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# Transition Monitoring Process Training

**Based on Division of DD Guideline #67**

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## *Overview*

- What is transition monitoring?
- The Benchmarks and authorities with some examples;
- APTS data;
- Annual Trend Reports;
- Reminders

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## *Transition Monitoring*

- The Community Transitions Manual was implemented July 1, 2016.
- Guideline #67 was developed in conjunction with the Community Transitions Manual and was implemented November 1, 2017.
- Guideline #67 was implemented to assist with identifying trends around transitions.
- The purpose is to provide continuity of care for the individuals as they move from one location to another and to shape consistency throughout the state.



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## *Transition Monitoring*

The Community Transition Process is driven by Waiver Assurances and HCBS requirements. The Division of Developmental Disabilities is responsible to ensure compliance with these authorities.

- Housing is separate from services.
- Individuals/families are integrated into and participate in their communities.
- Individuals/families live in communities that are safe and in homes they can afford.
- Individuals/families make informed choices about housing options.
- Individuals/families are in control of their home environments.

The HCBS Rule states:

“The setting is selected by the individual from among setting options including non-disability specific settings. (42 CFR 441.301(4)(ii))”

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## *Transition Monitoring*

- In conjunction with Support Coordination, the Community Living Coordinators (CLCs) help link individuals looking for residential options with providers and help plan for a smooth transition when they move.
- Guideline #67 applies to the Transition Monitoring Process to be used by all Community Living Coordinators (CLCs), TCM entities and Providers.
- The CLC at each Regional Office will complete on-going monitoring of the transition process as individual transitions occur.

Link to Guideline #67: <https://dmh.mo.gov/dd/docs/guideline67transition.pdf>

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## *Benchmarks for the Transition and Transfer Process*

- Specific benchmarks required for all transitions will form the basis for the monitoring of the transition process.
- Benchmarks were developed to focus on the essential activities that need to be completed throughout a transition.
- The benchmarks do not cover everything which may occur during a transition.

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## *Transition Monitoring Tool*

### Benchmark #1

*(Applies to Sending Support Coordination and Providers)*

- Was the individual placed on the referral database?

**HCBS rule states:**

**"Facilitates individual choice regarding services and supports, and who provides them." —42 C.F.R. § 441.301 (c)(4)(v) (about HCBS waivers); § 441.710(a)(1)(v)**

## *Consumer Referral Database*

- The CRD ensures we are in compliance with CMS assurances on individual choice of provider.
- Including the SC early in the discussion will ensure the entire process is implemented as established in the Transition Manual and Guideline 67.

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## *Consumer Referral Database*

The Consumer Referral Database is required when:

- Individual/guardian requesting to change residential service provider;
- Individual transitioning from non-residential to residential even if the individual receives PA/CI services and their current provider also offers residential services;
- Current residential provider has given notice and the individual is in need of a new residential provider.

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## *Consumer Referral Database*

The Consumer Referral Database is NOT required when:

- Individual is currently funded via CD (child specific contract) and the funding source is the only change (IDA).
- Individual requests to change setting types with the same provider (For example, GH to ISL). This does NOT require being added to the CRD as the individual has already made their choice of provider, they just desire a different setting.

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## *Consumer Referral Database*

- The referral should be placed on the database for at least 2 weeks to allow time for providers to respond, unless the individual has already moved or a move is so imminent that delaying it would be detrimental to the individual.
- In the event the CLC discovers a referral has not been placed on the consumer referral database, the CLC will work with the Support Coordinator to obtain the referral information.
- CLC will check the sex offender registry for all individuals seeking a residential setting, regardless of age or history.

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## *Transition Monitoring Tool*

### Benchmark #2

*(Applies to Sending Support Coordination & Providers)*

- Was the Housemate Compatibility Tool used prior to selecting a new provider or moving to a new home with the same provider?

The HCBS Rule states:

“The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person centered service plan and are based on the individual’s needs, preferences, and, for residential settings, resources available for room and board.” —42 C.F.R. § 441.301(c)(4)(ii) (about HCBS waivers); § 441.710(a)(1)(ii)

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## *Housemate Compatibility Tool*

When to use:

- Individual receiving residential supports requests to move to a new setting within the same provider agency;
- Individual receiving residential supports required to move to a new setting with a new provider;
- Individual approved for residential services and seeking a provider for the first time.

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## *Housemate Compatibility Tool*

### How to use:

- This tool shall be completed by an individual who is seeking a living situation with housemates, and potential housemates who may have someone move in with them.
- The tool should be completed by the individual, with support as needed from someone who knows the individual well.
- The information is considered by the planning team in determining compatibility of two or more housemates.
  - It is essential to also ensure the needs, wants, and desires of the individual(s) already living in the home are discussed and shared with the planning team.



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## *Transition Monitoring Tool*

### Benchmark #3

*(Applies to Sending Support Coordination & Sending Provider)*

- Was a transition meeting held prior to the move?

Community Transitions Manual states:

"The sending SC and CLC will arrange and co-facilitate a transition meeting far enough in advance of the move to ensure a smooth transition." (Section regarding "Transitions for Individuals Receiving Services in DD Residential Settings, Planning for Transition")

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## *Transition Meetings*

Formal transition meetings will occur for the vast majority of transitions.

A meeting shall occur for individuals:

- Who are moving from a non DMH residential setting into a DMH residential setting;
- Who are moving from one residential provider to another;
- Who are going from a lesser to more restrictive setting; or visa-versa;

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## *Transition Meetings*

A meeting shall occur for individuals:

- Who will be transitioning to a new TCM entity, even when the provider stays the same;
- Who are moving into or out of the Regional Office area;
- Who are transitioning from a crisis placement to a new provider;
- Who have an emergency situation where an Initial/Pre-Move meeting did not occur.
  - *In these situations, an Initial Post-Move meeting needs to occur, as well as a Follow Up Post-Move meeting (30 day call)*

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## *Transition Meetings*

- The Checklist for Residential Community Living Moves form should be completed, as much as possible, and sent to the Sending CLC prior to the Initial Call/Meeting taking place.

Community Transitions Manual states:

- “The sending SC and CLC will arrange and co-facilitate a transition meeting far enough in advance of the move to ensure a smooth transition.”
- “An initial transition meeting (Pre-Move), a follow-up transition meeting (if needed), and a Post-Move transition meeting (within 15-30 days of the move), should occur to ensure a smooth transition/transfer.”

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## *Transition Monitoring Tool*

### Benchmark #4

*(Applies to Sending Support Coordination)*

- Was the Checklist for Residential Community Living Moves document utilized by the Support Coordinator during the transition meeting, with completion of all necessary follow up?

Community Transitions Manual

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## *Transitions Where the Provider, Service, and TCM Remain the Same*

- The Checklist for Residential Community Living Moves document and housemate tool need to be completed for ALL moves.
- Completing the Checklist for Residential Community Living Moves document ensures the team came together to determine if the move was in the individual's best interest, and that all necessary topics have been addressed to ensure a smooth transition for the individual.
- When the same roommates are simply moving to a new home (address change), the Checklist for Residential Community Living Moves document still needs to be completed and sent to the planning team. The housemate tool is not required in this example.

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## *Transitions Where the Provider, Service, and TCM Remain the Same*

Examples of items that might apply from the Checklist for Residential Community Living Moves document include:

- ISL Site Review may need to be done;
- Address & other info. need to be updated in CIMOR/ISP;
- Necessary entities need to be informed of the move (SSA, Utilities, Medical supplies, etc.);
- Budgets/authorizations are updated (especially R&B costs);

## *Transitions Where the Provider, Service, and TCM Remain the Same*

Examples continued:

- Arrangements have been made for transporting the individual and belongings on the move date;
- If a Registered Sex Offender, must update their info on the registry;
- Other Items as applicable

All sections that appear to be not applicable, should still be discussed by the team to ensure that this is an accurate reflection of need.

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## *Transition Monitoring Tool*

### Benchmark #5

*(Applies to Sending Support Coordination)*

- Did the sending SC update the ISP to reflect current service and support needs prior to the transition?

The ISP Guide states:

"The ISP must be updated or amended to include current information regarding the change in living situation. It must include adequate supports for health and safety and to minimize difficulty in adjusting to any changes in his/her life that may occur with the change in living arrangements or supports." (Page 18)



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## *Transition Monitoring Tool*

### Benchmark #6

*(Applies to Sending Support Coordination & Receiving Provider)*

- Was a post-move transition meeting held within 30 days of the move?

Community Transitions Manual states:

Section regarding "Transitions for Individuals Receiving Services in DD Residential Settings, Post-Move Follow-up"

- A Post-Move review meeting or call will be held within the first 15 to 30 days after the move. The Post-Move review meeting/call will be jointly facilitated by the sending SC and CLC to include but not limited to, the individual and, if applicable, the legally responsible party, the receiving SC, receiving CLC, and provider. Outcomes and action steps shall be reviewed at this meeting. If changes are needed or new outcomes and action steps are developed, the sending SC will provide an up to date ISP amendment to the receiving SC upon transfer".

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## *APTS Database*

- All findings related to the benchmarks from the Transition Monitoring Tool will be entered into the APTS database. A copy of this information will be provided to the Support Coordinator and/or Provider.
- APTS was designed to track findings from monitoring that requiring resolution as well as positive practices.
- Findings will only be entered when one of the benchmarks is not met.



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## *APTS Resolution Process*

- The CLC will work with the Support Coordinator and/or Provider to evaluate the benchmarks on the transition monitoring tool and determine how findings entered into APTS can be resolved.
  - If the APTS entry is related to a TCM agency responsibility, the CLC will inform the SC/SC Supervisor and send a copy of the APTS information.
  - If the APTS entry is related to a Provider responsibility, the CLC will inform the Provider and send a copy of the APTS information.
  - CLC will then work with the SC / SC Supervisor or Provider, as needed, to ensure resolution.

## *APTS Resolution Process*

- Once the action taken for the finding is verified as being resolved by the CLC then they will enter the resolution verification date into the APTS database and notify the appropriate entity.
- If attempts to resolve the identified finding regarding the transition are not effective, the CLC will work with the TCM TAC, Provider Relations (or the Regional Office administration, as appropriate), and with the agency to develop a plan to resolve the issue.



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## *Annual Trend Report*

- Transition monitoring findings entered into the APTS database will be included on the TCM agency's annual report completed by the TCM TAC. Transition process performance indicators (benchmarks) will be included in the annual TCM monitoring review to determine evidence of the quality of the transition processes.
- Transition monitoring data entered into the APTS database will be included on the Provider agency's annual trend report.

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## *Data Analysis*

- The Division of DD would like to be able to track/trend (compare) the number of transitions occurring during a given period of time to the number of successful transitions (no issues identified through the 6 benchmarks).
- There may be a report developed in the future which can compare total transitions to the total APTS Resolutions per TCM Agency and Provider Agency.

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## *Friendly Community Living Coordinator Reminders*

- For Transfers: Be sure to access the Support Coordination Transfer Contact Brochure that is updated on the DMH/DD Website monthly.
- Ensure that you are using the current version of documents as included in the Community Transitions Manual. Examples include: Transfer from, Consumer Profile Form (for Consumer Referral Database), and Checklist for Residential Community Living Moves Document.
- The Community Transitions Manual can be accessed at <https://dmh.mo.gov/dd/manuals/docs/communitytransitionmanual.pdf>

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## *Friendly Community Living Coordinator Reminders*

- General Transition Process: The Transition Manual webinar provides training on the overall process and is available on the DMH/DD Website. If you haven't seen webinar or attended a local training by your CLC, we encourage you to do so.

<https://dmh.mo.gov/dd/webinar/CommunityTransitionProcesses.wmv>

- CLC's are also available to provide local training regarding the Guideline #67 process and benchmarks.

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## *Final Thoughts*

Communication is vital when it comes to transitions and transfers. Please make sure you notify your local CLC whenever:

- An individual in a residential service is moving;
- The move will require a new TCM entity and/or a new Regional Office;
- An individual is seeking residential services from a non DMH setting;
- An individual is seeking a new Residential Provider or;
- An individual is having difficulty adjusting to a new transition.

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*CLC's are here to help!!!*

Please see the link below for a listing of your local CLC.

<https://dmh.mo.gov/dd/docs/communitylivingcoordinatorcontactinformation.pdf>

- Better to over-communicate with the CLC than under-communicate!!



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**QUESTIONS??**