Service: Community Transition Planning

Service Definition

Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face or telephonic contact with the individual prior to release from a facility. Additional Transition Planning activities include educating the individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan.

In partnership between other community service providers and the hospital/f facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the individual's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. CTP may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the individual in the community or will work with the individual in the future to maintain or establish contact with the individual.

CTP consists of the following interventions to ensure the youth, family, and/or caregiver transitions successfully from the facility to their local community:

1. Establishing a connection or reconnection with the youth/parent/caregiver through supportive contacts while in the qualifying facility. By engaging with the youth, this helps to develop and strengthen a relationship.
2. Educating the youth/parent/caregiver about local community resources and service options available to meet their needs upon transition into the community. This allows the youth/parent/caregiver to make self-directed, informed choices on service options to best meet their needs;
3. Participating in qualifying facility team meetings especially in person centered planning for those in an out-of-home treatment facility, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward recovery goals, personal strengths, available supports and assets, medical condition, medication issues, and community-based service needs;
4. Linking the youth with community services including visits between the youth and the Community Support staff, or IFI team members who will be working with the youth/parent/caregiver in the community to improve the likelihood of the youth accepting services and working toward change.
5. Conducting any screenings or necessary assessments to engage the youth and refer them to appropriate services.

Admission Criteria

Individual who meets DBHDD Eligibility while in one of the following qualifying facilities:

1. State Operated Hospital,
2. Crisis Stabilization Unit (CSU),
3. Psychiatric Residential Treatment Facility (PRTF),

4. Jail/Youth Development Center (YDC), or
5. Other (ex: Community Psychiatric Hospital).

Continuing Stay Criteria

Same as above.

Discharge Criteria

1. Individual/family requests discharge; or
2. Individual no longer meets DBHDD Eligibility; or
3. Individual is discharged from a qualifying facility

Clinical Exclusions

Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: Developmental Disability, Autism, Neurocognitive Disorder, Traumatic Brain Injury.

Required Components

Prior to Release from a Qualifying Facility: When an individual is admitted to a Qualifying Facility, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded, and a copy of the Plan shall be included in both the youth's hospital and community record.

Clinical Operations

1. Because individuals receiving CTP may be in settings in which there are needs for immediate engagement, yet there is restricted access to the setting, the initial IRP for an individual may be more generic (i.e., less individualized) at the onset of treatment/support.
    a. The allowance for "generic" content of the IRP shall not extend beyond three (3) months.
    b. It is expected that the IRP be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual.
2. IFI providers may provide this service to those youth who are working towards transition into the community (as defined in the CTP guideline) and are expected to receive services from the IFI team. Please refer to the CTP Guideline for the detail.
3. Community Transition Planning activities may include:
    a. Telephone and Face-to-face contacts with youth/family/caregiver;
    b. Participating in youth's clinical staffing(s) prior to their discharge from the facility;
    c. Applications for resources and services prior to discharge from the facility, including:
        i. Healthcare;
        ii. Entitlements for which they are eligible;
        iii. Education;
        iv. Consumer Support Services;
        v. Applicable waivers, i.e., PRTF, and/or Intellectual and/or Developmental Disabilities (I/DD); and
        vi. Obtaining legal documentation/identification(s).

Service Accessibility

1. This service must be available 7 days a week (if the qualifying facility discharges or releases 7 days a week).
2. This service may be delivered via telemedicine technology or via telephone conferencing.

Billing & Reporting Requirements

1. The modifier on Procedure Code indicates setting from which the individual is transitioning.
2. There must be a minimum of one face-to-face or telephone contact with the youth prior to release from hospital or qualifying facility in order to bill for this service.

Documentation Requirements

1. A documented Community Transition Plan for all individuals.
2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.