DSHS
WASHINGTON STATE
Department of Social and Health Services

REPORT TO THE LEGISLATURE

Transitional Care Management

ESSB 5693 Sec. 203 (1)(gg)

December 1, 2024

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Introduction

The Legislature enacted Engrossed Substitute Senate Bill 5693 Section 203(1)(ee)(i) during the 2022 session. It provides the Washington State Department of Social and Health Services 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 transitional care management teams for people who move from one setting to another. This annual report includes details of the actions we have taken to improve transition coordination. These actions include:

- Identifying the number of people 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.
- Making Recommendations for changes to the transition coordination teams to increase stability.

Our administration continues to support around 1,500 people annually to transition from one setting to another. Partners tell us the extra resources developed have brought positive changes for those moving from one place to another. Case managers have reported significant benefits from the additional support internal professional staff provide when supporting medically and behaviorally complex individuals requiring specialized expertise. Families have noted that using standard processes have made coordination better. Several people who have been receiving services at our Residential Habilitation Centers have successfully transitioned to a new community-based settings. Monitoring stability and robust quality assurance have provided data we will use to develop algorithms. This data will help us identify when someone might be at risk for unsuccessful transitions and return to an institution. Some of our community partners have shared that the extra resources for providing transitional support, clinical expertise and standardized processes are making a difference.

The legislative investment is improving the lives of the those we serve. It has helped vulnerable people move into new homes. These moves often happen during high-risk situations like going into a hospital, losing a provider or a long-term stay at an institution.

Executive Summary – Overview of Transition Outcomes

In January 2023, the Transitional Care Unit launched the transition framework as our pilot group. The pilot is showing us that clients need more support during transitions.

Continued expansion of the transitional care management work will need:

- Extra case management, resource management and regional quality improvement staff to provide wrap around support.
- More clinical and nursing teams to support professional consultation for individuals with complex medical and behavioral needs.
- Provider rates that incentivize more specialized expertise.
- Improved support for parents through our waiver transformation project, innovative service options and targeted service outreach.
- Provider development and better use of technology to address workforce shortages in rural and underserved areas.
- Increased visibility of individuals with developmental disabilities highlighted in legislation that seeks to improve the lives of marginalized people.

We added more case managers to support person-centered transitions into the communities clients choose.

Original Case Management Staffing Structure	Expanded Case Management Staffing Structure
20 Case Managers – • Nine proviso-funded transition case managers and • Eleven previous Roads to Community Living case managers	+ Four more case managers + One administrative staff + One additional supervisor

Region 2 has also added another children's case manager that the children's transition coordinator supervises.

Each transition case manager serves up to 35 clients. They currently support 526 people piloting the transition framework. The framework makes sure all programs follow the same policies and procedures when someone moves from one setting to another. This improves efficiency and provides data to track timelines and stability measures. The transition framework has three stages of transition:

Transition Preparation	Active Coordination of Transition	Post Move and Stabilization
• Starts when the person asks to move • Personal goals and service requests • Mutual acceptance - Client and provider choose to work together • Review current support plans with provider	• Initial transition meeting includes behavioral health and nursing professionals • Clarify roles and responsibilities • Develop transitional activities • Meet roommates, staff and see their home • Check that all the needed supports are in place	• Case manager follows up and monitors • Nursing professionals follow up and support clients and provider with nursing related activities and training • Address concerns that come up • Verify staff are trained and plans are in place • Check that the person is happy with their supports • Transition survey • Continue quality follow up

A. Transition preparation starts with the person's request for services. It includes discussing their goals, support needs and preferred residential setting with the individual. This stage focuses on identifying services, supports and residential settings that could support the person. During transition preparation, the case manager follows program processes to create the referral packet. They will also help the person choose a residential setting that matches their goals and support needs. We ensure an agreement between the individual and the provider to work together in the new home.

125 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 prepare the person's home for the move. The transitional care coordination team meets regularly to identify medical and behavioral referral needs and make sure support plans are in place to support a successful transition. The case manager facilitates the transitional care coordination team using a person-centered process that keeps the individual engaged and ensures their goals are addressed by a team developing their care plans and setting up their services.

45 individuals are currently supported in ACT

C. The post-move and stabilization process starts the day the person moves into their new home. This stage can last up to one year. The case manager will make sure the person has access to all the services and supports identified in their Person-Centered Service Plan and that their plans are implemented in a timely manner. The professional nursing staff visit the person in their new residence. It reviews medical services and supports to ensure the client has access to necessary medical equipment and medications and staff and trained on healthcare-related services.

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individuals are currently supported in Post Move and Stabilization

During the post-move, the transition case manager and the performance and quality specialists work together to determine if the individual is adequately being supported and satisfied with their services and supports needed to access their community and participate in their chosen activities. The table below 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.

Since our project started in January 2023, we have supported 733 people in using the transition framework process. Out of those, 693 have made a successful transition or are on track to have one. Thirty-nine people experienced one failed transition and needed a second attempt to succeed. One person succeeded on their third attempt. As of June 25, 2024, 526 individuals are receiving care from the transitional care unit to find a suitable provider to support their needs.

693 Total individuals have had or are on track for a stable transition.

39 individuals had a failed transition and required support through a second round through the stages of the framework to achieve success.

1 individual had 2 failed transition attempts and required support a 3rd round through the stages of the framework to achieve success.

275 individuals have successfully completed the transition process and achieved stability.

Seventy-nine percent of the individuals supported by the transition teams were adults and twenty-one percent were youth or young adults under 21. In addition, the children's transition coordinators in each region are supporting children's transitions across the administration's system by:

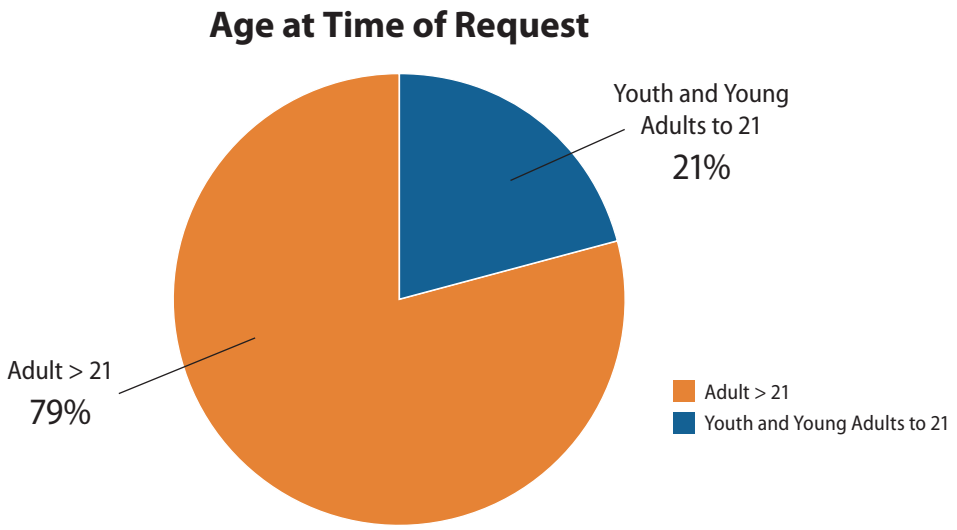
- Supporting all the cases in their respective region who are involved with Department of Children Youth and Families.
- Tracking youth transitioning out of Department of Children Youth and Families services.
- Representing their region in coordinated care meetings with Department of Children Youth and Families.
- Collaborating with Health Care Authority Managed Care Organizations and Behavioral Health Administration.

- Identifying best practices from regional transitions for children and youth.
- Implementing statewide processes for all children, youth and young adults transitioning from one setting to another under 21 years of age.

Proviso funds were allocated to have one staff member in each region to support youth and young adult transitions up to 21. Many of these transitions support youth who are receiving concurrent services from the Department of Children Youth and Families and are in dependency or transitioning out of extended foster care. These children's transition coordinators provide needed support to staff who may not have experience with the foster care system or the services and supports available to youth in dependency.

"I have been working with a youth who was aging out of care with DCYF. He is diagnosed with an intellectual disability and has very high support needs. He had been in DCYF custody most of his life, and with the same foster family most of the time he was in care. He did not want to leave the foster home, and the foster parent wanted him to stay, but he was concerned he could not meet the client's high support/supervision needs and still maintain a job. I talked with the team about the option of a Companion Home, and the foster parent was very excited about this option. We worked closely with DCYF and the DDA Resource Team to ensure that the Companion Home rate/services would meet the needs of the client and the foster parent. The client successfully transitioned over to Companion Home [Residential Habilitation] Services in June, and now he can remain with the people who supported him the majority of his life.

– Children's Transition Coordinator R2"



Of the 21 percent served on the transitional care units who are youth, almost half are between 18-21. When youth are aging out of children's and into adult services, it takes a team of experts to ensure the transition goes smoothly. Between 18 and 21, youth are aging out of EPSDT benefits, often requiring them to identify new primary care and specialty care providers. They are aging out of Part C special education services and moving into adult supported employment opportunities. Many of the youth served on the transition teams have received WISe benefits through their community behavioral health system, and there is no adult equivalent to those wraparound services provided. Many youth in extended foster care require additional support to transition all their services from the Department of Children, Youth and Families to the programs offered through DSHS DDA.

> **Ryan is a young man participating in Extended Foster Care in a therapeutic (Behavioral Rehabilitation Services) foster home. Ryan and DCYF were working towards a plan of having Ryan return home to be supported by his biological father and his stepmother. Unfortunately, it became clear that Ryan's father was not in a position to be a successful support for him. I worked with Ryan's CRM, and the CRM's supervisor to put together ongoing meetings with the DCYF team, the WISe providers, the foster parents, and the BRS company to collaborate on Ryan's supports and establish options for him. The CRM was able to utilize pre-1188 funding to pay for Staff and Family Consultation and Specialized Habilitation. The CRM and supervisor also worked with the WISe team, DCYF, the foster parents, and Ryan, to put together a Supported Living referral packet. Ryan now has mutual acceptance with a provider in Region 2. We will continue to work through the transition process with Ryan and the rest of the team, with the included complication of ensuring that Ryan is ready to disenroll from Extended Foster Care on the day that we are ready to enroll him on the Core Waiver.**
>
> **– Children's Transition Coordinator R3**

The case manager facilitates the transition framework by coordinating with subject matter experts across the agency and with external partners who are all supporting the individual to have a successful transition to their new home. The world metrics 2024 report states, "According to a study of 2,000 Americans conducted by OnePoll, 64% ranked moving as one of the most stressful life events." https://worldmetrics.org/moving-stress-statistics/.

DSHS DDA-supported individuals who are served by the transition framework have some of the most complex support needs in our system of care. They have frequent hospital stays for medical or psychiatric reasons. Many struggle to keep a stable home environment. This could be because the professionals or family members caring for them need additional training to meet their complex needs.

The transition framework, funded by the legislature to help high-needs individuals, has supported shorter times to get a person moved into a long-term home with supports in place, and positive feedback from providers, individuals and their legal representatives. Timeliness is measured across each stage to determine:

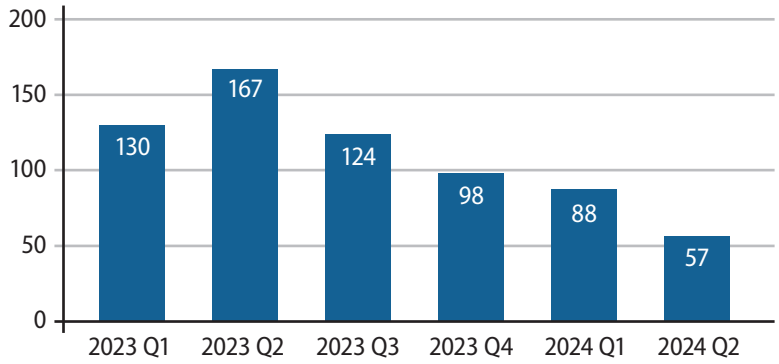
1. **Transition preparation:** how much time does it take for the individual to find a provider when trying to move? What is the impact of transitioning too quickly?
2. **Active coordination of transition:** how much time does is take for the transition coordination team to develop the needed care plans and support to prepare for the move? What are the barriers that prevent moving?
3. **Post-move and stabilization** is a fixed time of 365 days. As we collect data, we aim to develop algorithms that can identify risk factors for instability and have flexibility in the post-move to identify that an individual has reached stability and no longer requires the intensive level of support of the post move activities.

The graphs below highlight the improvement across quarters, over the last fiscal year beginning with January 2023, when we began collecting data.

Figure 1.1

Transition Preparation Stage

Average Number of Days Grouped by CY Quarters



Since January 2023, the team testing the new transition framework in the transitional care unit has reduced the average time it takes to find a provider. One success is significantly reducing the mean average time to find a provider and a home for the individual.

Probable reasons for the reduction include:

1. Increased access to provider expertise through the complex needs pilot project
   - In May 2024 one person waiting for mutual acceptance for almost 4 years, was accepted by a provider under this complex need pilot project.
   - Ten individuals served by the transitional care unit were accepted into the pilot project in one month after searching for a provider for more than two years.

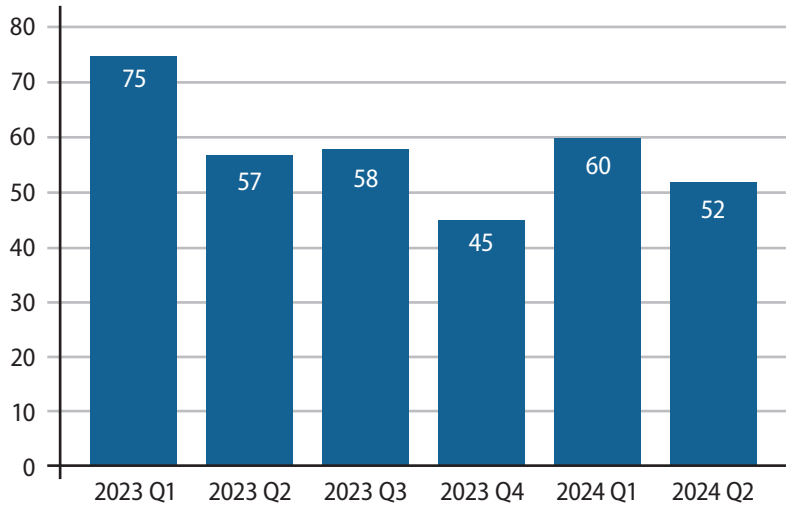
2. More people moving into adult family home settings,
   - The availability of Intensive Behavioral Supportive Supervision due to funding through their Apple Health managed care plan.
   - Work from the transition case manager adult family home teams, expansion of adult family homes in some areas of the state – particularly in Eastern WA.

It is important to note that the variability of times for transition preparation is significant. Though we have demonstrated substantial initial success, the average is heavily influenced by outliers. Additional statistical analysis will be done when more individuals complete the framework steps, and we can develop an additional measurement strategy. Our current quality assurance process is focused on understanding those outliers so that we can influence them in future efforts to increase consistency.

Figure 1.2*

Active Coordination of Transition Stage

Average Number of Days Grouped by CY Quarters



Since the project started in January 2023, the ACT stage has shown a significant decrease in the time required to coordinate care plans for individuals and prepare everything needed for a successful move.

*There are still cases in each quarter that are open. This means that an individual is still in the Preparation or ACT phase and the quarterly mean will continue to change until all individuals in that stage have moved to the next stage. The previous two graphs are mathematically derived to represent cases as if they were closed as of the day this data was pulled. The monthly averages for these quarters will keep changing until all cases initiated in these months are completed.

The post-move and stabilization period is fixed at 365 days. There are 51 individuals who were in transition preparation as of January 1, 2023 and completed a full 365 days of post-move

stabilization. The entire transition support process under the framework is about 18 months, with the time to locate a provider, develop needed care plans and receive the full 365 days of additional wrap-around support.

Quality Assurance Activities and Outcomes

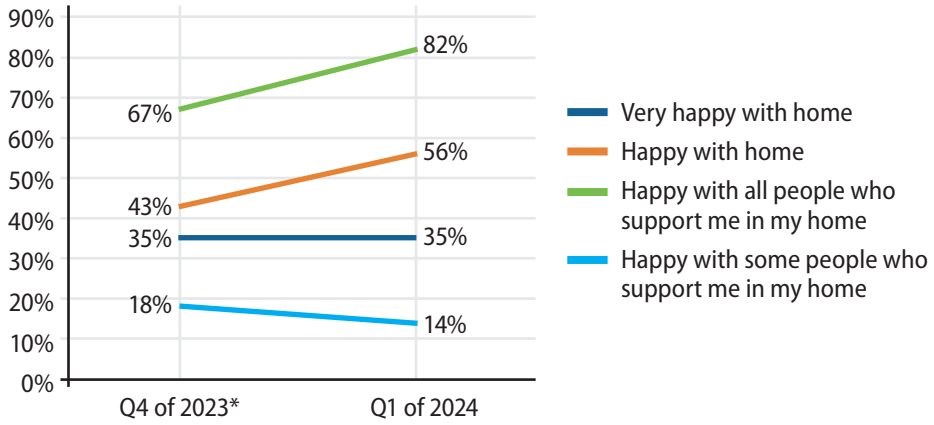
Overall Transition Survey outcomes: Individual Satisfaction

In August 2023, our performance and quality improvement specialists began using the new transition survey to evaluate overall satisfaction and individual stability. The transition survey was adapted from the previously used mover's survey. The mover's survey was used to evaluate transitions for individuals enrolled in the Roads to Community Living program. The revamped survey was further mapped to questions about satisfaction and stability to evaluate the effectiveness of transition framework processes.

Transition Survey	Timeline
Initial	45 to 60 days after transition date
Second	Four to six months after transition date
Third, if there are concerns about instability	10 to 11 months after transition date

Most people surveyed said they were very happy or happy in their home, and most also said they were happy with all or some people who support them in their home. The number of individuals who expressed satisfaction with all people who support them increased by 15 percent between the last five months of 2023 and the first quarter of 2024. Many families, guardians and advocates said they were very satisfied or satisfied with services from the provider, and more than 90 percent said they thought the transition was successful at the time of the survey.

Individual Satisfaction with Home and People Who Provide Support



*Q4 of 2023 also includes survey data from August and September, when the new survey format was implemented.

Transition Survey: Monitoring risk of instability

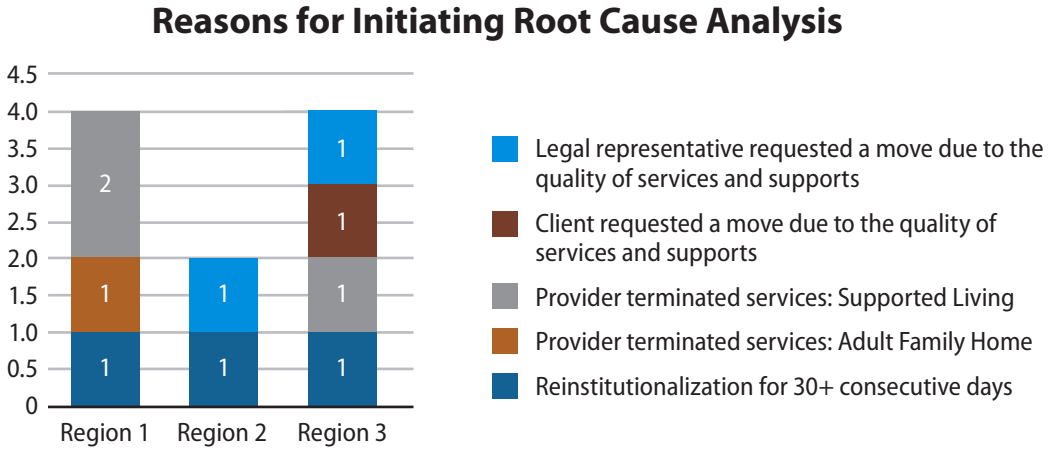
An analysis was completed to consider the development of an algorithm in May 2024 to determine a transition risk of instability at the time of transition survey. Certain survey responses were scored and compared to the individual's success at the end of the transition period. Preliminary results look positive and show a trend that may help us to predict whether the transition could be at risk. We need more data to develop a model for statistical validity to reevaluate our results in December 2024. If rates of significance are stronger with more data, we can use an algorithm to predict instability after each survey. Staff could be notified of this risk and preemptively work to determine what might stabilize the transition.

Root Cause Analysis trends: Evaluating unstable transitions

Root cause analysis is a collaborative quality assurance process that identifies new and recurring causes of instability that lead to the loss of an individual's home or provider. It enables us to make recommendations that will improve transitional care management processes and outcomes. Root cause analysis is completed when one or more of the following applies to a transition:

- Quality assurance manager deemed the transition unstable after approximately 12 months.
- Provider terminated services.
- Individual or legal representative requested a move due to the quality of services and supports.
- Individual is institutionalized in a hospital or Residential Habilitation Center for 30 consecutive days or longer.
- Region requests root cause analysis.

Nine transition cases have undergone RCA since December 2023, and four more transitions are moving through this process. The most common reasons for initiating RCA are hospitalizations for 30 consecutive days or longer and termination of services from a supported living or an adult family home provider. So far, 31 root causes have been identified. Preliminary analysis suggests the most frequent types of root causes contributing to unsuccessful transitions are unmet needs, staffing issues and communication issues. Common themes identified within these root causes are missing or inadequate mental health or behavior supports, incomplete or inadequate training of staff, lack of clear communication between individuals, families, or providers and mismanaged expectations about directing care.



Each region discusses action plans to solve root causes when there is an unsuccessful transition. In Region 3, one root cause of an extended hospitalization was that a stabilization service should have been utilized prior to the individual's transition to supported living. After another hospitalization, the region was able to support this individual in a diversion program for an additional period of stabilization before returning to supported living.

Discussions about RCA at the statewide level often lead to outreach and collaboration with other staff to clarify details about policies and procedures and to brainstorm potential systemic solutions to barriers. Two unsuccessful transitions led to collaboration with the benefits integration and community hospital program manager who was able to provide education about the scope of our agency services and settings to a hospital in Region 2 and another in Region 3. This program manager also established regular meetings with DSHS DDA and staff from the Health Care Authority to discuss root causes of unsuccessful transitions from community hospitals.

Discussion of trending barriers for specific provider types: RCA noted trends

Five of 13 individuals who qualified for RCA moved from a family home, and four moved from a community hospital. Six transitions to a supported living home and three transitions to an adult family home ultimately resulted in the need for RCA.

Region	Transitioned from	Transitioned to	Reason for RCA	Days between move and RCA trigger
1	Family Home	Adult Family Home	Provider terminated services	56
1	Lakeland Village RHC	State Operated Living Alternative	Hospitalization for 30+ consecutive days	198
1	Family Home	Supported Living	Provider terminated services	214
1	Family Home	Supported Living	Provider terminated services	349
1*	Family Home	Adult Family Home	Hospitalization for 30+ consecutive days	357
2	Community Hospital	Family Home	Hospitalization for 30+ consecutive days	79
2	Community Hospital	Supported Living	Legal representative requested move	110
2*	Community Hospital	Adult Family Home	Provider terminated services	145
3*	Children's Long-Term Inpatient Program	Family Home	Hospitalization for 30+ consecutive days	103
3	Skilled Nursing Facility	Supported Living	Individual requested move and Provider terminated services	116
3	Community Hospital	Supported Living	Hospitalization for 30+ consecutive days	141

*RCA is in process for these transitions but has not been completed

SUCCESS STORY

"Matt hit rock bottom in November of 2022 and was admitted to Evergreen Hospital on an administrative stay, where he remained until April of 2023. During that time the Transitional Care Management Team was convened to support Matt to transition back into the supported lifestyle that he had become so accustomed to and yearned for. Matt transitioned to Fircrest on an interim basis while the new agency supporting him made preparations to welcome him. In addition to following the mandated framework for Transitional Care, they went above and beyond to ensure a successful transition. Thankfully, after a 4 and a half year journey, Matt transitioned out of Fircrest to his new home in Federal Way supported by Community Integrated Services.

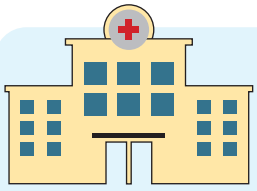
Matt's case was quite complex given his behavioral disorders. It is hard to imagine a scenario in which any individual or team of individuals could have delivered for Matt as successfully as his transitional care management team did.

– Guardian / parent of Matt"

Settings Moved To and From

The transition teams have supported moves from and to a variety of locations. Below is a heat map which highlights the distribution of moves to date (Jan 2023-current).

MOVING FROM	MOVING TO: AFH	Own Home	Supported Living	Relative's Home	Other
AFH	2	0	5	0	2
Nursing Home	16	6	57	2	2
Child Foster Home	1	0	6	1	1
Group Home	0	0	2	0	0
Medical Hospital	27	4	49	16	8
Out of State Facility	0	0	5	3	0
Supported Living	2	0	26	3	1
Psychiatric Hospital	2	0	9	3	2
Relative's Home	12	2	49	3	3
RHC	18	0	62	1	0
Own Home	1	1	7	0	0



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Hospital moves

The highest number of moves during this time has been from medical hospitals.

Acute Medical Hospitals

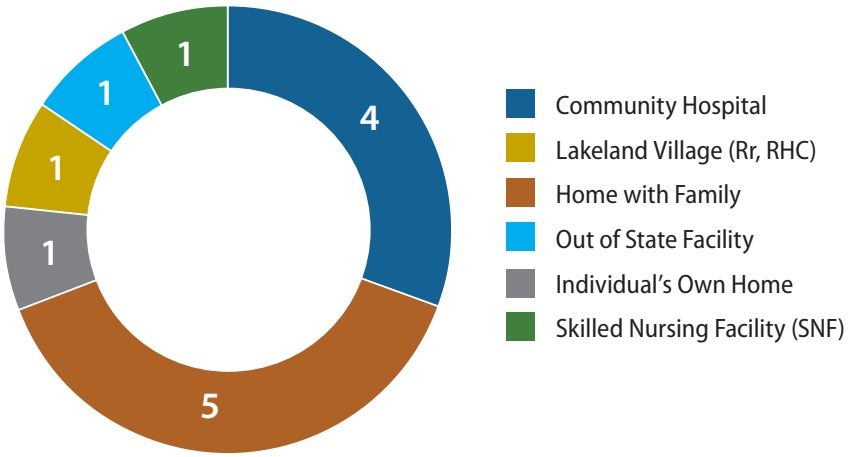
Medical hospital transitions are the most difficult and high risk of unsuccessful transitions for a few reasons:

1. The supports provided in the hospital are often not the same as the supports available in the community, and there can be a disconnect in the expectations of hospital discharge planners about available resources in the community that can appropriately meet the needs of individuals. The availability of a clinical team psychologist and DSHS DDA nursing care consultant provided training to the AFH staff on how to address this issue provided the extra support needed to facilitate the successful discharge.

> There was a referral for individual that was hospitalized and the AFH he was at were reluctant to have him back because of physically aggressive behaviors around tube feeding. Transition clinical team involvement was extremely helpful as I was able to collaborate with the DDA nurse consultant as well as create and train staff on how to feed him so that all parties stayed safe, and he was able to be discharged home.
>
> **– transition clinical team staff**

2. The regulatory environment in hospitals has different expectations than in-home and community-based settings. Many supports provided in hospitals are not required to comply with federal settings rules and individual's rights in a community setting, such as individual's rights to decline medications, to access preferred foods, or to restrict access to any of the areas of their home. Time is needed to set up appropriate interventions in an individual's home that safely supports independent living while preserving the individual's rights to choose how they want to live their day-to-day life. The need to create a new care plan to support medical and behavioral needs can add additional time to an individual's hospital stay, often creating stress for both the hospital, who is motivated to discharge, the case manager, who is under pressure to move the individual to their new setting, professional staff collaborating on discharge planning and education, and the individual, who needs to have their care plans set up and their staff trained before they can safely move to a less restrictive setting.
3. Acute hospital discharges are the most challenging for case managers and have correlated somewhat to higher staff turnover on the transition teams. Hospitals are funded through healthcare financing models that do not financially reimburse hospitals beyond the time an individual has completed their acute treatment and is deemed "medically stable" by their treating physician. When the hospital deems the individual ready for discharge, they are not motivated to take needed time to support the identification of an appropriate community provider, if needed or the amount of time needed to develop care plans, set up outpatient social, medical, and behavioral health services, identify medical and behavioral health care providers and ensure that the receiving staff at their discharge location have been adequately trained and prepared to begin supporting the individual upon their arrival in their new home.
4. In addition, community hospital discharges have a high rate of instability and unsuccessful transitions, exceeded only by individuals moving out of their family home.

Number of RCA Triggers by Move



Residential Habilitation Center Transitions

The department operates four Residential Habilitation Centers which provide ICF/IID services, Nursing Facility services, respite and Emergency Transitional Support. Each facility has a Transition Coordinator who works in close partnership with the Transitional Care Management teams to assist individuals to transition into their preferred community to receive supports. During the last fiscal year between July 1, 2023, and June 30, 2024, 32 individuals moved from an RHC into a community setting. The framework has been incorporated into a collaborative process between the RHC teams and transitional care management teams in field services. This has enhanced the success of coordination that supports individuals to move into their chosen community setting.

SUCCESS STORY

> We reached mutual acceptance between Duane and Life Supported Living on May 16, 2024. During the transition meetings, all parties communicated very well and fostered a very strong team environment. June 26, 2024, was selected as our target transition date, giving us a good amount of time for visitation, staff shadowing, and information sharing. Life was very thorough in their request and Lakeland Village was punctual in their responses and deliverables. As you know, just like with any other transition, unforeseen circumstances can arise and how the team responds to the situation can promote a positive or negative outcome. In this case a DME provider had a delay in delivering much needed medical equipment and we had to pivot and adjust the move date a couple of weeks. This gave the DME provider enough time to deliver the medical equipment prior to the move.

Duane transitioned to the community after receiving ICF services for 41 years! We just had one of our follow up meetings with LIFE and all seems to be going well. Duane is settling into his new home and is engaged with his peers, staff, and community.

I wanted to share this with you to bring to light that things happen that are sometimes out of our control. When all the stakeholders involved come together to support the resident and the transition it promotes a safe and successful move. Kudos to the transition case manager for his leadership and to the LIFE and Lakeland crew for their cohesive teamwork all with the intention to support Duane.

– Guardian of Duane

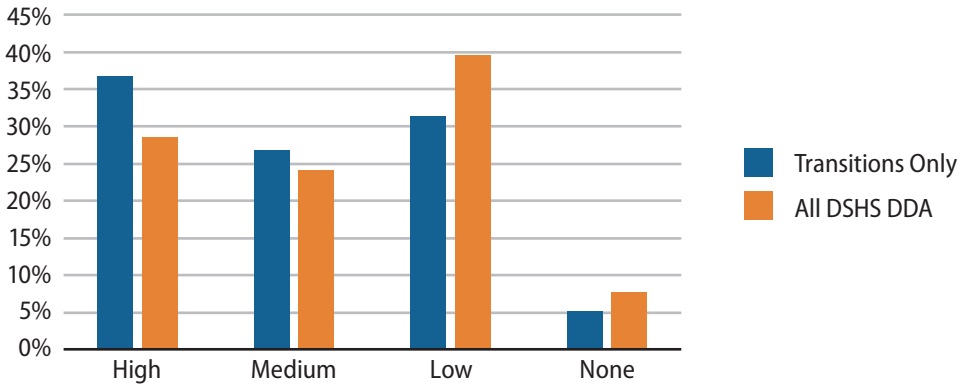
Nursing and Behavioral Support

A key driver of transition success has been the additional clinical and nursing support for individuals who are transitioning to a new setting. Case managers supporting individuals with complex medical and behavioral health needs rely on the specialized expertise of the clinical team psychologists, psychology associates and DSHS DDA nursing care consultants to ensure the transition care coordination team addresses all the behavioral and health care needs while protecting individual rights under integrated settings rules. Expansion of the nursing clinical team to offer more support for medically complex individuals has ensured that individuals have more support for a safe transition.

Clinical support for behaviorally complex individuals

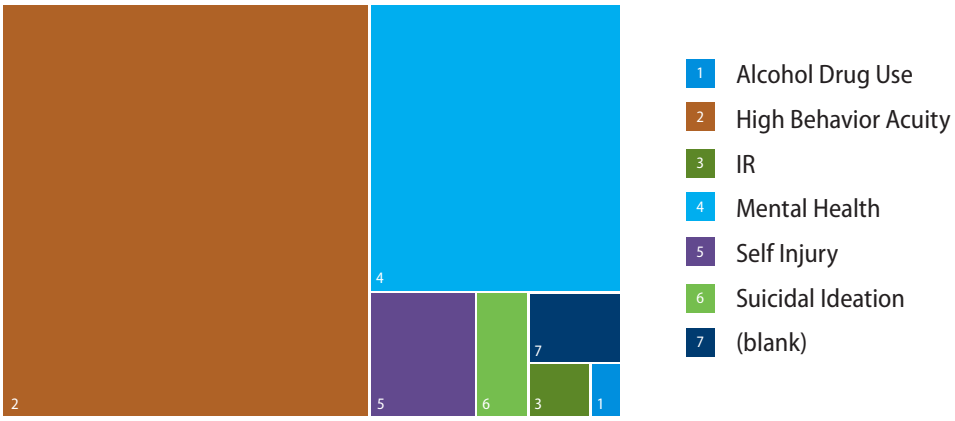
Case managers are directed to make referrals for additional behavior support when individuals have high behavioral acuity in their DSHS DDA CARE assessment. The transitional care unit case managers, who have a 1:35 caseload, support individuals with higher behavioral acuity, generally, than the typical case manager across the DSHS DDA continuum of care.

Behavioral Acuity – All DDA vs. Transition (%)



The transition clinical team became fully staffed, onboarded, and ready to actively receive referrals beginning in October 2023. The team supports individuals who are serviced by the transitional care units or are enrolled in the Roads to Community Living program. Since that time, the transition clinical team has reviewed 161 referrals. After screening, 139 were assigned to transition clinical team members. Adults accounted for 68 percent of referrals while children and youth referred were 32 percent. Referrals were made because of a high behavior score (59%), a mental health reason (28%), self-injury (5%), suicidal ideation (3%), drug or alcohol use (1%) or incident reports (1%). The majority were enrolled in the Roads to Community program (57%), from a transition care case manager (39%), or a specialized caseload (2%).

Transition Clinical Team Reason for Referral

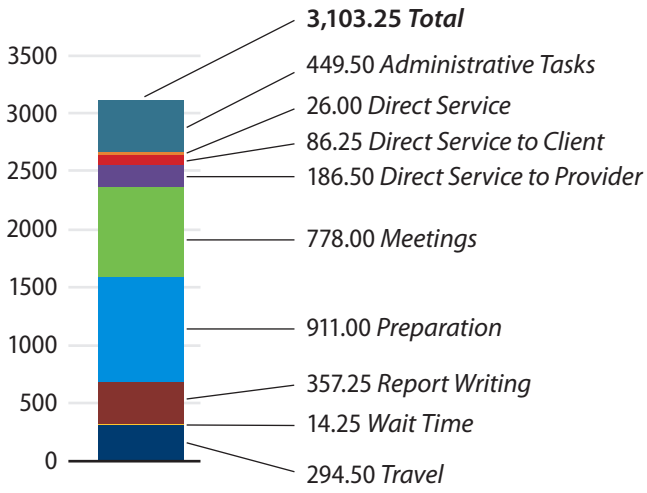


Individuals referred for transition clinical team services came from parents' or relatives' home 11 percent of the time, and an administration's contracted provider setting for adults 33 percent, and from DSHS DDA contracted provider setting for children and youth two percent of the time. Referrals from individuals wanting to move to a community-based setting from a residential habilitation center accounted for 15 percent. Community nursing facilities and hospitals accounted for 21 percent of referrals to the transition clinical team. Private and state psychiatric facilities accounted for 18 percent of referrals. Finally, individuals returning to Washington from an out-of-state treatment facility occupied 2 percent of referrals to the transition clinical team.

Referring case managers ask for transitional clinical team members to attend transition meetings in 43 percent of reasons for the referral. In 26 percent of the referrals, consultation services are requested, 14 percent want a positive behavior support plan developed, or a functional assessment developed (7 percent). Other services requested each accounted for an additional three percent and included staff training, home visits and other services.

The Transitional Clinical Team tracked their activities for their first nine months, rendering a total of 3,103 hours of service activities.

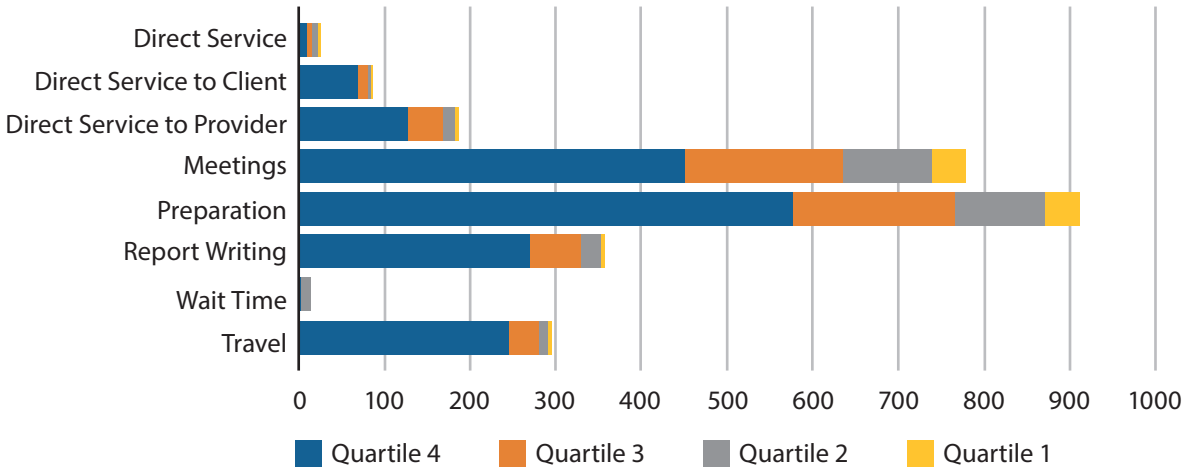
Team's Hours by Encounter Activity



Activities occupying the team's efforts are case preparation (29 percent of hours), meeting attendance (25 percent), and administrative tasks (14 percent). Direct services to providers, individuals, and others accounted for 10 percent of hours logged. Traveling to where the individual lives or the provider delivers services accounted for nine percent. The average time staff spent in preparation for each chase was 6.42 hours, attending meetings 5.22 hours, and 4.12 hours in completing administrative tasks. Once assessments and other clinical activities were completed, an average of 6.74 hours was spent documenting recommendations, findings, and clinical impressions.

There was significant variability in the time occupied by each case and the number of activity categories, as a result, cases were grouped into quartiles based on time logged for each case.

Relative Hours Consumed by Quartile



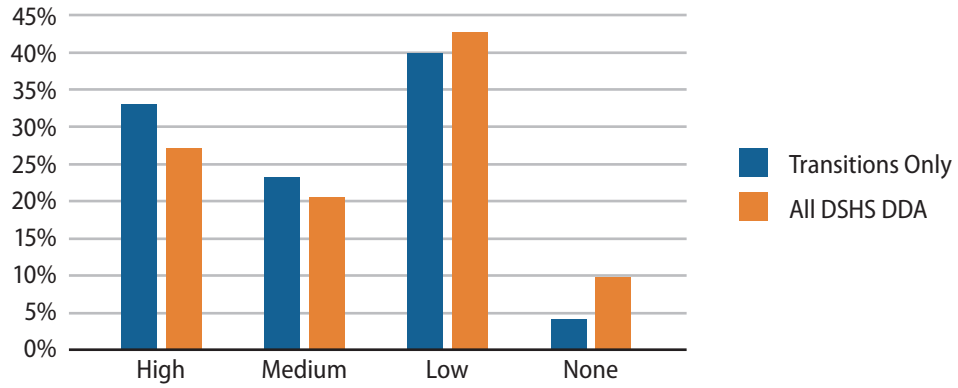
The fourth quartile (those cases utilizing the most staff time) is prominent in all service categories and accounted for 50 percent of transitional clinical team time consumed in assisting with transitions to community settings. These 42 individuals required 50 percent of the teams' efforts. The average case required 13.7 hours to prepare for the case, 10.7 hours of meetings, and 7.8 hours of administrative tasks. Consultation documents and recommendations required 10.8 hours. Services resulted in direct contact with the individual moving averaging 2.2 hours, to the provider 4.3 hours, and other direct services accounting for an additional 2.2 hours. Staff traveled to the individual and provider resulted an average of 7.2 hours per case. The lowest three quartiles reflected the pattern of the fourth quartile at lower average hours in each service category.

Nursing Consultant Support

Case managers are directed to make referrals for additional nursing care consultant support when the individuals they support have high medical acuity in their DSHS DDA CARE assessment. The transitional care unit case managers support individuals with higher medical acuity, generally, than the typical case manager across our system.

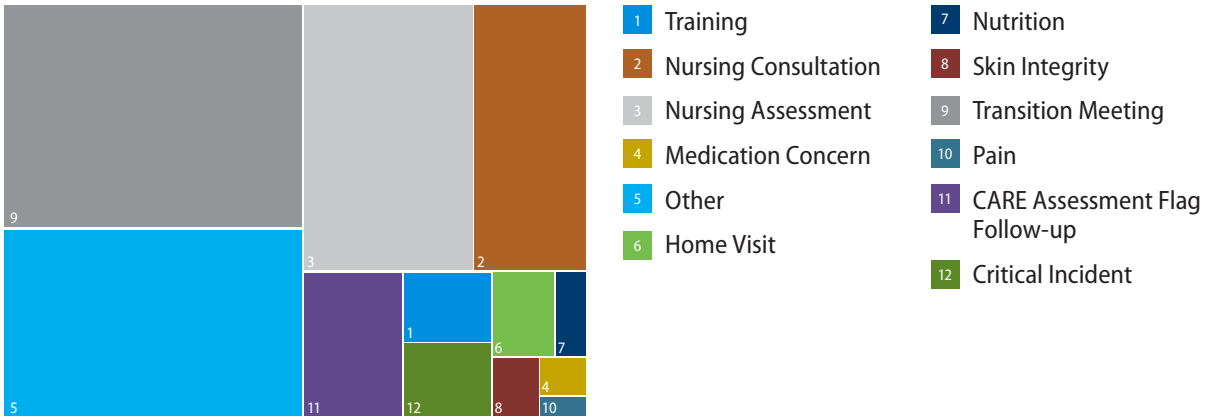
Of the 733 individuals supported by the transition framework, 242 required professional nursing support during their transition, to ensure health related services and supports were in place at time of discharge.

Medical Acuity – All DDA vs. Transition (%)



Transitional care management referrals accounted for a total of 242 of 644 nursing referrals across the agency system since January 2023. The transitional care unit accounts for approximately 38 percent of all nursing referrals, however, only make up one percent of the total individuals served by DSHS DDA field services.

Transition Nursing Team Reason for Referral



The nursing team expanded from five nursing care consultants to 11 in September 2022. Six new nursing care consultants were hired to assist with providing support with referrals for individuals with high medical acuity, individuals enrolled in specialized caseloads due to risk of abuse, neglect, or isolation, and those receiving transitional support. The support of the nursing team has been crucial to address high medical needs.

Some key themes for the support that nursing care consultants provided were:

- Nursing assessment and health screening, due to medical acuity. Including nutritional assessment, mobility review, evaluation of skin problems, medication review etc.
- Educate the client, family and care providers and health care instructions, to include hospital and skilled nursing facility discharge orders.
- Reinforcement health care training to mitigate rehospitalization.
- Health care provider consultation.
- Help with making health care plans and protocols for prescribed treatments.
- Medication reconciliation and education.
- Accessing medical equipment and orders.
- Assessment and recommendation for the following services: nursing delegation, private duty nursing, home health and skilled nursing.

The nursing team's support, combined with their crucial knowledge of the scope of services available in our contracted settings, and the regulatory environment in which our home and community-based services are delivered, has helped to fill a gap that previously led to unstable transitions.

Lessons Learned and Continued Implementation Strategies

The full implementation of our quality assurance strategies has yielded some observations that will inform our continued implementation and process improvements. The quality assurance activities of transition survey, root cause analysis and monthly evaluations of barriers to timeliness and stability have identified some trends to address with our pilot group of transitional care unit and as we eventually expand across our continuum of care.

1. Expansion of utilizing the framework to support individuals who are moving. We see that it results in improved outcomes, but success requires a small caseload to allow the case manager ample time to facilitate the wraparound components of the transition framework. Currently staff with a caseload ratio of 1:35 or less are using the entire framework. Staff with a full 1:75 caseload are only supporting transition preparation, as those tasks are part of existing policy expectations. The statistics cited previously show that one of the key components of success of the transition framework is the added professional consultation, and the intensive wrap around support, in addition to the smaller caseload ratio. Continued refinement of data is needed to identify high risk transitions and streamline referral processes for nursing and clinical support for individuals with complex needs.
2. Continued integration of transition framework into policy and programs across the continuum of care. Process improvement and alignment of fragmented procedures with greater standardization will result in simplifying steps needed to assist someone to identify potential providers, craft comprehensive and effective care plans, and receive needed wrap around supports following a move. Policies across 14 program areas were combined into a single case management process and policy for all settings requiring the individual to move to a new location to receive service. This aligns with the transition preparation tasks that are focused on referral processes and accessing providers. More refinement is planned over the next year to further align these policies for greater transparency around referral processes as individuals are supported to identify providers to support them.
3. Expansion of the residential referral tracking system into a single referral application and database. This will enable:
   - staff to document individual requests for services and match to providers who have capacity;
   - granular and aggregate data reporting to leadership;
   - analysis of "service deserts" throughout state; and
   - (with a high degree of security) ability for individuals or their representatives to submit requests and review potential service providers.

4. Creating an initiative to increase access to person centered plan facilitation. This service is available under multiple payment strategies, but there continues to be gaps in access to it. Our administration will identify strategies to increase utilization through the CIIBS and IFS waivers, Roads to Community Living funding and county individual and technical assistance dollars. Additional planning is needed to expand and simplify access to this service to make it more accessible and increase awareness of its benefits. A series of videos was created to assist in promoting the service to individuals and their families.
5. Resource development is needed to expand all provider types with specific focus in rural and underserved areas. We will work to get utilization data to better understand gaps between settings individuals are requesting and the available services in those settings and surrounding communities. Root cause analysis often identifies a need for more short-term stabilization services for individuals who need to exit a hospital but may require some additional stabilization to maximize success in a community residential setting.

Recommendations and Conclusion

We are excited about the initial success of this transitional care management work. With continued support, we expect this work to be transformational into our continuum of care. There are several priorities we see as being crucial to our continued success.

Person-centered transitions for individuals with complex needs require dedicated staff to carry the caseload, evaluate the 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 expansion of this work across our continuum of care, including the needed quality assurance and ensuring the individual's voice is heard, we need:

1. Additional performance quality improvement specialists to implement the new streamlined transition survey as we expand our transition framework across our continuum of care. We anticipate the need of three additional performance and quality improvement specialists to fully implement the transitional framework and quality assurance infrastructure.
2. Create a resource management position in each region to handle adult family home referral processes in alignment with how referrals are supported for other residential types so that the performance and quality improvement specialists can focus on quality improvement and the process for supporting referrals can be better aligned across referral settings.
3. Focused implementation on caseload reduction project from Oct. 2022 to facilitate expansion of the transition framework across our system, once all case managers have smaller caseloads.

4. Decreased caseload ratios for the transitional care unit to support the intensity of the workload and maintain continuity for the TCU teams, which currently experience high turnover due to workload intensity. The individuals they support are some of the most complex across our continuum of care and the goal of the department is to promote the success of the individuals we serve while also working to support long term staff longevity.
5. Add social workers to the transitional clinical team to assist individuals with complex needs access services in the communities they choose to reside in. These social workers serve as system navigators and coordinators with managed care organizations, behavioral health providers, physical health providers, social service options, and other services that currently are the burden of case managers. One quarter of the individuals served in the last nine months account for 50 percent of the time consumed with current clinical team services. Adding social workers will improve capacity for case management and licensed professionals by passing on the navigation and integration work that is part of the individual's setting up and managing the business of living in a community-based setting.
6. Increasing the number of dedicated nursing care consultants to focus on transitional care management. Nursing care consultants spend on average 68 days per referral due to the unique and complex level of nursing supports required during a transition and post move stabilization. Nursing care consultants play a key role in translation of medical information, collaboration with health care providers, and establishing heath care in a community of the client's choice.
7. Increased provider rates for complex individuals.
8. Increased support for parents.
    a. The HCBS waiver technical guide allows states to arrange for the provision of some services (e.g., home modifications) in advance of the transition of institutionalized persons to the community to ensure the continuity of care for these individuals. Individuals who receive services in an institutional setting for 60 days have access to Roads to Community Living for transitional support to discharge to the community, however those same supports are not currently available under the approved HCBS waivers. For the administration to submit an approved waiver amendment for transition dollars, we would need to ensure that we have adequate state funds to cover needed expenses incurred if an individual is not eligible to receive waiver services when they discharge.

b. Services that can allow individuals who live with their family to receive skilled support. Data shows individuals in family homes have the highest rate of transition failure and need to have supports that are more comparable to those offered in residential settings to allow individuals to have more housing options to meet their needs. Living in a family home is the most cost effective of all options and yet support to create a successful environment that can support an individual to have full community inclusion and qualified staff to support their needs are quite limited. Expansion of services such as:
   - More respite options to support the family to have breaks in caregiving, and
   - The addition of day habilitation services with enough funding to provide adequate hours of support to assist people with developmental disabilities to create meaningful days outside of employment, participate in community life and provide skill building support should be considered a priority.
   - Expansion of person-centered plan facilitation that can center the goals of the individual and strengthen the natural supports available to the individual and their support network.

9. Develop technological solutions that would allow real time matching up of an individual's support needs with a provider that would be qualified to support them. This would require investment in application security software, which would enable third-party (individual and provider) access to a portal which would allow an individual to select qualified providers with open capacity and request case management support to initiate a referral request.
10. Additional resource development capacity to increase access to service providers statewide, especially in rural and underserved areas.
11. Continue integrating the transition framework and data analysis across all the emerging cross system work focused on serving children and youth with complex needs such as:
    - The Governors Rapid Response team
    - Youth and Young Adult Housing Response Team
    - Kids' Mental Health Washington
    - Lake Burien Transitional Care Facility
    - Access to DSHS DDA services for dependent youth
    - School Engagement

    Continued partnership will be beneficial to identify collaboration opportunities when youth and young adults with complex needs are moving from one setting to another.

12. Create housing opportunities that are independent of service providers so individuals can have provider of choice without losing their housing.
    a. Increase use of assistive technology to increase individual independence in the community with less reliance on 24/7 caregiver presence.
    b. Include individuals with intellectual and developmental disabilities in legislation that supports increased access to housing and calls out specific marginalized populations.
13. Increasing access to community based mental and behavioral healthcare services by including individuals with intellectual and developmental disabilities in legislation that supports increased access to mental and behavioral health care and calls out specific marginalized populations.

We are thankful for the continuing investment of the Legislature to fund transitional coordination management teams and the work of transitional care management. This work creates systemic change to support the individuals we serve to experience person centered support during transitions. The transitional care teams are critical to supporting individuals before, during and after they move.