Absolute Total Care
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Transition Planning

Transition Planning implies the gradual stepping down of services to match an individual's clinical presentation, progress, and supports as they prepare to transition to a different level or environment of care.

WHY IS TRANSITION PLANNING IMPORTANT?

- Promotes a path toward effective independent functioning.
    - Providers should openly discuss long-term desired outcomes for treatment with members and/or caregivers at the start and throughout treatment.
    - This includes helping caregivers identify their support systems outside of therapy and assisting with coordination of care.
- Helps to ensure individualized treatment.
    - Treatment type and duration should always be matched appropriately to the nature and severity of the members' presentation.
    - Authorization requests (hours, setting, and participants) should be based on the individualized needs of the member.

DEVELOPING A TRANSITION PLAN:

Transition planning, or discharge criteria, should be identified at initiation of treatment and reviewed and adjusted as appropriate throughout the course of services. Criteria should be clearly defined and measurable, indicating the point at which services are appropriate for discontinuation and/or transfer to alternative or less intrusive levels of care. This may occur when:

- Member's individual treatment plan and goals have been met.
- There is expected transition to the utilization of alternative treatment settings, such as a school setting.
- Documentation that there has been no clinically significant progress or measurable improvement towards treatment plan goals for a period of at least six months, nor is there any expectation for progress.

COMPONENTS TO INCLUDE WITHIN A TRANSITION PLAN:

- Specific and measurable goals that are individualized to members that outline skills needing to be achieved to allow the member to continue to make progress with a lower level of care.
- Updated progress toward attainment of transition goals achieved over authorization period and achievement as compared to baseline presentation.
- Details indicating how hours are projected to be titrated based on achievement of transition plan goals.
    - If the member is school-aged but is not able to participate due to attending full time ABA, a transition plan for school needs to be supplied including communication with school system and Individualized Education Plan (IEP) status.
- Community resources that will support maintenance and generalization of skills for members and their family. This may include local and online options.

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CONSIDERATIONS:

- Evaluate potential need to increase frequency of caregiver training as member approaches transition criteria to assist with generalization and maintenance of skills.
- Ensure family is equipped with the tools and resources they need to maintain or progress skills after discharge including steps to take if the need for treatment arises again.
- Transition planning and discharge considerations should be made with input from the members' entire care team.

References: Council of Autism Service Providers [CASP] (2024). *Applied behavior analysis practice guidelines for the treatment of Autism Spectrum Disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* [Clinical practice guidelines]. https://www.casproviders.org/asd-guidelines