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Increasing the Knowledge About the Transitional Application Process Among Community Based Providers Serving Individuals With Intellectual and Developmental Disabilities (IDD) in Southeast Atlanta

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Manuscript: Increasing the Knowledge About the Transitional Application Process Among Community Based Providers Serving Individuals With Intellectual and Developmental Disabilities (IDD) in Southeast Atlanta

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Abstract

Introduction: Individuals with intellectual developmental disabilities (IDD) are part of the minority groups within the United States of America (USA) which has not received adequate planning when transitioning into adulthood. **Purpose:** The purpose of this project was to increase the knowledge about the transitional application process among community-based providers such as health care providers, community integration providers, therapists, and any other provider serving individuals with IDD. The ultimate objective of this project was to equip the providers serving families with individuals ready to transition into the community. **Methodology:** For this project, the Donabedian model of Structure Process and Outcome (SPO) was used to evaluate the need to increase the knowledge about the transitional application process among providers. Providers willing to participate were recruited at a transitional fair held at First Baptist Bible Church, located in Warner Robins - southeast Atlanta. Inclusion criteria for participation was; being a provider for individuals with IDD and having at least a bachelor's degree. The tools used were; the pre-transitional questionnaire to assess the knowledge level of providers, the process map illustrating the application process, and the post- transitional questionnaire used to access level of knowledge increase. **Results**: The feedback from both the pre and post transitional questionnaire to see the difference in responses from the providers. The ReAIM tool to evaluate and assess providers knowledge increase. **Conclusion:** Based on the feedback obtained from the surveys, it was concluded that the information shared with the providers increased their knowledge level about the transitional application process and they were willing to assist families during the transition.

Keywords: Intellectual and Developmental Disabilities (IDD), Providers (healthcare and community workers), Individuals, Donabedian Model, Transitioning process, ReAIM Tool

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Increasing the Knowledge About the Transitional Application Process Among Community Based Providers Serving Individuals With Intellectual and Developmental Disabilities (IDD) in Southeast Atlanta

According to the Residential Information Systems Project (RISP) done by the University of Minnesota; there are 7.39 million people in the United States of America (USA) with intellectual and developmental disabilities (IDD), 22% or 1.58 million are known to their state developmental disability agency, 19% or 1.4 million receive support services, 5.32 million people are 21 years or younger and 2.1 million are older than 22 years (University of Minnesota, 2022). One in four individuals receives state-funded support within the community (University of Minnesota, 2022). In a national survey done by Zablotsy et al., (2020) between 2000-2017, the authors found one in six children between 3-17 years were diagnosed with IDD. The prevalence of IDD diagnosis in the USA also increased from 5.76% to 6.99% between 2014-2016 (Zablotsky et al., 2019). With the increase in the number of individuals with IDD in the USA, there is an increase in the need for; health, education, social services, and specialized mental health services for this population (CDC, 2019). Dressler et al., (2018), also stated even with an increased interest and need for safe transitioning, only 41% of individuals with IDD received adequate transition planning, leaving 59% of the individuals without a transitional plan. With the lack of a transitional plan, individuals can not safely transition into the community.

Problem Statement

Treuer et al. (2016), stated even though society is aware of and recognizes individuals with IDD, there is still a challenge in transitioning these individuals into the community. Hart et al., (2019) also reported the transitioning process being a challenge because, regardless of aging, these individuals depend entirely on their families to meet their needs including community integration. In a survey done by Keller et al., (2020), the researchers noted there are four challenges to transitioning individuals into the community; inadequate preparation of providers, financial barriers, communication challenges between caregivers and providers, and specialized individual needs that can not be met. Over the past decade, there have consistently been 6,000 to 8,500 Georgians with IDD who do not have the necessary supports to transition into the community (Reimagine Possible, 2020). Currently, the state of Georgia has over 7000 individuals who continue to be on the waiting list to receive Medicaid waiver services needed to support individuals once they transition into the community, with the wait time being up to ten years (Reimagine Possible, 2020). For this project, I addressed the issue relating to the lack of knowledge about the transitional process among community-based providers serving families with individuals with IDD. According to Dressler et al., (2018), one of the greatest barriers to a smooth transition is the lack of information about the transitioning process. It is therefore imperative for providers to have a clear understanding of the transitional application in order to be supportive of the families they serve within the community.

Purpose of the Project

The purpose of this project was to assess the providers' knowledge level about the transitional application process. This project attempted to determine if providing a process map illustrating the transitional application process to providers would increase provider participation during the transitional period for individuals with IDD. Providers targeted included; health care providers (doctors, nurses, specialists), therapists (behavioral, physical, speech, and occupational), paraprofessionals, special education teachers, and social workers.

Clinical Question

For providers serving families with individuals with IDD, does having a process map illustrating the transitional application process for waiver programs supporting individuals within their communities increase provider knowledge and participation in the transitioning process?

Literature Review

The literature search was completed using EBSCO and PubMed databases. The initial search formula utilized was; community integration for individuals with intellectual disabilities and transitional care for individuals with IDD. The search from EBSCO yielded 18,689 articles, while PubMed yielded two articles. The search was further restricted to full-text, peer-reviewed journal articles in academic journals written within the last five years (2018-2022) focused on challenges faced by providers serving individuals with IDD. This search yielded 80 articles from which articles were identified for appraisal.

Review and Synthesis of Literature

The literature reviewed focused on the current delivery of information to providers and families of individuals with IDD. According to Hodapp et al., (2017), individuals with IDD are living longer and outliving their parents, therefore, needing adequate planning to transition. In a study done by Molfenter et al., (2018), many communities are faced with the challenge of equipping and supporting individuals with IDD transitioning to adult life. According to a survey of non-institutionalized individuals aged 3-17 years done by Zablotsky et al., (2019) between 2009 – 2011 and 2015 – 2017, the researchers found an increase of 16.93% in IDD prevalence in the USA. With the increase in the number of individuals with IDD, there is a need for providers to assist families during the transitioning process. One of the challenges outlined by the researchers for this study was the lack of a favorable sample size which may have affected the overall outcome of the study (Zablotsky et al., 2019).

McGinley et al. (2021) reviewed data from 49 states, the authors noted individuals with IDD are part of the aging population and require advanced planning when transitioning into the community. The researchers stated by 2030 the number of adults with IDD will increase and possibly triple which will require additional support to safely transition into the community (McGinley et al., 2021). The researchers also identified the use of online tools as one of the ways of integrating individuals with IDD into the community; the tools were used to; express their wishes, decide where to live, finance the future, determine employment and daily activities, support life decisions, and make social connections (McGinley et al., 2021). By equipping providers with the necessary resources, they can support the families.

Ellman et al. (2020) reviewed different parents' experiences in South Africa in relation to transitioning individuals into the community. The researchers noted transitioning from high school is a challenge in itself, and more complicated when the individual has a disability (Ellman et al., 2020). A qualitative approach was used and five families with individuals with IDD were interviewed (Ellman et al., 2020). Parents reported being uncertain of what would happen once the individuals aged out of school and as a result lived in fear of the unknown (Ellman et al., 2020). Parents reported they are never involved in the transitioning process and were poorly informed therefore causing uninformed decisions (Ellman et al., 2020). Since community-based providers are in close contact with families, they can share information about the transitioning process.

In a systematic review of literature about transitional planning, researchers reviewed 16 articles identifying the barriers to transitioning which included; lack of quality care in the adult service delivery system, difficult relationships with professionals, interdependency between parents and siblings, lack of information about alternatives to family care, difficulty in discussing planning given its emotional nature, caregiver reluctance to let go of their caregiver role, caregiver sense of duty, the individual with IDD fears independent living, caregiver concern regarding loss of control, and individual with IDD unwilling to leave the family home (Lee & Burke, 2020). Researchers suggested policymakers and practitioners such as providers should be supportive of families during the transitioning process (Lee & Burke, 2020). The researchers noted several family members and providers have limited information about the transitioning process, which makes this article relevant to the project.

Perryman et al. (2021) conducted a literature review on the need to customize support for individuals transitioning from high school. The article focused mainly on individuals with mental and developmental disabilities and reviewed different ways in which the individuals can be supported. The authors noted, the currently available programs are not widely spread and there is a lack of collaboration between the schools and counseling services (Perryman et al., 2021). The authors suggested there is a need to have all stakeholders involved in the care of the individuals as part of the transition planning (Perryman et al., 2021). In another article by Zeng et al. (2020), a survey of 50,212 participants revealed only 47% of youth received coordinated care during the transitioning process. The lack of coordinated transition made it difficult for individuals to transition into the community easily (Zeng et al., 2020).

In another systematic review evaluating the barriers and facilitators of transitioning individuals with IDD, forty-one articles were reviewed, and a stepwise process was used to analyze the data (Fontil et al., 2019). The researchers noted families with individuals with IDD needed to be motivated and guided on how to access the available resources (Fontil et al., 2019).

The researchers noted the lack of training on how to facilitate the transitioning process among community-based providers, therefore, finding it hard to assist families with the process (Fontil et al., 2019). The authors further suggested there is a need to collaborate care in order for the transition to occur smoothly (Fontil et al., 2019). Santiago Perez and Crowe (2021), also performed a systematic review focused on the need for individuals with IDD to participate in the community within which they live. The researchers reviewed eight studies out of 1,054 articles that addressed the transition of aged youth with IDD (Santiago Perez & Crowe, 2021). The review also revealed there is a need to establish programs that foster collaboration during the transitioning process (Santiago Perez & Crowe, 2021). These programs can be established through collaboration with providers.

Spassiani et al. (2017), used semi-structured interviews to gather information from two non-profit agencies, and a total of nineteen interviews were conducted. The researchers agreed utilization of community-based services provided the possibility for individuals with IDD to engage in the community. Even though the agencies were well aware of the need to integrate individuals into the community they did not have the necessary resources to foster integration, which in turn impacted the health outcome for the individuals (Spassiani et al., 2017). Limitations identified for this research were; lack of policy, budget constraints, and lack of support (Spassiani et al., 2017).

Dressler et al. (2018) surveyed 29 primary providers at 18 clinics who provided care to individuals with IDD aged 12-26 years transitioning from pediatrics to adulthood. The authors used three navigators to offer resources and non-health support to families transitioning from pediatrics to adulthood (Dressler et al., 2018). The researchers noted barriers to engaging in transition planning included; issues with resources provided, and being able to provide positive feedback (Dressler et al., 2018). The researchers, therefore, suggested there is a need to further explore ways in which information about transitioning can be provided to families (Dressler et al., 2018).

In a review of nine interviews of families with individuals with IDD aged 20-40 transitioning into the community, the researchers found one of the greatest challenges the individuals experienced was gaps in the transitional process (Freeman et al., 2018). The researchers suggested involving providers such as clinicians in the transitioning process to make it easier for individuals to transition (Freeman et al., 2018). Even though the article addressed the clinical question, it had a very limited sample size which affects the validity of the article.

Tyler and McDemott (2021) also reported in order for a transition to occur, full engagement of the individual, the providers (medical professionals) and the family is critical. The transitioning process involves three phases which should be initiated in early adolescence (Tyler & McDemott, 2021). These phases are; preparation, transfer from pediatrics to adult care, and integration into adult-based care (Tyler & McDemott, 2021). Without adequate preparation, it is hard for the transition to occur and without a smooth transition, it is hard for the individual to thrive in the community. The article was relevant to the research question because it addressed the need to coordinate and collaborate care with all stakeholders in the transition process.

Through the use of semi-structured interviews with nineteen physicians, researchers were able to collect data pertaining to the care of individuals transitioning from pediatrics to adulthood (Hart, et al., 2019). The researchers noted despite the fact that individuals with IDD have multiple specialties none of the providers is willing to take the lead in coordinating care for the individual, therefore, requiring providers to be well aware of the transitioning process (Hart, et al., 2019). Some limitations of this study were the small sample size and lack of a generalized sample. This article supports the need to equip providers with the right information pertaining to the transitioning process.

Financial Implications for Transitioning

In a study done by Molfenter et al., (2018), the researchers noted that the Individuals with Disabilities Education Act Amendment of 1997 (IDEA) and the School-to-work Act of 1994 called for an improved process to the transitioning planning for individuals with IDD. The researchers used community conversations to share information about the transitioning process, they encouraged schools and providers to also utilize the same technique(Molfenter et al., 2018). Community conversations were found to be cost-effective and time-saving for families with individuals ready to transition into the community (Molfenter et al., 2018).

In another study done in Canada by Lunsky et al. (2018), the authors noted, health care costs for individuals with IDD are four times higher than those of individuals without IDD. These costs may include; health care supplies as well as expenses relating to community integration, if the individual is enrolled in a program that supports community integration, some of these costs may be covered. Community-based providers are responsible for providing most of the services within the community, therefore being a stakeholder in the transitioning process. It is therefore important for the providers to have all the information they need pertaining to the transitioning process in order to support families.

McLean et al. (2020), reviewed 764 articles to evaluate the financial benefit of having individuals transition appropriately into the community. The researchers reported full utilization of Medicaid waiver programs focused on home and community-based services provided an economic benefit for the state and families (McLean et al., 2020). The Medicaid programs reduced the unmet healthcare needs for individuals, provided the ability for parents/ caregivers to continue working, and reduced any disparities related to access to care (McLean et al., 2020).

In an article by Levy et al. (2020), the authors did a systematic review of transitional care interventions for individuals with IDD. The authors reviewed 13,787 articles and identified fifty-two articles that were reviewed to see the effect of transitioning individuals on their families, and healthcare providers. The authors noted individuals and families reported a positive financial outcome once they were integrated into the community (Levy et al., 2020). The authors also agreed early initiation of transitional care contributed to an overall improvement in the health outcomes of individuals (Levy et al., 2020).

Summary of Literature Review

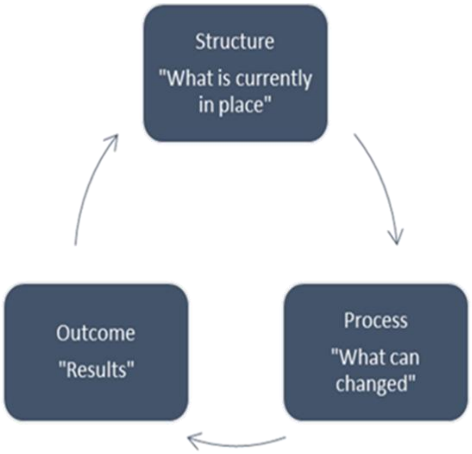
In summary, from the literature reviewed, it was noted that there was a lack of knowledge among several community-based providers about the transitional application process. Currently, these individuals come into close contact with different providers, therefore equipping the providers with information about the transitional application process will enable them to adequately support families of individuals with IDD.

Conceptual Framework

For this project, the Donabedian framework of Structure-Process-Outcome (SPO) was used to illustrate the challenge faced with transitioning individuals from pediatrics to adulthood. According to Tossaint-Schoenmakers et al. (2021), the Donabedian Structure Process Outcomes framework was designed in the 20th century, and it is used to assess the quality of health care through three components relevant to an organization; structure (i.e., requirements of the organization), process (i.e., actions to be taken) and outcomes (i.e., end results). The three components of the Donabedian model were used to evaluate the current structure of how resources are provided to families and address the challenge faced by families while transitioning individuals with IDD to adulthood. Figure 1 illustrates the Donabedian SPO framework that the writer will be using for the DNP project.

Figure 1

Illustration of Donabedian Framework

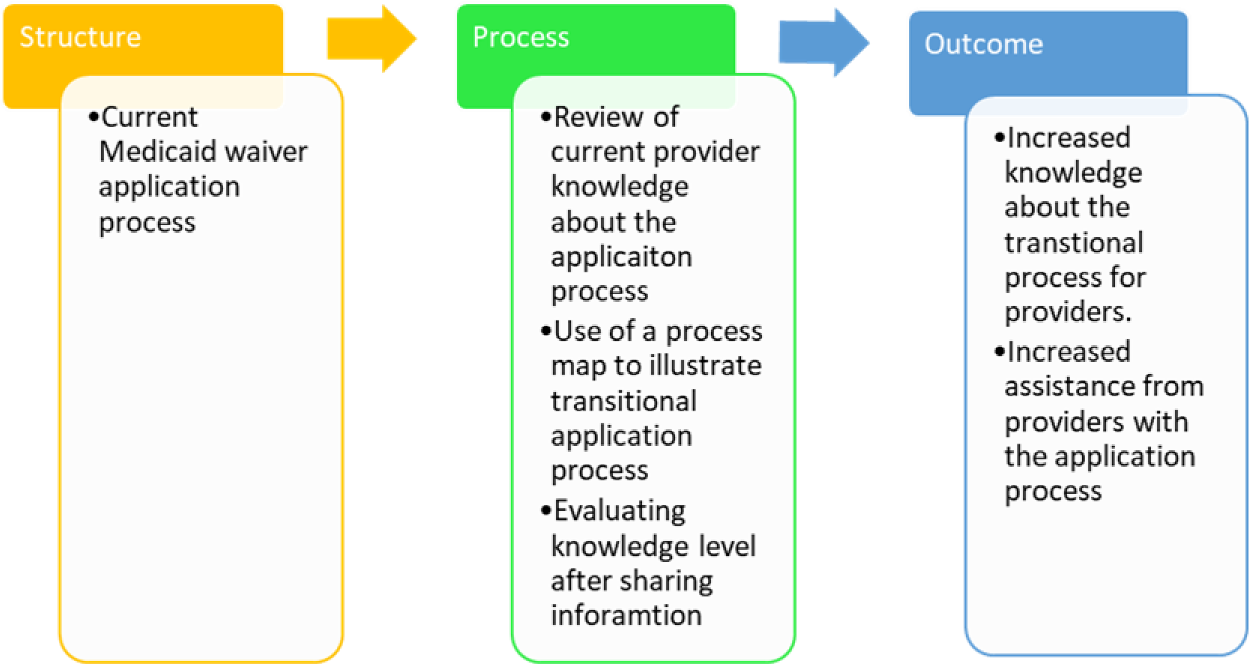


Note. Adapted from (Donabedian, 1997)

Structure in the Donabedian model refers to the requirements that influence the delivery of services (Donabedian, 1997). In the context of the DNP project, the structure being evaluated is the current awareness about the transitioning process among community-based providers serving individuals with IDD. According to Donabedian (1997), process refers to what is being done. In relation to the DNP project, the process is how information about transitioning is shared with providers. The outcome is the desirable or undesirable change that can occur (Donabedian, 1997). In the context of the DNP project, the desired change is to increase awareness about the transitioning process among providers for individuals with IDD transitioning from pediatrics to adulthood. Figure 2 will illustrate how the model will be implemented for the DNP project.

Figure 2

Utilization of the Donabedian Framework



Note: Adapted from (Donabedian 1997)

Donabedian Model in Relation to the Clinical Question

For this section, the Donabedian model was used to address the clinical question for the project. The clinical question was developed based on the experience obtained while working with several community-based providers serving individuals with IDD transitioning into the community after high school.

Structure

According to the Texas Council of Developmental Disabilities (Texas Council of Developmental Disabilities [TCDD], 2020), individuals with IDD are outliving their caregivers, so there is a need to establish methods of continuing care after the primary caregivers are not available. Currently, the transition process is initiated by an application started once the individual turns 14 years in order for the application to be completed by the time the individual ages out of high school at 21-22 years (Ellis, 2017; Santiago Perez & Crowe, 2021). This is done for individuals who are already on the pediatric Medicaid waiver. If the application process for the Medicaid waiver is not started prior to aging out of high school at 21 years with the assistance of the parent-mentor representative, the family is directly responsible for their care as well as starting the application independently. The Georgia Department of Behavioral Health and Development Disabilities (DBHDD), supports people with IDD transitioning from pediatrics to adulthood by working with providers, advocates, individuals, and families through state-funded Medicaid waiver programs (Georgia Department of Behavioral Health and Developmental Disabilities [DBHDD], n.d.). The Medicaid programs through which services are provided are; New Options Waiver (NOW) which enables the individual to continue living with their own family while integrated within the community in which they live, and Comprehensive Waiver (COMP) which serves individuals with more intensive health needs including the need for residential services (DBHDD, n.d.). Through the Medicaid waiver programs, individuals are able to transition safely into the community, without having approval for the Medicaid waiver individuals are faced with challenges during the transitional process.

Working with individuals with IDD seventeen years and older for the last seven years, exposed a lot of deficits in the transitioning process. Through collaboration with several providers serving individuals with IDD and working with families of individuals with IDD, it was noted that several families were burdened with the caregiving role after the individual has aged out of school. At twenty-one, individuals with IDD leave high school, and depending on whether they were approved the Medicaid waiver services or not they would either remain at home or be enrolled in community access programs. These individuals depend on providers and family members to support them within the community, however, a large group of the support system is not aware of the transitioning process. In order for individuals with IDD to thrive within the community, changes have to be made to the current structure of how and when information is delivered. By using the Donabedian model, the current structure can be changed by ensuring that people involved in the care of the individuals (i.e., teachers, healthcare providers, and counselors) are well-informed about the transitional process. Batshaw et al. (2019) agreed due to the complexity of the care needed for individuals with IDD, it is important to have interdisciplinary collaboration to ensure the individuals transition well into their communities.

Process

The Donabedian component of the process involves evaluating the current ways that information about the transitioning application is provided to providers and families and what adjustments can be made. Currently, the DBHDD website has instructions on how to apply for state funding for the NOW and COMP Medicaid waivers, however, this information may not be readily available to either families or providers. One way of ensuring this information gets to the families is by involving all service providers. Perryman et al., (2021), agreed in order for the transitioning process to occur smoothly, service providers have to be involved. If providers have access to this information, they can share it with the families.

In addition to working with individuals with IDD, attending training sessions identifying possible changes that can be implemented with how information is shared with providers created a platform to share about how the current structure can be improved. On October 6, 2021, while attending a behavioral symposium, presenters outlined current ways information is delivered to providers and the challenges faced in relation to providing the information. During the training session, the presenters noted several of the community-based providers do not attend the ongoing training therefore they are not well-informed of any upcoming changes occurring within the application process. At another training held on October 13th, 2021, for new NOW and COMP providers, information about the Medicaid waiver programs was shared. During this training, the presenters discussed in detail what each waiver program covers and how the information can be shared with other providers in an effort to increase provider participation in the transitioning process. Attending the different training sessions demonstrated the need to clearly share information about the transitioning process with providers serving individuals with IDD.

Outcome

Treuer et al. (2016) reported there is an interruption when it comes to transitioning individuals to the community. This interruption can be resolved if all stakeholders involved in the care of the individual work together towards a smooth transitioning process. The Donabedian element of outcome will evaluate the results of changes made in relation to how information is delivered to the providers pertaining to the transitioning process. The desired outcome would be increased knowledge about the transitional application process among providers. Lee et al. (2017) agreed providing information about transitioning in a timely and simplified manner will increase participation in the transitioning process.

Benefits of the Donabedian Model

All the components of Donabedian's model are interlinked, which is a reflection of the relationship between the components; as stated by Donabedian “A good structure increases the likelihood of a good process and a good process increases the likelihood of good outcomes” (Donabedian, 1997, p. 1745). Munea et al. (2020) also agreed there is a relationship between input, process, and outcome based on the idea that a good structure promotes a good process which in turn promotes a good outcome.

Implementation

Project Design

IRB approval was received from GSU on August 17, 2022. The DNP team met on September 6, 2022, to practice the management of the project. Implementation began once the team approved the practice session. Participants completed surveys within one encounter with the student principle investigator (SPI). The completion date of the project was November 30, 2022. The SPI presented project findings to the team once the project was finalized. (See Table 1 illustrates the project outline.)

Table 1

Project Outline

Milestones	Description	Completion Date
Project Site Application Letter	New Generation Health Services	February 21, 2022
GSU IRB Application	GSU IRB Approval Letter	August 17, 2022 (Received)
Review implementation with the DNP team	Meet with the DNP team to review how the project will be implemented	September 06, 2022
Implementation	Start offering the questionnaire to participants	September 10, 2022
Data Analysis	Review all information collected from participants. Make an appointment with a GSU statistician to review the data	November 01, 2022, to November 30, 2022
Data Analysis	Review data collected and complete analysis	January 2, 2023

Note. Adopted from Moran et al., 2017 p.300

Participants

The targeted number of participants (n=100). At the transitional fair, 50 providers were in attendance. The providers in attendance included; physical therapists, speech therapists, occupational therapists, home health providers, dentists, host home providers, pediatricians, law enforcement, day program providers, and volunteer organizations representing individuals with IDD. Participants were obtained through convenience sampling based on providers in attendance at the fair. Providers were recruited using; a script given in person to each provider. Participation was voluntary for this quality improvement project. Inclusion criteria were; being a provider for individuals with IDD and having the ability to comprehend shared material. Participants were excluded from the study if they did not meet the above criteria. A total of 50 packets were shared with the providers, and 25 were returned by the end of the fair. Of the 25 packets, ten participants were eliminated because they did not complete both questionnaires in their entirety, and two were eliminated because they did not respond to the rating scale assessing the increase in knowledge. Thirteen completed surveys were analyzed.

Setting

The project took place at a transitional fair held at Fellowship Bible Church (FBC), located at 431 Dunbar Road, Warner Robins, GA 31093. FBC is a multicultural, non-denominational church that hosted the transitional fair on behalf of the Warner Robins school district. The church serves about 3000 members, which made it a suitable place to hold the transitional fair. Several providers were invited to be a resource for families with individuals with IDD ready to transition into the community within the Warner Robins area. At the transitional fairs, the SPI represented New Generation Health Services (NGHS) a home health agency, however, she recruited participants independent of the organization.

Tools

Participants were recruited using a script. The participants signed a consent form explaining the procedure and purpose of the project as well as how their responses will be used. The other tools used for this project are; the 6-question pre-transitional (Pre-T) questionnaire (see Appendix A), the reach, efficacy/effectiveness, adoption, implementation, and maintenance

(RE-AIM) tool, the 6-question post-transitional (Post-T) questionnaire (See Appendix B), and the process map (See Appendix C).

The RE-AIM is a planning and evaluation tool that addresses five dimensions of individual and setting-level outcomes important to program impact and sustainability (Kwan et al., 2019). The five components of the RE-AIM model are; reach, efficacy, adoption, implementation, and maintenance (Kwan et al., 2019). Table 2 illustrates the RE-AIM tool

Table 2

Key Translation and Pragmatic Questions to Consider in Addressing the RE-AIM (Reach Effectiveness Adoption Implementation Maintenance) Dimension

RE-AIM Dimension	Key Pragmatic Questions to Consider and Answer
Reach	WHO is (was) intended to benefit and who actually participates or is exposed to the intervention? Measured by number and similarity of participants to your target group.
Efficacy	WHAT are (were) the most important benefits you are trying to achieve and what is (was) the likelihood of negative outcomes? Measured by change in the key outcome(s) and consistency across subgroups.
Adoption	WHERE is (was) the program or policy applied and WHO applied it? Measured by what settings and staff take up the intervention and which do not.
Implementation	HOW consistently is (was) the program or policy delivered, HOW will it be (was it) adapted, HOW much will (did) it cost, and WHY will (did) the results come about?
Maintenance	WHEN will (was) the initiative become operational; how long will (was) it be sustained (setting level); and how long are the results sustained (individual level)? Measured by longevity of effects (individual level) and program sustainability (setting level).

Note. Terms in parentheses are phrased for postintervention evaluation. The basic questions are phrased for use in program or policy planning.

Adapted from (Glasgow & Estabrooks, 2018, p. 7)

Reach refers to an individual-level measure of participation and the percentage and risk characteristics of persons who receive or are affected by a policy or program (Glasgow et al., 1999, p. 1323). For this project, the participants targeted are providers serving individuals with IDD who had limited knowledge about the transition application process. Efficacy refers to evaluating the interventions and assessing both positive and negative consequences and the need to include behavioral, quality of life, and participant satisfaction (Glasgow et al., 1999, p. 1323). For this project, the process map illustrating the transitional application process was shared with providers, who would share the information with families of individuals with IDD. The expected outcome of the project will be increased participation of providers during the transitioning process.

Adoption refers to the proportion and representatives of settings (such as work sites, health departments, or communities) that adopt a given policy or program (Glasgow et al., 1999, p. 1323). By the end of the project, the process map will be adopted by several other providers who provide different services to families of individuals with IDD. The process map will also be shared with other stakeholders such as state employees who oversee the Medicaid waiver programs, with the aim of sharing the process map with families. Implementation refers to the extent to which a program is delivered as intended (Glasgow et al., 1999, p. 1323). By the end of the project, information delivered to the providers will be evaluated to ensure that they clearly understand what was communicated. Provider consent was obtained to contact those who agreed within a year to determine whether the process map was helpful. Provider contact information was obtained which will be used to follow up on the utilization of the process map in assisting families during the transitional process. Maintenance refers to the extent to which a health promotion practice or policy becomes routine and part of the everyday culture and norms of the organization (Glasgow et al., 1999, p. 1323). At the end of the project, the process map will be shared with the DBHDD and other stakeholders so that it can be adopted as a tool to be used during the transitional application process by providers and families of individuals with IDD.

Intervention

For this project, the DNP team consisted of one chair Dr. Lisa Cranwell-Bruce, and one team member Professor Laura Damars. Both team members were and continue to be readily available to support and guide, in addition to offering their expertise concerning the project. The team met on a monthly basis during the course of the project implementation and dissemination.

For the project, participants were given the Pre-T questionnaire, which was used to obtain the demographics of the participants attending the transitional fair and assessed their level of knowledge about the transitioning process prior to reviewing the process map. The process map illustrating the transitional application process with timelines was shared with the providers (the process map was developed after talking to a Planning List Analyst (PLA) who works with DBHDD). The Post-T questionnaire was administered to evaluate the effectiveness of utilizing the process map to assist with the transitioning process. Each questionnaire had a Likert scale that was used to assess the level of knowledge of the providers. Reviewing the Pre-T questionnaire, the process map, and the Post-T questionnaire took a total of 45 minutes. Responses were collected at the end of the transitional fair. There were no incentives for participation.

Security of Data

Data collected from the participants were stored separately in a locked cabinet. Consent forms were kept in another locked cabinet. In an effort to easily identify participants, data were identified by the first letter of their mother's maiden name and the last two digits of the participants' birth year. A code sheet with all participant information was kept separately from the rest of the data for the duration of the project. Any data provided disclosing participants' names were not analyzed. If any identifying information about the participant or others was inadvertently collected, that data was not transcribed or analyzed. The data collected was only accessible to team members. Data collected was kept for the duration of the project after which it was shredded.

Analysis

Statistical Tests

Due to the small sample size, no statistical tests were used. Data was easily compared and charted using Microsoft Excel (MS Excel).The RE-AIM tool was used to analyze the validity of using the process map. of the project. In a study done by Healy et al., (2021), researchers noted that utilization of the RE-AIM was effective in implementing change in a program supporting workers to sit less and move more. Both the Pre- T and Post-T questionnaire had a Likert scale, which was used to compare the increase of knowledge before and after reviewing the process map. MS Excel was the tool of choice because it enabled me to easily view and plot responses from participants which adequately answered my clinical question.

Limitations

One of the limitations of the project was timing. Usually, transitional fairs are held during the end of the school year (around May), so it was a challenge finding additional transitional fairs to implement the project. With the limit of attending one transitional fair, the sample size was smaller than anticipated. Another challenge faced was the lack of advanced practice providers' participation. From previously attended transitional fairs, there are usually one or two advanced practice providers compared to other disciplines, which is an illustration of the lack of participation among advanced practice providers in the transitional process for individuals. According to Ouellette -Kuntz et al., (2018), there is limited research on how advanced providers can support individuals with IDD. Without research to support the need for advanced providers to participate in the transitioning process, there is limited participation. According to Storey (2018), it is imperative that advanced providers obtain at least the basic knowledge about this process in order to adequately support the individuals during this process. If advanced providers are also provided with a copy of the process map, they would become familiar with the process and be more willing to support families and individuals with IDD. As mentioned by Dressler et a., (2018), providers were reluctant to participate in the transitioning process because; they lacked resources about the transitioning process.

Significance of Project/ Implications

According to Cadogan et al., (2018), unsuccessful transitions have the potential to; negatively affect health outcomes as reflected by increased hospital admissions, have an adverse impact on life satisfaction including decreased employment and increased depression. Once providers obtain an easier way of assisting families with the transitional process, they will be willing to readily participate in the transitioning process. Research done by Freeman et al., (2018) showed involving clinicians in the transitioning process made it easier for individuals to transition into the community. According to Smeltzer (2021), in order for healthcare providers to provide quality care to individuals with IDD, they need to grasp the day-to-day life activities of these individuals which includes being able to transition into the community. It is therefore imperative for advanced practice providers to become familiar with the transitional application process in order to adequately support families with individuals with IDD. Information obtained from the project will be shared with DBHDD and other providers within the community serving individuals with IDD. I plan to replicate the project at future transitional fairs with the hope of equipping providers with the transitional map that can be utilized to support families.

Discussion

Based on the responses from the participants there were; four behavioral specialists, two speech therapists, two physical therapists, four community providers, and one volunteer. Unfortunately, there were no advanced practice providers, which goes to show that very few advanced practice providers are engaged in the transitional process of individuals with IDD. Since the data obtained was not very large, the analysis of the findings was done using MS Excel (See Appendix D). Graphs were plotted using the ratings from the Likert scales from the Pre-T questionnaire and the Post-T Questionnaire (See Figures 3, 4, and 5). Based on the graph representation, there is an increase in the knowledge of several providers relating to using the process map for the transitional application process. In a review of currently available resources, McLean et al. (2021) agreed that there is a need to utilize community-based providers to improve the overall health outcome of individuals with IDD. Healthcare providers and all other stakeholders need to be aware of the need to collaborate during the transitioning period. According to Hart et al., (2019), individuals with IDD have multiple diagnoses and depend on their families and providers for assistance, therefore healthcare professionals need to be part of the transitional planning (Hart et al., 2019).

Figure 3

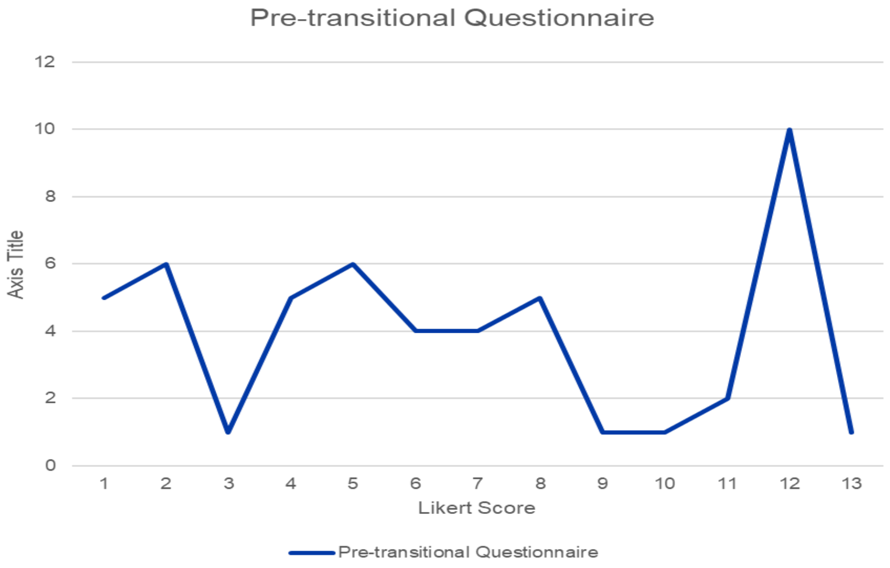


Figure 4

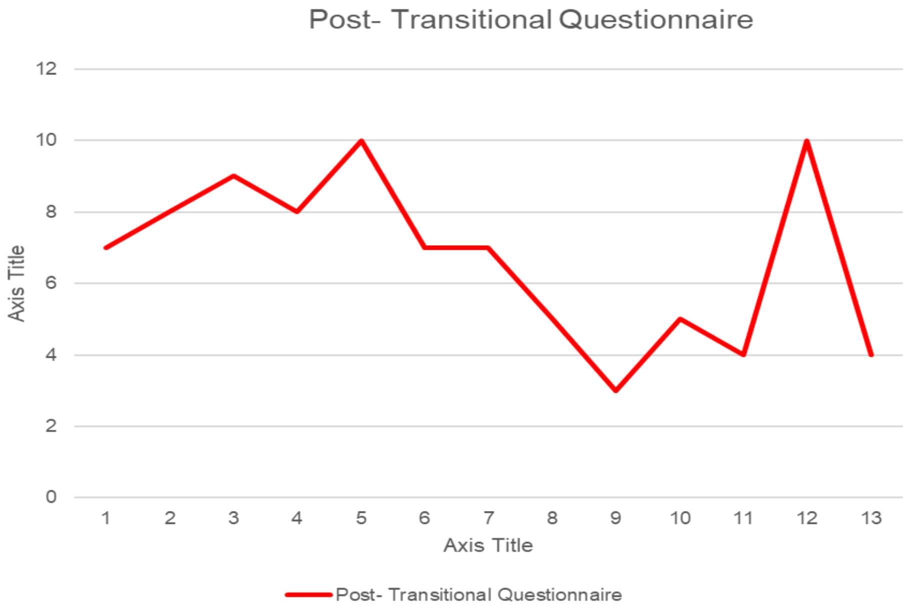
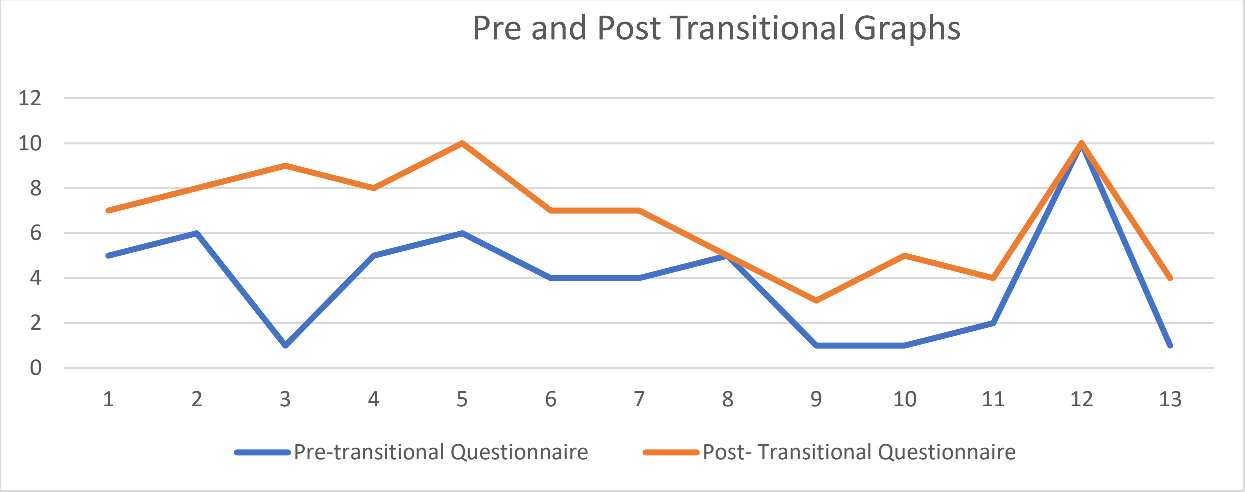


Figure 5



Conclusion

In conclusion, at the end of the project, it was noted that in order for individuals with IDD to continue thriving within their communities, there is a need to make sure that they transition safely after high school since several of them may not pursue college. One way of ensuring that the transitional process occurs safely and smoothly is by involving the providers who serve these individuals in different capacities. However, providers can not be involved in the transitional process if they are not aware of how the process works. Having a process map illustrating the transitional process can be used as a tool to guide providers about the transitional process. Through equipping the providers, who serve the individuals within the community, information about the transitioning process will be easily shared with the families that need it. The ultimate goal of this project was to increase the knowledge of providers about the transitional application process, and this was achieved at by the end of the project.

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Appendix A

Pre -Transitional Questionnaire

1. Do you serve individuals with intellectual developmental disabilities (IDD)?

    a. Yes

    b. No

2. Have you heard of the transitional application process?

    a. Yes

    b. No

3. Have you assisted any family with the transitioning process?

    a. Yes

    b. No

4. How many Regions do you serve? Select all that apply

    a. Region 1

    b. Region 2

    c. Region 3

    d. Region 4

    e. Region 5

    f. Region 6

5. On a scale of 1 to 10 how comfortable are you with the application process? With 1 being least comfortable and 10 being very comfortable?

    1, 2, 3, 4, 5, 6, 7, 8, 9, 10

6. How many NOW/COMP Waiver Services do you provide? Select all that apply

    a. CLS (Community Living Supports)

b. CAI (Community Access Individual)

c. CAG (Community Access Group)

d. SMS (Specialized Medical Supplies)

e. SEI (Supportive Employment Individual)

f. CRA (Community Residential Access)

g. Respite services

h. Behavioral Supports

i. Therapist (Speech, Physical, occupational)

j. Physician

k. Other (Please Specify):

Identifier: First letter of mother's maiden name and last two digits of the birth year for example Mother's name Jones, the birth year 1976 – J76

Appendix B

Post -Transitional Questionnaire

1. Was the information shared clearly understandable?

    a. Yes

    b. No

2. Did having the process map for the application process simplify the application process?

    a. Yes

    b. No

3. Will you be willing to support families by sharing the application process map?

    a. Yes

    b. No

4. Will you be open to being followed up within a year?

    a. Yes

    b. No

5. On a scale of 1 to 10 how comfortable are you with the application process? (1 being the least comfortable and 10 being very comfortable)

    1, 2, 3, 4, 5, 6, 7, 8, 9, 10

6. If you answered Yes to the above question, please provide contact.

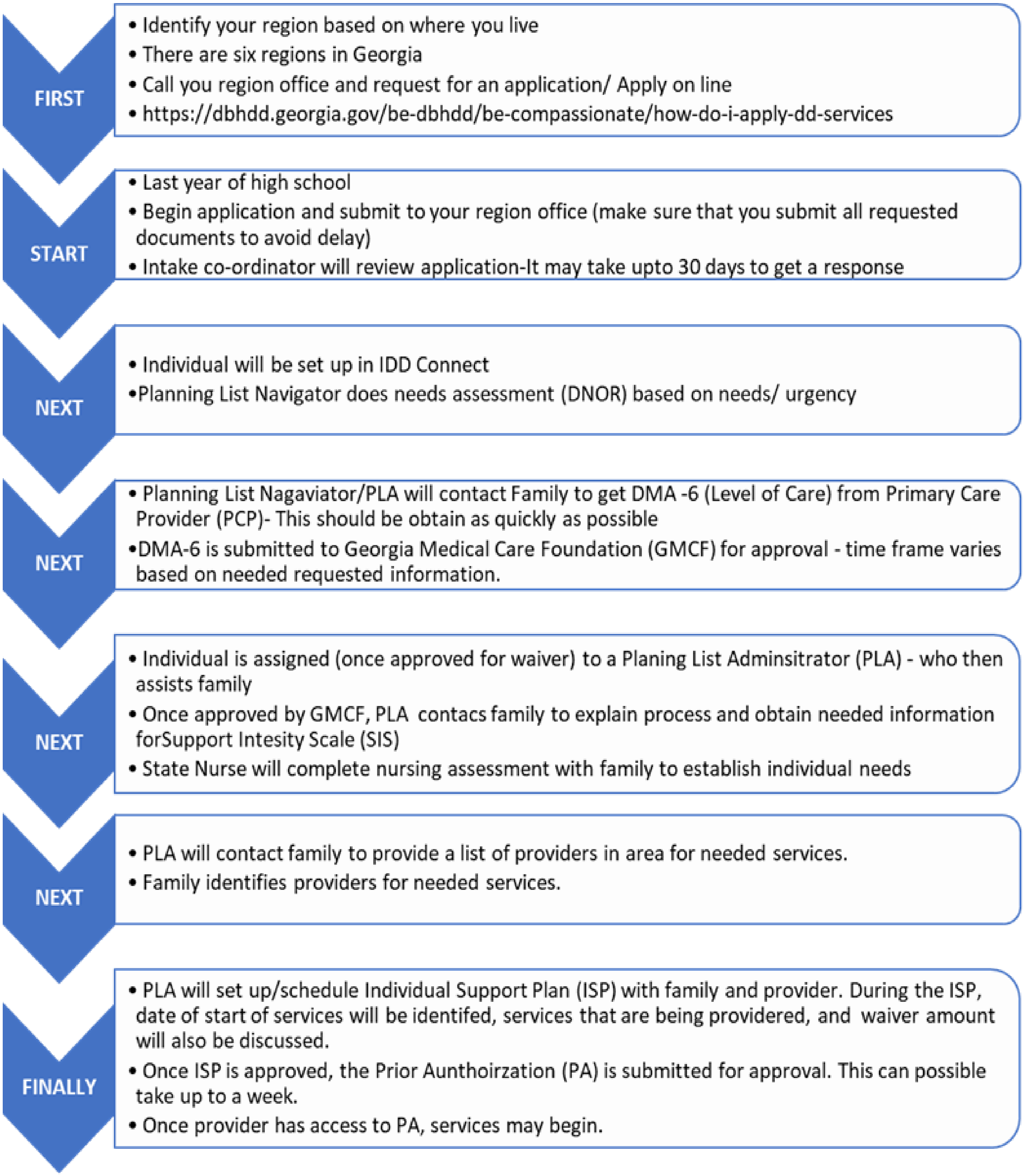
Name:

Email:

Phone:

Appendix C

Process Map



FIRST

- Identify your region based on where you live
- There are six regions in Georgia
- Call you region office and request for an application/ Apply on line
- https://dbhdd.georgia.gov/be-dbhdd/be-compassionate/how-do-i-apply-dd-services

START

- Last year of high school
- Begin application and submit to your region office (make sure that you submit all requested documents to avoid delay)
- Intake co-ordinator will review application-It may take upto 30 days to get a response

NEXT

- Individual will be set up in IDD Connect
- Planning List Navigator does needs assessment (DNOR) based on needs/ urgency

NEXT

- Planning List Nagaviator/PLA will contact Family to get DMA -6 (Level of Care) from Primary Care Provider (PCP)- This should be obtain as quickly as possible
- DMA-6 is submitted to Georgia Medical Care Foundation (GMCF) for approval - time frame varies based on needed requested information.

NEXT

- Individual is assigned (once approved for waiver) to a Planing List Adminsitrator (PLA) - who then assists family
- Once approved by GMCF, PLA contacs family to explain process and obtain needed information forSupport Intesity Scale (SIS)
- State Nurse will complete nursing assessment with family to establish individual needs

NEXT

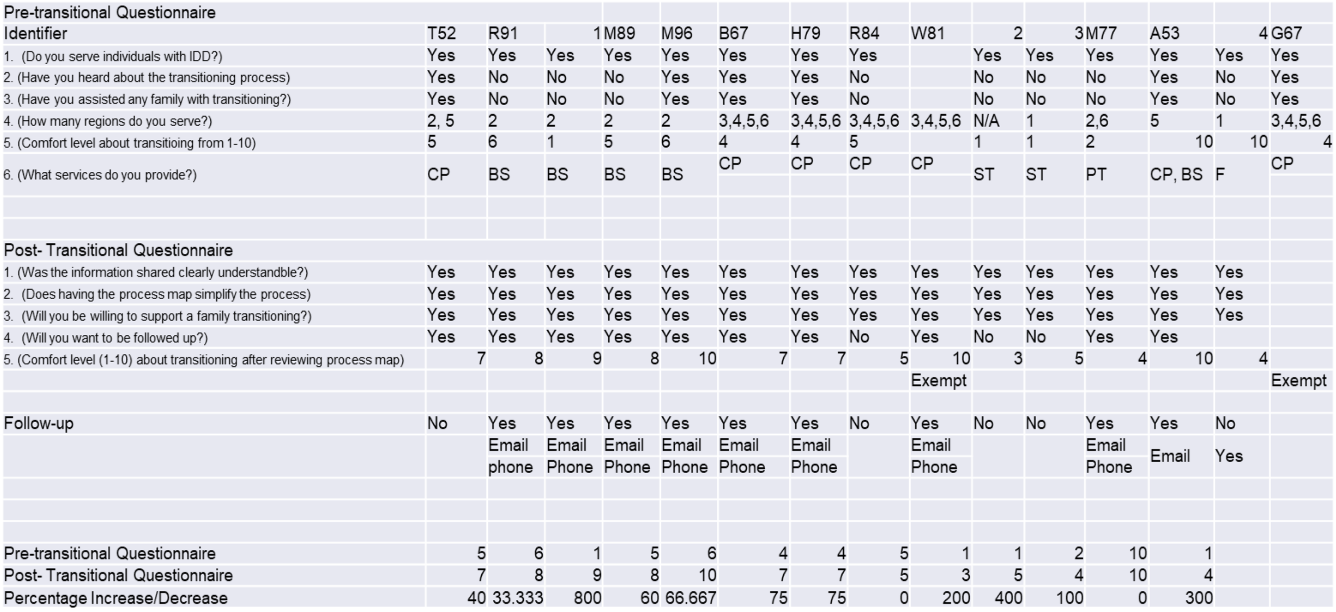
- PLA will contact family to provide a list of providers in area for needed services.
- Family identifies providers for needed services.

FINALLY

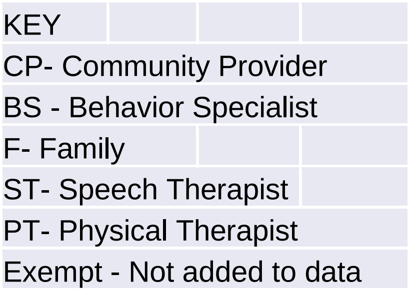
- PLA will set up/schedule Individual Support Plan (ISP) with family and provider. During the ISP, date of start of services will be identifed, services that are being providered, and waiver amount will also be discussed.
- Once ISP is approved, the Prior Aunthoirzation (PA) is submitted for approval. This can possible take up to a week.
- Once provider has access to PA, services may begin.

Appendix D

Table of results (MS- Excel)



Pre-transitional Questionnaire															
Identifier	T52	R91	1	M89	M96	B67	H79	R84	W81	2	3	M77	A53	4	G67
1. (Do you serve individuals with IDD?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes
2. (Have you heard about the transitioning process)	Yes	No	No	No	Yes	Yes	Yes	No		No	No	No	Yes	No	Yes
3. (Have you assisted any family with transitioning?)	Yes	No	No	No	Yes	Yes	Yes	No		No	No	No	Yes	No	Yes
4. (How many regions do you serve?)	2, 5	2	2	2	2	3,4,5,6	3,4,5,6	3,4,5,6	3,4,5,6	N/A	1	2,6	5	1	3,4,5,6
5. (Comfort level about transitioing from 1-10)	5	6	1	5	6	4	4	5		1	1	2	10	10	4
6. (What services do you provide?)	CP	BS	BS	BS	BS	CP	CP	CP	CP	ST	ST	PT	CP, BS	F	CP
Post- Transitional Questionnaire															
1. (Was the information shared clearly understandble?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
2. (Does having the process map simplify the process)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3. (Will you be willing to support a family transitioning?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
4. (Will you want to be followed up?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes		
5. (Comfort level (1-10) about transitioning after reviewing process map)	7	8	9	8	10	7	7	5	10	3	5	4	10	4	
									Exempt						Exempt
Follow-up	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	No	
		Email phone	Email Phone	Email Phone	Email Phone	Email Phone	Email Phone		Email Phone			Email Phone	Email	Yes	
Pre-transitional Questionnaire	5	6	1	5	6	4	4	5	1	1	2	10	1		
Post- Transitional Questionnaire	7	8	9	8	10	7	7	5	3	5	4	10	4		
Percentage Increase/Decrease	40	33.333	800	60	66.667	75	75	0	200	400	100	0	300		



KEY
CP- Community Provider
BS - Behavior Specialist
F- Family
ST- Speech Therapist
PT- Physical Therapist
Exempt - Not added to data

Appendix E

GEORGIA STATE UNIVERSITY

SCHOOL OF NURSING

APPENDIX L

ACADEMIC HONESTY STATEMENT

Please include this Academic Honesty statement with each paper submitted.

Author Note:

Pursuant to the academic honesty standards of the University, it is important to note that some information pertaining to this paper has been used in other classes for the DNP Project. The information in this paper has also appeared in other papers that the writer has already presented and will present in the future. Additionally, some research performed related to this paper has been used as background information for other papers or projects conducted throughout the course of study, and then added to throughout the curriculum. In all circumstances, the information has been built upon to gain depth and knowledge related to the area of research and this assignment has not been submitted in full for any other assignment within the School of Nursing or the University