DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	TRANSITIONAL CARE MANAGEMENT	3.03

Authority: ESSB 5693, Section 203 (1)(ee)(i) Chapter 297, 2022

PURPOSE

This policy describes Transitional Care Management expectations and procedures.

BACKGROUND

Each year an average of 1,500 clients transition from one residential setting to another. Many of these clients have complex medical and behavioral conditions that require additional time for planning, teaching, and training of the staff who support them.

The transitional care management framework was created under legislative direction in Senate Bill 5693, Section 203, and addresses barriers to successful client transitions by increasing efficiencies in current practices.

SCOPE

Transitional Care Management applies across the DDA system of care where any staff are supporting clients to move from one location or setting to another. All DDA employees may have a role in ensuring clients have the support they need to have a seamless transition to a new location.

DEFINITIONS

Active coordination of transition (ACT) stage means the timeframe when the client has their initial transition coordination meeting with their Transitional Care Coordination Team to identify medical and behavioral referral needs and ensure support plans are in place to support a successful transition, until the client moves into their new, permanent home.

Client stability means whether the client experienced a pattern of disruptions to services during the post-move and stabilization period (e.g., incident reports, incarceration or legal issues, satisfaction from Transition Survey).

Community living stability means whether the client is at risk of losing or has lost their home or provider.

Failed transition means the client loses their housing or residential provider due to an unstable transition.

Regional Quality Assurance Teams means Quality Assurance Managers (QAMs) and Performance & Quality Improvement Specialist (PQIS) staff.

Post-move and stabilization means the period of time from the first day the client is living in their new, permanent home until they have been determined stable by the regional Quality Assurance Manager, typically 365 days after the move.

Regional Transitional Care Management Team or TCMT means all of the units that have dedicated transition work. These units include transitional care units, the Regional Transitional Care Program Manager, the transition clinical teams, Nursing Consultants (NCCs), and the Quality Assurance Managers (QAMs).

Roads to Community Living or RCL means Washington State's Federal Money-Follows-the-Person (MFP) grant administered by the Centers for Medicare and Medicaid Services.

Root cause analysis means a collaborative quality assurance process that identifies new and recurring causes of instability that led to the loss of a client's home or provider. This strategy allows DDA to make recommendations that will improve Transitional Care Management processes and outcomes.

Stability risk means circumstances which put the client at risk of hospitalization, diversion, or failed transition.

Transition framework means the process that aligns policy steps to facilitate a client’s transition from one setting to another.

Transition preparation means the tasks necessary to identify the client’s personal goals, support needs, and preferred residential setting types, using person-centered strategies to identify a location to move to and receive support needs. Transition preparation starts with the request to move through mutual acceptance and a warm handoff.

Transition survey means a quality assurance tool used to measure satisfaction and stability after a client transitions from one setting or provider to another.

Transitional care management means the body of work that includes the development and implementation of the transition framework, the IT Infrastructure to implement it, the staffing and training to carry it out, and process improvements across the DDA system of care to improve the client's experience in moving from one setting to another.

Transitional Care Unit or **TCU** means the units consisting of case managers and their supervisors supporting dedicated TCM and RCL processes.

Unstable transition means the client experiences disruptions, such as hospitalizations, diversion programs, or loss of provider.

Warm handoff means a meeting or meetings between an existing provider and a new provider to review the client's support needs and ensure all needed documents are available; and if a change in case manager will occur, a warm handoff includes the current case manager and new case manager discussing the client's transition planning needs.

POLICY

A. All programs must reference the transition framework in policies and processes that include components of moving across settings and locations.

B. The framework consists of the following three stages:

1. Transition Preparation;

2. The Active Coordination of Transition (ACT); and

3. The Post-Move and Stabilization stage, which begins on the first day the client moves into their new home and lasts up to one year.

C. Field staff must follow the transition framework with respect to their assigned role and the phased-in implementation plan.

1. Case managers must:

a. Facilitate the transition process outlined in the Transitional Care Management Procedural Manual Chapter 1 as described in the phased-in implementation plan;

b. Use DSHS 10-574A, *Transition Preparation,* to document the steps completed for transition preparation;

c. Use DSHS 10-574B, *Active Coordination of Transition,* to document transition planning activities as required.

i. Case managers in the transitional care unit (TCU) and those with specialized caseloads—including clients enrolled in Roads to Community Living (RCL)—must use part B as of July 1, 2024.

ii. Case managers with a 1:75 caseload may use part B.

d. Use DSHS 10-574C, *Post-Move and Stabilization,* to document the first 30 days of post-move activity if the client is on a TCU or other specialized caseload.

2. Resource managers must continue to follow referral processes for residential programs the client has chosen to pursue housing and services in this setting. Resource managers must follow steps outlined in program-specific policies to support identifying a provider for clients who are requesting Supported Living, Group homes, Group Training Homes, Companion Homes, and Out-of-Home Services.

3. Performance and Quality Improvement Specialists must:

a. Support referral processes for Adult Family Homes and Assisted Living Facilities who are contracted to provide Adult Residential Care or Enhanced Adult Residential Care when the client has chosen to pursue housing and services in this setting.

b. Complete a series of transition surveys during the post-move for clients:

i. Receiving Roads to Community Living support;

ii. Assigned to the regional transitional care unit; and

iii. Assigned by the regional Quality Assurance Manager as described in the Transitional Care Management Procedural Manual, Chapter Three.

4. Transition Clinical Teams must:

a. Receive and review referrals to support a client's transitional care planning when the client:

i. Has a behavioral acuity that is high;

ii. Is at risk for suicide; or
iii. Has high mental health needs.

b. Consult with contracted community residential providers to develop appropriate habilitative supports to address a client's distress and behavior response.

c. Consult with transition care coordination teams to provide subject matter expertise on habilitative interventions that protect a client's rights in integrated settings and meet the client's behavioral support needs.

d. Consult with field staff and HQ to problem solve challenges and barriers, and support root cause analysis.

5. Nursing Consultant Teams must:

a. Respond to referrals to support a client's transitional care planning no more than two working days after receiving the referral by discussing with the case manager when:

i. The client has a medical acuity that is high; or

ii. The client has an identified need for nursing consultation and care planning to ensure safe transition to a clinically appropriate setting.

b. Review the case and priority level with the case manager and adjust the request as needed.

c. Work in collaboration with CRMs to consult with Managed Care Organization Care Coordinators to connect to appropriate medical supports to address client clinical needs.

d. Consult with transition care coordination teams with subject matter expertise on community nursing interventions that protect the client's health and safety in integrated settings and meet their complex clinical support needs.

e. Consult with field staff and HQ to problem solve challenges and barriers, and support root cause analysis.

PROCEDURES

TRANSITION FRAMEWORK

A. **Transition Preparation.** All case managers must follow the transition preparation activities when a client requests to transition to a new setting. The transition preparation stage begins when the case manager meets with the client to identify their person-centered goals.

Note: For clients served by the TCU or are enrolled in RCL, Transition preparation will start a Quality Assurance tracking process that will assist DDA in measuring the length of time it takes for a client to achieve their desired transition.

1. The case manager must use the My Page One-Page Profile, or the client's person-centered plan if they have one, to document the client's goals.

2. For a client receiving services in a community setting, the request to move may occur at an annual or significant change assessment, or when the client requests to move to a new care setting.

3. For a client receiving services in a facility (e.g., ICF-IID, state-operated nursing facility, community nursing home, or community or state-run hospital), transition preparation begins when a case manager receives a referral from the facility staff, Preadmission Screening and Resident Review (PASRR) assessor, or HCS Nursing Facility Case Manager, to assess the client for DDA services such as RCL, waiver services, or state plan programs to receive services in the community.

4. After documenting the client's goals, the case manager must:

   a. Record the client's goals in CARE and update the client's profile.

   b. Write a service episode record stating that the client has begun the transition process using a contact code of "transition" and an appropriate reason code.

   c. Create a transition record in the DDA Transition Tracking node in the case management folder in CARE. Add a Transition Preparation event and include:

      i. Reason the client is entering the transition stage-new transition;
      ii. Preparation start date, based on 2 or 3 above;
      iii. Residence prior to Preparation-the client's current residence.

NOTE: If the client is currently in the hospital, select "hospital" for (iii).

d. Follow referral requirements in DDA Policy 4.01, *One Referral,* for the setting where the client is moving.

e. Notify the regional PASRR team as soon as it is known that a client will be transitioning to or from a state-operated or community nursing facility. Follow additional procedures per DDA Policy 16.02, *PASRR Communications Protocol*.

Note: The contact date recorded in the service episode record marks the beginning of the transition preparation process.

5. Before finalizing a referral packet and routing according to the program-specific policy, the case manager must:

a. Ensure all information in CARE is current and accurate, including:

i. Residential address;
ii. NSA name and contact information;
iii. Guardianship and legal representative contact information;
iv. Emergency contact details; and
v. Medical provider details.

b. Verify in Barcode that there is a copy of the current guardianship documents, if applicable.

6. The case manager must discuss the preferences of the client and the client's legal representative regarding frequency of updates and engagement in the referral process. The case manager must:

a. Use the MyPage Profile in the client's preferred language or;

b. Consider offering a facilitated person-centered plan, when available. Currently person-centered plan facilitation can be accessed in the following ways;

i. On the CIIS and IFS waivers

ii. With Roads to Community Living funding for enrolled clients

iii. Through county individual technical assistance (ITA) dollars when a client is receiving supported employment or community inclusion services.

c. Use the Transition Social Story to engage the client and their support person in understanding what to expect from the transition process.

d. Document on DSHS 10-574A how the client and the client's legal representative would like to participate in the meetings and receive updates about the transition status.

7. In addition to using DSHS 10-574A, the case manager must:

a. Write a service episode record each time updates are shared with the client and their legal representative; and

b. Follow individual, program-specific policies for any prior approvals, committee reviews, resource management, or other internal program eligibility procedures.

8. No more than five business days after mutual agreement, the case manager must:

a. Review the "Warm Handoff" section of DSHS 10-574;

b. Schedule a pre-meet between the current case manager, other relevant DDA staff, the sending provider, and the receiving provider to discuss the client's needs and review DSHS 10-635, *Residential Transition Exchange of Information*;

c. Review initial individual support needs with current and new provider;

d. Discuss any concerns that need to be addressed by the transitional care coordination team at the initial meeting.

9. Verify that the client's assessment details are consistent with support needs identified (e.g., accommodations or equipment);

Note: The guidance provided in the DDA CARE Guide to Assessments, Reassessments and Plan Amendments can assist in determining if an interim, significant change, or plan amendment is needed.

10. Identify the people who will need to be invited to the initial transition meeting and schedule the Transitional Care Coordination Team initial meeting.

11. The case manager must discuss with the client and the client's legal representative:

    a. How information will be shared; and
    b. How the client will be included.

12. The case manager must schedule the initial transition meeting.

13. The case manager must upload DSHS 10-574A into the Record Management Tool (RMT) when complete, and index under Plans-Transitional Care Management.

    NOTE: For the current stage of implementation, case managers who do not have a specialized, reduced caseload are encouraged, but not required to complete tasks for Active Coordination of Transition or Post Move and Stabilization.

B. Active Coordination of Transition (ACT)

1. The case manager facilitates the initial transition meeting within five business days of mutual agreement. The case manager must:

    a. Discuss how the client and their support person would like to participate in the transition meetings;

    b. Add an event in the transition record in the DDA Transition Tracking node in the case management folder in CARE. Add an ACT event and include:

        i. Reason the client is entering the ACT stage;
        ii. ACT start date—date of the initial meeting;
        iii. Planned residence type;

    c. Identify participants and roles on DSHS 10-474B;

    d. Address identified concerns and document tasks for follow up team members;

    e. Document planned coordination on DSHS 10-574B to include:

        i. Activities to be completed, with due dates and assigned responsibility; and

ii. Indicate items that are completed or not applicable;

f. Write a service episode record summarizing the initial meeting and refer to tracking sheet for planned areas of follow up.

2. Case managers must conduct subsequent meetings in similar fashion. Staff facilitating transition meetings must:

a. Utilize meeting best practices, including providing in advance, an agenda that highlights priority topics;

b. Provide a copy of the notes documented on DSHS 10-574B to all meeting participants; and

c. Follow up with the client and family in the manner they requested.

Note: The initial transition meeting marks the beginning of the ACT stage and will be used by Quality Assurance to track key timelines. The current expectation based on the phased in implementation plan is that the Quality Assurance teams are only tracking timelines on the transitional care unit, and only the specialized case managers-including the transitional care unit, are required to complete the full three-stage framework.

3. Before the client's move, at the final transition meeting, the case manager must:

a. Follow relevant program policy on move-in processes.

b. Review DSHS 10-574B and ensure all relevant transition activities have been completed.

c. Document in a service episode record (under the Transition contact), reason that everything is in place or when there are any concerns or needs that are still outstanding and the plan for resolution.

d. Notify the QAM the client will move and request PQIS assignment.

e. Confirm the day of move in a service episode record.

Note: The day of the client's move marks the beginning of the post-move and stability stage and will be used by Quality Assurance to track key timelines.

4. The case manager must upload DSHS 10-574B into the RMT when complete, and index under Plans, Transitional Care Management.

C. Post-Move Process.

1. Create an event in the transition record in the DDA Transition Tracking node in the case management folder in CARE. Add a post-move event and document the client's move date. Document post-move client contact on DSHS 10-574C for:

   a. The 2-3 day check in;
   b. The two-week virtual meeting; and
   c. The 30-day home visit.

2. No more than two or three business days after the client's move, the case manager must:

   a. Complete a post-move check in, which may occur via a phone call, virtual meeting, or in person, and document 2/3 day visit/contact date in the transition node current post move event and indicate "yes" or "no" if any concerns noted.

   b. Ask the client to share their initial impressions, such as comfort with staff, roommates, and daily routine.

   c. Verify all staff have received training on the client's support needs and all items in the person-centered service plan are being addressed.

   d. Verify all plans are in place as needed, including but not limited to:

      i. Nurse delegation;
      ii. Positive behavior support plan;
      iii. Individual instruction and support plan; and
      iv. Medical protocols (seizures, diabetes, skin protocols etc).

3. The case manager must complete remaining visits on the established schedule described in the Case Manager Transitional Care Management Procedural Manual, Chapter 1. The case manager must invite assigned PQIS staff to attend the two-week post-move check in.

   Note: The case manager must conduct at least one home visit during the first 30 days, but the virtual vs home visit schedule may be adjusted based on individual client need.

4. The case manager must write a service episode record "with post-move check in" as the purpose code, to record the date the post-move-in visit was completed for each post-move visit and describe any issues identified that require follow up.

5. The case manager must upload DSHS 10-574C into the RMT within seven business days of when the 30-day visit is complete, and index under Plans, Transitional Care Management.

6. The case manager must document the dates of post-move visits and indicate "yes" or "no" if they had concerns.

7. Quarterly Visits. The case manager must conduct post-move visits each quarter following the client's move.

    a. Case managers supporting clients on the Children's Intensive In-Home Supports (CIIS), Out-of-Home Services (OHS), or Enhanced Case Management Program (ECMP) caseload must document quarterly visits in their program node. Each quarterly visit the case manager must review the following information:

        i. Any issues or concerns with roommates or providers;
        ii. Planned services are meeting the client's assessed needs;
        iii. The client is working on their stated goals;
        iv. The client is accessing their community and preferred activities;
        v. Health or safety concerns;
        vi. Risks to the client's transition;
        vii. Informal support needs;
        viii. Overall wellbeing of the client; and
        ix. Any follow up on PQIS recommendations following the Transition Survey.

    b. Case managers supporting clients on the Transitional Care Unit (including Roads to Community Living), Community Protection, and Intensive Mental Health caseload must use the plan review screen to document quarterly visits. Each quarterly visit the case manager must review the following information:

        i. Any issues or concerns with roommates or providers;
        ii. Planned services are meeting the client's assessed needs;
        iii. The client is working on their stated goals;
        iv. The client is accessing their community and preferred activities;
        v. Health or safety concerns;
        vi. Risks to the client's transition;

vii. Informal support needs;
viii. Overall wellbeing of the client; and
ix. Any follow up on PQIS recommendations following the Transition Survey.

c. Case managers with a 1:75 caseload are not required to conduct post-move activities but may choose to utilize any TCM resources available to support successful transitions.

8. The transition survey will be completed by quality assurance teams for clients on the TCU, including those discharging from Lake Burien Transitional Care Facility, or enrolled in RCL. When a client receives a transition survey the case manager must:

a. Review the Transition Survey Cover Letter;

b. Respond to identified action items; and

c. Upload the cover letter and PDF of survey results to RMT and index under Plans, Transitional Care Management no more than seven business days after receipt.

D. Making a Referral to the Transitional Care Unit

1. When a client is moving from one setting to another and their case manager would like to request the client to transfer to the TCU, the case manager or supervisor must submit the request via SharePoint as follows.

a. Go to the Transitional Care Management SharePoint Homepage from the DDA SharePoint page or a regional SharePoint site;

b. Click on the screenshot of the referral homepage to navigate to the referral portal;

c. Click on the plus (+) sign at the top right of the referral page to open a new record;

d. Complete all required fields; and

e. Click on the check mark box in the upper right corner to submit.

2. The regional transition manager has the final approval authority to assign clients to the TCU. If the client is on the TCU and is moving to a different region, the

regional transition manager in the receiving region must assign the client to the TCU in the new region. All other requests are prioritized using the following categories (in any order):

a. The client has high medical or behavioral acuity as shown in the DDA assessment summary screen;

b. The client is currently admitted to a residential habilitation center (RHC), nursing facility (NF), evaluation and treatment (ENT) facility, or hospital;

c. The client is identified as a critical case per DDA Policy 4.24, *Supported Living Critical Case Protocol*;

d. The client has experienced three or more changes in living setting;

e. The client is a youth transitioning from an out-of-state facility.

3. Whether approved or denied, the regional transition manager must notify the requestor via email no more than five business days after the request is submitted.

NOTE: All staff should have SharePoint permissions to access this referral portal. If an employee is denied access to the portal, it means the employee is not in the distribution list for their region. The employee can request access via the prompt on SharePoint. The employee should notify their supervisor that they may need to be added to all applicable regional distribution lists.

E. Quality Assurance Activities

1. Transitional care QAMs and Transitional Care Program Managers (TCMs) must track trends and barriers to transition as a part of their everyday work. These trends and barriers may be identified through formal review and reporting requirements, or they may be identified informally through normal work processes.

2. QAMs must complete a monthly procedural review and upload a copy to the Transitions Monitoring Site. To conduct the monthly review, the QAM must:

a. Analyze the preparation, ACT, and post-move timeliness, identifying clients who have been waiting for extended periods in any stage based on current statewide performance.

b. Complete an individual review for each client who waited an extended period in any stage, and work with regional staff to identify any barriers, themes, or trends that might be slowing progress toward completion of the transition framework.

c. Work with regional staff to identify any regional trends and barriers impacting the quality and timeliness for transitions and present this information at a monthly Transitions Quality Assurance Meeting.

Note: A template for these reports can be found on SharePoint on the Transitions Monitoring Site and then following the QAM Reporting link on the left bar. This site has restricted permission and is available to staff who are part of quality assurance teams.

3. Transitions Quality Assurance Meetings will be held monthly.

a. This meeting is comprised of regional transition managers, QAMs, and HQ transitions staff throughout the state.

b. The purpose of this meeting is to identify action to counteract barriers and resolve problems that might prevent a timely or stable transition.

4. PQISs must conduct transition surveys on all clients who are:

a. Served by the TCU;
b. Enrolled in the RCL program; or
c. Assigned a survey by a QAM at regional discretion.

5. PQISs must complete surveys according to the following timelines.

Series	Intervals after transition
Initial Survey	45 to 60 days
Second Survey	4 to 6 months
Third Survey	10 to 11 months, if required*

Note: Refer to the TCM Procedural Manual for third survey requirements.

6. QAMs must complete root cause analysis for qualifying transitions as described in the TCM Procedural Manual, Chapter Five. Root cause analysis includes collaborating with the transitional management team to make stability determinations on all transitions at the time of close, whether due to failure or to ending at 365 days.

EXCEPTION

Any exception to this policy must have the prior approval of the Deputy Assistant Secretary.

SUPERSESSION

DDA Policy 3.03, *Transitional Care Management*
Issued August 15, 2024

Approved: _____ Date: March 1, 2025
Deputy Assistant Secretary
Developmental Disabilities Administration