DSHS
WASHINGTON STATE
Department of Social and Health Services

REPORT TO THE LEGISLATURE

Transitional Care Management

Engrossed Substitute Senate Bill
5693, Section 203 (1)(ee)(i)

December 1, 2025

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Contents

Introduction **1**
Best Practices for Successful Transitions 1
What is the Transition Framework 2
Key Outcomes for FY 2025 ..... **3**
Framework Expansion 3
Improved Provider Experience 3
Timely Response to client needs 3
Systems Improvement Tracking and Implementation 3
One Referral increased timeliness, transparency and accountability 4
Data and Analysis of Stages and Timeliness **4**
Transition Preparation **5**
Active Coordination of Transition (ACT) **9**
Post Move and Stabilization **10**
Client Critical Case Protocol **14**
Supporting Client Complexity **15**
Transition Close and Root Cause Analysis **17**
Recurring Themes and Trends 17
Region 2 success story : Lessons learned from Root Cause Analysis 19
Recommendations **19**
Increase Focus on Post Move 19
Partner with Behavioral Health and Habilitation Administration and community partners to improve youth inpatient facility discharges 19
Work with partners to enhance Adult Family Home success 20
Institutional care to community transition resource development 20
Accessible provider training and technical assistance 20
Increase parent support 20

Introduction

Engrossed Substitute Senate Bill 5693 Section 203(1)(ee)(i) was enacted during the 2022 legislative session. This annual report includes details on the actions DSHS/DDCS have taken to improve transitional care management by:

- Tracking timeliness of moves and client progress toward increasing stability.
- Comparing transition outcomes against the outcomes achieved in prior fiscal years.
- Identifying lessons learned from past transitions and creating process improvements to improve timelines for transitions.
- Addressing workforce stability by streamlining and simplifying processes for case managers to have increased ability to support their complex clients through increased process efficiency.

People with intellectual and developmental disabilities may need extra help when they move to a new home. This is one of many kinds of "transitions." Moving can be hard because it means:

- A new place to live
- New people around (whom the person may not know)
- Different daily routines to get used to
- Different sounds, smells and other sensory input
- Different regulatory expectations from one setting to another

These changes can feel scary or confusing for the person and create a lot of stress while they are preparing for and adjusting to the move, which increases the risk of instability in their home, unnecessary hospitalization or loss of provider.

Best Practices for Successful Transitions

In 2022 the department conducted a comprehensive needs assessment though a variety of stakeholder engagement meetings. Known Best Practices established by multiple national resources such as Center for Health and Research Transformation (CHRT) highlight the below best practices.

- **Multidisciplinary Teams:** Involving behavioral health, medical, and social support professionals.
- **Individualized Transition Plans:** Tailored to medical, behavioral, and environmental needs.
- **Early and Frequent Communication:** Between sending and receiving providers, caregivers, and clients.
- **Post-Transition Monitoring:** Especially during the first 30 days to prevent destabilization.
- **Training and Support for Community Providers:** On managing complex behaviors and medical conditions.

The department utilizes the Transition Framework to incorporate each of these best practices into a three stage process that allows for increased monitoring of key performance tasks to support optimal outcomes.

What is the Transition Framework?

The transition framework helps different programs work together so people can move smoothly from one living situation to another. It uses a consistent process across the state and includes tools to track how long transitions take and how well they go. The process is broken into three stages:

Transition Preparation

- Starts when someone asks to move.
- The case manager talks with the person about their goals, what kind of help they need, and where they would like to live.
- They look at different housing options and services that match the person's needs.
- The case manager creates a referral packet and supports the person in choosing a place that fits their needs.
- The person and the provider agree to move forward together.

Active Coordination of Transition (ACT)

- Begins with a meeting to plan the move.
- Everyone involved—the person moving and their family or other support people, the case manager, school representatives, providers, medical and behavioral health staff—discuss who is doing what and when they will provide status updates.
- The transition team plans activities to help the person get ready, like meeting future housemates and staff, and visiting the new home.
- The team makes sure all needed supports are ready prior to the move, such as staff are trained; medical providers and pharmacy are identified and in place; environmental modifications are in place; care plans are developed etc.
- The case manager leads the planning, tracks which team members are following up on specific tasks, and keeps the person involved in all decisions.

Post-Move and Stabilization

- Starts the day the person moves in and continues with wrap around support for up to a year.
- The case manager checks in regularly to make sure services are in place and working well.
- They make sure staff are trained and the person's care plan is followed.
- Case managers asks the person how they feel about their new home and supports.
- Quality Assurance staff completes transition surveys with the client, guardian and provider.
- Case managers continue to follow-up to make sure everything stays on track as the client adjusts to their new home.

Quality Assurance processes are in place that allow for monitoring of timeliness, barriers to moving, and early identification of concerns. Quality Assurance staff work with case managers to mitigate concerns and provide wrap around supports during the 365 day post move and stabilization period, to better support stability. In addition, quality assurance staff lead interdisciplinary team meetings to conduct Root Cause Analysis (RCA) for qualifying unsuccessful transitions, so that teams can plan for more prevention strategies and identify risks for subsequent transitions.

Key Outcomes for FY 2025

The transitional care unit continues to be the pilot group for early adoption of processes, with a full caseload of clients navigating the full transition framework, including the quality assurance activities. Other specialized case managers who carry a reduced caseload, typically ~1:35, are following the complete framework but do not have the added quality assurance processes in place. A non-specialized case manager carries a 1:72 caseload.

- **Framework Expansion:** In spring of 2025, we expanded the framework across our system of services, with a modified post move expectation for case managers who have a non-specialized caseload and carry a 1:72 caseload size. Over the course of the fiscal year, July1 2024 to June 30, 2025, we were able to expand the number of clients served by transitional care management supports by 158%, from 737 clients on our pilot and specialized caseloads to 1460: an increase of 158%
- **High levels of satisfaction from the perspective of clients and family/guardian/advocates:**
  - 97% of individuals report satisfaction with the people who support them.
  - 83% of individuals report satisfaction with their home
  - 88% of families, guardians and advocates were satisfied with the provider.
  - 90% of families, guardians and advocates rated the transition as successful.
- **Improved Provider Experience:** DDCS conducted a provider survey with contracted waiver residential providers in February 2025 about their experience with the transition framework. The Transition Survey highlights provider perspectives during the post move. Qualitative outcomes highlight:
  - An improvement in client adjustment, leading to increased stability.
  - Improved process efficiency.
  - Increased provider satisfaction.
  - Improved relationships with clients and guardians.
  - The average rate of family/guardian/advocate satisfaction with the provider from the Transition Survey is 84%, and the average rate of transition success from this perspective is 90%.
- **Timely Response to Client Needs:** Quality Assurance processes allow staff to evaluate risk factors for instability or barriers to timeliness. This enables case managers and field staff to respond to issues more quickly and resolve them earlier. An algorithm is being piloted to test and evaluate stability risk.
- **The transition framework has improved timeliness, helping people to move to their new setting more quickly:**
  - 27% increase in timeliness between FY 24 and FY 25.
  - Almost 40% improvement in timeliness since implementation began.
- **Systems Improvement Efforts and Collaboration:** DDCS has worked across programs to address comprehensive systems improvement.
  - A new systems improvement tracking process is in place to allow quality assurance data to inform systems improvement across DDCS programs and track how programs across the DDCS service system are responding to lessons learned in transitional care management work.
  - Expansion of residential services has created more access to providers and decreased the time to find a home and provider support for a person looking to move to their community
  - The client critical case protocol (CCCP) reduced housing/provider loss risk in supported living from 25 cases per quarter to 7 per quarter over 4 years by enabling timely staff intervention during unstable transitions.

  - Improved hospital coordination, leading to a 72% increase in notifications when DDCS-enrolled individuals are hospitalized, allowing staff to support client moves more quickly and resulting in a decrease in hospital length of stay from a median of 101 days in 2023 to 11 days for the 2025 fiscal year.
- **One Referral increases timeliness, transparency and accountability:** DDCS implemented a policy and process improvement project, "One Referral", aligning referral processes across 14 programs, creating a single process for field staff to follow.
  - The policy was updated to reflect timeline expectations to improve process transparency and empower case managers to better communicate referral status to clients.
  - A single point of entry for all referrals uses automated notifications that are routed to receiving programs to review referral documents.
  - Initial feedback from field staff was positive, with staff stating that the new process was easy to use.
  - The One Referral process aligns with DDCS' strategic priorities, enhancing cross program collaboration, increasing client satisfaction, and strengthening the foundation for future policy and technology integration.

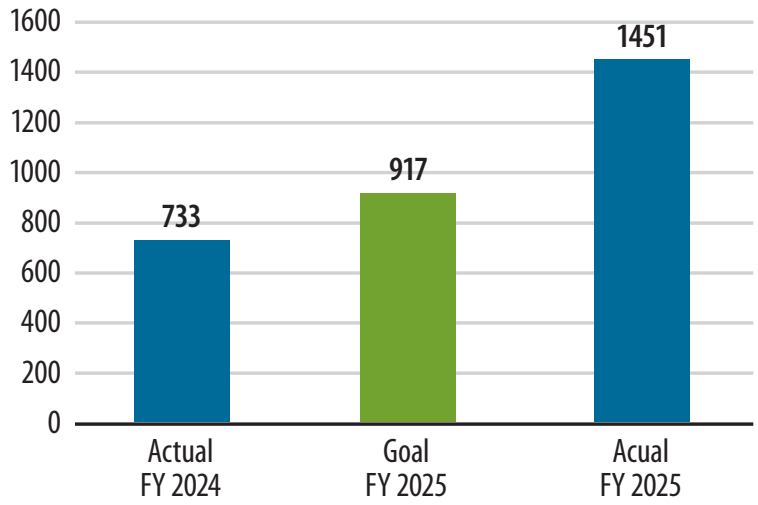
These strengths and preliminary outcomes are setting our system up to achieve better outcomes, greater process efficiency and stronger provider relationships. Reinforcing and building on these successes sets us up to lower costs from crisis interventions and achieve better long term stability for the people we serve.

Data Analysis of Stages and Timeliness

The Department established a strategic plan goal:

Strategic Goal #2: Expand Accessibility, Services, Capacity and Increase Utilization of Supports and Services for Individuals with Developmental Disabilities: By June 2025, increase clients served by the transition framework by 25%. During FY 2024, 733 clients received supports from the transition framework. The goal of increasing the number of clients served by the framework by 25% would have a target of serving 917 people on the framework, however 1451 clients were supported by the transition framework during FY2025. The Department exceeded the 2025 goal, and increased the number served by 158.2% over the prior fiscal year, as illustrated below.

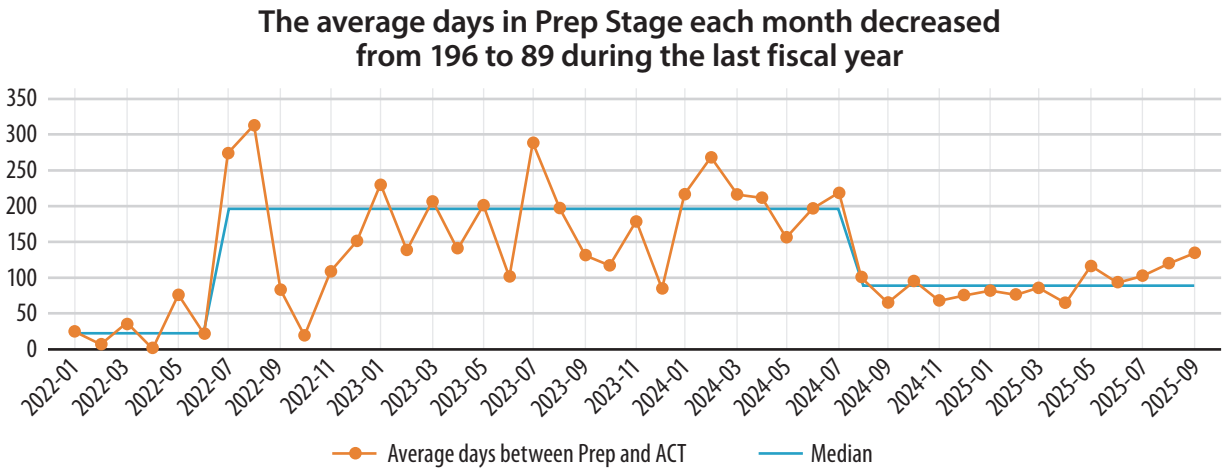
Department increased the number served by 158.2%



The framework was expanded across all caseload types to include following a standardized statewide process and has increased consistency in client experience. It has given us a structure to evaluate success, and to support people who experience barriers and setbacks. Each stage of the framework is evaluated for successes and barriers, and adjustments are made as staff learn what is working well and what scenarios require increased support from department staff.

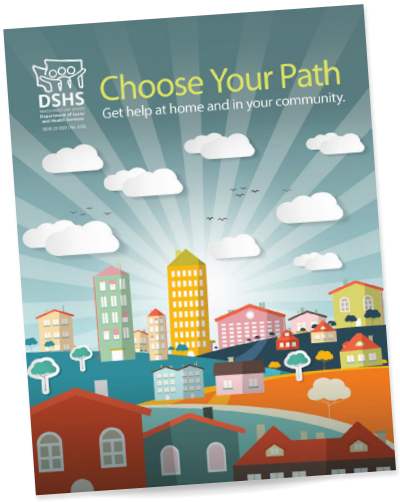
Transition Preparation

Transition preparation is the stage that supports person-centered planning and referral processes.



New projections for the next few months suggest that the average monthly number of days in the prep stage will be around 85 days with a 95% likelihood of between 52 and 126 days.

Best Practices in Transitional Care Management highlight **individualized transition plans**, tailored to medical, behavioral, and environmental needs and **early and frequent communication**. Several resources have been developed or identified to help people and their representatives to consider what makes a meaningful life for them.



Case managers are asked to share these publications with families and individuals to help them identify their goals and engage them in the transition process as key drivers of decisions that affect them.

Providers have noted that that the more the person is engaged in their transition process, the more quickly they adjust to their new home and providers. One provider commented on the importance of person centered planning and said:

"During one planning process, the team brought in the client's favorite community member — the barista from their daily coffee shop — to discuss ways to integrate social routines into their week. The client's happiness and engagement soared within the first month in their new home." – provider

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Transition Preparation also includes referral processes. After the person identifies their goals and where they want to live, case managers help them find a place to live and receive support from a provider of their choice. Clients with Intellectual and Developmental Disabilities are one of the most diverse populations served by the department. They can be any age, have a variety of types of disabilities, and can range in medical and behavioral complexity. As a result of this diversity, DDCS supports a large variety of types of housing and provider options:

The 3 charts below shows client moves for all clients with a currently open transition record who are receiving transition support.

ADULT (18+) Transitions to Community *(most recent move)*

To ➔ / From ↓	Adult Family Home	Assited Living Facility	Other	Own Home	Waiver Residential	Parent/ Relative's Home	SOLA	**TOTAL**
Adult Family Home	29		29		30			**59**
Adult Residential Care (ARC)	3		3		1			**4**
Assisted Living Facility (non-ARC)	1		1					**1**
Correctional Facility	2		2					**2**
Group Home DDA								**2**
Homeless					2			**2**
Medical Hospital	46	2	2	3	65	32	1	**151**
Nursing Facility	32		2	12	84	4	3	**137**
Other	6		4	2	20	10		**42**
Own Home	4		1	2	35	1	1	**44**
Waiver Residential	5	1	2	1	80	5		**94**
Parent/Relative's Home	27	3	2	4	142	7	5	**190**
Psychiatric Hospital	4		2		31	7	1	**45**
Residential Habilitation Center (RHC)	20				60	1	21	**102**
SOLA					3			**3**
TOTAL	**144**	**6**	**15**	**24**	**524**	**67**	**32**	**812**

YOUTH (<22) Transitions to Community *(most recent move)*

To ➔ / From ↓	DCYF	Group Home	OHS	Other	Own Home	Companion Home	Supported Living	Parent/ Relative's Home	SOLA	TOTAL
DCYF Setting	1		4	1		2	10	3		**21**
Medical Hospital		1	7	2	3					**14**
Nursing Facility		1		2	1					**4**
OHS			7				14	1		**22**
Out-of-State Facility			3	1			6	7		**17**
Parent/Relative's Home	1	8	25	2	4		10	7	5	**62**
Psychiatric Hospital			5	2						**7**
TOTAL	**2**	**10**	**51**	**10**	**8**	**2**	**40**	**18**	**5**	**147**

**Count of ADSA; ^Some may have duplicates for moves for clients 18-21*

INSTITUTION to Community Moves-All Ages *(most recent move)*

To ➔ / From ↓	AFH	ALF	ESF	Group Home DDA	OHS Children's SOLA	OHS	Other	Own Home	Companion Home	Supported Living	Parent/ Relative's Home	SOLA	TOTAL
Correction at Facility	2												**2**
Medical Hospital	46	2	1	1		7	2	3	3	61	32	1	**160**
Nursing Facility	32		1	1			2	12	2	81	4	3	**140**
Out-of-State Facility						3	1			6	7		**17**
Psychiatric Hospital	4				2	3	2			31	7	1	**50**
Residential Habilitation Center (RHC)	20			1	1	1				59	1	21	**104**
TOTAL	**104**	**2**	**2**	**3**	**3**	**14**	**7**	**15**	**5**	**238**	**51**	**26**	**473**

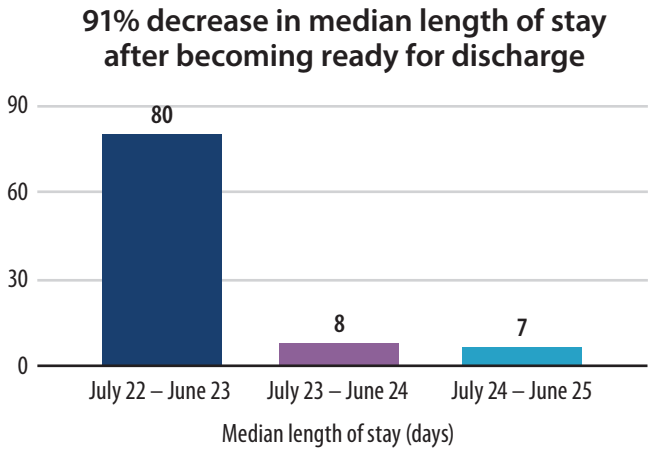
Individuals with developmental disabilities may experience an acute care hospitalization without a medical need.

Barriers for discharging from acute care hospitals included 61% of individuals having behavioral and psychiatric service needs and/or 21% of family no longer being able to support the individual in their family home.

Since 2023, DDCS has increased communication and collaboration with acute care hospitals statewide. This led to a 72% increase in notifications from hospitals, when an individual enrolled with DDCS is hospitalized.

This has also led to a decrease in median length of stays since the individual was ready to discharge, resulting in a decrease in unnecessary admission days by 91% from 2023 to 2025, from 80 days to 7 days.

For youth, ages 0-17 the most common setting types for individuals entering and discharging an acute care hospital is to their family home while the most common setting type for ages 18+, remains supported living.



The decrease in length of stay at hospitals reflects the work across DDCS team to implement transition processes that use transition best practices. The transition framework has allowed the department to implement a consistent and efficient process to support timely moves to the community.

One Referral Project

Field staff often tackle many challenges when helping people find housing and service providers that can meet the needs of people with complex needs. The process has been complicated, with different rules and steps depending on the program. This made it hard for staff to know what to do and added extra work.

The One Referral project was created in 2023 to align referral policies across the DDCS service system. Phase 2, added during this past year brought technology solutions and automation to further assist staff in streamlining referral processes to support people looking for homes and residential providers. The vision for this project was:

- Case managers have one streamlined process to follow to more quickly connect people to potential providers across multiple setting types.
- Staff have increased comfort to navigate referral processes more easily.
- A standard process for moving across all settings and locations streamlines the client's experience.
- Concrete timeline expectations for both staff and contracted providers increases process transparency for clients and their families and maximize their engagement.

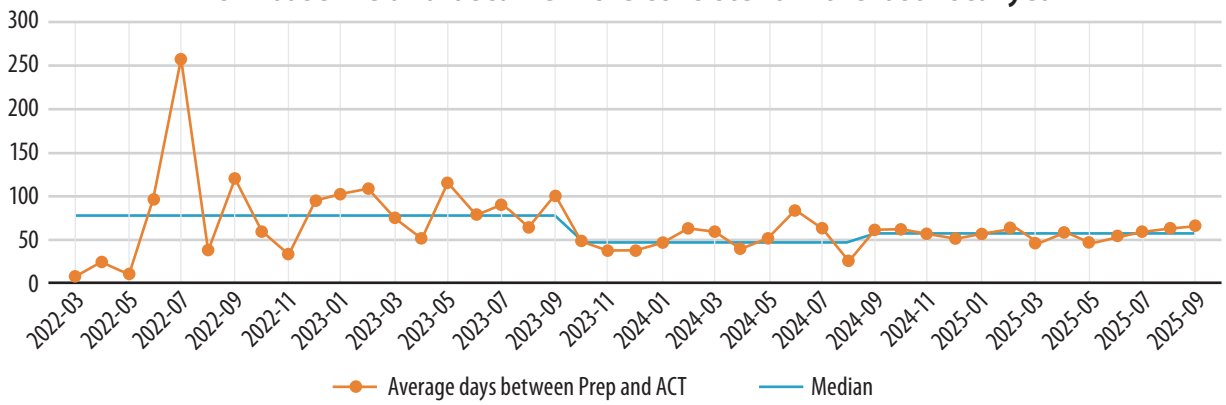
Transition Preparation ensures that the client and their family have an opportunity to identify the setting of their choosing, make an informed decision about the setting that best meets their needs and ensure that relevant information is given to the provider, so that plan development can happen in the ACT stage. The quality assurance processes evaluate Transition Preparation activities and often identifies trends that show increased risk for unsuccessful transitions when Transition Preparation steps are not followed. For example, when a move to an Adult Family Home (AFH) is coordinated by a hospital or family/guardian without case manager involvement, the transition can be rushed and not person-centered. This may put the person at risk for instability or rehospitalization.

Transition Preparation is a critical stage of planning and a crucial element to support a successful transition to a setting the individual and their family choose through engaged, informed decisions with the support of their DDCS case manager.

Active Coordination of Transition

The Active Coordination of Transition stage (ACT) is focused on care coordination and plan development. The department evaluates ACT stage activities through continuous quality improvement and engagement with field staff, MCO representatives, and providers on best practices. Quality assurance staff monitor timeliness and barriers each month and address them in real time.

The average days the ACT Stage each month decreased overall from baseline and became more consistent in the last fiscal year



The average number of days between initial meeting and moves has held steady since October 2023. We can expect an average of 56 average days per month with a 95% likelihood of 29 – 77 days.

The biggest barrier in this stage is often environmental modifications for people who need accessible spaces. Identifying contractors, getting bids and getting the work completed on time can often cause delays in moving. Another delay in timeliness can be caused by the need for step-down services. Many clients with unsuccessful transitions may be in a hospital or psychiatric facility and cleared for discharge but are not stable enough to receive services in the community. These individuals can benefit from a step-down setting, such as a facility that provides on-site stabilization services or diversion. Field Managers participate in the quality assurance debriefing process and take these lessons learned back to their teams to improve transitions for other clients with similar experiences.

Post Move and Stabilization

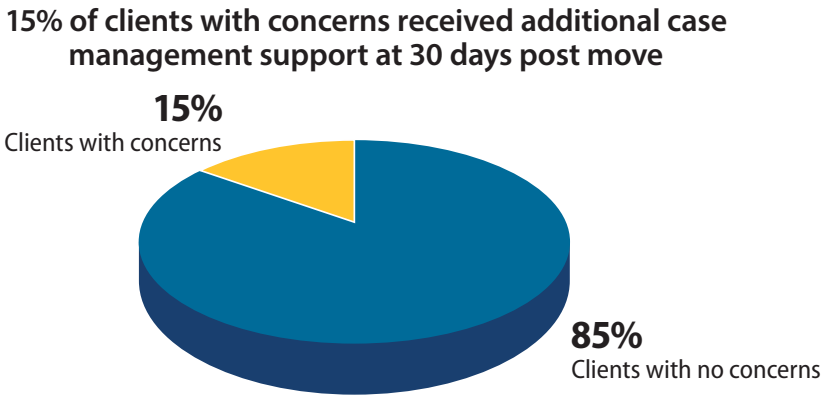
The post move and stabilization period provides wrap around supports to people on specialized caseloads for one year after they move. During this time, DDCS staff continue with a team approach to supporting the client to adjust to their move and achieve stability in their new home. These case managers, who have a reduced caseload, check in a minimum of three times during the first 30 days, with at least one home visit, to ensure:

- The person is getting settled in and satisfied with services;
- They have all of the things they need;
- All services are in place;
- Staff have received training and understand the person's support needs and goals; and
- Care plans are being finalized.

The case manager documents in the client's record when there are concerns about the move at two to three days, two weeks, and 30 days. Of the 244 clients who are currently supported in on a specialized caseload:

- 207 clients had no concerns at 30 days
  - 16 clients had concerns at two to three days and two weeks
  - Five clients had no concerns at all three check-ins
- 37 clients had concerns at 30 days

Since the average time for a transition to destabilize is 94 days for adult family homes and 165 days for supported living, being able to identify concerns within the first 30 days allows staff to address risks early for those 15% of clients who struggle with adjusting to their new home.



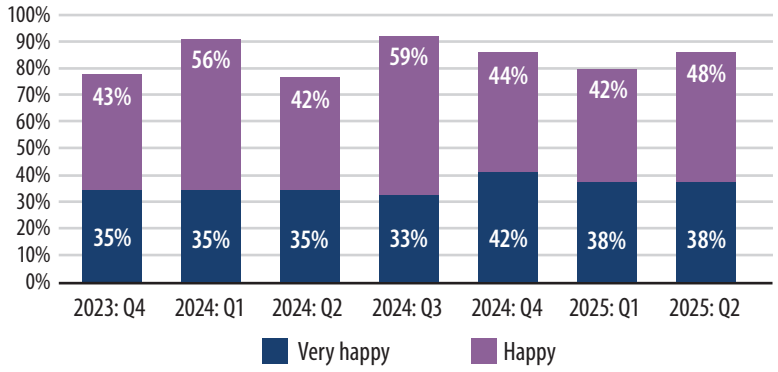
In addition to visits and check-ins from the case manager, a transition survey is conducted to check client stability during the first year post move.

The Transition Survey helps check overall satisfaction and client stability after they move. The survey consists of three separate interviews: individual receiving services, family/guardian/advocate and provider. A survey is considered complete if all parties are contacted and at least one interview is obtained. On average, 130 surveys are completed each quarter.

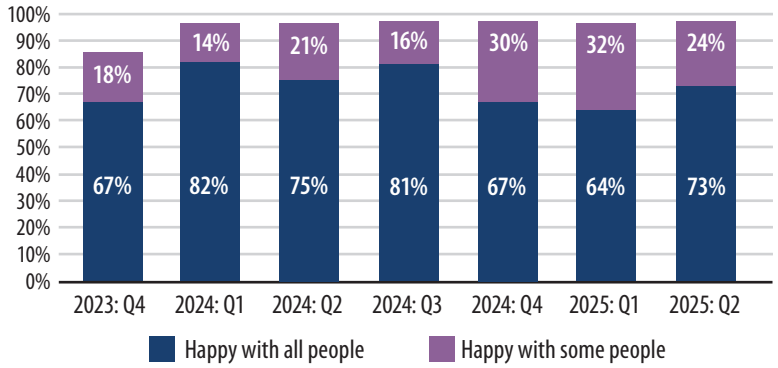
Transition Survey	Timeline for Completion
Initial	45 to 60 days after transition date
Second	Four to six months after transition date
Third, if there are concerns	10 to 11 months after transition date

Individuals receiving services tend to be happier with the people who support them compared to where they live. The average rate of an individual's satisfaction with their home is 84% (Figure 1), and the average rate of satisfaction with people who support them in their home is 95%.

Over 80% of individuals are consistently happy with their home



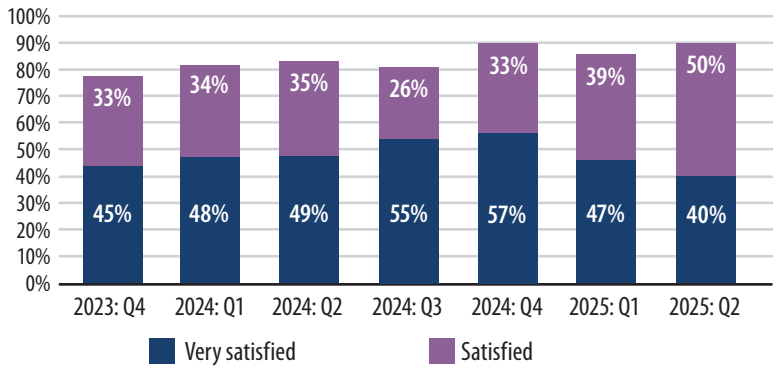
Over 90% of individuals are typically satisfied with people who provide support to them



Note: Quarter 4 of 2023 also includes survey data from August and September 2023.

The average rate of family/guardian/advocate satisfaction with the provider is 84%, and the average rate of transition success from this perspective is 90%.

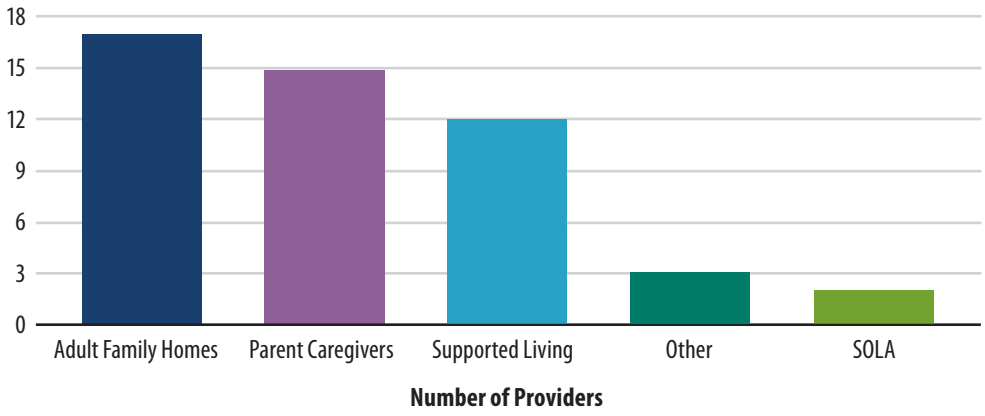
Families and guardians had a slight increase in satisfaction with their provider to 90% over the last 2 fiscal years



Note: Quarter 4 of 2023 also includes survey data from August and September 2023.

According to the provider Transition Survey conducted during the post move, 5% of providers (49 of 899 surveys) indicated a need for more support from DDCS to transition an individual into their home and receive supports and services. The Transition survey is conducted on the pilot group In the Transition Survey, Adult Family Homes had the highest frequency of needing more support to successfully transition a client with IDD into their home.

AFH providers and parent caregivers are more likely to need help than other provider types



In addition, a one-time survey was given to waiver residential providers to gather feedback and identify awareness of the transition framework and its impact on transitions as a whole.

Some key findings from the provider survey are:

Strengths Identified in the Feedback*

Strength Area	Evidence From Responses
Collaborative "team" approach	Many providers praised the coordination between providers, case managers, and other partners at transition meetings. The process was described as comprehensive and supportive.
Clear benefits of transition meetings	When structured well, these meetings were seen as essential to align expectations and responsibilities.
Positive case manager engagement	In some responses, case managers were highlighted as proactive and responsive, making the process smoother for all involved.
Post-move support appreciated	Even with mixed views on timing, several noted that extended follow-up after move-in helped clients stabilize.
Commitment to person-centered planning	Providers noted care plans were more thorough when all perspectives — family, provider, and case manager — were considered.
Willingness to problem-solve	Teams were praised for adapting when barriers arose, such as finding creative solutions for equipment or funding gaps.

**This survey output was plain talked by Copilot and follows expectations outlined in DSHS Administrative Policy 15.28 Use of Artificial Intelligence*

What's working well

- Coordination is a standout strength — when all team members are present and engaged, the transition process is seen as smoother and more holistic.
- High-value relationships between providers and responsive case managers help overcome bottlenecks and keep momentum going.
- Structured, intentional meetings are appreciated when they stick to relevant updates and actionable items.
- Follow-through after transition signals commitment to long-term stability.
- Team flexibility to tailor solutions to individual needs boosts provider confidence in the system.

Areas for improvement

- Increased consistency in using the established transition framework- the phased-in implementation has some case managers more confident and familiar with the framework than others.
- Family and guardian expectation management-it can be challenging to support the implementation of a new care plan for a new client while simultaneously providing training and support to families and guardians to understand waiver residential models of care, and what the providers can and cannot do.
- Role and Responsibility clarity-some clients have many staff from DDCS involved and it is not always clear who the responsible person is during the post move period or why they are there.

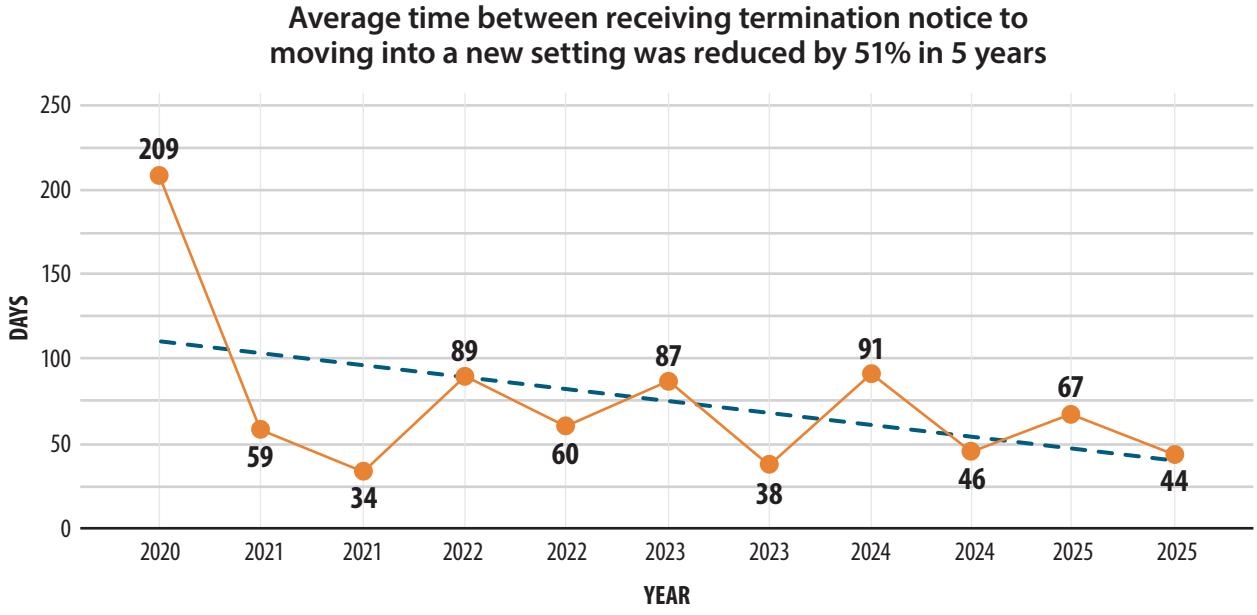
One measure of stability from the residential provider perspective is whether they are considering termination of services. Since August 2023, 878 residential providers have been interviewed by quality assurance staff. Only 20 of them (2%) said they were considering termination. Ten were Supported Living providers, six were Adult Family Home providers, three were providers for staffed residential homes for children and one was a group home provider. No one said they were considering termination during the second quarter of 2025.

Client Critical Case Protocol (CCCP)

The Client Critical Case Protocol was The intent of the CCCP is to ensure a supported living client's person-centered service plan (PCSP) is implemented to meet their residential support needs, stabilize the client's current situation, and prevent the risk of unnecessary institutionalization or hospitalization. An important success because of starting the CCCP process, is only about a third of clients who start the CCCP process have providers continue toward termination. Early interventions once a challenge has been identified by the client or the agency, are having positive effects by successfully addressing challenges to reduce clients needing termination.

Termination notice to new setting

Due to client and agency participation in the CCCP process as issues are identified, referrals are often started later in the CCCP process after some problem solving has occurred. CCCP Clients are also already in residential service and have needed plans established therefore often transition easier into another program. The largest reason for termination is safety of self and others in a home. Sometimes the ability to change settings can resolve specific challenges with a particular home setting. Average times to new settings was about 90 days up until 2024 and since then it has reduced to less than 50 days in 2025.

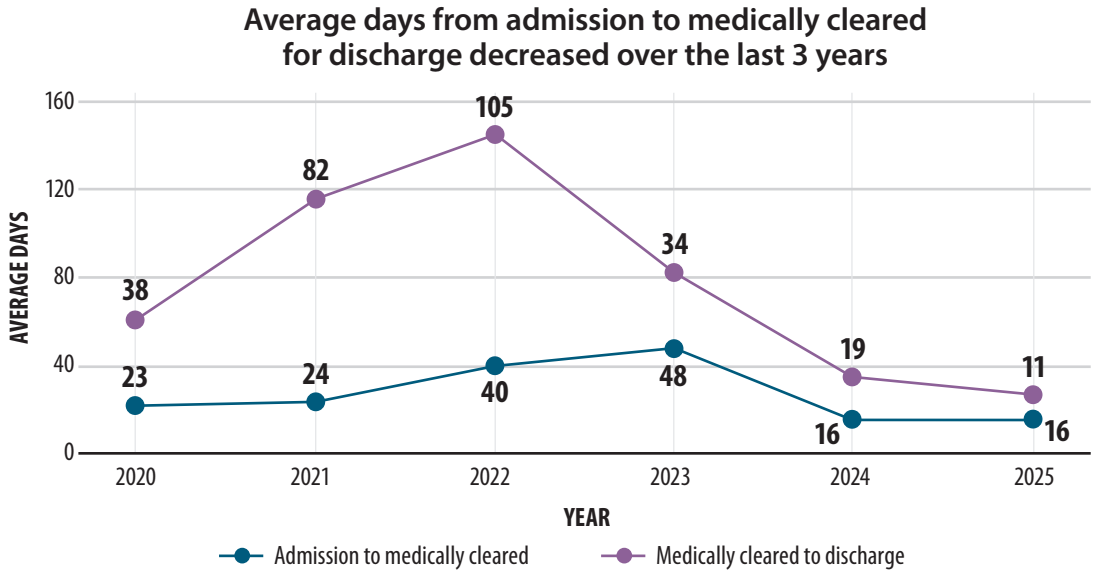


Days to offer from CCCP start date

There has been some large improvement in timelines for the time it takes to get clients residential service offers once the CCCP process has started. In 2021, averages were around 90 days and in 2025 this time is now around 55 days for clients wanting to move. More clients are getting offers and they are happening earlier faster in the process. Several clients are getting offers very quickly to other settings and they are making these transitions much faster than previous years.

Hospitalizations due to CCCP

The graph below highlights improvement in times for clients that went to a hospital because of CCCP. There has been a substantial decrease in the amount of time clients spend in the hospital. Clients are being treated and stabilized faster and moving into community settings. Hospitals and MCOs are working with DDCS to support providers with additional behavior supports upon discharge and assisting in the transition process. With both systems working together, unnecessary time in hospitals have greatly reduced.



Supporting Client Complexity

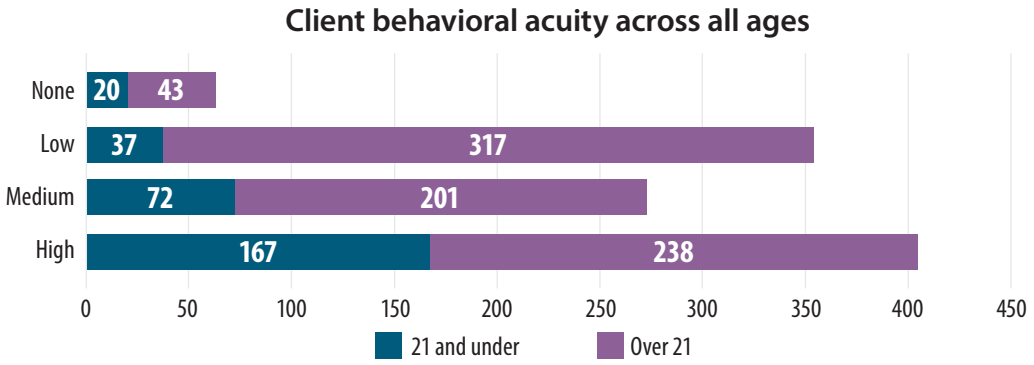
Individuals served by DDCS have a wide variety of often complex support needs. Transitional Care Management received legislative investment in 2022 to hire a team of psychologists and behavior analysts, and add to the staff to the nursing team to provide professional support and consultation to address complex needs during the transition process.

One important reason transitions have improved is because case managers supporting transitions are able to get extra help from nurses and psychologists. Case managers who work with people who have serious medical or mental health support needs depend on experts like nurses and psychologists to make sure the care team understands and supports each person's needs while also respecting their rights. The regulatory environment of institutional settings has substantially different expectations than Home and Community Based Settings rules that govern DSHS contracted community residential services and so different strategies and interventions need to be planned as people transition to less restrictive environments.

The transition clinical team supports clients who are served by the transitional care units or are enrolled in Roads to Community Living, Washington's Money Follows the Person grant to support transitions from institutional care. Noted activities:

- The Transition clinical team has received 366 referrals.
- 320 were assigned to transition clinical team members. Adults accounted for 67% of referrals while children and youth referred were 32%.
- Reasons for psychologist referral were:
  - high behavioral acuity score (62%),
  - a mental health reason (31%),
  - self-injury (3%),
  - suicidal ideation (3%),
  - drug or alcohol use (1%) or
  - high incident reports (1%).

Of the total clients who have been served by Transitional Care Management (including those whose transitions are completed and closed), the majority have had high behavioral acuity.



Below is an example of a client success as a result of receiving professional consultation from the Transition Clinical Team.

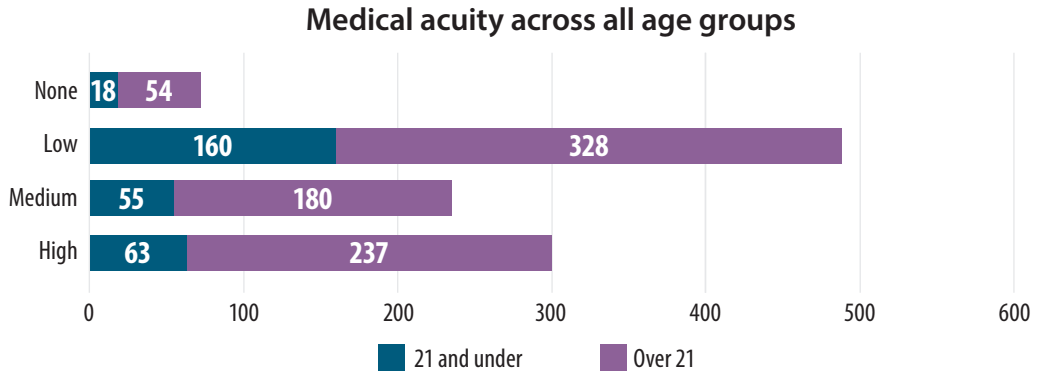
Case example

In August 2024, the clinical team received a referral to support a 20-year-old young adult to transition from a hospital to the community. The client was in a hospital setting where she had resided for an extended period after her mother lost guardianship. Once a court appointed guardian was found, DDCS staff and her care team began to plan her move to supported living. Locating a provider was difficult, as her support needs were complex. The provider agreed to support her. The psychologist attended all the transitions meetings, created a Functional Assessment and wrote the initial Positive Behavior Support Plan. The psychologist trained provider staff twice – once in person and once virtually, as well as conducted two home visits to assess the staff's knowledge and ability to implement the plan.

Clinical team involvement was crucial for this client, as this provider collaborated with DCYF and PNW Roots staff to support the client long term to ensure they transition successfully.

The transition was successful and the client is doing well at her home and is gaining more independence daily. The Case manager and staff report she is thriving and stable.

Case Managers are directed to make referrals for nursing support when clients have high medical needs in their case manager assessment. The transitional care unit case managers support clients with higher medical needs, generally, than the typical case manager across the DDCS system.



In 2023, the nursing team expanded from three staff to six to support additional referrals for transition clients with high medical acuity. The support of the nursing team has been crucial to address high medical needs. Due to state budget layoffs, the nursing team was reduced to three in 2025 and is working more closely with the clinical psychologists to offset the change in capacity.

Key themes for the support provided by nurse consultants:

- Medication/equipment access.
- Appropriateness of care providers – nurse delegation, private duty nursing, home health, skilled nursing.
- Collaboration on medical equipment assessment and ordering.
- Reinforcement training to mitigate rehospitalization.
- Family/provider training.

Professional consultation is a crucial part of the formula for success to support complex transitions, including:

- Reduced readmissions: Coordinated consultations lower the risk of clients returning to institutional care by stabilizing their health and psychosocial conditions. Their expertise in community-based care plans can address creative interventions that are different than those provided in institutional settings.
- Improved satisfaction: Providers are better able to serve medically complex individuals when supported by nurse-led consultations, especially in terms of personalized care and accessibility.

Transition Close and Root Cause Analysis

Ater individuals complete their one-year post move, or if they experience a failed transition, their transition record is closed. When a transition record is closed, quality assurance teams are notified to complete a stability review.

Recurring themes from prevalent root causes of instability

Most transitions are unstable due to one or more of the following causes:

Unmet Needs:

- Necessary supports not in place (e.g., medical, mental health, behavior)
- Lack of providers in geographic area (e.g., medical, mental health, behavior)

Communication Issues:

- Inconsistent communication between individual, family/ advocates, and residential provider
- DDCS staff need to use plain talked tools to help individuals and families better understand all services available to them

Residential Staffing Issues:

- Support plans were not applied consistently by all staff
- Staff often need additional training to effectively implement individual support plans

Institutional Issues:

- "Discharge readiness" from the community hospital perspective does not always align with the person needs to support success in HCBS settings
- Adequate planning time is needed to support youth discharges from inpatient facilities when they much leave prior to their 18th birthday

Each region discusses and develops action plans to address causes of unstable transitions. Regional leadership meets as needed to determine what can be done to avoid similar problems during other transitions. For example, a supported living provider in one region took more than 90 days to develop two support plans for a client with an extended hospitalization. DDCS staff in the region met with leadership from the supported living agency to discuss systemic service issues (e.g., timely use of startup funds, medication management, policies for developing support plans).

Discussions about root cause analysis at the statewide level often lead to outreach and collaboration with subject matter experts to clarify policies and procedures and to brainstorm potential solutions to systemic barriers. For example, challenges related to services at community hospitals and certain facilities were discussed during meetings between staff from DDCS and the Health Care Authority. Root causes from several categories were reviewed during these meetings (e.g., institutional issues or service setting mismatch).

Quality assurance staff complete Root Cause Analysis) on qualifying transitions that are unsuccessful. They identified the following trends:

- An unsuccessful Adult Family Home AFH move has a 22% higher rate of rehospitalization than Supported Living, resulting in a loss of the client's home.
- Staff have identified that transitions supported by case managers using the transition framework have a higher success than when they are not.
- For example, people living in an Adult Family Home lost their home in an 57% faster than in Supported Living when the transition was not successful and the person was reinstitutionalized and was asked to leave their home. The below table shows how many days, on average, it took before someone lost their Adult Family Home (AFH) placement. This happened either because they got a 30-day notice to leave or because they were hospitalized and were not able to return.

Care Setting	Average Duration (Days)
Adult Family Home (AFH)	94
Supported Living Home	165

Regional success story: Lessons learned from Root Cause Analysis

Case example

A 17-year-old individual was required to exit a facility before her 18th birthday. Referrals were sent to multiple settings (e.g., Adult Family Home, Residential Habilitation Center, Supported Living). An Adult Family Home provider was identified two weeks before the discharge date. Within just a few hours of discharge, the young woman experienced a behavioral crisis at the home and was admitted to the psychiatric unit of a community hospital with no discharge plan. Root Cause Analysis was completed to identify what led to the unsuccessful transition. Results showed that the young woman's specific preferences should have been more closely aligned (e.g., few people in the home, minimum noise), and she needed more time for transition planning and relationship-building with support staff at the home. A supported living provider was identified, and lessons learned formed the foundation for the second transition. Residential staff with the agency visited the client multiple times during her hospitalization to strengthen relationships, and she was involved in making decisions for the set-up of her new apartment. This young woman has been supported in her apartment for five months. She is enrolled in school and has a provider committed to ensuring her success in the community.

Recommendations

Increase focus on post move

- In order to increase capacity of the Transitional Care Unit to support the most complex moves, DDCS should work with Research and Data Analysis (RDA)to use our preliminary statistical analysis to develop a risk algorithm to identify stability for clients who may not require a full year of post move support.
- Evidence based best practices for successful transitions identify community connection as a high proxy indicator and predictor of transition success. Data analysis is needed on service utilization with metrics that align with the goal of increasing service utilization for services that support client connection to their community, such as community engagement, supported employment, facilitated person centered planning and assistive technology.
- Case management tool should be streamlined to use existing technology resources in a more efficient way, such as streamlining documentation to increase compliance on data tracking expectations for the post move period.

Partner with Behavioral Health and Habilitation Administration and community partners to improve youth inpatient facility discharges

- Partner with HCA and BHHA to align inpatient discharge expectations with a standard process across inpatient settings
- Increase utilization and access to step-down options for youth leaving inpatient settings.
- Provide training and resources for inpatient facility staff to assist in discharge planning and better understanding the system of care and capacity of community providers for youth and young adults with intellectual and developmental disabilities.

Work with key partners to enhance Adult Family Home success

- Continued training and promotion of Intensive Behavior Support and Supervision (IBSS) for people in Adult Family Homes.
- State Plan Team offer trainings to AFHs to enhance their skills in supporting DDCS clients.
- Expanding clinical team referral opportunities to assist in behavioral support and to provide recommendations to support DDCS clients living in Adult Family Home Settings.
- Tracking of Adult Family Home referrals and capacity to serve people with intellectual and developmental disabilities
- Increasing efficiency in Adult Family Home referral processes for people served by DDCS.
- Partnering with HCS and RCS in providing training's to AFHs on HCLA services and policies.

Institutional care to community transition resource development

- Provide training and promotion of step-down settings to field staff for complex clients who may not be ready for community settings.
- Continue to make better use of shared data so we can clearly see how people are moving in and out of institutional settings. This will help us understand the full capacity of the system and make smarter decisions about where support is needed.
- Leverage technology to better monitor system capacity and improve the speed and coordination of transitions into and out of institutional settings.
- Identify training opportunities to institutional providers on DDCS service system to increase understanding of community readiness indicators and needs.

Accessible provider training and technical assistance

- Ensure provider access to centralized training resources to serve complex clients
- Increase offerings of DD Specialty training for Adult Family Homes and Assisted Living Facilities who may want to offer support to people served by DDCS.

Parent support

- Family homes are often the best place for individuals to live, both in terms of personal well-being and long-term sustainability. Transitions to parent homes from institutional care are at risk for failed transitions and parent support is needed to stabilize youth in their family home.
- To help families continue providing care, we need to invest in supports like respite services, day programs, crisis services and in-home assistance. These services not only help families stay strong, they also make smart use of public resources.
- Monitor crucial informal supports such as access to EPSDT funded services through MCO care coordination and escalation when gaps exist.
- Support connection and coordination with schools to ensure school aged youth and young adults can continue to access educational services through their transition years.