DEPARTMENT OF HUMAN SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES
INDIVIDUALIZED SERVICES

Community Transitions Procedure #30

DATE ISSUED: April 6, 2018
April 20, 2018
November 28, 2018

I. TITLE: TRANSFERRING INDIVIDUALS FROM INSTITUTIONAL SETTINGS

II. PURPOSE: To identify which entity completes the transfer from institutional settings.

III. SCOPE: This procedure applies to all Developmental Centers (DCs), State Psychiatric Hospitals (SPHs), and Skilled Nursing Facilities (SNFs).

IV. POLICY: To ensure that individuals receive appropriate support regarding transition from institutions to community settings.

V. DEFINITIONS:

A. Individual – means a person eligible for Division Services pursuant to N.J.S.A. 30:6D-23 et seq. and N.J.A.C. 10:46.

B. Treatment Team– an individually constituted group responsible for the development of a single integrated Service Plan. The team shall consist of professionals and representatives of service areas who are relevant to the identification of the person's desires and needs and the design of programs to meet their desires and needs.

C. Service Plan – means a written, individualized service plan consistent with the requirements of N.J.S.A 30:6D-10 through 12, developed with the individual, and/or his or her legal guardian, and the IDT. It is an outcome-based planning tool that, at a minimum, identifies each individualized program, support and/or service requested by and provided to the individual, for which the individual demonstrates a need. It identifies the person and/or agency responsible for its implementation.

D. Division Case Manager - a DDD placement worker who serves as a link between the institution and all other parties involved in the identification of

supports, transitional activities and subsequent transfer of individuals from an institutional setting to community services.

E. Support Coordinator (SC) – agency staff responsible to facilitate planning sessions to develop an Individual Service Plan (ISP) for individuals residing in the community; connect individuals with community service providers to support the individual in the community and participate in monitoring to assure identified services and supports are provided.

VI. PROCEDURES:

A. Transitions From Institutions

1. Division Case Management in the Community Transitions Unit is responsible for all transitions and placement activities from Developmental Centers.

    a. Prior to discharge, the Division Case Manager will develop a service plan that remains in place for 90 days.

    b. 30 days following the date of community placement, a Support Coordinator will be assigned to overlap with the Division Case Manager for the remaining 60 days to ensure continuity of care.

    c. The Division Case Manager will be the primary person responsible for the transition during the first 60 days, after which the Support Coordinator will become the primary person responsible for the individual's transition and service planning process. For the first 30 days the Division Case Manager will be responsible for completing the Monthly Monitoring Tool.

2. Following an admission of an eligible individual to one of the state psychiatric hospitals, if the hospital treatment team has determined that the length of stay will be greater than 30 days then then case will be automatically reassigned in the iRecord from the assigned Support Coordination Agency to the Division of Developmental Disabilities. The Community Transitions Unit with the Division of Developmental Disabilities (DDD) will then be responsible for all transition and placement activities.

    a. Prior to discharge, the Division Case Manager will develop a service plan that remains in place for 90 days.

    b. 30 days following the date of community placement, a Support Coordinator will be assigned to overlap with the Division Case Manager for the remaining 60 days to ensure continuity of care.

c. The Division Case Manager will be the primary person responsible for the transition during the first 60 days, after which the Support Coordinator will become the primary person responsible for the individual's transition and service planning process.

3. Following an admission of an eligible individual into a skilled nursing facility, ICF/ID etc. for the purpose of rehabilitation, respite, etc. the assigned Support Coordination Agency will retain the case up to 90 days from the date of admission. (The Community Care Program (CCP) and Supports Program (SP) will remain active for up to 180 days, thus allowing the Support Coordination Agency to bill for services rendered.)

   a. Support Coordination will complete monthly monitoring in accordance with established Support Coordinator Responsibilities and Deliverables as described in the CCP and SP manuals.
   b. The Support Coordinator will conduct all placement activities to transition the individual back to the community if the individual is returning to their original residence or a new residence if one is needed and already identified.
   c. If the individual has not transitioned after being in an institutional setting for 90 days, Support Coordination will transfer the case to a Division Case manager to complete the transition using the Community Transitions Unit Case Transfer Form (Attachment 1).

      1. Support Coordination Agency will forward this form to the DDD SC Helpdesk.
      2. The DDD SC Helpdesk will forward the form to the Community Transitions Unit.

   d. The case will be reassigned in the iRecord from the assigned Support Coordination Agency to the Division of Developmental Disabilities. The Community Transitions Unit with the Division of Developmental Disabilities (DDD) will then be responsible for all placement activities.

Attachment 1

Community Transitions Unit Case Transfer Form

<table>
<tr><td colspan="3">DDD/SC Staff Completing Form: Click here to enter text.</td><td colspan="2">DDD/SC Staff Phone: Click here to enter text.</td></tr>
<tr><td colspan="3">Name of Division QAS/Mentor:</td><td colspan="2">QAS/Mentor: Phone Number:</td></tr>
<tr><td colspan="3">Individual’s Name: Click here to enter text.</td><td>DOB: Click here to enter text.</td><td>DDDiD: Click here to enter text.</td></tr>
<tr><td colspan="2">Guardianship:
Plenary: ☐ Limited: ☐ Self: ☐</td><td colspan="3">Guardian Name: Click here to enter text.
Guardian Address: Click here to enter text.</td></tr>
<tr><td colspan="2">Level of Care (LOC) Eligible?
Yes: ☐ No: ☐ In Process: ☐
Comments: Click here to enter text.
NJCAT/DDRT Scores: Click here to enter text.</td><td colspan="3">CCW Eligible:
Yes: ☐ No: ☐ In Process: ☐ Comments: Click here to enter text.</td></tr>
<tr><td colspan="2">Medicaid Number(s): Click here to enter text.</td><td colspan="3">Medicare Number: Click here to enter text.</td></tr>
<tr><td colspan="5">Currently Placed In: (Check One)
State Psychiatric Hospital: ☐ Nursing Facility: ☐</td></tr>
<tr><td>Current Facility Name: Click here to enter text.</td><td colspan="2">Current Facility Address: Click here to enter text.</td><td colspan="2">Date of Admission: Click here to enter text.</td></tr>
<tr><td>Originating ALA Provider or Own Home (OH) Name: Click here to enter text.</td><td colspan="2">Originating ALA or OH Address: Click here to enter text.</td><td colspan="2">Contact at Provider/OH: Click here to enter text.
Telephone Number: Click here to enter text.</td></tr>
<tr><td colspan="5">The following <u>must</u> be completed and outcomes known before case transfer can occur. Please note that Intake and Eligibility must be completed before case transfer.</td></tr>
<tr><td colspan="5">1. Discussion with originating provider about allowing the individual to return to residence has occurred (Required if person was placed with an agency immediately prior to hospitalization)?
Yes ☐ No ☐

Please describe outcome in detail (Offers of additional supports, etc…)
Click here to enter text.</td></tr>
<tr><td colspan="5">2. Referral to Emergency Capacity Systems (Required if person meets LOC)?
Yes ☐ No ☐

Please describe outcome in detail (Offers of additional supports, etc…)
Click here to enter text.</td></tr>
<tr><td colspan="5">3. Referral to available vacancies (Required if person meets LOC)?
Yes ☐ No ☐

Please describe dates of referral(s) and outcome(s) in detail (Offers of additional supports, etc. Specify if residential placement has been confirmed with the individual’s guardian.)
Click here to enter text.</td></tr>
</table>

4. In-Home Supports discussed with family? Yes ☐ No ☐ Please describe outcome in detail: Click here to enter text.
5. Referral to available day program? If applicable. Yes ☐ No ☐ Please describe dates of referral(s) and outcome(s) in detail (Offers of additional supports, etc…) Click here to enter text. *For Olmstead Unit Use Only*
Request Made By?: ______________________________ **Date of Request:** _____________
Case Transfer Approved: Yes ☐ No ☐ If transfer not approved, provide reason: Click here to enter text.