Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Roads to Community Living (RCL)
Person Centered Transition Planning

RCL PARTICIPANT'S NAME	
ADSA ID NUMBER	DATE ENROLLED

TEAM MEMBER NAME	ROLE / ORGANIZATION	CONTACT INFORMATION

Purpose: This is a best practices document intended to be used as a guide for DDA transition staff coordinating a move from a facility setting to the community. The timelines stated here are intended as guidelines and not backed by rule. The one exception is the "Signing Up For Roads To Community Living (RCL)" section, where the tasks listed must be completed for the moving individual to be able to participate in the Roads to Community Living grant.

Phase 1: Deciding on supports to move to the community.

In this phase, the individual and family members / guardians decide to explore moving to the community through Roads to Community Living. This transition phase can take as much time as needed to develop a Person Centered Transition plan that will ensure success which includes identifying community supports. During this phase, individuals and their families / guardians select a community living provider to support their move to the community or can ultimately decide to stay in the congregated setting.

SIGNING UP FOR ROADS TO COMMUNITY LIVING (RCL)	WHO	DATE COMPLETED	OUTCOMES / COMMENTS
Review RCL with Person / family / guardian			
RCL enrollment form signed and sent to CO RCL team			
Consent forms signed			
Enrollment information entered in CARE			
Determine financial eligibility			
Determine DDA eligibility if needed			
Recommended: Family Mentor resource offered if not used already			

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IDENTIFYING INDIVIDUAL SUPPORT NEEDS / DESIRES	WHO	DATE COMPLETED	OUTCOMES / COMMENTS
Team identified within 14 days of RCL enrollment including person, family / guardian, others person / family identifies, RHC / facility staff, Regional staff, RCL liaison / staff, school personnel, etc. List each member of the team in this document as he/she is identified.			
With team develop a Person Centered Description which includes what the ideal place to live would look like and critical components for success.			
Identify appropriate community living model that matches the person's description (family home, companion home, Supported Living, Adult Family Home, Assisted Living or other model) through individual discussions and team meetings. Person does not qualify for RCL if desired living model does not meet federal Home and Community Based Services (HCBS) settings requirements.			
Complete CARE assessment and add RCL enhancements if identified, within **45 days** of enrollment.			
Assemble Referral Packet to include: • Summary of initial plan (personal description, critical components for success, and what he/she desires/needs for successful community living) • Client referral information form (DSHS 15-358) • Relevant records from current setting: o Medical o Risk Assessments o IHP / IEP (plan documents) o Psychological Evaluations o History o Work history / vocational assessments			
IDENTIFY COMMUNITY LIVING PROVIDERS	**WHO**	**DATE COMPLETED**	**OUTCOMES / COMMENTS**
Region identifies potential providers or develops desired / appropriate residential resource			

Region sends referral packet within **7 days** to identified community residential provider(s) preferred by the person / family / guardian			
Person / family / guardian tours and interviews community providers with members of team			
Providers meets person in current setting; gathers additional information			
Final decision / agreement made between chosen provider, person, family / guardian, and region. All consents are signed.			
Initial Planning Meeting to review the Person Centered Description and **discuss** what person would like / need in the community and to ensure that the residential agency is still a good fit for the person. Topics to discuss include: • Individual skills, interests, and goals for community living • Housing (where, type, adaptations, environmental supports) • Level of staff and skills needed • Housemate (ideal housemate description) • Health / Medical / Medications • Professional Services • Safety concerns • Positive Behavioral Supports • Communication (assistive technology) • Relationships (staying in touch with family and friends) • Employment/School • Community Involvement/Recreation • Daily routines / schedule (what would make a good day?) • Adaptive equipment / mobility • Learning style / skill development			
Identify initial RCL enhancements (i.e. Person Centered Planning, Assistive Technology, Family Counseling, Consultations)			
Ensure Family Mentor resource was offered			
County and/or school district notified of person moving to identified county / district			

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APPLY FOR DOCUMENTS IF INDIVIDUAL DOES HAVE THEM	WHO	DATE COMPLETED	OUTCOMES / COMMENTS
Birth Certificate			
Guardianship papers			
Washington ID Card			
Social Security Card			

Phase 2: Making the transition from the institutional setting to a new home in the community.

During this phase, the person stills lives at the RHC or other facility and is now working with the identified community providers and the other members of his/her team to establish collaborative relationships and to further develop the transition plan that will ensure a successful move to the community.

COMMUNITY PERSON CENTERED TRANSITION PLAN AND ACTIONS	WHO	DATE COMPLETED	OUTCOMES / COMMENTS
Schedule regular visits throughout this transition phase between residential provider and person at RHC/other setting and in new community / home			
Further develop RCL Transition Plan with expanded team which includes new provider and others as needed (county, school, employment, mental health) to address the following (this will take as much time and as many meetings as needed):			
Housing (where, type, adaptations, environmental support, welcoming):			
• Locate affordable and safe housing			
• Tour home (person, family, CRM, RCL) to make final decision			
• Section 8 Housing application submitted			
• Determine necessary environmental support for home; obtain an OT evaluation for housing adaptations			
• Contract hired for and completes environmental adaptations			
• Identify and purchase household items			
• House decorated/furnished to welcome person (shared living space and bedroom)			
• Determine activities for person to choose and get to know new housemate (s)			

Health and other professional services (identify health / medical / professional needs)			
• Medical and/or adaptive equipment ordered / obtained			
• Set up nurse delegation, if needed			
• Set up community pharmacy, doctor, dentist			
• Identify other specialized health care or professional services (i.e. nutritionist, OT, PT, Speech)			
• Identify any other safety concerns and how to address			
• Ensure adaptive equipment is present in home and fits the house properly			
Behavioral and Mental Health:			
• Develop PBSP, if needed			
• Develop cross systems crisis plan, if needed			
• Enroll in community Mental Health, if needed			
• Develop relationships with local law enforcement, hospital, mental health providers as needed			
Communication and choices:			
• Determine any communication materials that need to be developed for transition i.e. social stories, pictures			
• Determine assistive technology needed for communication			
• Choices: list of choices person currently makes			
Daily routines / employment / school / community involvement:			
• New school staff visit person at current school (connected to RHC, other)			
• Set up opportunities to choose employment providers (providers meet person at facility, person/family interview employment providers)			
• County Service Authorization (CSA) established, if appropriate			

• Explore new local community			
• Determine and establish community involvement/recreation activities			
• Establish daily routine/schedule for new home/community			
• Set up transportation in the community			
Relationships / family:			
• Determine how person will see / stay in touch with family / friends			
• Identify family concerns and how to address them			
Finances:			
• Determine payeeship and SSI determination; NOTE: This should be reviewed as soon as a residential provider is selected.			
• Set up community bank accounts			
• Apply for food stamps and other benefits			
• Reconcile finances at current setting (RHC, SNF, etc.)			
Staff support (staff needed and trained):			
• Determine staff needed, skills desired, and hire staff			
• Provide staff training in person's plan (PCP, PBSP, PCSP, CSCP, communication style, choices, medical needs, etc.)			
• Determine Technical Assistance for the individual and/or agency (if needed, request RCL TA or RCL Staff support)			
• Agency develops plan for how staff will get to know the person and what staff need to learn about the person while still living at the institutional setting			
• New staff spend time with person at current setting to build relationships and learn skills			
Plan for the moving day:			
• Determine what would make a successful move: who should be there, how will it happen, special activities, any specific supports			

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ADDITIONAL REGION TASKS	WHO	DATE COMPLETED	OUTCOMES / COMMENTS
Update CARE if needed for rate setting			
Rate setting with community provider			
Determine and obtain prior approval or exception to policy requests			
Determine additional RCL enhancements as needed, consider how these will be phased out after one year			
Notify Regional Quality Assurance manager and PQI staff of person who is moving at least **30 days** in advance of move			
Notify CSO; complete Barcode notification			
DISCHARGE PLANNING ACTIVITIES	**WHO**	**DATE COMPLETED**	**OUTCOMES / COMMENTS**
Convene discharge planning meeting with team to review / update plan			
• Determine moving date and plan			
• Determine any support needed from RHC / other setting after person moves and how that could be accomplished (staff training, medical supports, etc.)			
• Sign any consents that are needed / desired (i.e., sharing information with RHC / facility)			
• Identify any remaining concerns			
Complete and review property inventory at RHC / other setting with person/family/guardian			
Final meeting to hand off medications and other documents (day person moves from RHC)			
Transition Team visits home before move to make sure everything is in place, if needed			
RHC / other facility completes Final Discharge Packet which includes: • MD and Nurse Discharge Note • Coupon and Medicare Card • Supply of Medication (15 - 30 day) • Personal Money • Birth Certificate • Guardianship papers • Social Security Card • Any updated assessment			

• Washington State ID • SSA or SSI Award Letter • Any available photographs of person			

Phase 3: Living in the community for the first 365 days.

This phase includes adjusting and enhancing the RCL participant's transition plan and community supports for one year after the person moves from an RHC, CLIP facility, skilled nursing home or other congregate living setting. (RCL participants continue to be enrolled in RCL for 365 days after leaving the facility).

SETTING UP, WELCOMING, AND SETTLING IN	WHO	DATE COMPLETED	OUTCOMES / COMMENTS
Check to see how move went with person/contact families within three to five days of move			
Activities to welcome person to new home (house warming party, out to dinner, etc.)			
Information is readily available in the person's home and is in an understandable format for staff: Person Centered Description; one page profile; likes/dislikes; choices; PBSP; routines; medical information; etc.			
• RCL CRM reviews first "Mover's Survey" completed within 30 days of move and addresses any concerns			
COMMUNITY PERSON CENTERED PLAN AND ACTION	**WHO**	**DATE COMPLETED**	**OUTCOMES / COMMENTS**
Development of the Person Centered Service Plan (PCSP) based on the personal description and relevant elements of the transition plan.			
Ideally, person, family/guardian and other team members (include RHC/facility staff if possible) reconvene in first 1-3 months to review initial plan, identify what's working/not working, and make changes as needed. Include:			
• Person's / families hopes, dreams, fears			
• Housing / environmental issues			
• Medical / safety concerns (possibly done in conjunction with DDA Nursing Care Consultants)			
• Employment/School (include Counties/employment providers and/or school personnel in team meetings)			
• Relationships (developing new/maintaining old)			

• Positive behavior supports			
• Community inclusion/activities			
• Communications / Assistive Technology			
• Learning new skills			
• Identify any needed staff training / technical assistance/additional RCL enhancements or special projects			
Ideally, person, family/guardian, and team members reconvene in 6 months to review plan and identify what's working/not working in the above areas. This check in could be a face to face meeting, phone call, or email update, depending on the situation.			
Person, family/guardian, and team members meet in 9 – 10 months to review plan and identify what's working/not working in the above areas If it occurs, it is essential to complete this review with sufficient time to ensure needed purchases are made or services are received during the RCL 365 day demonstration period.			
Develop plan to transition/maintain service once RCL funding converts			
ADDITIONAL QUALITY ASSURANCE ACTIVITIES	**WHO**	**DATE COMPLETED**	**OUTCOMES / COMMENTS**
CRM reviews second "Mover's Survey" completed four to six months of move and addresses concerns			
CRM reviews third "Mover's Survey" completed by 11 months after move and follows up with concerns identified.			
RCL YEAR END TASKS – BEGIN 60 DAYS PRIOR	**WHO**	**DATE COMPLETED**	**OUTCOMES / COMMENTS**
Assign a Waiver Case Manager, if needed			
Put in waiver request **at 60 days prior** to end of RCL year and apply for Waiver.			
Complete new assessment for waiver services			

Guiding Principles for RCL Transition Planning

The focal person drives the transition process.

- Listen carefully to the person, no matter the communication style. Honor the person's choices of what is needed and desired to be successful.
- Base decision making on building a better and better understanding of the particular details of what really matters to the person.
- Build on the person's capacities, including interests and skills, and support achievable goals that build success.

Involve the person's "support network" to create a collaborative transition process.

- Identify and involve people who knows the person well, who have positive relationships, and a long history such as family members, current and past providers, and friends.
- Identify the "key person" who will be involved throughout the person's transition and will help ensure the transition is successful.
- Build a "support network" that works well together which includes:
  - Clear and active communication and clarifying who does what;
  - Flexibility when making plans so everyone can show up (i.e. RHC staff schedules, family's available time);
  - Information shared that is positive and useful, so the person's story is not lost when moving from one setting to another; and
  - Expertise shared between institutional and community staff, such as doctors, direct support staff.
- Involve families and address their concerns and the supports they may need for this transition, such as, reassurance, other families who can provide advice, or professional counseling.

Develop a transition process that's realistic and ensures success.

- Start transition planning as soon as possible.
- Provide helpful resources and enhancements while the person is still at the institutional setting and determine what and how those helpful supports can be translated to the community setting.
- Take as much time as needed for the move to be successful while taking into consideration the benefits of moving with what's necessary to be in place before making the move. There may be additional considerations when individuals are moving across the state or to a community they don't know.
- Balance attention to meeting assessed needs with actions that create new stories that grow from what becomes possible with the move.

Build community supports so the person can be an active member of the community and have positive relationships.

- Start to develop community supports, networks, relationships before the person leaves the institution that will enhance success including locating affordable housing in a safe neighborhood, working with local first responders and medical and mental health providers, identifying employment supports along with the appropriate county, developing relationships with neighbors, identifying social groups and activities available in the community.
- Continue to build on these community support networks and relationships once the person moves including maintaining old and establishing new non paid reciprocal relationships with others (family, community members, and staff), securing employment and getting involved in social groups and community activities outside of home.