

INDIVIDUAL'S NAME	ADSA ID NUMBER	PROPOSED MOVE DATE
INDIVIDUAL'S STATED TRANSITION GOAL		
INDIVIDUAL'S STATED SUPPORTS NEEDED TO ACHIEVE GOAL		



DEVELOPMENT DISABILITIES ADMINISTRATION (DDA)
Transitional Care Planning Tracking

Purpose: This document is intended to be used as a facilitation guide and tracker for DDA staff coordinating a move from one setting to another. Case Managers who are facilitating care coordination meetings will use this document to track progress and highlight individual needs and readiness to transition to their identified setting. A copy will be provided to the individual and their representative to update them on transition progress as well as to transition team members as appropriate.

A. Transition Preparation: Individual requests to move to a new setting.

Transition preparation consists of the tasks that are needed to identify the individual's goals and support needs, identify preferred setting to live, and review eligibility for applicable programs. In some cases, the individual will transfer to a transition or RCL caseload or to a different office or region. The new case manager will facilitate the team meetings that occur in the ACT stage (see Part B). In these cases, the primary case manager will transfer the case after mutual acceptance has occurred between an individual and a provider after a warm handoff.

ACTIVITY	WHO	EXPECTED UPDATE	NOTES AND STATUS UPDATES	DONE	DATE
Assist to complete or update MyPage and incorporate goals into client profile	CRM			<input type="checkbox"/>	
Review CARE with the individual and their family / guardian and ensure it is current and accurate				<input type="checkbox"/>	
Discuss living options, identify preferred living arrangement, and identify appropriate community living model that matches description				<input type="checkbox"/>	
Have conversation with guardian about providing needed legal documents (refer to form DSHS 10-635): <ul style="list-style-type: none"> • Washington State ID, • Current legal decision-making paperwork, • Social Security Card, • Insurance cards, and • Any other legal documents. 				<input type="checkbox"/>	
Determine financial eligibility for applicable programs	LTC Unit			<input type="checkbox"/>	
The individual / family / guardian tours and interviews community providers	Individual, Family, or Guardian				
Assemble and send referral packet form and follow referral process per applicable policy.	CRM			<input type="checkbox"/>	
For Community Residential: Region sends referral packet per policy to identified community residential provider(s) preferred by individual / family / guardian	<input type="checkbox"/> RM <input type="checkbox"/> PQIS <input type="checkbox"/> CRM			<input type="checkbox"/>	
Providers have met the individual and guardian in the current setting				<input type="checkbox"/>	
Housemates have met and agreed to live together				<input type="checkbox"/>	

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Necessary environmental modifications identified			<input type="checkbox"/>
DDA verified that the provider agreed to provide support to the individual, if applicable	<input type="checkbox"/> RM <input type="checkbox"/> PQIS <input type="checkbox"/> CRM		<input type="checkbox"/>
DDA verified the individual and guardian have agreed to receive services from the provider	<input type="checkbox"/> RM <input type="checkbox"/> PQIS <input type="checkbox"/> CRM		<input type="checkbox"/>
Mutual agreement when the individual has chosen a provider to meet their care needs and the provider agrees to provide care			<input type="checkbox"/>
Referral to NCC and/or Clinical team if high acuity			CRM
<p>Warm Handoff: Sending and receiving CRMS (if transitioning to a new CRM) work with the individual and guardian, as well as the current and future provider to review the individual's goals, understand their support needs and create the transition team. This may be multiple meetings, depending on the circumstances. The case manager identifies the team members who will attend the initial transition meeting during the ACT stage to develop the care plans that will support the client. The initial meeting marks the beginning of the Active Coordinator of Transition (ACT) stage.</p> <ul style="list-style-type: none"> Review Policy 3.02 for instructions on case transfer and interoffice / interregional moves. 			
Sending CRM:		Receiving CRM:	Date:
Meet with current and new provider and case manager(s) and ensure new residential provider has copies of all relevant documents on the DSHS 10-635 checklist. Document missing items. Identify transitional care coordinator team members.			Date: <input type="checkbox"/> Completed <input type="checkbox"/> Provider Declined
Please describe how the individual and their guardian or representative would like to participate in the meetings and receive updates about the transition status:			

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B. Active Coordinator of Transition (ACT): Team meets regularly to support transition		
<p align="center">Transition Team</p> <p>The transitional care coordination team meets regularly to develop and implement the care plan, identify medical, dental, referral and assessment needs, set up housing, identify and implement environmental modifications and equipment needs, confirm financial eligibility, and facilitate introductions to providers, roommates, and community activities.</p> <p>Please be sure to include the client when identifying who should be at their meeting and ensure that they provide permission for attendance. All participants in a meeting should have copies of the tracking notes to ensure they are able to monitor expected updates and transition progress.</p>		
TITLE / ORGANIZATION	NAME	ROLE
Individual		Engage with the team on community living goals and preferences
DDA Transition Case Manager		Facilitate transitional care coordination meetings; coordinate assignments and deadlines; model person centered practices
Current / Sending Provider		Provide expertise regarding individual's care needs
Medical Provider		Discuss medical supports needed, including post move medications and referrals to appropriate PCP or specialists if needed
Behavioral Health Provider		Discuss behavioral supports needed, including post move psych medications and FA/PBSP coordination
DDA HQ Transition Clinical Staff		If identified high medical or behavioral acuity, or if otherwise needed for consultation
Receiving Provider		The agency or responsible provider of services in the setting where the individual will move
Guardian or Representative		Support the individual with decision making regarding the implementation of their goals and their needed supports and services
<p>Instructions: Invite all persons who are identified to attend the initial meeting. Prior to each subsequent meeting, review expected updates and ensure that the persons responsible for those updates will be on the agenda and attending the meeting. When a person is expected to follow up on a task, put their name in the column "person responsible" and enter a date <u>when they will be reporting back to the team</u>. Add a note on what task they will be completing and the status updates for those tasks. Change the expected update date as needed. Check "done" when the task is completed, and the date.</p>		
HOUSING	PERSON RESPONSIBLE	EXPECTED UPDATE
Environmental modifications needed / set up		
Rental application and lease completed / in place		
Furnishings and décor		
Resource management		
Meet staff, roommates, and visit home		
NOTES		

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BEHAVIORAL SUPPORTS	PERSON RESPONSIBLE	EXPECTED UPDATE	NOTES AND STATUS UPDATES	DONE	DATE
Psychiatric needs, including prescriber, if needed				<input type="checkbox"/>	
Community behavioral health provider identified and follow up				<input type="checkbox"/>	
FA / PBSP				<input type="checkbox"/>	
Cross Systems Crisis Plan (CSCP) or safety plan, if needed				<input type="checkbox"/>	
Behavior related IR follow up needed				<input type="checkbox"/>	
New / emerging behavioral support needs				<input type="checkbox"/>	
NOTES					
MEDICAL AND DENTAL	PERSON RESPONSIBLE	EXPECTED UPDATE	NOTES AND STATUS UPDATES	DONE	DATE
MCO care coordination needs				<input type="checkbox"/>	
Primary care confirmed				<input type="checkbox"/>	
Specialists needed are in place				<input type="checkbox"/>	
Dentist				<input type="checkbox"/>	
Therapy needs: • PT / OT / ST • Dietary				<input type="checkbox"/>	
New / emerging needs				<input type="checkbox"/>	
NOTES					
FINANCIAL AND LEGAL	PERSON RESPONSIBLE	EXPECTED UPDATE	NOTES AND STATUS UPDATES	DONE	DATE
Verify SSI, SSDI, and other unearned income in place				<input type="checkbox"/>	
Establish payee if needed, and review financial supports for plan				<input type="checkbox"/>	
Apply for food programs, if eligible				<input type="checkbox"/>	
Are they on the correct funding program (RCL / Waiver)?				<input type="checkbox"/>	
Reconcile finances in current setting				<input type="checkbox"/>	
Guardianship paperwork in place, if applicable				<input type="checkbox"/>	
Bank account is setup in new location				<input type="checkbox"/>	
NOTES					
SERVICES SET UP	PERSON RESPONSIBLE	EXPECTED UPDATES	NOTES AND STATUS UPDATES	DONE	DATE
Confirm or initiate waiver or RCL enrollment				<input type="checkbox"/>	
Nurse delegator identified				<input type="checkbox"/>	

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<ul style="list-style-type: none"> Medication assistance needs are identified Date of move nurse delegation scheduled 					
Adaptive / AT equipment in place for sensory, communication, and ADL needs				<input type="checkbox"/>	
Employment / community inclusion				<input type="checkbox"/>	
School for clients under 21 <ul style="list-style-type: none"> Will individual need specialized transportation to access their community? Who will transport them to upcoming appointments? 				<input type="checkbox"/>	
Transportation needs <ul style="list-style-type: none"> School enrollment confirmed IEP transfer is completed or in process 				<input type="checkbox"/>	
NOTES					
STAFF TRAINING	PERSON RESPONSIBLE	EXPECTED UPDATE	NOTES AND STATUS UPDATES	DONE	DATE
Nurse delegation is in place for all staff				<input type="checkbox"/>	
Staff are trained on all care plans and individual support needs				<input type="checkbox"/>	
NOTES					
Prior to move in date	NOTES AND STATUS UPDATES			DONE	DATE
Current provider / new provider consultation				<input type="checkbox"/>	
All needed documents are in client provider file				<input type="checkbox"/>	
All previous tasks have been reviewed and completed				<input type="checkbox"/>	
All plans are in place	<input type="checkbox"/> PBSP <input type="checkbox"/> IISP	<input type="checkbox"/> CSCP <input type="checkbox"/> Protocols	<input type="checkbox"/> Other		
NOTES					
DAY OF MOVE	PERSON RESPONSIBLE	DUE DATE	NOTES AND STATUS UPDATES	DONE	DATE
Transportation to new home				<input type="checkbox"/>	
Items to be moved <ul style="list-style-type: none"> Property list confirmed 				<input type="checkbox"/>	
Provider receives medications and MAR				<input type="checkbox"/>	
Finances are transferred				<input type="checkbox"/>	
Arrangements for meals enroute				<input type="checkbox"/>	

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Confirm the move on the DSHS 15-345 LTC form				<input type="checkbox"/>
<input type="checkbox"/> Confirm the move on the DSHS LTC form				
NOTES				

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C. Post Move and Stabilization		
The case manager visits at regular intervals and meets with the individual to ensure they are adjusting, ensure that staff are trained and implementing planned strategies to support the individual, and that all plans are in place and being implemented. The PQI staff works with the case manager to have conversations about identified concerns from the Mover's Survey so that the case manager can follow-up and address any unmet needs.		
Two – three business days post move – individual is getting settled.		
ACTIVITY	NOTES	RESOLUTION NEEDED
Individual is comfortable with staff		<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider is comfortable with supports in place		<input type="checkbox"/> Yes <input type="checkbox"/> No
Issues with behaviors, nutrition, medications, etc.		<input type="checkbox"/> Yes <input type="checkbox"/> No
FA / PBSP in place and staff trained		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual is satisfied with sleep and daily routine		<input type="checkbox"/> Yes <input type="checkbox"/> No
Nurse delegation is in place and medications are being used		<input type="checkbox"/> Yes <input type="checkbox"/> No
Two weeks post move – staff are able to address client's needs.		
Individual is comfortable with staff		<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider understands individual's support needs and comfort with interventions		<input type="checkbox"/> Yes <input type="checkbox"/> No
Issues with behaviors, nutrition, medications, etc.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual is satisfied with sleep and daily routine		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual is planning community activities of interest		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual shares general feedback about their experience so far		<input type="checkbox"/> Yes <input type="checkbox"/> No
30 days post move – plans are all in place.		
Provider has finalized IISP, NCP, or other relevant care plans		<input type="checkbox"/> Yes <input type="checkbox"/> No
Home is decorated and personalized per the individual's preference		<input type="checkbox"/> Yes <input type="checkbox"/> No
All staff have completed needed or required training to meet individual's needs		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual is participating in community activities of interest		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual has unmet needs or areas of concern to be addressed		<input type="checkbox"/> Yes <input type="checkbox"/> No

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Quarterly check ins (3 months / 6 months / 9 months / 11 months)			
ACTIVITY	RESOLUTION NEEDED	NOTES	DUE DATE
is engaged in community activities	<input type="checkbox"/> Yes <input type="checkbox"/> No		3 months: 6 months: 9 months: 11 months:
Supports in place are meeting the support needs for	<input type="checkbox"/> Yes <input type="checkbox"/> No		3 months: 6 months: 9 months: 11 months:
is participating in the cultural and spiritual activities of their choice	<input type="checkbox"/> Yes <input type="checkbox"/> No		3 months: 6 months: 9 months: 11 months:
All staff are familiar with and their needs	<input type="checkbox"/> Yes <input type="checkbox"/> No		3 months: 6 months: 9 months: 11 months:
IISP, NCP, or other program required care plan is effectively meeting the individual's needs • Verify 60 and 90 program requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No		3 months: 6 months: 9 months: 11 months:
Updated supports, services, or needs have been identified, if applicable, and follow up is occurring	<input type="checkbox"/> Yes <input type="checkbox"/> No		3 months: 6 months: 9 months: 11 months: