developmental Services

Departmental Instruction 6/16/17

STAFF INSTRUCTION

SUBJECT: ***Procedure for Person Centered Discharge Planning***

I. **Purpose.** The purpose of this Instruction is to establish policy and procedures to ensure that TRAINING CENTERS use person-centered principles and practices to help individuals living in training centers consider more integrated options and make informed decisions for discharge planning. Person-centered principles and practices will be used by those persons who support the individuals who live at TRAINING CENTERS, and help them identify and make informed choices regarding specific supports and services necessary to live successfully in the most integrated setting. Person-centered principles and practices will also be used to define requirements for pre-move activities, transition, discharge planning, and Post Move Monitoring.

II. **Cancellation**: All previous editions of this Instruction, original 6/1/12 and 5/1/15.

III. **Reference.** Departmental Instruction 216(RTS)12 Training Center Responsibilities Related to Person Centered Discharge Planning, technical updates and addition of position responsibilities.

IV. **Procedure.** The Commonwealth of Virginia has adopted a person-centered philosophy toward service delivery to support individuals as they plan for their lives now and in the future; work towards their desired outcomes; and access essential supports. This philosophy stresses processes, structures, and practices that support informed choice and the development of plans that help people attain what is important to them while addressing issues of health and safety. This procedure is to be followed for all Individual Support Plan (ISP) and Person Centered Discharge Planning to ensure that each individual residing at TRAINING CENTERS is supported in the most integrated setting that is appropriate to meet his or her needs consistent with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L. C, U.S. 581 (1999).

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Departmental Instruction 216(RTS)12
Training Center Responsibilities Related to Person-Centered Discharge Planning

216 - 1 Background

The Department of Behavioral Health and Developmental Services (Department) is committed to ensuring that each individual residing at a training center is supported in the most integrated setting that is appropriate to meet his or her needs consistent with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L. C, U.S. 581 (1999).

216 - 2 Purpose

The purpose of this Departmental Instruction (Instruction) is to establish policy and procedures to ensure that training centers implement person-centered principles and practices and help individuals living in training centers and those who support them identify and make informed choices. The focus of planning will be specific to supports and services necessary to live successfully in the most integrated setting. The process will define requirements for pre-move activities, transition, discharge planning, and Post Move Monitoring.

216 - 3 Definitions

The following definitions shall apply to this Instruction:

Authorized representative (AR) This means a person permitted by law or in the Human Rights Regulations (12 VAC 35-115-30) to authorize the disclosure of information or to consent to treatment and services or participation in human research. The decision-making authority of an authorized representative recognized or designated under these regulations is limited to decisions pertaining to the designating provider. Legal guardians, attorneys-in-fact, or health care agents appointed pursuant to § 54.1-2983 of the Code of Virginia may have decision-making authority beyond such provider.

Barriers This means issues, obstacles, or impediments that delay an individual from moving from the training center to a more integrated setting. These include any essential supports not currently available to meet the needs and preferences of the individual.

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Community Home	This means the home in the community to which an individual will move after leaving a training center.
Community Integration Managers (CIM)	This means the central office positions, physically located at each training center, that are 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 their needs and desires. These positions provide support and direction to all aspects of the individual's transition to the community including addressing identified barriers to discharge.
Community Resource Consultant (CRC)	This means the person who provides consultation and technical assistance to community providers, CSBs and case managers on community service options and programs most commonly related to Medicaid home and community- based waiver services.
Community Services Board	This means the public body established pursuant to §37.2-501 or §37.2-602 of the Code of Virginia that serves the area in which an adult or in which a minor's parent or guardian resides, and that provides support coordination and discharge planning support to an individual living in a training center.
CSB Support Coordinator	This means the person who, on behalf of the CSB, performs the duties listed in12VAC35-105-1240 and possesses a combination of work experience with individuals with intellectual disability and relevant education that indicates the person possesses the knowledge, skills and abilities as established in 12VAC35-105-1250. This term is synonymous with "case manager."
Discharge Plan and Discussion Record	This means a written plan and discussion record prepared by the CSB support coordinator and training center support coordinator or social worker in consultation with the training center personal support team, pursuant to § 37.2-505 of the Code of Virginia. The document is initiated when the individual is admitted to the training center and documents the planning for supports and services needed to assist with the individual's move from the training center, the supports needed after discharge from the training center, barriers to implementation, and identifies a reasonable timeframe to plan for and prepare the individual and AR for the discharge. Discussion topics may include opening rounds, profile review, assessment review, important to/for decisions, protection from harm, essential and non-essential supports needed for community transition and rights restrictions, shared planning, objections/agreements, responses to questions, and signatures.

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Employee	This means any training center classified, non-classified, probationary, non-probationary, wage (hourly, WE-14) or contract employee.
Individual	This means a person who is receiving supports in a training center or community setting.
Informed choice	This means providing individuals and their ARs with accurate and thorough information that encourages them to make choices and assists in their selection of the most appropriate services and supports options and providers.
Individual support plan (ISP)	This means a document developed collaboratively with the individual's personal support team through comprehensive assessments of the individual that outlines all of the supports and services that are important to or for the individual and that ensure their protection from harm; reflects the individual's preferences, strengths, needs and desires, and essential and non-essential supports; and includes methods to measure, track, and document progress toward identified outcomes.
Most integrated setting	This means a setting which allows the greatest opportunity for the individual to be integrated into the community based on the individual's strengths, needs, goals, and preferences, in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).
Person-centered	This means focusing on the needs and preferences of the individual (not the system or service availability) and empowering and supporting individuals in defining the direction for their own lives and promoting self-determination, and community inclusion--recognizing that all individuals are capable of living in smaller, integrated settings when supports are designed around an individual, and not around a program.
Personal support team (PST)	This means a team, formally known as an interdisciplinary team (IDT), of professionals, paraprofessionals, and non-professionals who possess the knowledge, skills, and expertise necessary to accurately identify a specific individual's comprehensive array of needs and design a program that is responsive to those needs. At a minimum, the PST includes the individual, AR, CSB support coordinator, and other invited members of the individual's interdisciplinary team or those involved in the individual's life.
Post move monitor (PMM)	This means a training center employee whose job functions include monitoring and assisting individuals as they transition from the training center to community living to ensure that the ongoing needs of the individual are being met in the new

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Post-move monitor (PMM) *(continued)*	placement and that essential and non-essential supports agreed upon in the discharge plan are being provided. This includes monitoring the individual's adjustment to his or her new home; recommending additional support services to the individual, AR, provider, or CSB; providing necessary recommendations to the community provider to resolve identified concerns; and documenting steps on the Post Move Monitoring action plan.
Provider	This means a public or private entity which delivers community-based servicesand supports to individuals with intellectual disability: i.e. residential, day, employment, skilled nursing, and personal assistance.
Regional support team (RST)	This means a regional team facilitated by the CIM that is composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs.
Training center Support coordinator	This means the person who performs the QMRP duties listed in CMS Guidelines – Intermediate Care Facilities for Persons with Intellectual Disabilities 483.430(a)/ tag 159 -163; is assigned primary responsibility and accountability for the individual's ISP; and ensures the ISP reflects person-centered planning.
Virginia's choice protocol	This means a protocol developed by the Department that offers guidelines to CSBs and other providers of support services who struggle with issues of providing and ensuring choice when addressing individual needs and limited resources.

216 - 4 Responsible Authorities

Central office

The **Assistant Commissioner** for the Division of Developmental Services, or designee, is responsible for:

- Interpreting this Instruction;
- Providing directions, guidance, technical assistance, and consultation to CSBs and state facilities in the development and implementation of case management services and discharge planning; and
- Monitoring the delivery of case management services and discharge planning through outcome and performance measures and utilization management and review activities.

The **Director of Training Center Discharges and Community Integration**, or designee, is responsible for:

- Ensuring that implementation of the training center discharge process complies with this Instruction;

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Central office *(continued)*

- Identifying systemic discharge issues and developing statewide action plans to address those issues;
- Ensuring statewide consistency of the discharge planning process; and
- Updating Departmental Instructions related to transitions and discharge.

Community integration managers (CIMs) are responsible for:

- Ensuring that training centers comply with the provisions of this Instruction;
- Maintaining a system for reporting information related to moving individuals to the community and providing standardized reports;
- Monitoring the discharge process in all training centers and providing periodic briefings to the Commissioner and the Department's senior leadership;
- Ensuring that the training center personnel training programs support the needs of workforce in implementing this Instruction;
- Communicating with the training center director regarding transition planning;
- Gathering information from monitoring follow-ups to identify gaps or need; and
- Coordinating the RST.

Training center

Training center **directors** are responsible for:

- Ensuring that all staff have full knowledge of this policy;
- Implementing procedures outlined in this Instruction; and
- Providing staff with the training necessary to implement the requirements of this Instruction.

Training center **social work directors** are responsible for:

- Collaborating with the CIMs and other stakeholders for the implementation of the discharge process;
- Supporting the social worker in transition and discharge planning activities;
- Assisting the social worker in clarifying and resolving AR concerns;
- Advising the human rights advocate of any rights issues.

Training center **discharge social workers** are responsible for**:**

- Collaboration with AR, CSB and PST for discharge related activities;
- Contact with Individual, AR and family to provide most up to date and best information related to options for consideration in discharge planning;
- Coordinating with the training center supports coordinator to convene pre-move meetings;
- Developing pre-placement relationships with providers in the community;
- Documenting discharge planning activities;
- Assisting individuals to identify and ensure essential community supports are in place prior to discharge;

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- Collaborating with CSB staff to ensure applications for Medicaid, Medicare, Social Security benefits and other financial entitlements are submitted to the appropriate agencies and that any personal funds are released in a timely manner prior to the individual's discharge;
- Notifying the CSB of the date on which any entitlement application was submitted and copying the CSB, individual, and AR to facilitate follow-up;
- Coordinating with the reimbursement office to communicate official move date so individual can begin to bill for community services.
- Completes paperwork to include social histories, applications for birth certificates, social security cards, financial resources; and
- Maintains support notes related to all individual, AR and family communication related to education of options and discharge activity as prescribed in SW note established for use July 2014.

Community integration/ transition **support coordinators** are responsible for:

- Working with the social worker and other PST members to develop a plan of care that focuses on planning, skills training, and supports necessary for discharge/transition planning;
- Ensuring that any discrepancies or conflicts between programmatic, medical, dietary, and vocational aspects of the individual's assessment and program are brought to the PST to resolve;

Training center *(continued)*

- Assisting the social worker as needed in recording pertinent transition plan meeting information in the individual's official clinical record; and
- Coordinating schedules to ensure availability of appropriate staff for meetings, visits and other support functions as required by the PST.

Training center **nurses** are responsible for:

- Ensuring that all medical information about the individual is current;
- Participating in identifying essential and non-essential medical supports needed by the individual;
- Ensuring all medical clearances, medications, and equipment are available for pre- move visits to provider agencies;
- Ensuring that medical equipment that is being sent with the individual is available and in good working order;
- Reviewing medically applicable environmental considerations with the PST;
- Providing consultation as requested by the CSB through the social worker;
- Providing training to the service provider regarding all pertinent medical needs of the individual;
- Ensuring pertinent records pertaining to the individual are provided to the community primary care physician and other medical professionals and that medical history and current treatment plan information is discussed prior to discharge; and
- Participating in Post Move Monitoring as requested.

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Training center **psychologists** are responsible for:

- Ensuring that the individual's psychological assessments are current;
- Providing consultation and training during transition;
- Ensuring an initial contact with the community psychiatrist, psychologist, and behavioral consultant, as needed, prior to discharge to provide treatment history and current treatment plans; and
- Participating in Post Move Monitoring as requested.

Training center **direct support professionals** are responsible for:

- Providing transition support as requested which may include on-site services in the community as part of the transition process;
- Ensuring all of the individual's personal items are inventoried, labeled and accompany the individual;
- Communicating information related to formal/informal supports to PST;
- Participating in the training of community service providers regarding the individual's activities of daily living (ADLs); and
- Participating in Post Move Monitoring as requested.

Training center **ancillary services** (PT, OT, speech, visual services, dietary services, nutritional management, etc.) employees are responsible for:

Training center *(continued)*

- Ensuring that the individual's assessments maximizes their participation and independence in more integrated settings by;
    - identifying the individual's strengths, preferences, needs (clinical and support), and desired outcomes;
    - assessing and identifying the specific supports and services that build on strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;
    - including, documenting and implementing skill building outcomes that support community integration;
    - creatively addressing the availability of community resources/alternative treatments;
    - researching and recommending equipment and supports more commonly used in integrated settings;
    - routinely reassessing restrictive supports and implementation of a reduction/elimination plan;
- Providing consultation during transition as requested pertaining to environmental assessments, modifications and training; and
- Participating in Post Move Monitoring as requested.

Position details

More details regarding the roles and responsibilities of central office and training center community integration project team positions related to this Instruction are provided in Attachment 1.

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216- 5 Specific Guidance

Policy

The Commonwealth of Virginia has adopted a person-centered philosophy toward service delivery to support individuals as they plan for their lives now and in the future; work towards their desired outcomes; and access essential supports. This philosophy stresses processes, structures, and practices that support informed choice and the development of plans that help people attain what is important to them while addressing ongoing support for health and safety.

Discharge planning

The Department is committed to meeting CMS Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) regulations for discharge planning, including:

- Developing a final summary that addresses the individual's choices, personal preferences, developmental, behavioral, social, health, and nutritional status;
- Providing documentation to support the reason for and assure that the transfer or discharge is in the best interest of the individual;
- Providing reasonable time to plan for and prepare the individual and family or AR for the transfer or discharge (except in emergencies);

Discharge planning *(continued)*

- Sharing the appropriate information with provider agencies to assure a successful transition; and
- Providing a final discharge plan that will assist the individual to adjust successfully to his or her new home.

216 - 6 Procedures for Ensuring Staff Have Sufficient Knowledge to Implement Person-Centered Discharge Planning

Required training

All training center leadership and clinical and other employees who serve on PSTs shall complete training on the implementation of this Instruction. Training on the implementation of this Instruction and person-centered thinking shall occur during initial orientation training and through annual refresher courses.

Each training center shall maintain documentation that its employees have successfully completed required training and demonstrated full understanding of the policy and procedures in this Instruction. Documentation shall be maintained in each employee's personnel record.

216 - 7 Procedures for Personal Support Team Participation in Discharge Planning

PST member knowledge

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PST members shall have sufficient knowledge about community services and supports to:

- Propose appropriate options about how an individual's needs could be met in a more integrated setting;
- Present information to the individual and AR about specific opportunities for community placements, services, and supports; and the opportunity to discuss and meaningfully consider those options; and
- Answer questions from the individual and AR about community options and makes appropriate referrals per conscensus of the PST.

PST functions

Through a person-centered planning process, the PST shall assess an individual's treatment, learning, quality of life, and habilitation support needs and recommend how the individual could best be served. To accomplish this, the PST shall:

- Be driven by the individual's choice, services and support needs and are based on the individual's strengths, desires, and preferences related to community integration.
- Assist the individual in achieving ISP outcomes that promote his or her growth, well-being, and independence in order to move sooner than later into the most integrated settings, addressing each domain of the individual's life, including community living;

PST functions *(continued)*

- Develop programs and supports in a plan of care that is geared toward the return of the individual to integrated community living;
- Identify the following for each individual:
  - type of s needed to meet the individual's needs;
  - essential and non-essential supports needed by the individual for transition;
  - skill building recommendations to promote independence;
  - specific, detailed, and measurable barriers or obstacles to transition, if any; and
  - strategies to address any identified barriers or obstacles.
- Ensure that the individual and AR have information and input into discharge planning.
- Review and revise each individual's discharge plan at admission and during regular scheduled plan of care reviews.

PST competency

PST ability to implement its functions in a person-centered manner shall be monitored and enhanced through training that will occur during initial orientation and through annual refresher courses. Quality assurance shall be provided through documented observation of PST meetings by central office staff, and through ongoing monitoring and support of person-centered coaches and mentors. Each training center shall designate person-centered thinking coaches who receive additional training. The coaches will provide guidance to PSTs to ensure

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implementation of the person-centered tools and skills. Coaches throughout the state shall have regular and structured sessions with person-centered thinking mentors. These sessions shall be designed to foster additional skill development and ensure implementation of person-centered thinking practices throughout all levels of the training centers.

216 - 8 Procedures for Discharge Planning Activities

Discharge plan content

The discharge plan shall contain the following:

- An assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available. This includes supports needed in the areas of:
    - Staffing supports;
    - Nutritional;
    - Environmental;
    - Medical/nursing;
    - Behavioral;
    - Supported employment/day support;
    - Mental health;
    - Substance abuse;
    - Physical therapy;
    - Occupational therapy;
    - Speech/language therapy;
    - Communication;
    - Equipment;
    - Transportation;
    - Social;
    - Recreational;
    - Financial;
    - Legal;
    - Advocacy;
    - AR appointment;
    - Educational;
    - Housing; and
    - Accessibility.
- A listing of the essential and non-essential supports that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes and that are needed to ensure a successful move to the community, including persons identified by the team as responsible for securing the essential supports and the evidence that will be reviewed to ensure that the supports are in place;
- A listing of specific types of providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;

Discharge plan content *(continued)*

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- Documentation of barriers preventing the individual from moving to a more integrated setting and a plan for addressing those barriers.
    - Such barriers shall not include the individual's disability or the severity of the disability.
    - For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.
- Specific actions that need to be taken by the training center, CSB, and provider, including:
    - Team members specified as responsible for these actions and the timeframes in which such actions are to be completed;
    - Strategies to implement the plan and coordinate the plan with provider staff; and
    - Review with the individual and AR.

Discharge planning requirements

Discharge planning activities shall be implemented in a manner that is consistent with the Community Services Performance Contract, Department admission/ discharge planning and choice protocols, State Board of Behavioral Health and Developmental Services policies, state and federal statutes or regulations, and best clinical and person-centered practices.

Discharge planning requirements *(continued)*

All discharge planning shall be based upon the presumption that with sufficient supports every individual can live in a community setting. Discharge planning shall:

- Begin upon the individual's admission to the training center;
- Include the individual's participation in his or her services and supports and discharge planning to the maximum extent possible, regardless of whether the individual has an AR;
- Provide necessary supports, including communication supports, to ensure that the individual has a meaningful role in directing the process;
- Utilize a person-centered planning process facilitated by the individual's PST to:
    - Assess the individual's needs;
    - Identify essential and non-essential supports that are important to or for a successful move to the community; and
    - Make recommendations as to how the individual can be best served.
- Provide reliable information to the individual and AR regarding community options and offer a choice of providers and locations consistent with the individual's identified needs and preferences and Virginia's Choice Protocol.
- Document that the CSB support coordinator, with collaboration from PST members, have:
    - Coordinated with the specific providers that have been identified as offering appropriate community-based services in the discharge plan to

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provide the individual, AR, and his or her family with the following opportunities before they are asked to make a choice regarding options:

- Speak with those providers;
- Visit community placements, including overnight visits; and
- Facilitate conversations and meetings with individuals who are currently living in the community and their families;

- Assisted the individual and AR following provision of opportunities described above, in choosing a provider or providers; and
  - Ensured that the chosen provider or providers are identified, engaged, and can prepare for the individual's transition to the community within the timeframe the individual expects to move.
- Include conducting and documenting discussions of the individual's progression toward discharge through regularly scheduled community integration project team meetings to discuss the:
  - Status of each individual; and
  - Availability and accessibility of community supports that will advance each individual's move to a more integrated setting/community.

Discharge plan and discussion record completion and reviews

The training center social worker shall ensure that a discharge plan is completed and incorporated in the individual's ISP within 30 days of the individual's admission to the training center. To facilitate the development of the discharge plan, the social worker shall provide support to the CSB support coordinator who will provide the individual and AR with:

- Specific options for community placements, services, and supports that are based on the criteria outlined in the discharge planning process; and
- The opportunity to discuss and meaningfully consider those options.

The discharge plan must be reviewed at the conclusion of 30 days, 60 days, and 90 days after its completion and at all subsequent reviews conducted in coordination with the CSB support coordinator.

For all individuals residing in a training center on March 1, 2012, a revised discharge plan shall be developed within six months of September 1, 2012.

Information compiled at discharge

Within 30 days prior to discharge, the discharge plan, which outlines all agreed-upon services and supports to be provided once the individual is discharged, shall be revised to include the specific community-based providers that have agreed to provide those services and supports.

Prior to an individual's day visit to a potential provider a discharge packet, minus the final plans, shall be sent to the CSB and the provider.

At discharge, the assigned member of the CIPT shall compile a packet of information that will include the individual's:

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- Final discharge summary, which includes the date of discharge, lists appropriate services and supports and the providers that have agreed to provide them, and identifies key contacts in the community including the licensing specialist, the human rights advocate, the community resource consultant and the CSB support coordinator; and
- A copy of the discharge plan and discussion record.

216 - 9 Procedures for Assuring Opportunities for Informed Choice

Community provider fairs

Each training center shall hold a community provider fair with educational activities at least annually. Signature sheets shall be used to document participation of individuals, providers, ARs CSB and training center staff. A copy of community provider fair signature sheets shall be maintain and made available to the Assistant Commissioner for Developmental Services, or designee, upon request.

Community opportunities information sessions

Training centers and CSBs, in collaboration with the members from the Office of Licensing and Office of Human Rights, CRCs, family resource consultant, and CIMs, shall host quarterly community opportunities information sessions to discuss service and supports available through the Medicaid waiver, the waiver referral process, and the availability of waiver and Money Follows the Person (MFP) waiver slots, and the option for community based ICF/IID supports.

Signature sheets shall be used to document participation of individuals, providers, ARs, and CSB and training center staff. Copies of community opportunities session signature sheets shall be made available to the Assistant Commissioner for Developmental Services, or designee, upon request.

Information on community opportunities

The individual and AR shall be provided information related to community opportunities via information posted on the Department's website, email correspondence, written brochures and information packets, telephone conversations, personal visits with the AR, provider visits, and discussions during quarterly and annual meetings.

Training center social workers, community integration staff and family resource staff shall offer information about regional supports that may be available, including peer and family mentors, support groups, and hotlines.

To facilitate increased knowledge and understanding of person-centered practices, the individual and AR may be offered training in person-centered thinking and person-centered planning.

To educate families about oversight provided in the communities, the individual

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and AR may be offered educational opportunities with Department staff who are involved in quality oversight (licensing) and human rights protections.

Tours of community provider homes

Each individual and his AR shall be afforded the opportunity to participate in tours of community provider homes, employment and day opportunities. Tours shall be facilitated by each training center and scheduled in conjunction with the CSB.

Social workerand assigned staff shall record the individual's tour participation.

Conversations and visits with community providers

The PST and the CSB support coordinator shall coordinate and facilitate efforts to provide the individual and AR with the following opportunities before they make an informed choice regarding options:

Conversations and visits with community providers *(continued)*

- Speak with providers that are qualified to support the individual;
- Visit community residences and program options; and
- Facilitate, if appropriate, conversations and meetings with prior training center residents and their families.

216 - 10 Procedures for Identifying Essential Supports and the Most Integrated Setting

Annual PST reviews

At least annually, the PST shall review the person-centered planning process and shall document participation in the review. This review shall include discussion of a "Good Life" during which the individual describes what is most important to or for his or her life. Documentation of this information must be included in the discharge plan and discussion record and be tied to the individual's support plan.

The PST shall identify all needed supports, protections, and services to ensure successful transition to the most integrated setting appropriate to the individual's needs and desires.

Community opportunity discussions

Discussions of community opportunities shall take place during each individual's annual PST meeting and at the request of the individual, AR, or other PST members and during regular contact.

If an individual or AR makes a request for community placement at a time that is not in conjunction with the annual ISP or quarterly review, the PST shall meet to discuss the request within six weeks of the request. The designated CSB and the AR must be given an opportunity to participate in the meeting.

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The community opportunity discussion shall be documented in the discharge plan and discussion record. At a minimum, topics shall include:

- The individual's vision of an optimal living environment. The PST and individual should answer "who", "what", "where", "when" and "why" questions. For example,
  - With whom is the individual going to reside?
  - In what type of living arrangement will the individual reside?
  - Where will this living environment be located?
  - When do the individual and the PST see the individual residing in this environment?
  - Why is the selected environment the most appropriate setting for the individual?
- The individual and PST must discuss the optimal living environment at the annual review meeting;

Community opportunity discussions *(continued)*

- Education of the individual or AR, or both, of alternate living options;
- Preference of the individual or AR, or both, for a specific living option;
- Essential and non-essential supports and services needed by the individual for transition to a community placement; and
- Barriers to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and strategies intended to overcome identified barriers.

Record of community discussion

Community opportunity discussion results shall be used by the PST to assess needed individual supports. The PST shall include documentation of needed individual supports in the discharge plan and discussion record.

The discharge plan and discussion record also shall identify any supports currently in place that the PST determines are not needed and the rationale for this determination.

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216 - 11 Procedures for Identifying and Addressing Barriers to Moving to the Most Integrated Setting

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Identifying barriers to transition

The individual's PST shall identify the barriers to the individual's transition to the most integrated setting consistent with the individual's needs and preferences identified during annual, quarterly PST meetings and scheduled pre move meetings including any community supports required to meet the individual's needs and preferences that are not currently available.

The PST shall document identified barriers in the discharge plan and discussion record and shall identify and implement strategies in the ISP that are intended to overcome those barriers.

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The support coordinator shall review and document progress in overcoming identified barriers as part of the quarterly review and reassessment and/or during special circumstance meetings when in active discharge planning.

Reporting barriers to discharge to central office

The training center Discharge Compliance Manager(DCM)/CIM shall compile a comprehensive listing of specific supports and services identified by the PSTs that cannot be secured in a community setting. All barriers to discharge shall be reported to the Director of Training Center Discharges and Community Integration, or designee, quarterly.

Required CIM notification

The assigned social worker must notify the CIM in all of following circumstances:

- When the PST recommends that an individual:
  - Transfer from a training center to a nursing home,
  - Transfer to a residential setting with five or more individuals, or
  - Remain in a training center;
- When the PST cannot agree on an individual's discharge plan outcome within 15 days of the annual PST meeting or within 30 days after the admission to the training center;
- When the PST is having difficulty identifying or locating a particular type of community placement, supports and services for an individual within 90 days of development of a discharge plan during the first year of the Agreement; Within 60 days of development of a discharge plan during the second year of the Agreement; within 45 of development of a discharge plan in the third year of the Agreement; and within 30 days of development of a discharge plan thereafter.
- When the individual or AR refuses to participate in the discharge planning process;
- When the individual or AR opposes discharge after all the discharge planning and informed choice requirements in this Instruction have been satisfied; or
- When, after all visits are completed, the individual is not discharged within three months of selecting a provider.

The PST shall identify the barriers to discharge and notify both the facility director and the CIM. Once notified, the CIM shall work with the PST in addressing barriers to discharge and shall make monthly reports to the central office.

PST actions - recommended discharge to or continued placement in training center

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In all cases where the PST recommends that an individual transfer to a nursing home or a residential setting with five or more individuals or continued residence in a training center, the PST shall:

- Document the decision in the discharge plan and discussion record;
- Identify the barriers to placement in a more integrated setting; and
- Describe in the discharge plan the steps the team will take to address the barriers.

For those cases where the PST recommends that the individual remain in a training center, the PST and CIM shall perform a quarterly re-assessment to ensure that the individual is in the most integrated setting appropriate to his or her needs.

PST actions - lack of active involvement by the AR in discharge planning

If the individual lacks capacity to consent to placement decisions and the AR is not actively involved with the individual in discharge planning, the PST must make all efforts to address the individual's request or PST recommendation for community placement. This includes decisions involving the identification of:

- Needed supports, protections, and services to ensure successful transition;
- Barriers to successful placement; and
- Strategies for overcoming those barriers.

PST actions - AR opposition to PST placement options

In the event that an individual or AR opposes the PST's proposed options for placement in a more integrated setting after having been provided information about available opportunities, the CIM/DCM shall ensure that the individual's PST:

- Identifies and seeks to resolve the concerns and objections of the individual and/or AR with regard to community placement;
- Meets to discuss the individual's or AR's concerns and objections with the CIM/DCM, or designee, social work director, and all parties, including the family resource consultant;
- Develops and implements individualized strategies to address the individual's or AR's concerns and objections to transition; and
- Documents the steps taken to resolve the concerns of the individual and AR and provides information about community placement.

Regional support team assistance

Each training center may access the expertise of a RST to review a case and resolve identified barriers. The PST can request assistance through the CIM when it believes such assistance is needed. In addition, the CIM may consult at any time with the RST.

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Required RST referrals

The CIM shall refer an individual's case to a RST:

- If the CIM is unable to document attainable steps to be taken to resolve barriers to community placement within two weeks of referral by the PST;
- If the PST recommends continued residence in a training center; and
- If the CIM believes external review is needed to identify additional steps that can be taken to remove barriers to discharge, including suitable alternatives.

For these cases, the RST shall have the authority to recommend additional steps to be taken by the PST or CIM, or both.

216 - 12 Procedures for the Transition Process

Discharge coordination focus

The focus of discharge coordination shall be on those individuals scheduled to move within the next year and other exceptional priority cases for which extra support is needed.

Active transition phase

The CIM or designee shall collaborate with the individual's PST, including the CSB support coordinator to:

- Identify individuals for intensive placement activities during the the transition process; and
- Distribute the list of identified individuals to appropriate staff.

The social worker shall coordinate with the PST to schedule the initial pre-move meeting. At this time the discharge plan and discussion record shall be reviewed and revised.

The training center support coordinator shall review and revise the transition-specific outcomes under the transitional goal in the individual's ISP with target dates for completion. Transition-specific person-centered outcomes shall include the following components:

- Receiving education about the types of supports available;
- Touring and visiting potential providers such as residential, employment, and day programs;
- Ensuring accuracy of information/assessments/physician's orders/plans/guidelines and event reporting used in development of the discharge plan and discussion record;
- Ensuring skill building outcomes and activities are developed and implemented to promote independence and successful community participation; and

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- Ensuring that prior to transition an individual's rights have guided the development of any supports related to an individual's security and safety in a more integrated-less restrictive setting.

The community integration/transition support coordinator shall review and revise the transition-specific outcomes under the transitional goal in the individual's ISP with target dates for completion. Transition-specific person-centered outcomes shall include the following components:

- Identifying training needs for the service provider;
- Coordinating with the CSB support coordinator to identify and secure auxiliary support services such as primary care or psychiatric services;
- Securing any adaptive equipment necessary;
- Developing relationships with persons in the individual's new residential community and strengthening family and natural supports; and
- Completing discharge plan that includes a "crisis plan".

Active transition phase *(continued)*

Provider selection

Based on the information collected at the initial pre-move planning meeting, the CSB support coordinator shall work with the individual and AR to make every attempt to find at least three viable residential and work or day support options for the individual to tour. The assigned social worker shall coordinate with CSB support coordinator to tour the providers.

At the same time, the assigned staff shall submit a "provider information request" to the CIM or designee. The CIM or designee shall request information from the Department's Office of Licensing and the Office of Human Rights.. The Office of Human Rights shall complete avisit to each potential provider and shall provide feedback to the CIM regarding any concerns that could affect the ability of the provider to ensure the health and safety of the individual as well as any corrective action plan needed to address these concerns. Every attempt should be made to receive all feedback prior to beginning the individual visits to a potential provider.

Visits to providers

Once an appropriate home is identified, the discharge coordinator or assigned staff shall:

- Schedule a provider pre-move meeting where the discharge plan and discussion record will be reviewed and revised. The provider shall have an opportunity to ask questions and offer alternative means of meeting the individual's needs;
- Discuss training that the provider will receive prior to individual's move;
- Discuss discharge specific tasks and identification of the responsible parties;
- Schedule an opportunity for the provider to shadow staff at the training center and interact with the individual in the training center environment;
- Schedule a series of trial visits to evaluate the individual's response to the new environment and how well his or her needs are met there and complete visit

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documentation; and

- Distribute discharge packet, minus final plans, to CSB support coordinator and to provider.

At a minimum, trial visits will include a day visit, an evening visit, and an overnight/weekend visit, unless otherwise approved by the CIM. Additional visits shall be scheduled as determined necessary. For each of these visits, written feedback will be provided describing the individual's response to the visit and identifying any additional supports that might be needed for a successful placement. This information shall be reviewed with the PST, including the CSB support coordinator.

PST evaluation of community visits

If, after the trial visits, the PST determines the individual and the provider are a good match, the discharge coordinator shall call a final pre-move meeting in coordination with the individual, AR, appropriate training center staff, CSB and the community provider. The PST shall:

- Review the visit forms and documentation,
- Decide if the potential placement appears to meet the individual's needs,
- Address any problems that were identified on the visits,
- Confirm the projected move date, and
- Begin making any arrangements to ensure that they are completed prior to the move.

This meeting shall be documented by the training center supports coordinator or designee in the discharge plan and discussion record.

Provider training

Once a provider has been identified to serve an individual, the PST shall facilitate introductory and specific training needed by the community provider related to the care and treatment of the individual, persons responsible for conducting the training, and timelines for completion of the training. This training will be provided at the training center and/or provider agency by the center's professional disciplines and staff.

All providers must participate in the required training. Providers may show proof that they offer the required training internally or may choose to receive the training through the training center or another resource.

Providers should choose staff to attend the trainings who will be interacting with the individual and who can accurately share information gathered from the training with staff unable to attend the training.

Completion of required training shall be documented on separate training records for each session and signed by all participants. As part of the training, the trainer will determine and document provider's ability to show competency within the

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training environment.

Any concerns regarding training shall be discussed with the PST and resolved prior to an individual leaving the training center. All training must be completed prior to an individual's unaccompanied overnight visit. Providers will submit verification of staff trainings to the CIM or designee.

CIPT transition activities

Once a placement has been agreed upon, the following transition activities shall occur:

CIPT transition activities *(continued)*

- The CIPT designee shall prepare a memo that includes all relevant details surrounding the placement, projected discharge date, and the date and time of the discharge staffing. This memo shall be distributed to all major divisions of the training center. Placement notification will typically occur two to four weeks in advance of the placement date.
- The CIPT designee shall prepare a discharge memo that includes all relevant details surrounding the placement, projected discharge date that is sent to the individual, AR, and relevant community providers. The CIPT confirms with the CSB that all essential supports are in place.
- CIPT confirms date of Final Pre-move meeting with residential and employment/day support.

216 - 13 Procedures for Pre-Move Site Reviews

Pre-move site review

After the final discharge plan meeting and prior to an individual's discharge, the CIPT designee and CSB support coordinator shall determine if a pre-move site review is needed. This review, if needed, shall include a general overview of the living environment and the availability of essential supports.

- ***Essential Supports:*** Essential supports must be in place prior to moving to the community. The CIPT designee or CSB support coordinator, shall verify that essential supports identified by the PST are in place.
- ***Non-Essential Supports:*** The absence of supports identified as non-essential shall not be considered a barrier to transition, but a written agreement enclosed in the final discharge plan, setting forth the implementation date of those non-essential supports shall be signed by the provider and received by the CIPT designee and CSB support coordinator prior to the individual's discharge.

Once completed, the pre-move site review shall become a part of the individual's discharge plan documentation. Review findings shall be shared with the PST.

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Final pre-move meeting

After completion of the pre-move site review, and confirmation that supports are in place, final arrangements shall be initiated for the individual's move to the community.

If the Pre-Move Site Review confirms that the provider setting is not yet appropriate for the transition of the individual, due to the absence of agreed-upon supports, the CIPT designee shall make written recommendations for specific remedies to address the problems and expected time frames and send these recommendations to the provider, individual, AR, CSB support coordinator, and CIM.

Pre-move site visit findings *(continued)*

The individual or AR has the option of:

- Waiting until the recommendations have been or are in the process of being implemented by the provider; or
- Continuing with the move without the PST determination that the recommendations have been or are in the process of being implemented by the provider.

The individual's or AR's decision to continue with the move shall be documented and the CIM shall share the information with applicable post move monitoring stafffor further action as required. .

Final Pre-move Meeting

PST meeting shall be held after the individual's final visit to the provider has been completed. The provider and CSB may participate by phone. The meeting shall include:

- Confirmation of training center Post Move Monitoring dates;
- Completion of the final discharge checklist
  - CSB support coordinator notifies receiving CSB when a selected provider is outside of home CSB region.
-
- Confirmation of the date set for final medical information to be sent to community physicians, provider and CSB and confirmation of medical to medical communication between training center medical professional and community medical professional.
- Review of the visits to determine results and impact for supports required for the move are reflected in the final plan.

216 - 14 Procedures for Post Move Monitoring and Reporting

Post Move Monitoring process

The goal of the Post Move Monitoring process is for training center staff to work collaboratively with the CSB, CIM, individual, AR and provider to:

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- Ensure essential and non-essential supports agreed upon in the discharge plan are being provided;
- Monitor the individual's adjustment to his or her new home;
- Offer additional support services to the individual, AR, provider, or CSB;
- Provide necessary recommendations to the community provider to resolve identified concerns and document steps in the Post Move Monitoring report; and
- Provide access to Post Move Monitoring report with the training center director, or designee, CSB supports coordinator, CIM, Office of Licensing, and Office of Human Rights.

Post Move Monitoring process *(continued)*

The post-move monitor (PMM) is a **required** participant in the final pre-move planning meetings with the individual and AR. The PMM shall ensure that essential support are written in mearsureable terms.

Post Move Monitoring contacts

The training center Post Move Monitoring process shall begin on the date of discharge and shall continue for a minimum of 45-60 days post discharge. The PMM shall conduct Post Move Monitoring visits a minimum of four times following an individual's movement to the community setting. Other contacts may be made during the year as necessitated by the individual's needs.

Post Move Monitoring visits shall be conducted within each of four intervals (3, 10, and 17, and post 30 days) following an individual's movement to the community setting.

- All four post-move contacts shall involve face-to-face contact with the individual.
- At least three of the four post-move contacts shall involve visits to the residential provider.
- At least one visit shall occur at the work site or day program.
- All monitoring shall include a phone or face-to-face contact with the individual's AR.

Documentation of the monitoring visit shall be made using the Post Move Monitoring checklist.

Monitoring visit results and all supporting documentation shall be sent to the CIM or designee within two working days following the monitoring session. The CIM or designee shall share the post-monitoring report with the CSB support coordinator, provider, Office of Licensing and Office of Human Rights as requested.

At the conclusion of the four Post Move Monitoring visits, the PMM, with input from the PST as needed, shall make a determination if additional monitoring by the training center should continue. The PMM shall document this decision on the forth post-monitoring report.

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The CSB support coordinator will conduct a post move monitoring visit within 7 days and monthly thereafter for at least 12 months. The CSB support coordinator will share the CSB PMM documentation with the training center PMM coordinator.

Resolution of areas of concern

If during the term of the post-monitoring the PMM, PST, CSB staff, CIM. (1) believe that an expected essential support has not been put in place by the community provider, (2) identify some other concern related to the protection of the individual, or (3) determine an individual is in an unsafe environment, they shall **immediately** notify the appropriate parties, which may include the:

- Department's Director of Licensing or designee;
- Department's Director of Human Rights or designee;
- Adult Protective Services;
- Individual's AR;
- CIM; and
- CSB.

During monitoring visits, if the PMM identifies areas of concern, i.e., cleanliness of home, kitchen not properly stocked, etc., the PMM shall:

- Make necessary recommendations to the community provider to address the identified concerns;
- Communicate identified concerns to the CSB supports coordinator; and
- Document those concerns and actions on the Post Move Monitoring checklist.

If the PMM determines during a monitoring review that an agreed upon support, not affecting health or safety, is not in place by the community provider **or** identifies some other concern related to the individual, the PMM shall:

- Document these concerns on the Post Move Monitoring checklist, along with the action taken; and
- Provide these findings to the CIM along with any recommended changes, who will send this information to the CSB support coordinator, provider, and the Office of Licensing (if applicable).

If the PMM determines that the individual is in potential harm and if he or she is not immediately removed to an alternate setting, the PMM shall immediately notify the following parties: Adult Protective Services ,CSB support coordinator, the Office of Licensing, Office of Human Rights, and Community Integration Director, CIM,.

If action plans are required, the PMM, with the CIM, shall coordinate with the community provider and CSB support coordinator to ensure that all required action plans are completed and shall document such in the post monitoring checklist.

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If changes or revisions are made to the identified supports and services outlined in the discharge plan, the PMM shall note this in the post monitoring checklist.

Role of the regional teams

If following the individual's discharge, the provider does not comply with the provisions of the discharge plan and the CSB has exhausted all options to resolve the conflict, the CSB may submit an RST referral.

The individual shall be provided the opportunity to receive a temporary placement with another provider or respite services until a new community provider can be chosen. If the situation warrants, the discharge coordinator shall determine if the CSB is interested in submitting an application to the training center Admissions Management Committee (AMC) for respite/emergency care until such time that another community provider can be obtained.

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216 – 8 References

- 12VAC35-105 Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (DBHDS)
- 12VAC35-115 Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department (DBHDS)
- Admission and Discharge Protocols for Persons with Intellectual Disability, March 3, 2011
- Code of Virginia - Sections 37.2- 505, 37.2- 506, and 37.2- 837
- Community Services Performance Contract; Central Office, State Facility, and Community Services Board Partnership Agreement; and Board Administrative Requirements, DBHDS
- CMS Intermediate Care Facilities/ Intermediate Care Facilities for Persons with Intellectual Disabilities regulations
- CMS Interpretive Guidelines – Intermediate Care Facilities for Persons with Intellectual Disabilities, Tags W201 – W204 (as related to facility discharge)
- Departmental Instruction 105(TX)99, Authorized Client Leave Practices
- Olmstead v. L. C., 527 U.S. 581(1999)
- Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101

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- United States of America v. Commonwealth of Virginia Settlement Agreement, filed in the United States District Court for the Eastern District of Virginia, Richmond Division, January 2012
- Virginia's Choice Protocol: A Protocol for Offering and Resolving Issues Regarding Choice in Virginia's Intellectual Disability & Day Support Home and Community Based Waivers, revised January 2011

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Connie L. Cochran
Assistant Commissioner Developmental Services

Effective Date: June 16, 2017

Attachments

1. Training Center and Central Office Positions - Primary Implementation Responsibilities

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Attachment 1

Training Center and Central Office Positions - Primary Implementation Responsibilities

	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Training Center Social Worker	• Completes paperwork to include o social histories, o applications for birth certificates, o social security cards, o financial and releases • Maintains support notes related to all individual, AR and family communication related to education of options and discharge activity in established SW note	• Provides ongoing education related to options • Ensures regular contact with families • Documentation to be reflected in established SW note	• Serves as liaison for CSBs	• Maintains contact with providers and make referrals to CIPT • Assists with touring and identifying provider options
Director of Social Work	• Collaborates with CIM for planning, based on individual's support needs and how individuals should be prioritized for the active move list • Trains new social workers about resources and responsibilities related to discharge • Provides professional guidance and supervision to social workers related to discharge • Monitors and supervises social work activities to ensure continuity and consistency, regulatory compliance, and effectiveness of services related to discharge • Ensures SW staff comply with DBHDS and facility requirements related to discharge • Monitors social work staffing needs and makes recommendations to maintain necessary staffing levels as facility downsizes • Evaluates social worker DC training needs and provides or arranges for training as needed • Monitors social worker participation in ISP and Pre move Planning meetings • Reviews social work documentation and performance for overall effectiveness and adherence to federal, state laws and DBHDS regulations related to discharge • Oversees AR and guardianship process for all training center individuals	• Works effectively with facility's parents/relatives organization (as invited) • Facilitates relationships with individuals' families • Manages admission referrals	• Ensures CSBs have schedules for ISP reviews and participate in plans, and ensures all ISP documentation is completed and sent to CSBs • Develops working relationships and effectively identifies and utilizes available community resources • Ensures all community options have been exhausted and process of CSB, CRC, RST and CCCT has been followed before convening AMC.	• Takes calls and inquiries from providers around state and refers to the Community Integration Team for follow up

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Community Integration/Transition Support Coordinator	• Serves as a member of PST • Guides PST to indentify supports needed for more integrated living options and preparation for moving • Works with team to develop strategies to overcome barriers • Facilitates development and documentation of the Discharge Plan and Discussion Record (DPDR)	• Guides family through the development of the Discharge Plan and Discussion Record	• Guides CSB through the development of the Discharge Plan and Discussion Record	• Guides provider through the development of the Discharge Plan and Discussion Record
Community Integration Clinician/Specialist	• Attends pre-move meetings • Coordinates all tours and visits with AR, CSB SC, SW, DC, and provider • Arranges and provides transportation for tours and visits • Follows-up with residential, medical, ancillary to ensure all meds, equipment, clothes, and medical clearance for the trip • Is in charge of overnight visits and assigning tasks • Completes discharge related tasks under the guidance of CIM and DCM • Completes and collects written reports related to results of visits from providers • Maintains support notes related to all discharge coordination activity	• Contacts families regarding discharge activities • Accompanies AR on visits as needed	• Collaborates with CSB SC and individual to facilitate provider tours and visits	• Visits providers to obtain information about available services • Accompanies families and individuals on tours of community providers • Participates in visits with training center staff • Reports results to DC

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Discharge Coordinator/Social Worker	• Becomes the social worker of record for all discharge coordination • Facilitates identification of adaptive equipment • Participates in all pre-move meetings to ensure all necessary actions are completed • Meets regularly with CIM, DCM and FRC regarding challenging cases or when CO support may be needed • Completes discharge related tasks under the guidance of the CIM and DCM • Coordinates and ensures time line for discharge activity with all other members of discharge team • Provides written update for progress toward move for review • Ensures all discharge services have been completed ahead of time and are ready at time of discharge, i.e.- physical, meds, equipment, personal items, funds transfer • Maintains support notes related to all discharge activity • Informs CIM (CIM), Discharge Compliance Manager (DCM) and Family Resource Consultant (FRC) of families who will not consider discharge in order to work with them to coordinate educational efforts • Coordinates CSB and provider visits to the training center • Collaborates with Community Integration/Transition Support Coordinator to ensure accuracy of DPDR	• Educates families about community living options, Olmstead etc. • Assists family to connect with community stakeholders • Ensures releases are obtained	• Works with CSB SC to ensure provider choice process is completed	• Coordinates visits between individuals/families/ providers

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Post Move Monitoring Coordinator/Post Move Monitor	• Coordinates all Post Move Monitoring • Ensures visits are completed within established time frames • Ensures PMM documentation is completed • Reviews reports • Follows up with CSB and training center monitors. • Follows up to ensure Post Move Monitoring requests and concerns are addressed • Addresses concerns with CIM • Reports potential training needs discovered from Post Move Monitoring to the person responsible for training coordination • Keeps data on gaps in services, trends etc. • Shares Post Move Monitoring reports with appropriate partners when provider training is indicated • Collects Post Move Monitoring visit data and inputs data for tracking to the CIM • Completes Serious Incident follow up reports • Collects and develops stories related to individuals who have successfully moved to community options	• Educates families about Post Move Monitoring process • Contacts family for follow up related to Post Move Monitoring • Provides completed training center Post Move Monitoring reports to family as requested • Identifies families interested in serving as a Family Mentors or Community Living Contact and refers to FRC	• Educates CSB about Post Move Monitoring process • Coordinates with CSB SC to obtain CSB Post Move Monitoring reports and information for follow up • Provides completed training center Post Move Monitoring reports to CSB SC	• Educates provider about Post Move Monitoring process • Provides Post Move Monitoring, assistance and follow up • Provides completed training center Post Move Monitoring reports to providers
Training Coordinator	• Provides internal review and quality assurance of the discharge process as it relates to training • Communicates all information and concerns related to provider training and the discharge process to CIM • Closely monitors time lines and target dates pertaining to completion of training to facilitate steady and appropriate progress towards discharge • Ensures that all training is completed for items identified as essential and individualized supports • Maintains documentation and data related to provider training • Collaborates with DSP and other training center staff to identify individual preferences for informal/formal supports	• Coordinates requested training between training center staff and families	• N/A	• Coordinates all required training between training center staff and providers • Obtains verification of provider training records • Educates provider on “train the trainer” model and receives documentation of training

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
RN Quality Manager	• Reviews physicians' orders to evaluate implementation in the community while maintaining quality and safety • Reviews discussion records for congruence with physicians' orders and current best practices • Resolves discrepancies regarding supports and documentation with department heads as needed • Conducts special audits/reviews whenever significant event occurs (ex., death in the community) and as assigned • Follows up with appropriate CIPT and Training Center medical staff regarding errors, issues and concerns related to medical support needs • Conducts review of medical history and submits to Post Move Monitoring Coordinator for inclusion in Serious Incident Follow-Up Reports • Compiles and analyzes data from audit findings and presents written findings to the CIM as requested • Conducts special reviews and audits as requested regarding support needs, diagnoses, etc • Ensures training center nurses are completing discharge related tasks (directly or via communication with the Director of Nursing) • Provides training and education to Training Center Medical Staff as needed regarding issues related to the discharge process • Serves as a Subject Matter Expert for members of the CIPT on issues related to medical care and support for individuals in the active discharge process • Ensures relationship building between community PCP and training center medical staff is established prior to discharge	• Educates families about community medical care and community options • Works with family and individual to facilitate effective transition of information related to medical care • Ensures relationship building between community PCP and families is established prior to discharge	• Works with CSB SC to facilitate effective transition of information related to medical care	• Coordinates medical care with providers • Works with all community providers to facilitate effective transition of information related to medical care

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Discharge Compliance Manager	• Monitors pre move meetings and discharge activities • Inputs monthly discharge-related activity data • Provides ongoing communication between Community Services Office and other departments to monitor discharge-related issues that involve individuals, ARs, and community agencies • Serves as liaison between the CSB, providers, and discharge team and meets with the discharge team on a weekly basis • Updates moving timeline • Monitors consistency of all assessment discharge paperwork flows by observing meetings and completing audits of files • Oversees Completion of: o Discharge memos o Plans o Discharge packet for each person being discharged • Oversees ordering of adaptive equipment • Provides internal review and quality assurance of transition and final discharge plan • Facilitates and/or participates as a member of the Regional Support team • Analyzes and trends barrier data and facilitates action plan	• Coordinates with the CRC and/or FRC (whichever is more appropriate) to facilitate participation in training about community options • Works with individuals and families to overcome barriers preventing movement to more integrated settings	• Speaks regularly with CSB SC regarding systems issues or updates in regulations and expectations	• Is aware of providers and community resources for supports • Participates in Post Move Monitoring visits as needed

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
CIM	• Oversees compliance with any discharge related policies • Serves as liaison with CSB ID Directors and other community agencies • Ensures communication and policy development and implementation on a regional basis • Participates in regional planning and other issues by attending regional ID Director meetings, provides training as needed to regional staff regarding protocol issues • Ensures the Regional Support Team convenes when individual meets criteria • Oversees quality and accuracy of discharge process • Works with the FRC to maintain list of families opposed to community placement and monitors steps taken to resolve concerns • Monitors discharge targets and co-facilitates discharge status meetings • Analyzes and trends discharge data and facilitates corrective action plans • Analyzes and trends Post Move Monitoring data and facilitates action plan • Meets with the DC staff regularly to discuss concerns and provide proactive support • Oversees coordination of provider training • Keeps Director of Community Integration abreast of all pertinent information • Oversees scheduling and leads Provider Fairs annually • Facilitates resident, family and staff education of community options • Assists facility director in developing and implementing policies on staff becoming providers and ensures against conflict of interest of referrals • Collaborates with community stakeholders to asses provider capacity and assist with provider development	• Coordinates with the CRC and/or FRC (whichever is more appropriate) to facilitate participation in training about community options • Works with individuals and families to overcome barriers preventing movement to more integrated settings	• Speaks regularly with CSB ID Directors regarding systems issues or updates in regulations and expectations	• Works with the regions on identifying training needs, system barriers and developing strategies to address issues • Is aware of providers and community resources for supports

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Family Resource Consultant	• Organizes and conducts work groups in each region to develop a regional approach (including input from the Training Center perspective) to educate and inform families of community options including funding sources • Develops and tracks individual profile survey results for identification of needed individual supports and services • Collects and develops stories related to individuals who have successfully moved to community options • Maintains lists of concerns and issues and develops fact sheets to address the issues • Organizes and conducts opportunities for family education • Facilitates ongoing development of the Family Mentor Network Program o Recruits families/ARs interested in serving as a mentor or Community Living Contact • Provides training on MFP • Convenes parent workgroups • Participates in training about community options • Facilitates ongoing development of the Peer Mentor Program • Facilitates referral process for Family Mentor Network Program and Peer Mentor Program	• Connects with families to listen to their concerns and issues about community placement • Works with individuals and families to overcome barriers preventing movement to more integrated settings	• Organizes and conducts work groups in each region to develop a regional approach (including input from the CSB perspective) to educate and inform families of community options and funding sources • Participates in CRC Regional ID SC Roundtable meetings as needed	• Maintains Provider Services and Supports Survey to identify available and needed community capacity • Participates in CRC Regional Provider Roundtable meetings as needed
Community Resource Consultant	• Participates as a member of Regional Support Team and Admission Management Committee as needed • Provides ongoing PCT and PCP Training for staff who require training • Provides training and ongoing mentoring of coaches within the training center for those that are trained • Provides waiver training	• Provides information related to PCT, PCP and RST as requested • Provides information for community resources	• Provides ongoing PCT PCP, and waiver training • Provides training and ongoing mentoring of coaches in community	• Provides ongoing PCT PCP, and waiver training • Provides training and ongoing mentoring of coaches in community • Provides outreach to new providers • Arranges training for providers based on needs identified by CIM and DC • Provides monitoring for discharged individuals who may need additional support as requested • Provides regional/area specific technical assistance

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	Primary Responsibilities within Training Center	Interface with Families/ARs	Interface with CSBs	Interface with Providers
Director of Community Integration	• Monitors, under supervision of the Assistant Commissioner of Developmental Services, compliance of DOJ settlement agreement as it pertains to CRIPA and (Olmstead) movement from TC to the community • Helps facilitate system change to ensure individuals in TCs can be served in most integrated setting • Monitors any CRIPA plan • Ensures consistency implementation of CRIPA outcomes at all TCs • Provides regular on site monitoring of DOJ related plans • Ensures thorough and robust communication between various internal staff • Conducts research and shares findings related to DOJ actions in other states • Helps staff prepare for monitoring visits by DOJ monitor • Writes reports based on findings of internal audits and works directly with facility director • Reviews the data that is submitted by TCs to identify barriers to discharge planning and to use as planning for building community capacity • Reviews and provides quality/analytical reports • Reports on achievements and benchmarks as well as liaison with other state agencies as necessary • Assures that stakeholders are kept informed of DBHDS operational efforts as necessary • Ensures DBHDS efforts are meeting target dates/outcomes and that questions/ concerns are processed • Ensures any barriers to implementation are communicated to Assistant Commissioner	• Provides information and education related to community options and the discharge process as needed and/or requested	• Remains in contact with ID Directors • Works with CSBs to facilitate systems change as it relates to movement from the TC to the community	• Works with providers to facilitate systems change as it relates to movement from the TC to the community

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