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Community Integration:
A Holistic Approach to the New Core Services for Transition & Diversion

Implementation Strategies for Diversion and Transition & Group Discussion

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Strategies for Tracking Diversion & Transition—Methods of Documentation

- Using the CIL's data collection system, some may find it helpful to isolate Diversion and Transition into separate programs utilizing:
  - Custom Fields
  - Specific Goals
  - Services
  - Time Tracking
  - Programs

Diversion/Transition Begins with Intake Assessment

Regardless of the CIL's preferred method of documentation, the information must be complete and reflective of the Consumer's desires for several reasons:

1. This is Consumer's story and it needs to be told accurately.
2. It is the anecdotal information that usually answers the who, what, where, why and how.
3. CIL staff may miss at-risk factors (if the desired outcome is diversion) or the antecedents related to the Consumer's placement in an institutional setting from which they wish to transition.
4. A thorough intake assessment, combined with an objective at-risk survey, can provide a more comprehensive picture from which to proceed.

Why utilize a survey in conjunction with a detailed assessment?

It allows CIL administrators to:

- Look at actual numbers
- Run queries of specific at-risk factors
- Identify levels of at-risk
- View a snapshot of Consumers that are at-risk

Once Identified as "At-Risk"…

Once a person has been identified as "at-risk" or ready to transition into the community, "What do you do with that information?"

- Using the "At-Risk" and Transition custom fields, LIFE staff records the status and uploads the survey into the Consumer's document center.
- LIFE does not utilize a survey with Transition. The State requires that CILs document in a specific database that has the capability to run various reports.
- Another CIL in Texas has utilized the At-Risk Survey by incorporating it into a survey format on its data collection program.

Survey Contains Four Items

1. Consumer Name
2. Indication of medical conditions with a checkmark box, so that CIL administrators can get a better idea over time on the needs of the Consumers they serve and to identify any trends that may mean a person is at more risk than others
3. Indication of all other at-risk factors that apply
4. Total at-risk score

Survey

- Once the “submit survey” button is selected, instructions pop up to tell the CIL staff to go back to the Consumer record, add a custom field and enter the appropriate score, which is based on several ranges.
- The higher the score, the higher the risk.
- The CIL administrator can run a custom field report in her data collection program and identify how many total Consumers are presently “at-risk.”
- This CIL states that they use the information for outreach purposes as well.

Assist Consumer with Independent Living Plan (ILP)

- The next step would be to assist the Consumer in developing an Independent Living Plan that will increase the Consumer's chances of remaining in or transitioning to a community-based setting.
- The ILP specifically outlines the goals of the Consumer, the immediate and measurable steps to be taken, by whom, in what time frame, and the role of CIL staff and/or others the Consumer identifies as integral to the attainment of his/her goals.

Compliance Standard for Contact

- Ninety days is the compliance standard for contact, but insufficient contact when a person is at-risk.
- Assigning levels of at-risk may help in identifying the extent of services.
- Increased contact is a must, as matters can go awry quickly.
- Some Consumers will always be at risk of institutionalization, but they are taught, through self-advocacy, how to identify at-risk factors and to utilize various resources to avoid them.

Discussion of Other Approaches

Implementing a Transition Approach—Identification and Referral

- The relocation process begins with service coordination planning for nursing facility residents requesting services and for those “pre-identified” by the State.
- Other nursing facility residents assessed are identified through self-referrals, family, Area Agencies on Aging, Aging and Disability Resource Centers, etc.

Implementing a Transition Approach—Education & Outreach

- Brochures are distributed to social workers and discharge planners at each facility.
- Nursing facility residents are informed of relocation services through direct presentation, distribution of brochures, on-site presentations to groups, informal presentations given to resident's family members, and other means.
- The natural concerns of friends, family members and medical personnel are addressed as desired by the individual who is relocating.

Implementing a Transition Approach—Assessment

The assessment tool utilized by LIFE documents needs based on the components of community living that must be addressed when relocating an individual from a long-term facility into a community setting:

- What kind of housing is needed for a successful relocation to occur?
- Does the individual have resources prior to entry or will subsidized housing be required?

Implementing a Transition Approach—Assessment, cont'd.

- What kind of amenities would the individual prefer in his/her new community?
- What is the most realistic target date for relocation?
- What type of supports are needed, such as:
  - Housing
  - Transportation
  - Meal Delivery Services
  - Utilities
  - Household Goods

Implementing a Transition Approach—Relocation Services

- Assistance with eligibility and resource location
- Assistance with moving from facilities to the community (i.e., housing and transportation needs)
- Applying for various types of housing assistance offered by state and local housing authorities
- Coordinating the discharge date with the Consumer, nursing facility, and other service providers

Implementing a Transition Approach—Relocation Services, cont'd.

- Coordinating needed assistive technology supports (i.e., environmental controls, emergency response, home modifications, medical and therapy services)
- Assisting with the transfer of social security and other benefits during the relocation
- Coordinating therapies, behavioral health supports, counseling and other services needed by the individual
- Establishing networks and support structures

Implementing a Transition Approach—Relocation Day

- Verify dismissal time
- Verify delivery of Durable Medical Equipment, Personal Assistance Services, meal services, etc.
- Verify furniture/appliance delivered is correct
- Verify Consumer has a key to home
- Give Consumer relocation packet with resources for utility and rental assistance, food pantries and clothing closets for future reference

Implementing a Transition Approach—Follow-Up

LIFE provides follow-up for a minimum of 3 months.

- Follow-up includes face-to-face contacts, collateral and phone contacts:
  - 1st Month – Contact once a week
  - 2nd Month – Contact every other week
  - 3rd Month – Contact once

Implementing a Transition Approach—Follow-Up, cont'd.

- Immediately after relocation, the Relocation Specialist discusses with the newly relocated Consumer home health provision, their well-being, possible feelings of isolation or of being overwhelmed.
- As part of the follow-up, people important to the relocated Consumer are identified and with the Consumer's permission, can be contacted if needed.
- Intense issues require prolonged follow-up. These issues include compatibility and relationship issues with home health and medical providers, assistance with numerous daily living activities, access to reliable transportation options, problems with utilities, and socialization challenges.

Implementing a Transition Approach—Follow-Up, cont'd. 2

- LIFE addresses issues that could lead to re-institutionalization, such as poor money management, new equipment needs, and health issues. LIFE is authorized by SSA to provide Social Security Representative Payee services to the Consumer when needed.
- At the end of the 90-day follow-up, the Relocation Specialist administers a 90-day follow-up assessment to determine stability in the community. The 90-day follow-up includes questions regarding health, housing, and community supports.

Implementing a Transition Approach—Follow-Up, cont'd. 3

- LIFE uses peer support, individual and systems advocacy, and independent living skills training to help Consumers solve problems in the community. These non-time limited, independent living services produce low recidivism rates for relocated Consumers.
- A satisfaction survey is made available to the Consumer to track satisfaction or dissatisfaction with relocation services. This information is utilized to address issues for future relocations.

Questions & Answers

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