MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

Improving lives THROUGH supports and services THAT FOSTER self-determination.

Community Transitions

Procedures 9.4B-F

What is a Transition?

- A transition is the process of an individual physically moving to a new home with residential services, and/or changing residential providers.

- This process includes five phases:
  - Provider selection
  - Transition planning
  - Move coordination
  - Post-move follow-up
  - Transfer of the individual's record to a new support coordinator or case management provider (if applicable)

Who does this procedure apply to?

- This procedure applies to all individuals approved for a Comprehensive Waiver slot who are moving into a new home with residential services or who are changing residential service providers within the community.

- This includes youth awarded a Comprehensive Waiver slot funded through an Interdivisional Agreement (IDA) with Children's Division

What's really changing for Support Coordinators?

- Oversight of transition calls
  - From RPC to SC Supervisor/SC3/ROD

Community Transitions

Procedure 9.4B: Provider Selection

Responsibilities

- Sending SC will:
  - Initiate the transition process
  - Facilitate meetings between mutually interested parties to ensure the individual has choice of service provider and the provider fully understands the individual's support needs.
  - Evaluate whether the chosen service provider site (i.e., the individual's prospective home) is accessible to the person based on identified needs, integrated and supports full access to the community, and meets all requirements regarding an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Responsibilities

- Sending Support Coordinator Supervisor (SCS) and/or Support Coordinator Supervisor Designee will provide additional technical support to the SC for any transitions deemed an **emergency**.
  - Technical support includes, but is not limited to facilitation of emergency transition calls, provider outreach, plan amendments, submission of emergency Utilization Review (UR) requests, and increased coordination with the individual's planning team.

Responsibilities

- The Risk Prevention Consultant (RPC) is responsible for supporting the planning team during transitions deemed an **emergency**. Support includes:
  - Consulting on provider capacity to support the individual's behavioral needs
  - Offering to provide Tier 2 resources and support to a hospital, jail, or other temporary provider that currently supports an individual deemed in need of an emergency transition
  - Serving as liaison between the transition team with Tier 1, Tier 3, behavioral health and other state and local resources, as appropriate.
  - RPCs are responsible for connecting teams with appropriate resources; they are not responsible for developing or implementing individualized supports.

- The Risk Prevention Team is responsible for managing the transitions@dmh.mo.gov email inbox and the administration of the Consumer Referral Database. Primary duties will be with the Administrative Support Assistant for the Risk Prevention Team.

Emergency Transitions

- An individual is determined in need of an emergency transition when the individual is currently at a hospital, jail, temporary treatment center, ready for discharge from a State Operated Program, and/or is considered homeless.
- Regional Office Director (RoD)/Assistant Director (AD) may request that an individual outside of this established criteria be treated as an emergency transition or "red hot" on an as needed basis after reviewing the specific needs of the individual.
  - Additionally, the ROD/AD should send notice to transitions@dmh.mo.gov, if transition is in one of these elevated statuses.

Transition Procedure

9.4B: Provider Selection

Initiating a Referral

- The sending SC will complete a transition referral packet and email to Transitions@dmh.mo.gov.
  - Consumer Referral Profile Form
  - Housemate Compatibility Tool/Survey
  - Current Individual Support Plan (ISP) and Behavior Support Plan (BSP; if applicable)
  - Any amendments to ISP or BSP
  - Authorization for Disclosure of Consumer Medical/Health Information form if the individual is under the age of 21
  - Email to transitions inbox indicates need for emergency transition if applicable.

Transition Inbox and Reviewing Referrals

- The Administrative Assistant for the Risk Prevention Team is responsible for managing the transitions@dmh.mo.gov email inbox.
- The Administrative Assistant for the Risk Prevention Team will review the Consumer Referral Database packet to ensure all required documents are present and accurate.
  - If the Consumer Referral Database packet is determined to be incomplete, the Administrative Assistant will notify the sending SC that the packet has not been accepted and the reasons why.
  - The sending SC will resubmit the packet once deficiencies have been corrected.

Transition Inbox and Reviewing Referrals

- If the Consumer Referral Database packet is complete.
  - The Administrative Assistant will determine whether the individual seeking a new home is on the Missouri Highway Patrol Sex Offender Registry or Juvenile Sex Offender Registry to meet notification and data tracking requirements.
  - The Administrative Assistant will determine if the referral meets the requirement of an emergency transition, and if so, notify the RPC Leads who will assign a RPC.
  - The Administrative Assistant will publish the referral on the Consumer Referral Database (CRD).

Consumer Referral Database

- The RPC Team will send an email to the SC once the referral has been published on the CRD and provide the referral number and whether the case was determined to be an emergency transition.

- The Sending SC will notify the individual and/or the guardian once the referral has been published on the CRD.

Consumer Referral Database

- The Administrative Assistant will forward all acceptances from potential service providers on the CRD to the sending SC.

- The Sending SC is responsible for forwarding all provider acceptance to the individual and guardian.

Provider Selection

- If the individual shows an interest in receiving services from a provider who has accepted the referral, the sending SC will facilitate an introductory meeting between the individual, guardian, housemates, and potential new service provider. This introductory meeting can occur in-person, virtually, or over the phone. The purpose of this meeting is for the individual to determine whether he/she would like to pursue a transition with this particular provider.
  - If the individual declines to receive services from the provider participating in the introductory meeting, the process for provider selection continues until the individual locates an acceptable provider. The sending SC will notify the provider of the individual's decision.
  - Once the individual selects a new residential provider, the team will follow Procedure 9C Residential Transition: Planning the Transition.

Community Transitions

Procedure 9.4C: Transition Planning

Responsibilities

- Sending Support Coordinator (SC) is responsible for leading the transition planning process for the individual.
  - Primary duties include communication with transition planning team, updating the ISP, facilitating a site visit, and completing other transition duties as outlined in the Checklist for Residential Community Living Moves.
- Sending Support Coordinator Supervisor (SCS) and/or Support Coordinator Supervisor Designee is responsible for providing additional technical support to the SC for any transitions deemed an emergency.
  - Technical support includes, but is not limited to facilitation of emergency transition calls, provider outreach, plan amendments, submission of emergency Utilization Review (UR) requests, and increased coordination with the individual's planning team.

Responsibilities

- Sending Regional Office is responsible for approving all plans and budgets to support the individual's move to a new home.
- Sending and receiving Client Information Centers (CIC) are responsible for supporting the transition by:
  - Transferring the individual's file
  - Ensuring proper communication occurs to necessary Regional Office (RO) team members.
  - Management of the individual's Episode of Care in CIMOR

Responsibilities

- The Risk Prevention Consultant (RPC) is responsible for supporting the planning team during transitions deemed an **emergency**. Support includes:
  - Consulting on provider capacity to support the individual's behavioral needs
  - Offering to provide Tier 2 resources and support to a hospital, jail, or other temporary provider that currently supports an individual deemed in need of an emergency transition.
  - Coaching the newly selected residential provider to implement appropriate supports to help the individual be successful.
    - Appropriate supports include Safety Crisis Plan, Behavior Support Plan, establishing behavioral, medical, or psychiatric providers as appropriate, and staff training on recommended interventions to increase provider capacity.
  - Serving as liaison between the transition team with Tier 1, Tier 3, behavioral health and other state and local resources, as appropriate.
  - RPCs are responsible for connecting teams with appropriate resources; they are not responsible for developing or implementing individualized supports.

Transition Procedure

9.4C: Transition Planning

Transition Planning

- Once a provider is identified, the sending SC will notify via email the transition/transfer contact designees:
  - Sending and receiving Regional Offices
  - Transition/transfer contact designees at the receiving TCM or RO
  - The transitions@dmh.mo.gov email inbox.
- Transition/transfer designees can be identified in the Support Coordinator Transition and Transfer Contacts brochure. The notification should include an electronic copy of the ISP, BSP, and demographic page.

Transition Planning

- The receiving CIC will notify their RO nurse of the incoming residential move.
  - If moving into a Host Home ISL service site or Group Home, the sending CIC will notify their Business Office Lead of the outgoing residential move to end the SMT.
  - The receiving CIC will open a second Episode of Care to support the individual's transition.
- If the individual has been determined in need of an emergency transition, the RPC is responsible for providing additional support to the transition planning team.
  - Support includes consulting on whether provider capacity would be appropriate to support the individual's behavioral needs, identifying with the newly selected residential provider appropriate supports to help the individual be successful, and connecting the transition team with Tier 1, Tier 3, and behavioral resources, as appropriate.

Transition Planning

- If the individual is moving into residential services for the first time an initial Health Risk Screen and any identified Health Risk Support Plans shall be completed as part of the ISP amendment process for initiating residential services.
  - The designated Residential RN HRST Rater will facilitate the completion of the screen and any applicable Health Risk Support Plans.
  - The Health Risk Screen is to be updated at least annually as a component of the ISP review process. The process also requires that the HRST be updated throughout the ISP year when changes in status are identified that change any of the 22 HRST rating item scores.
- If the individual is moving to a new provider directly from the hospital the sending SC will contact the hospital as soon as possible after admission to request participation in discharge planning and ensure the receiving provider has been provided all written medication orders as well as training and instruction regarding care procedures, techniques, use and monitoring or equipment, and other elements of care.

Initial Transition Meeting

- The sending SC will schedule an initial transition meeting. The transition meeting can occur in person, virtually or over the phone.
  - The sending SC should strive to hold the initial transition meeting at least two weeks before the anticipated move date.
  - The transition meeting will include the individual, guardian, receiving SC or SCS, current provider if applicable, and new provider. The sending and receiving nurses should be included in the call when person-centered planning and needs assessments like the Health Risk Screening Tool (HRST) indicate the need for a health risk support plan.
  - If the individual has been determined in need of an emergency transition, the sending SC Supervisor or SC Supervisor designee should offer additional technical assistance to the sending SC during the transition planning phase to ensure all necessary components of the transition are met.

Initial Transition Meeting

- During the transition call, the sending SC should utilize sections A, B, and C of the Checklist for Residential Community Living Moves to identify and resolve pending action items.
- The sending SC will need to set up the post move call to occur within 15 to 30 days after the move in date.
- The sending SC will send the Checklist for Residential Community Living Moves to transitions@dmh.mo.gov for tracking within 10 days of the initial transition meeting.

Transition Planning

- The sending SC will arrange for the individual to complete a site visit at their new home.
  - If in-person site visit is not in the individual's best interest, use of pictures, videos, or other methods may be utilized to introduce the individual to their new home.
- The sending SC will document the plan for the move in an ISP amendment.
  - If during the transition process, the individual's annual ISP becomes due within90 days of the move date, the sending SC is responsible for renewing the ISP.
- The sending SC will have the individual or guardian sign all necessary documents (ISP/ amendment, Medicaid Waiver, Provider and Services Choice Statement).
- The sending SC will submit the ISP, ISP amendment, and budget through the sending Regional Office's Utilization Review process.

Community Transitions

Procedure 9.4D: Move Coordination

Transition Responsibilities

- Sending Support Coordinator (SC) is responsible for ensuring that the individual is supported during the move phase of a residential transition.

Transition Procedure

9.4D: Move Coordination

Move Coordination

- The sending SC and Regional Office will maintain responsibility for the individual and support coordination through the duration of the transition.
- For the first 30 days after the move the receiving provider will bill the sending Regional Office for approved services until the effective date of the transfer.
- For the first 30 days after the move, event reports will be sent from the provider to the receiving Regional Office and Support Coordinator where they will be entered into CIMOR. The receiving Regional Office will send a copy of the Event Report Form to the sending SC.

Move Coordination

- Sending SC must ensure the following items are provided to the receiving provider at least one week before the move in date:
  - Current ISP, including addendums and budget/funding authorizations
  - Safety Crisis Plan, if applicable
  - BSP if applicable
  - Current physician's orders (as of the day of the transition);
  - Current specialized medical information
  - Information regarding diet and allergies

Move Coordination

- Sending SC must ensure that no later than the day of the move the following is received by the receiving provider:
  - A minimum of a seven day supply of current medications
  - Current physical, vision, and dental exams
  - Medicaid, Medicare, and Social Security cards
  - Current immunizations records
  - Adaptive equipment
  - Clothing
  - Personal care items
  - Personal property inventory
  - Documentation of guardianship and payee
    - Personal spending money which has been assigned to the individual will move with the individual. Personal spending money still in the provider's account will be returned to the RO, or as otherwise directed by the RO within 30 days.

Move Coordination

- Sending SC will update CIMOR with individual's new demographic information.
- The sending SC is responsible to remind the sending and receiving providers to review and sign off on the personal inventory form.
- If the home is a new Individualized Supported Living (ISL) service site and repairs or changes were necessary based on the initial ISL Environment Site Review form, the sending SC is responsible for ensuring the new ISL home passed inspection prior to the move. If repairs or changed were needed and have yet to occur, a new move date must be chosen post-repairs/modification

Community Transitions

Procedure 9.4E: Post Move Follow Up

Transition Responsibilities

- The sending SC is responsible for facilitating the post-move meeting and ensuring that all final components of the transition are completed.

Transition Procedure

9.4E: Post Move Follow Up

Post Move Meeting

- The sending SC will facilitate a post-move meeting within 15 to 30 days after the move.
  - The post-move meeting date is set during the initial transition meeting as outlined in Procedure 9C: Transition Planning.
  - The post-move meeting will include the sending SC, individual, guardian, receiving SC, and provider.
  - The sending SC verifies on the call that all pieces of the transition have been completed by reviewing Sections A – C of the [Checklist for Residential Community Living Moves.]
  - The sending SC completes the final components of the transitions as outlined in Section D of the Checklist for Residential Community Living Moves.
  - If any changes are needed or new outcomes and action steps are developed during the post-move meeting, the sending SC will provide an up to date ISP amendment to the receiving SC upon transfer.
  - A transfer date must be determined at the post-move meeting. The transfer must be completed within 30 days of the move. If additional service requests are needed, the transfer must still occur and the new receiving SC will complete the request for new services through UR.

Post Move Follow Up

- The sending SC will send the completed Checklist for Residential Community Living Moves to the planning team, consumer file, and transitions@dmh.mo.gov.
  - The Administrative Assistant for the Risk Prevention Team will review the checklist for completion and document its completion. The Administrative Assistant will remove the individual from the Consumer Referral Database.
- The sending SC starts the administrative file transfer process by following Procedure 9F: File Transfer.

Community Transitions

Procedure 9.4F: Transfer

Transition Responsibilities

- The sending SC is responsible for completing the Transfer Form triggering the file transfer process.
- The sending and receiving Client Information Centers (CIC) are responsible for tracking all file transfer requests, starting and ending any Episodes of Care, and finalizing the file transfer process.

Transition Procedure

9.4F: Transfer

Transfer of Records

- Once a transfer acceptance date has been determined in the post-move meeting, the sending SC will complete the Transfer Form and verify that all items on the file audit checklist are contained in the file.
- The sending SC will send the transfer packet (transfer form, consumer profile, housemate survey, current ISP and any addendums) to the sending and receiving contacts as outlined in the [Transition and Transfer Contacts brochure.]
  - The sending CIC will notify the sending BO of the file transfer.
- Within three days of receiving the transfer packet, the receiving SCS will confirm receipt of the transfer packet, provide an effective date of transfer, and name the assigned SC.

Transfer of Records

- The sending SC will update all information in CIMOR and ends authorizations one day prior to the date of transfer.
- The sending CIC will end the Episode of Care one day prior to the date of transfer.
- The receiving CIC will open the Episode of Care.
- The receiving SC will enter in authorizations.
- The file shall be transferred by the sending Regional Office or sending TCM entity within five business days of the effective transfer date. The transferred documents should include all documents as outlined in Directive 1.060 Appendix A

Questions / Comments

- Please send questions / comments to tier2@dmh.mo.gov with the subject line "Transition Procedure Question"

Transition Policy Timeline

- Policy/Procedure Comment – 3/17/2023
- Webinar w/ Q&A–
  - April 12th: 11-12 p.m.
  - April 17th: 11-12 p.m.
  - April 20th: 3-4 p.m.
- Tier 2 Coffee and Chat- May 9th
- Go-Live – May 15
- New Hire Training (for supervisors/SC3)– ongoing