Discharge Plan and Discussion Record

1.29.21

Meeting Date:

Individual: Click here to enter text.

DOB: Click here to enter date.

Avatar Number:

Levels of Mobility:
Ambulatory without support ☐; Ambulatory with support ☐; Uses wheelchair ☐; Total assistance ☐

Admission Date: Click here to enter a date.

Highest Level of Communication:
Spoken Language, fully articulates without assistance ☐ ;Limited spoken language, needs some staff support ☐; Communication device☐; Gestures ☐; Vocalizations ☐

Substitute Decision Maker: Click here to enter text.
Guardian ☐; Authorized Representative/SDM ☐

Training Center Social Worker: Click here to enter text.

Residential Manager/QIDP:

Home CSB:

CSB Support Coordinator: Click here to enter text.

Please check all that apply:

☐ 30 Day Review ☐ 60 Day Review ☐ 90 Day Review ☐ Annual Review
☐ Initial Pre-Move ☐ Provider Pre-Move ☐ Final Pre-Move
☐ Special Circumstance related to discharge number # Click to enter number. (Only review barriers)

Did the individual participate in discharge planning?
☐Yes ☐No; if no, reason(s):

Did the Substitute Decision Maker/Guardian participate in discharge planning?
☐Yes ☐No; if no, reason(s):

Agenda

1. **Positive Attributes -** share the positive attributes you admire most about the individual.

2. **Personal Support Team and Individual discuss the Personal Profile (i.e. the Good Life, Talents/Contributions, Working/Not Working).** (*Pull up PC ISP Part II to refer to-Discharge Plan must be tied to Person-Centered Plan)*

   Good Life

   Talents/Contributions

   Working

   Not Working

3. **Team decides on Important TO/Important FOR including protection from harm.** *(Pull up and refer to PC ISP Important To/For Outline):* Based on Review of the Profile, Comprehensive Functional Assessment (CFA) recommendations,

(and/or other assessments). Must bring Event/Incidents Data for the last year & review analysis of event data *(i.e. hospitalizations, falls, aspirations, etc.).*

Things that are Important To:

Things that are Important For:

INCIDENT REPORT SUMMARY FOR PAST YEAR

HOSPITALIZATION/ER VISITS:

# OF EPISODES	Details/Type of Incident/injury and intervention required

(Code of Virginia - Sections 37.2- 837)

In the following section, be brief but concise and include information related to the supports that the individual is <u>currently</u> receiving. Based upon the "Important To(s)" and "Important For(s)" listed above, please specify if the person has skill development needs and recommend skill development activities.

Staffing Supports Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Supported employment/day options Currently has skill development needs? ☐Yes ☐No	(Note: Is individual currently employed or volunteering/how many hours?) Recommendations for skill development activities:
Environment Currently has skill development needs? ☐Yes ☐No	(i.e. space, accessibility, proximity to other people/shopping/roads/housing etc.) Recommendations for skill development activities:
Medical/nursing	

Currently has skill development needs? ☐Yes ☐No	
Mental health (Psychological/psychiatric/substance abuse) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Behavioral Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Nutritional Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Physical Therapy Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Occupational Therapy Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Speech Language Therapy	Recommendations for skill development activities:

Currently has skill development needs? ☐Yes ☐No	
Communication (Communication Dictionary and outcomes developed by others who are not SLT.) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Equipment Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Transportation Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Social (family, friends, volunteers, church) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Recreational Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:

Financial (management of funds) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Legal	
Advocacy/SDM Appointment	
Additional Comments	

4. Based on the assessment results, describe essential supports needed for transition to community based services.
(I.e. If the individual moves today, what supports does he/she need? Detail staffing needs for daytime, overnight, community etc. Which Department will complete the Specific Training for the providers?)

Essential Health and Safety Supports Group similar support needs together based on the following categories: *Staffing Supports, Type of supported employment/day placement/optimal length of day, Needs for the person's environment (space, accessibility, proximity to other people/shopping/roads, etc., Medical/nursing, Psychological/Psychiatric, Behavioral, Nutrition, Physical Therapy, Occupational Therapy,* Speech Language Therapy, *Communication (pain and distress), Equipment, Transportation, Social (family, friends, and volunteers, church), Recreational/Leisure, Financial, Legal, Advocacy/AR Appointment*	**Training** *To be scheduled at provider pre-move meeting* **Choose dates below.**		
	Scheduled	**Completed**	**Training to be completed by (please enter the name and discipline)**
Staffing Support			
Supported employment/day options			
Environment			
Medical/nursing			
Mental health (Psychological/psychiatric/substance abuse)			

Discharge Plan and Discussion Record

1.29.21

Behavioral			
Nutritional			
Physical Therapy			
Occupational Therapy			
Speech Language Therapy			
Communication (Communication Dictionary and outcomes developed by others who are not SLT.)			
Equipment			
Transportation			
Social (family, friends, volunteers, church)			
Recreational			

Name: Avatar Number: Meeting Date: 6

DPDR is draft and subject to change as required. The document used with supporting plans and assessments will become final upon discharge.

Financial (management of funds)			
Legal			
Advocacy/AR Appointment			
Additional Comments			

5. Team discusses rights restrictions.

The following rights restrictions were identified (e.g. Adaptive Clothing; Limited Access to Personal Hygiene Items; Sedation for Preventative Medical Care; Physical/Mechanical/ Pharmacological Restraints; Seat Belts and Bed Rails, Locked Doors.)**:**

Describe plans to address rights restrictions:

6. Concerns – Use Chart below to explain concerns or any reasons the Individual, any team member, SDM or family member is reluctant to transition. If "yes" is selected under Barrier, please complete the Barrier Table below. Describe plans to address these concerns: (This must be updated, as needed at each meeting. Be sure to include dates for each step!)
**** If 3 viable options are not offered, list this as a concern**

Concerns	Plan/Steps to Address Concerns	**Barrier** Yes/No – meaning PST cannot resolve	Person Assigned	Due Date	Comments
		Choose one	Click to name	Choose date	
		Choose one	Click to name	Choose date	

If barriers to move to a more integrated setting were identified above, were steps undertaken to resolve such barriers? ☐Yes ☐No; if no, reason(s):

Barriers related to Waiver Service Options or Other (Please use key below to identify barriers)

1. Employment and Day Options — Select unavailable service — List multiple services and barrier #(s)

2.	Self-Directed Options (may be Agency Directed)	Select unavailable service	List multiple services and barrier #(s)
3.	Residential Options	Select unavailable service	List multiple services and barrier #(s)
4.	Crisis Support Options	Select unavailable service	List multiple services and barrier #(s)
5.	Medical and Behavioral Support Options	Select unavailable service	List multiple services and barrier #(s)
6.	Additional Options	Select unavailable service	List multiple services and barrier #(s)
7.	Other	Description	List corresponding barrier number(s)

Barrier Key (Choose all barrier numbers that apply and place in the applicable list above)	
1	Services not available under currently enrolled waiver
2	Services and activities unavailable in desired location
3	Community location is not adapted for physical access (not wheelchair accessible or ADA compliant)
4	Direct Support Staff- may not have experience or demonstrate competency to provide support with behavioral expertise
5	Direct Support Staff- may not have experience or demonstrate competency to provide support with mental health expertise
6	Direct Support Staff- may not have experience or demonstrate competency to provide support with medical expertise
7	Professional Behavioral staff- Psychiatric, PBS facilitator, Applied Behavioral Analyst, or other specialist unavailable
8	Professional Medical staff- Dental, nursing or any medical specialist unavailable
9	Accessible transportation unavailable
10	Individual/SDM/LG chooses less integrated option
11	Individual/Substitute Decision Maker (SDM)/Legal Guardian (LG) not interested in discussing/exploring options/refuses supports
12	Individual/SDM/LG does not choose provider after visit/still exploring community options
13	Frequent hospitalizations- medical and/or mental health hospitalizations
14	Delay in move and/or acceptance to a more integrated setting- due to unexpected or late medical interventions
15	Provider has determined placement is not a good match- provider is not willing/able to support individual
16	Service/Provider Development or Loss- Construction/Renovations/Environmental Modifications/Staffing/On-boarding/Licensing
17	Other (please list all other barriers below)

Comments :	

7a. All of the following types of residential options have been discussed with the Substitute Decision Maker(s) prior to beginning the active move process. Please provide the date(s) the discussions occurred with the SW, CSB SC and PST. Please note if preferred option(s) is only available out of the region where the individual wishes to reside:

Option	SW	Dates	CSB SC	Dates	PST	Dates	Service is only available out of region where the individual wishes to reside.
Own Home (Rental Assistance Voucher)							
Leased Apartment (Rental Assistance Voucher)							
Family Home							
Sponsored Home							
Group Home (4 or fewer)							
Group Home (5 or more)							
ICF							
Nursing Home							
Training Center							
Other							

Was it documented that the individual, and if applicable, his/her Authorized Representative, were provided with information regarding community options? ☐Yes ☐No; if no, reason(s):

Was placement, with supports, in affordable housing, including rental or housing assistance, offered? ☐Yes ☐No; if no, reason(s):

7b. All of the following types of employment/day support options have been discussed with the Substitute Decision Maker(s) prior to beginning the active move process. Please provide the date(s) the discussions occurred with the SW, CSB SC and PST. Please note if preferred option(s) is only available out of the region where the individual wishes to reside:

Option	SW	Dates	CSB SC	Dates	PST	Dates	Service is only available out of region where the individual wishes to reside.
Self-employment							
Individual Supported Employment							
Group Supported Employment							
Workplace Assistance							
Community Engagement							
Community Coaching							

Group Day Services							
Volunteer							
Retirement							
Other:							

Is the individual interested in employment? ☐Yes ☐No

If yes describe:

If no, reason(s):

What are the potential barriers to employment?

Individual/AR was given information and opportunity to be referred to Department of Aging and Rehabilitative Services (DARs):

☐ No referral needed, not interested

☐ Yes information was given

☐ Yes, a referral to DARS was made

Date referred: Click here to enter a date. By whom? Click to name (Title) Click to enter title

8a. Potential Viable Community Residential Provider(s) Identified: At least one viable provider must be 4 beds or fewer. If the 4-bed option is outside of the preferred region, that option will be considered the 4th option.

1. Click here to enter provider

2. Click here to enter provider

3. Click here to enter provider

4. Click here to enter provider

5. Click here to enter provider

6. Click here to enter provider

7. Click here to enter provider

8. Click here to enter provider

9. Click here to enter provider

10. Click here to enter provider

Name, address and contact for Residential Provider selected: Click here to enter selected provider.

Is the individual being served in the most integrated setting consistent with their informed choice and needs?
☐Yes ☐No; if no, reason(s):

8b. Potential Viable Community Employment/Day Providers – Virginia is an Employment First State which means Supported Employment must be offered as a first choice. An individual/AR may decline such offer. Individual is "unable" to work is not an acceptable response; instead please document supports the individual would require to work successfully in the community.

1. Click here to enter provider

2. Click here to enter provider

3. Click here to enter provider

4. Click here to enter provider

5. Click here to enter provider

6. Click here to enter provider

Name, address and contact for Employment/Day Provider selected: Click here to enter selected provider.

Please check all services that apply.

☐ Individual Supported Employment ☐ Group Supported Employment

☐ Workplace Assistance Services ☐ Community Engagement

☐ Community Coaching ☐ Group Day Services

8c. Discuss and review other identified community Providers (Dental, Specialist, Durable Medical Equipment (DME), Pharmacist, Psychiatrist/Behavioral Specialist (Positive Behavioral Support Facilitator (PBSF), Applied Behavioral Analyst (ABA), etc.), REACH Coordinator, Developmental Disabilities Health Service Network (DDHSN) etc. if applicable. *Please attach specialist form*.

9. Provider type requiring CIM review

Provider Type Requiring CIM Review			
Type of Program Chosen	**Choose one (indicate Yes/No)**	**Reasons Identified for choosing home or not choosing Employment/ Day Options**	**Actions taken** Note: If a move to a residence serving five or more individuals was recommended, referral to the Regional Support Team (RST) will be made to identify barriers to placement in a more integrated setting
5 or more individuals served in a home	Choose an item.		
ICF/ID	Choose an item.		
Nursing home	Choose an item.		
More than one (1) program on a site	Choose an item.		
Employment not chosen	Choose an item.		
Day Options not Identified	Choose an item.		

Retired	Choose an item.		

**** If any of the above are "yes" –CIM or Designee must complete and submit an RST referral form**

☐ RST Referral form will be completed

Date referred: By whom? Click to name (Title) CIM Click to enter title

RST Follow Up Information:

☐ RST Referral form does NOT need to be submitted at this time.

If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Regional Support Team (RST) identify barriers to placement in a more integrated setting? ☐Yes ☐No; if no, reason(s):

10. Referrals

REACH - Individual/AR was given information about REACH and opportunity to be referred to REACH for assessment**.**

☐ Yes, information was given.

☐ Yes, a referral to REACH was made.

Date referred: Click here to enter a date. By whom? Click to name (Title) Click to enter title

☐ N/A – individual does not currently have any need for REACH services.

☐ Individual/Family did not choose REACH services.

FAMILY RESOURCE CONSULTANT - Individual/AR was given information about Family Resources (all individuals/ARs MUST receive information) and was offered a chance to be referred to the Family Resource Consultant for connection to the following options.

☐ Yes, individual/SDM received community resource materials and was offered to be referred to the Family Resource Consultant – (This should always be checked as we have an established packet that is sent to all ARs as well as a packet that is given to individuals/SDMs at each annual and initial pre-move meeting).

☐ Yes, a referral to the Family Resource Consultant was made.

Date referred: By whom? Click to name (Title) Social Worker

☐ Yes, individual/SDM wants to speak with other individuals with ID/DD who live and work successfully in the community.

☐ Yes, individual/SDM wants to speak with family members of individual with ID/DD who live and work successfully in the community. (Community Living Contacts - One time discussion)

☐ Yes, individual/SDM would like a Family Mentor.

☐ Yes, individual/SDM would like a Peer Mentor.

☐ Individual/SDM not interested in any referrals.

Was it documented that the individual and, as applicable, his/her Substitute Decision Maker, were provided with opportunities to speak with individuals currently living in the community and their families? ☐Yes ☐No; if no, reason(s):

SDM prefers to be contacted by:

☐ **Name:** ☐ **Phone:**

☐ **Email:**

☐ **Mail:** ☐ **Home visit:**

11. Discharge process confirmation: Important to note that the move process is an individualized process. Some individuals may move in a shorter or longer period of time. However, every individual will be given a targeted move date and PST members must provide clear documentation/justification of changes in move dates and steps taken to address delays. This would be documented either under concerns/barriers, as appropriate.

When	Event	Date to be completed	Tasks	Comments
Week 1	Initial pre-move meeting		Sign DP/DR form within 48 hours of meeting; send DP/DR form to CSB/ Provider/AR within 72 hours	
Week 2	Choose providers to tour		Schedule tours with individual/AR/TC/ Family/Providers	
Weeks 3/4	Provider tours		Tour provider locations	
Week 5	Provider Assessment on site		Provider completes onsite assessment of individuals	
Week 5	Providers selected to visit		Send PIR to CRC/OHR/OL within 1 day of choice(s); complete PIRs within 6 days Complete Onsite Provider Shadowing preferably by date of meeting and prior to specific training.	
Week 6	Special Circumstance as needed: Number of SC #1		Send DP/DR for Special Circumstance Pre-move meeting to CSB/Provider/AR within 72 hours prior.	
Week 6	Provider pre-move meeting		Send DP/DR for Provider Pre-move meeting to CSB/Provider/AR within 72 hours prior.	
Week 7	Day visit		Complete Day Visit Form with 48 hours	

Week 8	Evening visit		Complete Evening Visit Form within 48 hours	
Week 9	Provider Training and Final/overnight visit		Complete Provider Training prior to overnight visit. Complete Final/Overnight Visit Form within 48 hours	
Week 10	Final pre-move meeting or Special Circumstance as needed		Send DP/DR for Final Pre-move Meeting to CSB/Provider/AR within 72 hours prior	
Week 12	Move to new home.		Enter Discharge Date	
PMM 1	Schedule (announced) PMM visit by day 3		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	
PMM 2	Schedule (announced) PMM visit by day 10		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	
PMM 3	Schedule (announced) PMM visit by day 17		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	
PMM 4	Schedule (announced) PMM visit between days 45-60		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	

**** For below General Discussion area, include any recommendations received by OHR/OLS from the PIR and plans to address or reasons why recommendations do not need to be addressed.**

12a. General Discussion Annual Meeting:

Recommendations:
Day Support/ Vocational:
Medical/Nursing:
Residential:
Psychology:
Nutrition:
Physical Therapy:
Occupational Therapy:
Recreational Therapy:
Speech Therapy:
Social Work:

12b. General Discussion Initial Meeting:

12c. General Discussion Special Circumstance Meeting #__:

12d. General Discussion Provider Pre-Move Meeting:

12e. General Discussion Final Meeting:

13. Confirmations:
CSB SC notifies receiving CSB when a selected provider is outside of home CSB region. ☐Yes ☐No ☐N/A

CSB received updated documents or requested documents from TC partners. ☐Yes ☐No ☐N/A

Provider received updated documents or requested documents from TC partners. ☐Yes ☐No ☐N/A

Provider received safety alerts. ☐Yes ☐No

For Annual Review only:

14. Team develops shared goals and discusses outcome priorities for ISP Year. ***(PC ISP Location: Part V)***

15. Team reviews the individual planning questions in Part IV and explains any "No" selected from the list and signs in agreement. *(PC ISP Location: Part IV and Signature Page)*

For Final Pre-Move Meeting

16. Final Pre-Move Meeting
Was the SIS completed? ☐Yes ☐No; if no, reason(s): Date: Click here to enter a date.

Have the CSB and community provider(s) confirmed there is a *Waiver Plan for Supports* in place that meet the essential supports identified in the *Discharge Plan and Discussion Record?* ☐Yes ☐No; if no, reason(s):

Have the CSB and community provider(s) agreed to provide a copy of the *Waiver Plan for Supports* that meet the essential supports identified in the *Discharge Plan and Discussion Record after completion?* ☐Yes ☐No; if no, reason(s):
Plan to be submitted to: Click here to enter text.

Has the CSB Support Coordinator (CSB SC) confirmed an agreement between the CSB and community provider(s) regarding which supports have been submitted for approval through WaMS based on individual's needs which are outstanding? ☐Yes ☐No; if no, reason(s):

Has attendance been confirmed for community provider(s)/representatives in mandatory trainings as applicable?
☐Yes ☐No; if no, reason:

Have the CSB and community provider(s) confirmed that all essential supports listed are in place prior to move date?
☐Yes ☐No; if no, reason(s):

Has the SDM appointment for community partners been confirmed? ☐Yes ☐No; if no, reason(s):
CSB: Click to enter the name of SDM
Residential Provider: Click to enter the name of SDM
Employment/Day Provider: Click to enter the name of SDM
Appointment paperwork received for DC file: Choose an item.

Have the community provider(s) been informed of their responsibility to follow guidelines regarding reporting to Office of Licensing, Office of Human Rights and the Community Services Board? Provider(s) also informed that they must provide timely

notification to TC Post Move Monitoring Coordinator or CIM designee regarding change of address, change of telephone number, change of day /employment provider, any illness/ hospitalization or injury requiring medical treatment after an individual has moved. ☐Yes ☐No; if no, reason(s):

Was the discharge plan updated within 30 days prior to the individual's transition? ☐Yes ☐No; if no, reason(s):

Was community provider staff trained in the individual support plan protocols that were transferred to the community? ☐Yes ☐No; if no, reason(s):

Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists? ☐Yes ☐No; if no, reason(s):

Are all essential supports in place before the individual is scheduled to move? ☐Yes ☐No; if no, reason(s):

Does the discharge plan (including the Discharge Plan Memo completed following the final meeting) list the key contacts in the community, including the licensing specialist, Human Rights Officer, Community Resource Consultant and CSB supports coordinator? ☐Yes ☐No; if no, reason(s):

☐ Check box if move has **NOT** occurred within 6 weeks after final visit to home. *(list this as a barrier in the above barrier chart)*

Discharge Plan and Discussion Record

1.29.21

Signatures of partners who agree to help me implement my plan:			
☐ Initial Pre-Move ☐ Provider Pre-Move ☐ Final Pre-Move ☐ Annual Review ☐ Special Circumstance related to discharge No. # _____ TIME of meeting: _____			
Individual: ☐ **Present** ☐ **Not Present (give explanation):**			**Date**
Individual's Signature:			
Support Coordinator:			**Date**
☐ **Guardian/** ☐ **Authorized Representative:**			**Date**
Partner (please print name)	**Signature**	**Relationship/ Service/Support**	**Date**
Names of partners who contributed to my plan and were not here for planning:			
Partner	**Relationship/Support**		**Date**
Names of partners who contributed to my plan via Telephone and were not here for planning:			
Partner	**Relationship/Support**		**Date**
Comments:			

Completed by: _____ Title:_____ Date:_____

Reviewed by: _____ Title:_____ Date: _____

Reviewed by:_____ Title:_____ Date:_____

DPDR is draft and subject to change as required. The document used with supporting plans and assessments will become final upon discharge.