Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Transitional care management:
Supporting clients to move to new settings

ESSB 5693 Sec. 203 (1)(ee)(i) Chapter 297, 2022 Laws

December 1, 2022

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Executive Summary

Engrossed Substitute Senate Bill 5693 Section 203(1)(ee)(i) was enacted during the 2022 Legislative session. It provides DSHS Developmental Disabilities Administration with $2,172,000 in general funds (state appropriations) for fiscal year 2023 and $1,666,000 in general funds (federal appropriations) to establish transition coordination teams for clients who move from one care setting to another. This preliminary report includes baseline data on clients who have moved from one residential setting to another. It also details the actions we have taken to improve transition coordination management by:

1,600
the expected number of clients needing transition support in 2023

- Identifying lessons learned from past transitions.
- Establishing a transition coordination team structure, including recruiting and hiring 33 new staff (15 hired to date).
- Developing a plan to better support transitions through newly created person-centered practices.

Transition teams are only one thread in the fabric of supports needed to ensure people relocate to homes where they are happy, healthy and fulfilled for the long-term. This report also includes recommendations necessary to support transition coordination teams and increase the stability of client placements.

Studies show that moving is one of the top five major life stressors, ranking with the death of a loved one, divorce, major illness and losing a job.[1]

[1] The Top 5 Most Stressful Life Events and How to Handle Them; University Hospitals Health@UH

Background

Between 2017 and 2020, an average of 1,400 individuals each year transitioned from one residential setting to another. Every individual transitioning to a new home requires assistance:

- Selecting a DSHS Developmental Disabilities Administration service provider.
- Finding appropriate housing where the client wants to live.
- Establishing new medical services.
- Gaining access to medical and behavioral providers.
- Identifying support needs, environmental modifications and technology to promote their independence.

We serve individuals who often have complex medical and behavioral conditions that require additional time for planning, teaching and training staff to support them and address barriers to their transition. Under the current process, the case manager coordinates and facilitates the transition process and shares essential information with the client and family/legal representatives. Together they select the services and providers to meet the client's needs and goals in their new home.

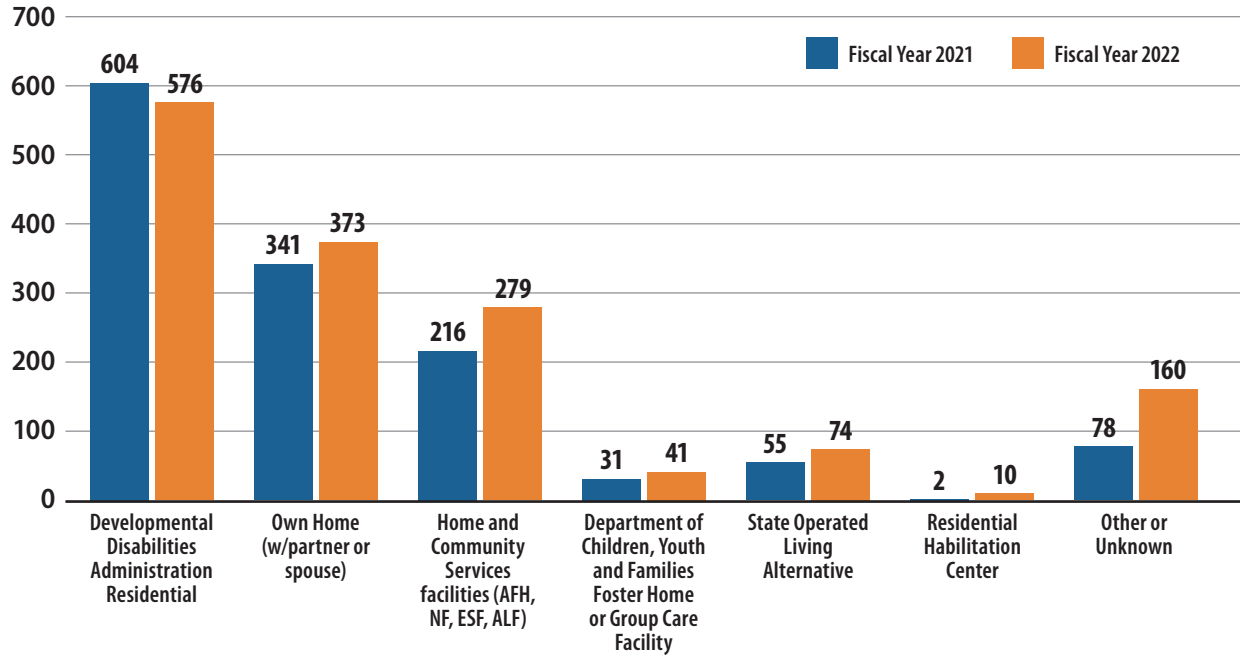
Enhanced transition coordination of care is needed to reduce or prevent Relocation Stress Syndrome, which is characterized as feeling lonely, depressed, angry, anxious, insecure, experiencing changes in sleep and eating patterns, as well as a loss of trust.[2]

In fiscal year 2021 and 2022, the number of clients receiving services who transitioned from one setting to another was 1,327 and 1,513 respectively. The residential settings they moved to are represented in the chart below. An additional 21 clients became homeless during this timeframe. We are working through the Affordable Housing Program to address the needs of these individuals.

[2] Melrose, Sherri, Ph.D. R.N. (2013). Relocation stress: How staff can help. Canadian Nursing Home, 24(1): 16-19.

Client transitions to specific settings

Data Source: Caseload Activity Report, August 29, 2022



Stakeholder Engagement

We developed this report with input from the people we serve, case managers and other stakeholders. In addition, we gathered comments and information from past National Core Indicator surveys. Through this stakeholder engagement, we heard:

- Case managers are currently the primary source of information for clients and legal representatives.
- Clients want more information on the transition process than case managers have the time to deliver.
- All transition information should be easy to understand.
- The transition process isn't consistent across the state.
- There is a lack of provider capacity in preferred communities.

We have learned the following lessons from the Rainier School transitions that occurred from September 2018 to September 2019.

- It worked well to have a diverse team of experts collaborating to address barriers to accessing services, providers, treatments/specialized plans and client supports.
- Families need early and more frequent communication to understand the process and their role in the transition.
- Initial communications should clearly outline the transition process and family's role in the move.

Additional Qualitative Data Collected

In preparing this report, we also collected information from case managers, supervisors, Residential Habilitation Center transition coordinators, regional management and other DSHS staff. We worked with them to analyze how current policies and tools are being used, evaluate existing materials and staff roles and to identify current best practices for quality assurance and information sharing.

These findings of our analysis inform system improvement of transition processes. These improvements include removing repetitive processes and promoting better understanding and more efficient work practices by updating policies and procedures, such as:

- Mover's survey (quality assurance tool).
- Referrals for residential services.
- Sharing information about agency services.
- Contracting new providers.

KATHY'S STORY

"Kathy visited and toured some of our home sites and she chose the home that she is living in. She's receiving supports all day for everything that she's wanting to do. She's thriving since she moved in."

– Kathy's Supported Living provider

Watch Kathy's story on YouTube at https://www.youtube.com/watch?v=qyMDc63Rfnc

Organizing Transition Coordination Teams

We appreciate the Legislature's support for creating and organizing teams to support clients as they move to new homes. Transition coordination teams will include case managers, psychologists, psychologist associates, nurses, nurse practitioners, transition care managers and quality assurance personnel. Together they have a wide expertise to assist in all aspects of the individual's life. Case managers with a smaller caseload would have more capacity to coordinate the transition process and to connect the individual and legal representatives with local resources.

Your Transition Coordination Team

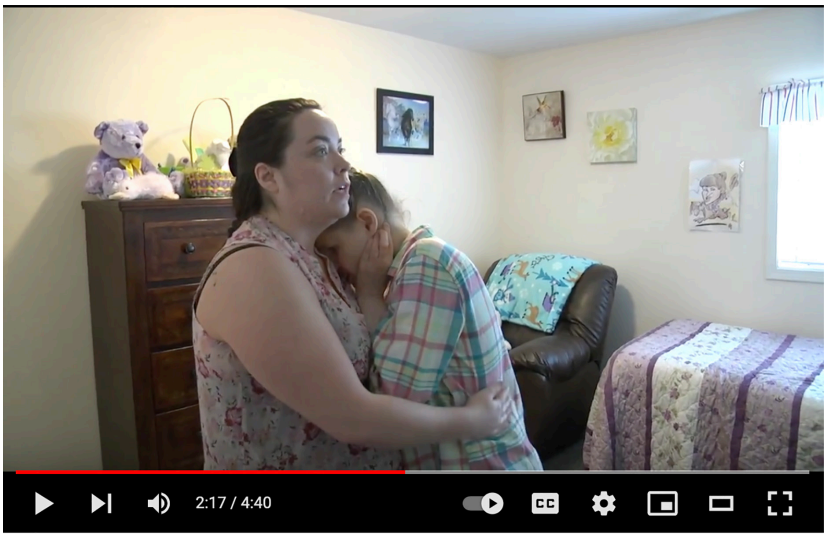
Teams will meet regularly to plan all transition steps to ensure services and supports are in place at time of transition. Coordination with the individual and their family, providers and managed care organizations will provide enhanced support and access to appropriate Medicaid services, job assistance and community involvement. This person-centered approach will set up timely, tailored and stable supports in the client's new home.

Transition Coordination Team Approach

The development of a statewide transition process and quality assurance metrics promote stability by centering on the individual's involvement and their satisfaction of services. This approach focuses on supporting client transitions with:

- Smaller caseloads, which started July 2022 for some clients thanks to recent Legislative funding focused on enhancing transitional case management.
- Consistent statewide transition process to follow the client in their new home for a year.
- Additional information about the transition process for clients, families and legal representatives.
- Shared information on agency services and programs to promote understanding and access.
- A consistent approach for accessing psychological, behavioral and nursing supports during transitions and after the move. This promotes client training, evaluation and assistance.

- Processes to ensure physical and behavioral healthcare are accessed on-time through care coordination.
- A process to address training and support for trauma-informed care.
- Statewide quality metrics to evaluate system improvement and learn best practices, such as:
  - Presenting information in plain talk to help people understand services.
  - Assistance with making decisions regarding services.
  - Access to community medical and behavioral supports.
  - Enough provider capacity where the individual wants to live.
  - Access to affordable housing.
  - Trained staff to support individuals.
  - Access to community, cultural and spiritual events.



NOLA'S STORY

"At first, it was definitely an adjustment. I mean, new place. She seemed a little . . . off, but we were learning about each other. But she adjusted so well. So well. And she loves it here. She loves being home."

– Nola's care provider

Watch Nola's story on YouTube at https://www.youtube.com/watch?v=nlLNSqPWW0w

Hiring Transition Coordination Team Members

We have made progress in the developing, recruiting and hiring positions authorized in Senate Bill 5693. We expect all positions will be filled by the end of January 2023. Below is the status of positions as of Dec. 1, 2022.

Transition Coordination Team Hiring		
Condition	**Allotted**	**Hired** (as of 12/1/22)
Case Manager	9	7
Behavioral Analyst	1	In process
Psychologist 3	3	In process
Psychologist Associate	2	In process
Nurse Care Consultant	3	3
Quality Assurance Manager	1	1
Social and Health Program Coordinator Quality Assurance	2	1
Transitional Care Management Manager	1	In process
Quality Assurance Program Manager (Regional)	2	1
Children's Transition Coordinator (Regional)	3	In process
Transition Care Management Manager (Regional)	3	In process
Public Benefits Specialist 4	2	2
Management Analysis 3	1	In process

The nine new case managers will ensure 280 clients are assigned to a transition case manager with a 1:35 caseload ratio. With this smaller caseload ratio, these case managers will have more time to connect clients to services that support the transition and are tailored to their needs and goals.

In fiscal year 2022, approximately 1,500 clients moved from one setting to another. We expect at least 1,600 transitions in 2023. Most of these clients will be assigned to case managers carrying typical 1:75 caseload in which there is limited capacity to complete a thorough transition process. If there were more staff in the future to support transitions, the individual's transition into their new home would be even better.

In the meantime, we will prioritize enrollment onto a transition case management caseload for clients who need a higher level of time and attention. This prioritization process will look at individuals who have:

- Current stays at a state hospital or acute care psychiatric treatment facility who are preparing to exit.
- Complex medical or behavioral support needs.
- A history of housing or service disruptions.
- Housing insecurity, such as those living with elderly parents, who are ready to transition.
- Limited informal supports.
- Reached the age of 18 – 21 and are ready to transition into adult services.

Watch Mark's story on YouTube at https://www.youtube.com/watch?v=QuEbPgGDVEo

MARK'S STORY

"I was actually very involved in the transition. I actually went to Rainier and worked with some of his staff, especially because of his diet. Because it was something we had never encountered before here at Options. So, I worked with a lot of his support staff to learn that. And then transitioning here. And, you know, Mark's blossomed."

– Mark's care provider

Recommendations

We are grateful the Legislature has recognized the need to fund transitional coordination management teams. These teams are critical to supporting clients before, during and after they move. However, transition teams are only one thread in the fabric of supports needed to ensure people relocate to homes where they are happy, healthy and fulfilled for the long-term. Person-centered transitions need dedicated staff to carry the caseload, fill local housing needs, strengthen the provider workforce, support decision making for those who need it and ensure transition procedures are fully implemented.

Affordable housing is lacking throughout Washington state. In addition to the transition coordination team's efforts, we need an increase in affordable housing so that there are homes available where people want to move when they are ready to relocate. Additional details about the housing issues people with intellectual and developmental disabilities face, as well as recommendations to improve them can be found in Oct. 1, 2022, DDA Housing Fund Priority Study report and the Dec. 1, 2022 Housing Needs for Individuals with Intellectual and Developmental Disabilities in Washington State report.

We are thankful for the funding recently given to hire nine case managers with a 1:35 transitional coordination caseloads. The Legislature made a significant improvement with the funding provided, and if there were more staff in the future, the transitional support would be even better for all client's moving from one residential setting to another. Alternatively, the Oct. 1, 2022 Caseload ratio reduction project report details a five-year plan to reach a case manager to DDA client ratio of 1:35 across the board. Through this plan, all clients would be assigned case

managers who have the time to support them through the transition process whenever they are ready to relocate. If this plan is funded, in the first year we would consider how to prioritize people in transition for an early switch to a 1:35 caseload. This would ensure clients have staff with the capacity to provide the extra support they need throughout the relocation process.

Some people have the support of a guardian. The cost of guardianship is a barrier to transitioning into the community. The Oct. 1, 2022 *Guardianships laws: impacts and recommendations* report includes recommendations to breakdown this barrier. For example, increasing the number of state-funded public guardians through the Office of Public Guardianship would allow residents of RHCs to retain a guardian when moving into the community. In addition, it would serve to address the problem of not being able to afford a guardian when a guardian is needed. A dedicated guardianship coordinator for each region and a program manager with statewide responsibilities would partner with transition coordination teams to ensure guardians have the information they need to support a successful move into a community of choice.

Finally, we will learn much when the transition coordination teams are up and running in 2023. Our final report to the Legislature may include additional recommendations for changes necessary to increase the number of stable client placements. In addition, our final report will also showcase outcomes for the clients supported by these coordination teams. We look forward to sharing how the transition coordination teams traveled alongside clients to ensure they successfully moved into a stable and supportive home.