Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Transition Care Management

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

December 1, 2023

Developmental Disabilities Administration
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Washington State Department of Social & Health Services
Transforming lives

Background

Engrossed Substitute Senate Bill 5693 Section 203(1)(ee)(i) was enacted during the 2022 legislative session. It provides the 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 care management team for clients who move from one care setting to another. This annual report includes details on the actions we have taken to improve transition coordination management by:

- Identifying the number of clients served on the transitional case manager caseload.
- Identifying the settings in which they received care.
- Tracking their 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 reduce timelines for transitions.
- Recommendations for changes necessary to the transition coordination teams to improve increasing stability of clients.

DDA continues to transition approximately 1,500 clients annually from one setting to another across the entire population. We are moving in the right direction with the additional allocations and support with this legislation to promote timely and stable transitions. Our partners have shared that the additional resources to provide transitional support, clinical expertise and standardized processes are making a difference.

The Family Mentor Project shared "The transition care management team, with the increased number of team members, has improved our client's community placements and decreased the timeline for completion of the transition. We credit those newer added members, on the transition teams, who have expertise such as health care coordination, benefits coordination and enhanced case management skills. Our clients are feeling the thoughtful and more person-centered approach, which delivers a more predictable and positive post-move outcome for them. We appreciate the Performance, Quality and Improvement that is done through this current approach of DDA."

– *Kelly Church Family Mentor Project Coordinator and Diane Larsen Family Mentor Project Assistant Coordinator*

Transition Coordination team

National hiring issues impacted the team's ability to fully staff up based on our originally planned timeline. It took longer than expected to work through position development, recruitment and hiring processes. We took a workforce development approach to recruiting behavior support professionals by hiring a clinical team manager who is a licensed psychologist and recruiting psychologists who needed a preceptor to obtain their licensure. This strategy has helped us to recruit clinical staff who will be able to gain their licensure and add credentialed professionals to the workforce who can continue serving our behaviorally complex clients into the future.

Transition Coordination Team Hiring

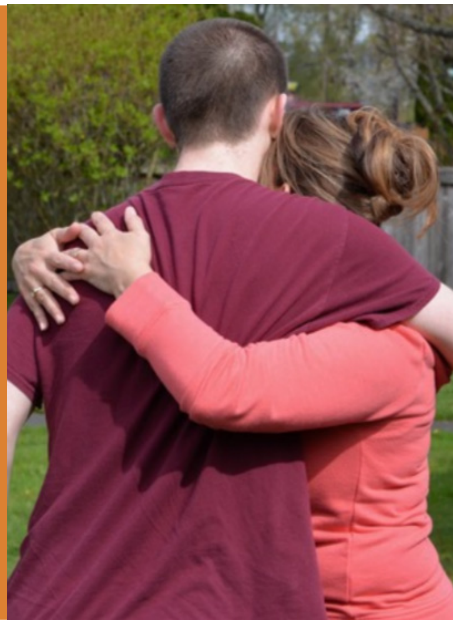
Condition	Allotted	Hired (as of 12/1/22)	Hired (as of 6/1/23)
Case Manager	9	7	9
Behavioral Analyst	1	In process	1
Psychologist 3	3	In process	2
Psychologist Associate	2	In process	2
Nurse Care Consultant	3	3	3
Quality Assurance Manager	1	1	1
Social and Health Program Coordinator Quality Assurance	2	1	2
Transitional Care Management Manager	1	In process	1
Quality Assurance Program Manager (Regional)	2	1	2
Children's Transition Coordinator (Regional)	3	In process	3
Transition Care Management Manager (Regional)	3	In process	3
Public Benefits Specialist 4	2	2	2
Management Analyst 3	1	In process	1

Infrastructure Development

We have heard from our stakeholders about the importance of effective transition structures and supports. We have spent the time to develop the infrastructure to support data collection, standardized transition framework and quality assurance strategies.

"Our brother (was) admitted to an RHC (Residential Habilitation Center) after the death of our father who was his main support person and caregiver. It was a sad and heartbreaking time for our family. We started working with the RCL (Roads to Community Living) team and it opened our eyes to the support and compassion that was available. We had frequent meetings and calls where they really listened to us and focused on our brother's strengths. They were patient, respectful and caring. Without the efficiency and structure of this team, our brother would likely not be as successful as he has been. Remarkable program and people.

– *Client's Family, Shoreline*



1. Piloting the Framework

In January of 2023 the Transitional Care Unit fully implemented the transition framework. The nine new transition case managers are currently supporting 227 individuals piloting the transition framework. This framework aligns existing policies across programs to create an efficient, statewide and standardized procedure for supporting clients who wish to move from one setting to another. The process has metrics built in, which we have incorporated into our database to track timelines and stability measures. The Transition Framework is separated into 3 stages of transition:

Transition Preparation

- Begins at the individual request to move
- Personal goals and service requests
- Mutual acceptance
- Review current support plans with provider

Active Coordination of Transition

- Initial transition meeting
- Clarify roles and responsibilities
- Develop transitional activities
- Meet roommates, staff and see their home
- Validate proper supports are in place
- Behavioral health and nursing professionals are included

Post Move

- Case resource manager follows up and monitors
- Address concerns that arise
- Verify staff trained and plans are in place
- Validate individual is happy with supports
- Complete transition survey
- Continue quality follow up

A. Transition Preparation begins with the client request for services, and includes talking with the individual about their goals, support needs and preferred residential setting. Activities in this stage are focused on identifying services and residential settings that could support the person. During transition preparation, the case manager follows existing program processes to create the referral packet and assist the client in choosing a residential setting that aligns with their goals and meets their support needs. Mutual Agreement is achieved between the individual and the provider.

78 clients are currently supported in Transition Preparation

B. The Active Coordination of Transition stage begins at the initial transition meeting. ACT focuses on tasks that inform the development of care plans and setting up the home where the client will move. The Transitional Care Coordination Team begins meeting regularly to identify medical and behavioral referral needs and ensure support plans are in place to support a successful transition. The case manager facilitates the Care Coordination Team using a person-centered process that keeps the client engaged and ensures their goals are addressed. by a team developing their care plans and setting up their services.

Currently 19 clients are supported in ACT

C. The Post-Move and Stabilization Process begins on the first day the client moves into their new home and lasts up to one year. The case manager will follow established timelines to ensure the client has access to all the services and supports identified in their person centered service plan and that the client's plans are implemented in a timely manner.

130 clients are currently supported in the post move and stabilization

During the post move, the transition case manager and the performance and quality specialists (PQIs) begin working together to determine if the client is adequately being supported and satisfied with their services and supports needed to access their community and participate in their chosen activities. The below table illustrates the focus of follow up at planned intervals.

Transition case managers provide intensive support during the first 30 days with a higher frequency of visits to ensure all plans are working and in place.

Staff	2 to 3 days-in person	14 days-virtual	30 days-virtual
PQI		X	
		Intro to individual, representative and provider and explain PQI role and Mover's Survey	
Case Manager	X	X	X
	• Check comfort level with new home, staff and roommate • Identify and address Concerns and questions	•Staff are meeting needs •Staff are using and refining care plan	•Confirm required plans are in place •Verifies staff are all trained in care plan •Reviews living arrangement is meeting individual's needs

Transition case managers provide intensive support during the first 30 days with a higher frequency of visits to ensure all plans are working and in place.

Staff	45-60 days- in person	Quarterly-in person	10-11 months-in person
Staff PQIS	X		
	Mover Surveys with the individual, Provider, and Family/Guardian/Advocate		Mover Surveys with the Individual, Provider, and Family/Guardian/Advocate
CRM	X	X	
	Case manager will meet the individual quarterly and ensure that they are adjusting to their new home, engaged in their community and all services are in place		The case manager will complete the annual assessment, ensure individual's support needs are met, and this completes the post move period

2. Settings and Stability

Several new databases have been created to track newly identified statewide metrics, process measures and outcome data to track settings, timeliness and stability of transitions.

- **Transition Tracking Database** - tracks key benchmarks as the client moves through the transition process and allows us to determine the average length of time in each transition stage and for the overall process. This will allow us to use strengths-based approaches to compare clients who have more timely transitions to clients who get "stuck," and use root cause analysis to identify key performance indicators that promote timeliness.

Our database allows us to see, in real time, the settings the client is moving from and where they are moving to. The heat map below provides a picture of where clients are coming from and moving to.

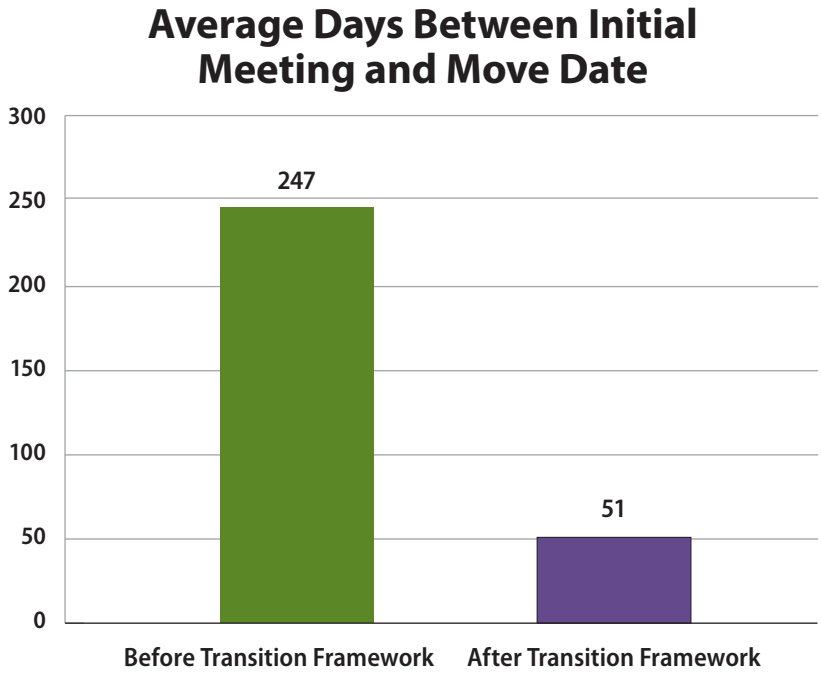
	AFH	Own Home	Supported Living	Relatives Home	Other
AFH	2		2		1
Nursing Home	2	3	11	2	2
Child Foster Home	1	1	2		
Group Home			1		
Medical Hospital	7	1	28	7	2
Out of State Facility	4		1	3	
Supported Living	1		8		1
Psychiatric Hospital			3		
Relatives Home	2	1	3		
RHC	10		27		
Own Home		1	1		

0 1-2 3-5 6-9 10-19 20-29

Number of clients moving from one location to another

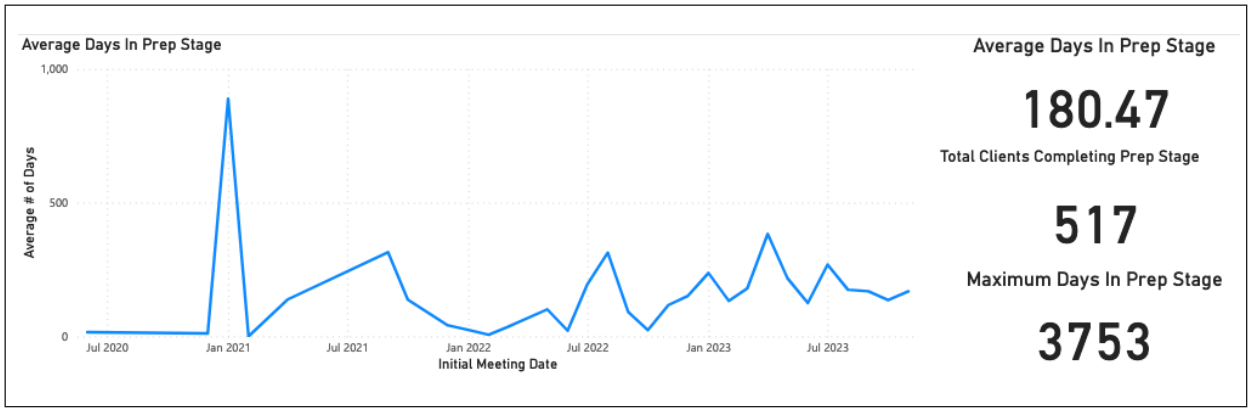
3. Timeliness

Transition timeliness is tracked through the three stages of transition. Preliminary data from our transition caseloads show a decrease in the amount of time it takes for a client to get from their initial request to move to moving into a new home.



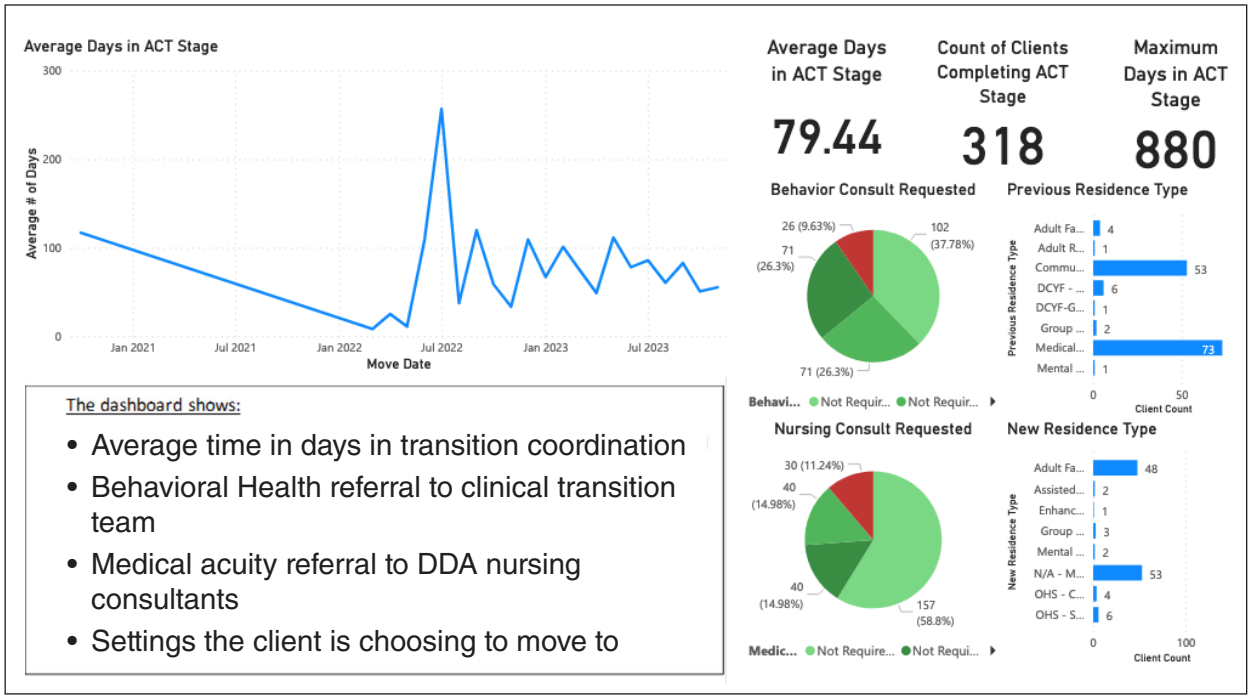
The database dashboard updates nightly and provides near real time information on the timeliness of current processes for each client. The information is filterable by region, by caseload type, case manager or individual client for any desired timeframe. The regional quality assurance managers and transition managers can use this dashboard to view any anomalies and manage the transition in their region with more data informed approaches.

Transition Preparation

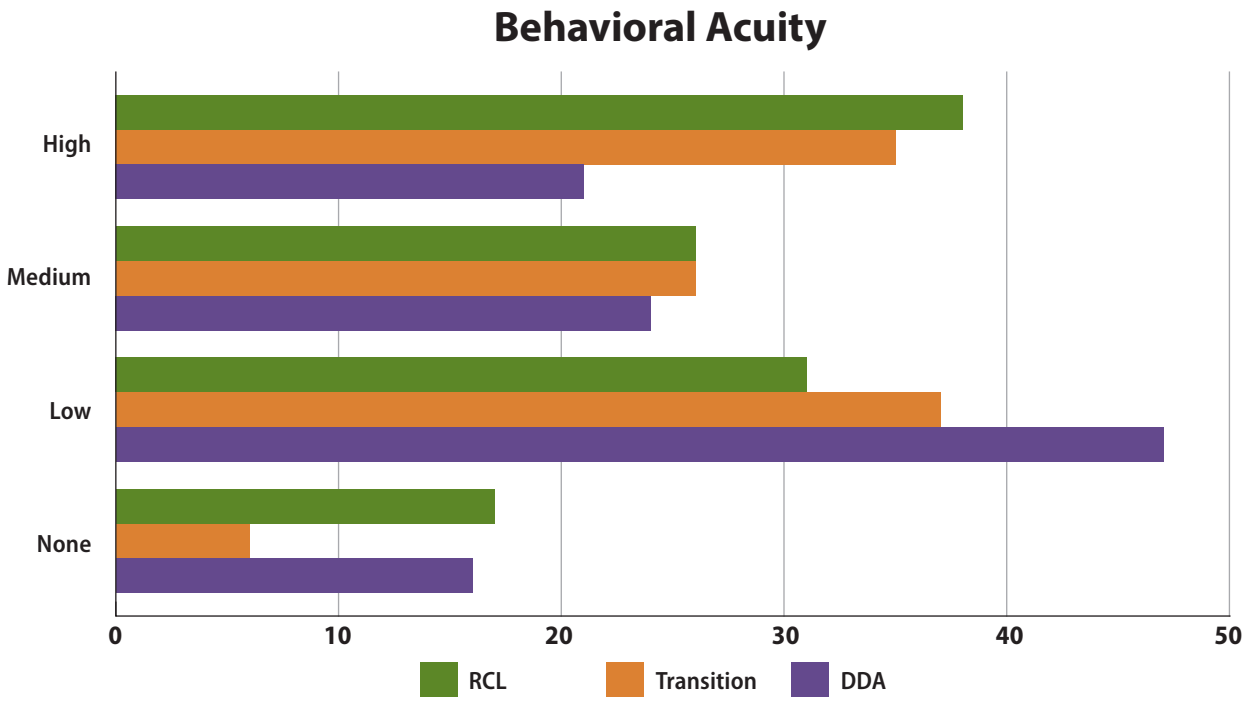


This data is for clients who have completed the transition preparation stage. Evaluating the time it takes for clients to move through each stage of the transition process allows a responsive system to address current process or barriers issues to achieve timely transitions. These enhanced databases have created a responsive process to address real time barriers at the individual support level.

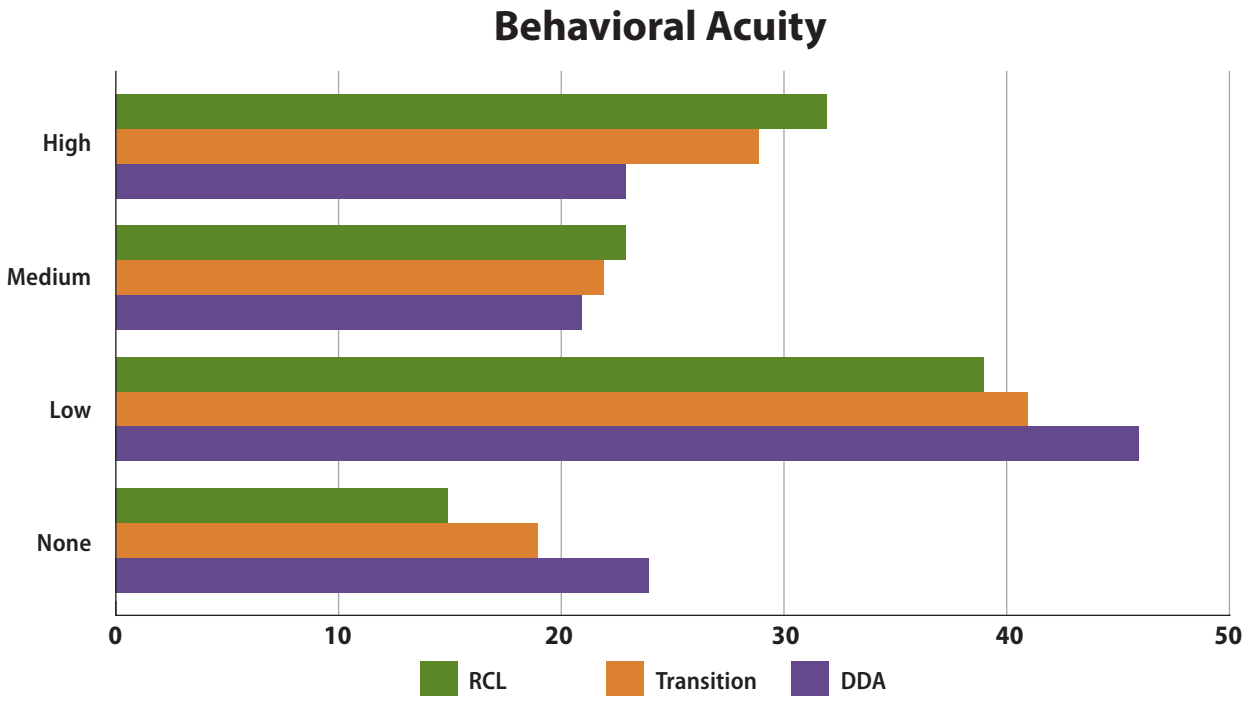
ACT



Regional transitional care managers and quality assurance managers use the database to monitor clients who are in the ACT stage by reviewing follow up which is required for behavioral or medical referrals, consult with those professionals on concerns notes, and monitor the length of time it takes to develop care plans. The ACT stage involves substantial coordination with various team members who have specialized skills. The transition caseloads have a higher percentage of high behavioral and medical acuity than the standard across client transitions generally.

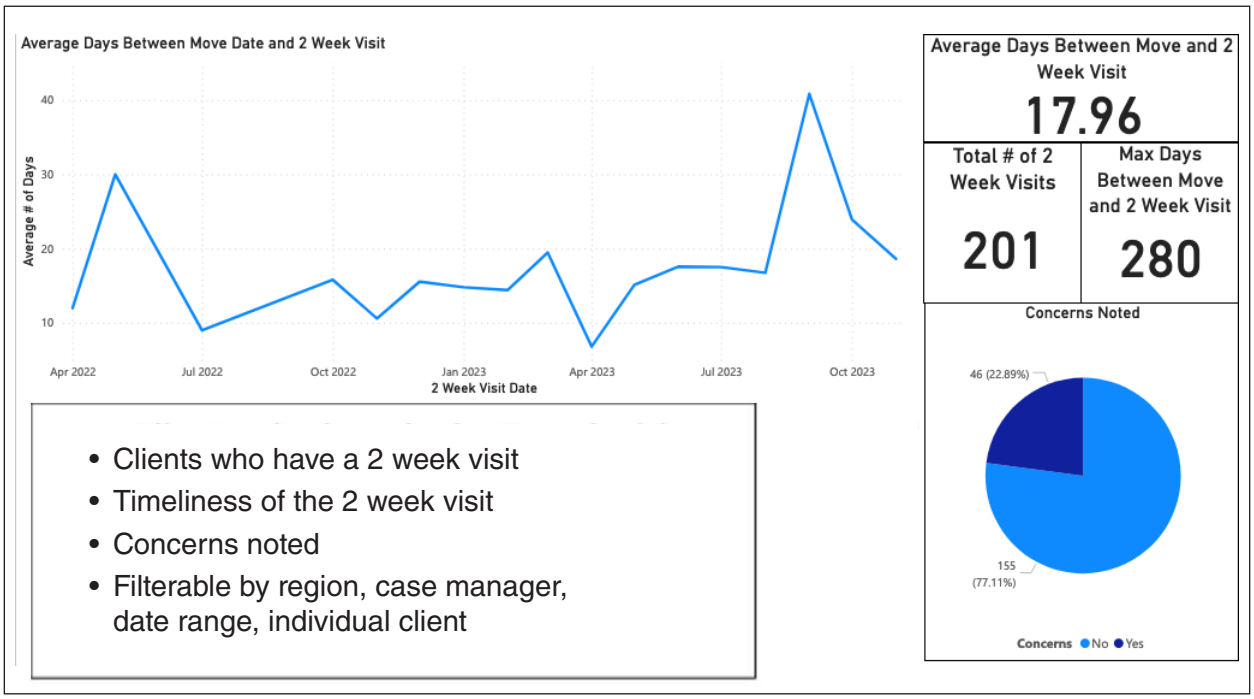


Twenty percent of clients across all DDA who transitioned from one setting to another during the most recent fiscal year had a high behavior acuity, however on a transition caseload 35% of the clients had a high behavioral acuity. The dashboard's ability to monitor that required behavioral referrals are being made is a critical part of our new infrastructure, as it allows staff to ensure that a Transition Clinical Team member can bring their professional expertise to the ACT meetings to ensure that behaviorally complex clients get the extra support of a clinical professional.



Twenty-three percent of clients across DDA who transitioned from one setting to another during the most recent fiscal year had high medical acuity, however on a transition caseload 32% of the clients had high medical acuity.

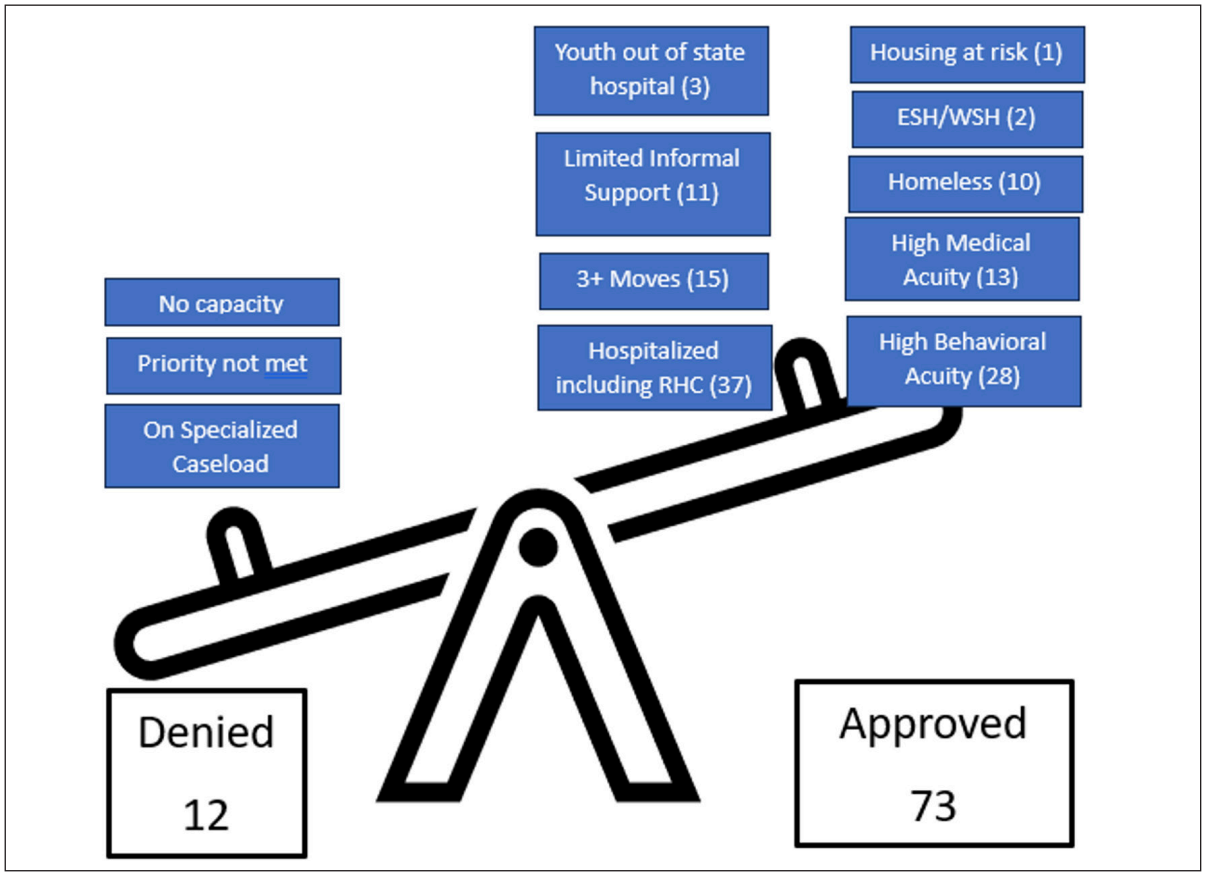
Post Move



When clients move, it is easy to see whether they are receiving the expected follow up and whether concerns are noted. Anomalies are quickly noted, and managers have increased situational awareness and can provide proactive follow up when needed. PQIS will provide additional eyes when they are preparing for transition surveys and follow up to ensure that noted concerns have been resolved.

Referral and Survey Databases

- **Transition Referral Database** - this portal allows case management staff to submit a referral request to the regional transitional care manager for consideration to transfer to a transition caseload. This database tracks client priority needs as well as approval and denial data and reason. We expect to use this data to evaluate caseload information and ensure statewide process efficiency and standardization. Of the 85 referrals that have been submitted since the database went live in July, 12 have been denied and 73 have been approved. The referral database tracks the reasons why individuals request the transitional care unit and what circumstances will require additional intensive case management. It can give us data to determine what areas of our transitional care management system may need to have heightened areas of focus. For example, in the infographic below, the most frequent priority cited across the transitional care caseloads is clients seeking discharge from a hospital, including behavioral health in-patient facilities, and RHCs. This will inform system development as we see what the highest support needs are for the clients we serve. Many of the 73 clients who were recently added to the transition caseloads have more than one of the listed priorities.



- **Nursing Referral Database** - this portal allows case management staff to submit a referral request to the regional transitional care manager for consideration to transfer to a transition caseload. This database tracks client priority needs as well as approval and denial data and reason. We expect to use this data to evaluate caseload information and ensure statewide process efficiency and standardization. Of the 85 referrals that have been submitted since the database went live in July, 12 have been denied and 73 have been approved. The referral database tracks the reasons why individuals request the transitional care unit and what circumstances will require additional intensive case management and can give us data to determine what areas of our transitional care management system may need to have heightened areas of focus. For example, in the infographic below, the most frequent priority cited across the transitional care caseloads is clients seeking discharge from a hospital, including behavioral health in-patient facilities, and RHCs. This will inform system development as we see what the highest support needs are for the clients we serve. Many of the 73 clients who were recently added to the transition caseloads have more than one of the listed priorities.

Medical Acuity

Home Evaluation/Equipment Needs	**6**
Incident Report	**1**
Instructions/Education for client/decision maker	**7**
Medication Management	**2**
Nurse-related Triggered Referral	**1**
Nursing Assessment	**53**
Nursing Assessment-Home Visit	**1**
Nursing Consultation	**34**
Nutritional Status	**3**
Other	**22**
Pain	**1**
Skin Integrity Problems (Other than SOP)	**3**
Transition meeting	**1**

- **Clinical Referral Database** - this database was implemented October 1 and will allow case managers to make a referral to the transition clinical team to access professional consultation for clients with high behavioral health acuity. The clinical teams have established metrics they will use to develop a clinical algorithm to refine prioritization and identify clients with high-risk behavioral health needs.

Transition Survey Database - The transition survey database was implemented October 1, 2023 and is a main source of data for both person-centeredness, and stability.
Transition Surveys can:

- Reveal insight about how the transition is progressing and whether the provider is supporting the individual's personal goals.
- Identify potential barriers to services or concerns about unmet support needs.
- Promote stability in the new home by asking DDA staff and the provider to address identified barriers or concerns.
- Verify whether supports are meeting the needs of the individual and their family/guardian/ advocate.
- Produce data that will be analyzed to identify trends and improve transition outcomes.

This survey asks specific questions that are mapped to quality assurance metrics identifying if the process was person centered and identifies the stability of the individual. Reports can be pulled for analysis and inform the transition process for improvements to increase client stability during transition.

Information and access to services

1. Publications: Resources have been developed for clients and families to help them understand services and setting options and processes associated with moving into a new setting with a new provider.
    - A workgroup updated the My Page Profile which case managers can use to start a person centered conversation with clients and families regarding their transition goals. My Page Profile is available in nine languages.
    - A Client Guide to the Transition Process was published in January 2023
    - Work is beginning to update service brochures and fact sheets to address stakeholder feedback about what information is most needed to inform a decision to move into a different setting type.

2. "Choose Your Own Adventure" :This was a stakeholder initiated project which will engage staff across our agency and external partners to develop content to make our forward-facing publications, videos and internet navigation more accessible and family and client friendly. This tool will help individuals and their families with decision making to choose a setting and services package that would meet their needs. This project is early in development and expected to take one to two years to fully implement all components; publications, resources, video content and webpage updates.

Lessons Learned

Development of the infrastructure took longer than anticipated due to hiring, development of processes and seeking input from all experts in transitions. Since the implementation, the infrastructure is highlighting areas of continued training needs for staff such as facilitation training and the process to bring the individual into the transition meetings.

Location of the transition case manager sometimes impacts the in-person mode of developing a person's goals as a result of nine case resource managers supporting individuals across Washington state.

The development of the transition team at DDA headquarters, which includes program and policy development, quality assurance and data analysis support has proven promising to implement the full framework and modifying transitional processes using continuous quality improvement strategies to inform the overall rollout across the agency. This framework creates a clear process for transition by:

- Identifying framework as three stages:
- Provide effective communication to families and clients on transition process' and service information.
- Promote greater evaluation of barriers associated with key steps of transition.
- Providing facilitation training to CRM to promote efficient meetings to promote timely transition.
- Development of databases creates transparency and timely response to transition challenges.

To fully engage individuals across the state with transitions, case managers need to have smaller caseloads that allow for time to facilitate and address all the tasks associated with a transition. Full implementation is necessary to create a system and culture change to transitions. The pilot demonstrates baseline data that supports timely and stable transitions when the transition framework is utilized. A soft rollout of the transition framework was implemented at different stages to meet the workload of case resource managers and the type of caseloads they managed:

Phase 1: In May 2023, all case managers implemented the first stage of transition preparation and began use of tracking form that tracks transition preparation policy steps.

Phase 2: In January 2024, case resource managers with a specialized caseload (1:35 caseload) will begin a soft rollout of the ACT process, use of Active Coordination of Transition form and transition framework as they identify clients on their caseload who plan to move.

Phase 3: In July 2024 specialized caseload case resource managers will implement the Post Move stage using tracking forms and follow post move and stabilization processes.

Phase 4: To implement the transition framework across remaining case resource managers carrying caseload of 1:75 the department will need:

- Reduced caseloads- from 1:75 to 1:35 or hire transition facilitators to specifically support transitions on case manager's caseloads.
- Increased PQIS staff to complete post move and stabilization Transition Surveys for all clients who transition.

Recommendations

We are thankful for the ongoing support of the Legislature to fund transitional coordination management teams. These teams are critical to supporting clients before, during and after they move. However, person-centered transitions need dedicated staff to carry the caseload, evaluate quality of the services, strengthen the provider workforce, support decision making for those who need it and ensure transition procedures are fully implemented. To fully implement the quality assurance and to ensure the individuals voice is heard, we need additional Performance Quality Improvement employees to implement the new streamlined Transition Survey. We anticipate a need of three additional PQI team members to fully implement the Transitional Framework and Quality assurance infrastructure.

Individuals receive better transition support when their case resource manager has the ability and time to walk them through service options, seeing potential roommates or house options, and talking with potential providers. Continued funding is needed to lower caseload sizes as identified in the caseload ratio reduction project. 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. This will promote continuity in service planning and eliminate one more change the individual experiences. 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.

Finally, we have a good infrastructure developed to address real time support for identifying barriers to transitions and complete process improvement for stability of an individual when moving to their new home. We will continue to learn from the data that is being collected and informing the success and challenges of the Transitional Care Management structure. In our next report, a more holistic and complete comparison from each fiscal year, will occur with the transitional care implementation. 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 travelled alongside clients to ensure they successfully moved into a stable and supportive home.