| INDIVIDUAL’S NAME | ADSA ID NUMBER | PROPOSED MOVE DATE |
| --- | --- | --- |
| INDIVIDUAL’S STATED TRANSITION GOAL |
| INDIVIDUAL’S STATED SUPPORTS NEEDED TO ACHIEVE GOAL |
|  |  DEVELOPMENT DISABILITIES ADMIISTRATION (DDA) **Transitional Care Planning Tracking** |
| Purpose: This document is intended to be used as a facilitation guide and tracker for DDA staff coordinating a move from one setting to another. Case Managers who are facilitating care coordination meetings will use this document to track progress and highlight individual needs and readiness to transition to their identified setting. A copy will be provided to the individual and their representative to update them on transition progress as well as to transition team members as appropriate. |
| 1. **Transition Preparation: Individual requests to move to a new setting.**
 |
| Transition preparation consists of the tasks that are needed to identify the individual’s goals and support needs, identify preferred setting to live, and review eligibility for applicable programs. In some cases, the individual will transfer to a transition or RCL caseload or to a different office or region. The new case manager will facilitate the team meetings that occur in the ACT stage (see Part B). In these cases, the primary case manager will transfer the case after mutual acceptance has occurred between an individual and a provider after a warm handoff. |
| **ACTIVITY** | **WHO** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Assist to complete or update MyPage and incorporate goals into client profile | **CRM** |  |  | [ ]  |  |
| Review CARE with the individual and their family / guardian and ensure it is current and accurate | [ ]  |  |
| Discuss living options, identify preferred living arrangement, and identify appropriate community living model that matches description | [ ]  |  |
| Have conversation with guardian about providing needed legal documents (refer to form DSHS 10-635):* Washington State ID,
* Current legal decision-making paperwork,
* Social Security Card,
* Insurance cards, and
* Any other legal documents.
 | [ ]  |  |
| Determine financial eligibility for applicable programs | **LTC Unit** |  | [ ]  |  |
| The individual / family / guardian tours and interviews community providers | **Individual, Family, or Guardian** |  |  |  |
| Assemble and send referral packet form and follow referral process per applicable policy. | **CRM** |  | [ ]  |  |
| For Community Residential: Region sends referral packet per policy to identified community residential provider(s) preferred by individual/ family / guardian | [ ]  RM[ ]  PQIS[ ]  CRM |  |  | [ ]  |  |
| Providers have met the individual and guardian in the current setting |  |  |  | [ ]  |  |
| Housemates have met and agreed to live together |  |  |  | [ ]  |  |
| Necessary environmental modifications identified |  |  |  | [ ]  |  |
| DDA verified that the provider agreed to provide support to the individual, if applicable | [ ]  RM[ ]  PQIS[ ]  CRM |  |  | [ ]  |  |
| DDA verified the individual and guardian have agreed to receive services from the provider | [ ]  RM[ ]  PQIS[ ]  CRM |  |  | [ ]  |  |
| Mutual agreement when the individual has chosen a provider to meet their care needs and the provider agrees to provide care |  |  | [ ]  |  |
| Referral to NCC and/or Clinical team if high acuity | **CRM** |  |  | [ ]  |  |
| **Warm Handoff:** Sending and receiving CRMS (if transitioning to a new CRM) work with the individual and guardian, as well as the current and future provider to review the individual’s goals, understand their support needs and create the transition team. This may be multiple meetings, depending on the circumstances. The case manager identifies the team members who will attend the initial transition meeting during the ACT stage to develop the care plans that will support the client. The initial meeting marks the beginning of the Active Coordinator of Transition (ACT) stage.* Review Policy 3.02 for instructions on case transfer and interoffice / interregional moves.
 |
| Sending CRM:  | Receiving CRM:  | Date:  |
| Meet with current and new provider and case manager(s) and ensure new residential provider has copies of all relevant documents on the DSHS 10-635 checklist. Document missing items. Identify transitional care coordinator team members. |  | Date: [ ]  Completed [ ]  Provider Declined |
| Please describe how the individual and their guardian or representative would like to participate in the meetings and receive updates about the transition status:  |
| **B. Active Coordinator of Transition (ACT): Team meets regularly to support transition** |
| **Transition Team**The transitional care coordination team meets regularly to develop and implement the care plan, identify medical, dental, referral and assessment needs, set up housing, identify and implement environmental modifications and equipment needs, confirm financial eligibility, and facilitate introductions to providers, roommates, and community activities.**Please be sure to include the client when identifying who should be at their meeting and ensure that they provide permission for attendance. All participants in a meeting should have copies of the tracking notes to ensure they are able to monitor expected updates and transition progress.**  |
| **TITLE / ORGANIZATION** | **NAME** | **ROLE** | **CONTACT INFORMATION** |
| Individual |  | Engage with the team on community living goals and preferences |  |
| DDA Transition Case Manager |  | Facilitate transitional care coordination meetings; coordinate assignments and deadlines; model person centered practices |  |
| Current / Sending Provider |  | Provide expertise regarding individual’s care needs |  |
| Medical Provider |  | Discuss medical supports needed, including post move medications and referrals to appropriate PCP or specialists if needed |  |
| Behavioral Health Provider |  | Discuss behavioral supports needed, including post move psych medications and FA/PBSP coordination |  |
| DDA HQ Transition Clinical Staff |  | If identified high medical or behavioral acuity, or if otherwise needed for consultation |  |
| Receiving Provider |  | The agency or responsible provider of services in the setting where the individual will move |  |
| Guardian or Representative |  | Support the individual with decision making regarding the implementation of their goals and their needed supports and services |  |
|  |  |  |  |
|  |  |  |  |
| **Instructions:**  Invite all persons who are identified to attend the initial meeting. Prior to each subsequent meeting, review expected updates and ensure that the persons responsible for those updates will be on the agenda and attending the meeting. When a person is expected to follow up on a task, put their name in the column “person responsible” and enter a date when they will be reporting back to the team. Add a note on what task they will be completing and the status updates for those tasks. Change the expected update date as needed. Check “done” when the task is completed, and the date. |
| **HOUSING** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Environmental modifications needed / set up |  |  |  | [ ]  |  |
| Rental application and lease completed / in place |  |  |  | [ ]  |  |
| Furnishings and décor |  |  |  | [ ]  |  |
| Resource management |  |  |  | [ ]  |  |
| Meet staff, roommates, and visit home |  |  |  | [ ]  |  |
| NOTES |
| **BEHAVORIAL SUPPORTS** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Psychiatric needs, including prescriber, if needed |  |  |  | [ ]  |  |
| Community behavioral health provider identified and follow up |  |  |  | [ ]  |  |
| FA / PBSP |  |  |  | [ ]  |  |
| Cross Systems Crisis Plan (CSCP) or safety plan, if needed |  |  |  | [ ]  |  |
| Behavior related IR follow up needed |  |  |  | [ ]  |  |
| New / emerging behavioral support needs |  |  |  | [ ]  |  |
| NOTES |
| **MEDICAL AND DENTAL**  | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| MCO care coordination needs |  |  |  | [ ]  |  |
| Primary care confirmed |  |  |  | [ ]  |  |
| Specialists needed are in place |  |  |  | [ ]  |  |
| Dentist |  |  |  | [ ]  |  |
| Therapy needs:* PT / OT / ST
* Dietary
 |  |  |  | [ ]  |  |
| New / emerging needs |  |  |  | [ ]  |  |
| NOTES |
| **FINANCIAL AND LEGAL** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Verify SSI, SSDI, and other unearned income in place |  |  |  | [ ]  |  |
| Establish payee if needed, and review financial supports for plan |  |  |  | [ ]  |  |
| Apply for food programs, if eligible |  |  |  | [ ]  |  |
| Are they on the correct funding program (RCL / Waiver)? |  |  |  | [ ]  |  |
| Reconcile finances in current setting |  |  |  | [ ]  |  |
| Guardianship paperwork in place, if applicable |  |  |  | [ ]  |  |
| Bank account is setup in new location |  |  |  | [ ]  |  |
| NOTES |
| **SERVICES SET UP** | **PERSON RESPONSIBLE** | **EXPECTED UPDATES** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Confirm or initiate waiver or RCL enrollment |  |  |  | [ ]  |  |
| Nurse delegator identified* Medication assistance needs are identified
* Date of move nurse delegation scheduled
 |  |  |  | [ ]  |  |
| Adaptive / AT equipment in place for sensory, communication, and ADL needs |  |  |  | [ ]  |  |
| Employment / community inclusion |  |  |  | [ ]  |  |
| School for clients under 21* Will individual need specialized transportation to access their community? Who will transport them to upcoming appointments?
 |  |  |  | [ ]  |  |
| Transportation needs* School enrollment confirmed
* IEP transfer is completed or in process
 |  |  |  | [ ]  |  |
| NOTES |
| **STAFF TRAINING** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Nurse delegation is in place for all staff |  |  |  | [ ]  |  |
| Staff are trained on all care plans and individual support needs |  |  |  | [ ]  |  |
| NOTES |
| **Prior to move in date** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Current provider / new provider consultation |  | [ ]  |  |
| All needed documents are in client provider file |  | [ ]  |  |
| All previous tasks have been reviewed and completed |  | [ ]  |  |
| All plans are in place | [ ]  PBSP [ ]  CSCP[ ]  IISP [ ]  Protocols | [ ]  Other |
| NOTES |
| **DAY OF MOVE** | **PERSON RESPONSIBLE** | **DUE DATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Transportation to new home |  |  |  | [ ]  |  |
| Items to be moved* Property list confirmed
 |  |  |  | [ ]  |  |
| Provider receives medications and MAR  |  |  |  | [ ]  |  |
| Finances are transferred |  |  |  | [ ]  |  |
| Arrangements for meals enroute |  |  |  | [ ]  |  |
| Confirm the move on theDSHS 15-345 LTC form |  |  |  | [ ]  |  |
| [ ]  Confirm the move on the DSHS LTC form |
| NOTES |
| **C. Post Move and Stabilization** |
| The case manager visits at regular intervals and meets with the individual to ensure they are adjusting, ensure that staff are trained and implementing planned strategies to support the individual, and that all plans are in place and being implemented. The PQI staff works with the case manager to have conversations about identified concerns from the Mover’s Survey so that the case manager can follow-up and address any unmet needs. |
| **Two – three business days post move – individual is getting settled.** |
| **ACTIVITY** | **NOTES** | **RESOLUTION NEEDED** | **DUE DATE** |
| Individual is comfortable with staff |  | [ ]  Yes [ ]  No |  |
| Provider is comfortable with supports in place |  | [ ]  Yes [ ]  No |  |
| Issues with behaviors, nutrition, medications, etc. |  | [ ]  Yes [ ]  No |  |
| FA / PBSP in place and staff trained |  | [ ]  Yes [ ]  No |  |
| Individual is satisfied with sleep and daily routine |  | [ ]  Yes [ ]  No |  |
| Nurse delegation is in place and medications are being used |  | [ ]  Yes [ ]  No |  |
| **Two weeks post move – staff are able to address client’s needs.** |
| Individual is comfortable with staff |  | [ ]  Yes [ ]  No |  |
| Provider understands individual’s support needs and comfort with interventions |  | [ ]  Yes [ ]  No |  |
| Issues with behaviors, nutrition, medications, etc. |  | [ ]  Yes [ ]  No |  |
| Individual is satisfied with sleep and daily routine |  | [ ]  Yes [ ]  No |  |
| Individual is planning community activities of interest |  | [ ]  Yes [ ]  No |  |
| Individual shares general feedback about their experience so far |  | [ ]  Yes [ ]  No |  |
| **30 days post move – plans are all in place.** |
| Provider has finalized IISP, NCP, or other relevant care plans |  | [ ]  Yes [ ]  No |  |
| Home is decorated and personalized per the individual’s preference |  | [ ]  Yes [ ]  No |  |
| All staff have completed needed or required training to meet individual’s needs |  | [ ]  Yes [ ]  No |  |
| Individual is participating in community activities of interest |  | [ ]  Yes [ ]  No |  |
| Individual has unmet needs or areas of concern to be addressed |  | [ ]  Yes [ ]  No |  |
| **Quarterly check ins (3 months / 6 months / 9 months / 11 months** |
| **ACTIVITY** | **RESOLUTION NEEDED** | **NOTES** | **DUE DATE** |
|  is engaged in community activities | [ ]  Yes[ ]  No |  | 3 months: 6 months: 9 months: 11 months:  |
| Supports in place are meeting the support needs for  | [ ]  Yes[ ]  No |  | 3 months: 6 months: 9 months: 11 months:  |
| is participating in the cultural and spiritual activities of their choice | [ ]  Yes[ ]  No |  | 3 months: 6 months: 9 months: 11 months:  |
| All staff are familiar with and their needs | [ ]  Yes[ ]  No |  | 3 months: 6 months: 9 months: 11 months:  |
| IISP, NCP, or other program required care plan is effectively meeting the individual’s needs* Verify 60 and 90 program requirements
 | [ ]  Yes[ ]  No |  | 3 months: 6 months: 9 months: 11 months:  |
| Updated supports, services, or needs have been identified, if applicable, and follow up is occurring | [ ]  Yes[ ]  No |  | 3 months: 6 months: 9 months: 11 months:  |