To facilitate a united provider voice for best practices, advocacy, partnerships and networking.

AADD
ALASKA ASSOCIATION ON
DEVELOPMENTAL DISABILITIES
P.O. Box 241742

May 8, 2018

Dear Duane,

You have requested that AADD provide a listing of services needed to successfully transition individuals who experience intellectual and developmental disabilities from a more restricted setting such as API or from and ICF/IDD outside of Alaska back into community services.

Two teleconferences were held with a small group of providers providing input to both develop and then review the grid that we developed to outline the transition services needed at each different phase of the process. In addition to the teleconferences, input was solicited from the AADD general membership. Suggestions submitted from the general membership were discussed at the second teleconference and added to the grid of needed services. The grid includes a number of phases in the transition process detailing the purpose of the service, the staffing needs, comments and who currently pays for that service. You will find the grid attached to this letter.

In the assessment phase a formal assessment is needed, but informal assessment materials must also be made available to the receiving organization including: IEP (if appropriate), current clinical notes, evaluations from any other providers, medications, medical concerns and historical background information.

In order to develop a meaningful treatment plan, the receiving provider needs the opportunity to travel to the sending organization for up to five days to observe both behaviors and successful responses, to understand successful de-escalation technics beyond medication. In addition to direct observation in the sending organization there is a need for regular teleconference/VTC contact following the transition. The behavioral subject matter experts need to ensure that a behavioral supports plan is detailed and communicated to the receiving organization. The treatment plan needs to involve the guardian and the family on an ongoing basis. Housing needs and options must be identified.

The discharge planning, or the transition plan needs to be reviewed to assure it is consistent with all the formal and informal assessment information. Staff from the sending institution need to cross train the receiving provider.

Staff training for the receiving provider requires specialized training and reimbursement to successfully deal with complex behaviors. There needs to be additional training funds for such staff. The plan needs to identify the staff levels needs (2:1 or 1:1 ratios) as an exception to current the 1:1 staffing ratio, for a specific period of time. There needs to be the capacity to request extra support for staff following any injuries received in providing care.

Funding through the waiver, in the case of transition, needs a case manager for the process prior to the hand off to the care coordinator. Currently, Qualis provides this type of broad support in behavioral health. There needs to be an exception from regular waiver limits of supports. Acuity does not work. Transition supports need to be offered for up to two years to allow for stabilization.

Additional sources of support could include ISA funds (DBH), E-mod grants and mini grants. There needs to be a mechanism for the coverage of cost for empty beds that are awaiting a transition recipient.

Environmental modifications need to be available to account for safety considerations ranging from fencing in the yard to ramps and furniture adaption to prevent damage. One of the difficulties is that the modifications need to be complete prior to the individual moving into the home. Specialized equipment needs to be considered including enabling technology. Many times insurance will not cover costs such as indestructible furniture.

Medication management is one of the most important categories. Placements with housing, staffing and services in place have failed through the lack of a local doctor able to manage the medications. Frequently individuals coming out of API or ICF/IDD placements are on multiple medications, in one case there were 17 different medications to be managed. API will only issue 3 days' worth of medications so a prescribing physician has to have appointments available at the point of transition. A medication transition plan is key prior to the transfer. The group wondered if telehealth could be utilized for medication follow up.

One of the key concerns is the ability to access additional supports when behaviors escalate after the initial transition is completed. It is not worthwhile to allocate resources to the transition only to have it fail after one of two years because of the lack of short term crisis intervention. This could look like a partnership with the sending institution allowing for a cooling off period. It could be a format for a quick amendment to waiver supporting short term additional staff. A crisis intervention team would be invaluable such as the CBC. Other options, recommended in the WICHI report are a brief stabilization location for up to 30 days. Another recommendation to avoid re-institutionalization is intensive intermediate intervention for up to 18 months before returning to the community provider.

Thank you for this opportunity to identify the needs for successfully transitioning individuals with complex needs back into the community.

Sincerely,

Lizette Stiehr
Executive Director, AADD