

# **IDD** Collaborative Discharge Guide

**Discharge Settings & Available Supports** 



## Community:

Potential supports include home visiting services, respite services, community and habilitation services, CSIDD and community healthcare providers.

- Medications and supplies must be purchased from a community vendor or ordered for delivery. Members may live independently with support as needed.
- If needed, a DSP (nonclinical Direct Support Professional), family or friend may provide support.

### IRA - Community-Based Residence:

### (Individualized Residential Alternative/Group Home)

#### Potential supports include home visiting services, community and habilitation services, CSIDD and community healthcare providers.

- Medications and supplies must be purchased from a community vendor or ordered for delivery. No on-site pharmacy, stock or med room present. RN, healthcare provider and mental health/ behavioral health staff available via on-call and for routine rounds, not on-site 24/7.
- DSPs (nonclinical Direct Support Professionals) are caregivers. Each IRA is unique, and the level of support varies from as-needed to 24/7.

## **EACT INTERING FACILITY (SNF/ICF):**

#### Support via on-site healthcare professionals: CNAs, LPNs, RNs, PT, OT, ST, RD and providers. May require support from community clinical specialists.

- Stock room for routine supplies. Med room on-site and stocked with routine medications, may or may not have an on-site pharmacist. Medications may have to be ordered via a community vendor for delivery.
- Multidisciplinary healthcare team provides care 24/7.



The Clinical Team Leaders at Partners Health Plan (PHP) are experts in IDD transitions of care. At PHP, we seek to support our members through collaboration and knowledge sharing with all members of the interdisciplinary team to promote safe transitions of care.



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### Discharge Planning Collaboration Opportunities:

- PHP Clinical Team Leaders are source of invaluable information of patient's needs and they can identify the barriers to care that may not be apparent to hospital staff
- PHP Clinical Team Leaders ensure continuity of care post-discharge and help reduce the likelihood of preventable readmissions
  - PHP Clinical Team Leaders can assist with identifying in-network providers and community resources
- PHP Clinical Team Leaders can bridge communication with the OPWDD residential providers



**To get in touch with the individual's Clinical Team Leader,** you may contact us by phone **8am to 8pm, 7 days a week:** 



Please share this message for all discharge planning team members. Fax the discharge summary within 24-48 hours of discharge to:

