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Transition Planning

Transition planning refers to 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 promote individualized treatment
    - Treatment type and duration should always be matched appropriately to the nature and severity of the member's 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 the 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:

- The member's individual treatment plan and goals have been met.
- There is an expected transition to the utilization of alternative treatment setting, such as a school setting.
- There is documentation of no clinically significant progress or measurable improvement toward treatment plan goals for a period of at least six months, with no further expectation of progress.

COMPONENTS TO INCLUDE WITHIN A TRANSITION PLAN

- Specific and measurable goals that are individualized to the member and outline skills needed to allow the member to continue to make progress with a lower level of care.
- Updated progress toward attainment of transition goals achieved during the authorization period and achievement as compared to baseline presentation.
- Details indicating how hours are projected to be titrated based on the 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 should be supplied, including communication with the school system and Individualized Education Plan (IEP) status.
- Community resources that will support maintenance and generalization of skills for the member and their family. This may include local and online options.

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CONSIDERATIONS

- Evaluate potential need to increase the frequency of caregiver training as the member approaches transition criteria to assist with generalization and maintenance of skills.
- Ensure the member's 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 member's 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