



Division Directive Number
4.270
Effective Date: 10.06.10
Revised: 09.28.11
Reviewed: 02.01.13; 05.31.14

Jeff Grosvenor
Jeff Grosvenor, Director

Title: Community Transition Process

Application: Regional Offices, State Operated Programs, Senate Bill 40 Boards, and Other Not-For-Profit Targeted Case Management (TCM) Entities

Purpose: This process outlines procedures and documentation requirements for State Operated Programs, Senate Bill 40 Boards, Other TCM Entities, and Regional Offices regarding transition of individuals residing in state operated Habilitation Centers to community living.

Definitions:

Behavior Resource Team: A regional office based team that can offer consultation for crisis support or to assist the family or support provider to develop and implement prevention and proactive strategies that will reduce the likelihood of problem behaviors by improving the person's quality of life.

Division of DD Person Centered Planning Guidelines: Describe the philosophy and values that form the foundation of the planning process.

Community Living Coordinator: A staff member at the DMH Regional Office who assists in locating community living options for individuals. Coordinators serve as regional contacts for housing resources and community transition.

Employment and Youth Transition Coordinator: A staff member at the DMH Regional Office who is dedicated to increasing the number of individuals who are competitively employed in the community. Coordinators provide training and technical assistance regarding topics such as job development and coaching, career planning, work incentives, awareness and business engagement.

Individual Support Plan: A document resulting from a person centered process directed by the individual served, with assistance as needed by a representative, in collaboration with an interdisciplinary team. It is intended to identify the strengths, preferences, needs and desired outcomes of the person served. The process may include other people freely chosen by the individual who are able to contribute to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes and the training, supports, therapies, and/or other services that become part of the individual support plan.

Interdisciplinary Team or Team: Those individuals (professionals, paraprofessionals, guardian and/or family members) who know the individual well and who possess the knowledge, skills, and expertise necessary to accurately identify a comprehensive array of the individual's needs and design a program which is responsive to those needs (Person Centered Planning Guidelines and Federal Standards ICF-MR W201 483.440(b)(4)(i), W202 483.440(b)(4)(ii), W203 483.440(b)(5)(i), W204 483.440(b)(5)(i), and W205 483.440(b)(5)(ii)). This

includes the individual, all appropriate facility staff who know the individual, as well as staff from other agencies who serve the individual, or will serve the individual when discharged, the Regional Office, the legally responsible party (guardian/individual), and other advocates chosen by the guardian or individual.

Placement Plan Document (Habilitation Center): For individuals currently residing in a state operated Habilitation Center, the Placement Plan is the last portion of their Habilitation Center ISP with a consent letter for those guardians/individuals who have already given consent for community placement and a consent letter for those guardians/individuals who have not consented to transition into community placement.

Regional Behavior Analyst: Licensed behavior analyst who is an employee of the Division of Developmental Disabilities and provides behavioral oversight to Behavior Resource Team and behavioral services for individuals served by the region.

Transition Coordinator/TCM Entity: Employee of either the Division of Developmental Disabilities or a local Targeted Case Management Entity whose role is to facilitate the transition process.

Transition Meeting: A meeting involving the individual's interdisciplinary team to identify and document all of the services, supports, accommodations, etc. that the individual will need to live in the community, and to set into motion the plans and actions needed for the individual to transition to the community.

Transition Plan: A document which outlines all of the specialized services, supports, accommodations, equipment, furnishings, etc. required in order for the individual to live in the community, including an action plan for overcoming the barriers to community placement with responsible parties assigned, dates, times, and locations of all follow-up meetings, provider acceptance, parent/guardian/individual preference of location of placement and choice of community providers, Medicaid eligibility status, and specific plans regarding the individual's move to the community. The Transition Plan is developed by the team utilizing the individual's Individual Support Plan, Placement Plan, and other available documents and information regarding the individual's needs and supports, and is the result of decisions made by the team at the individual's transition meetings. The transition plan includes the signatures of the guardian/individual and the team members involved in the transition planning process.

TRANSITION PROCESS

The transition process begins when the team identifies an individual that could live successfully in the community. The transition process also begins when an individual or person close to the individual advocates for transition to the community, or the guardian approaches the team asking for community placement.

The Transition Coordinator/TCM Entity and the Habilitation Center Social Service Worker or designee contact the guardian/individual together to discuss community placement options, explaining group homes, ISLs, shared living options, host family arrangements, work options, medical and behavioral supports that will be available to the individual in the community. The Transition Coordinator/TCM Entity and Habilitation Center Social Service Worker or designee identify the guardian/individual's preference for location, and discuss any questions the guardian/individual may have. This discussion shall include a description of the transition process regarding visits, team meetings, and post-move reviews. The option of Self-Directed Supports shall be explained to the guardian/individual as well.

In the event the guardian/individual decides to pursue the option of Self-Directed Supports, the Self-Directed Supports Coordinator at the Regional Office that covers the area where the individual will live will be a member of the individual's interdisciplinary team. Transition planning for individuals choosing Self-Directed Supports will focus on setting up the system of supports the individual will need including, but not limited to, hiring a

Support Broker if needed, determining how staff shall be hired and trained, determining roles and expectations of staff, locating housing if needed, referrals to community medical supports, referrals to support agencies, and determining emergency procedures. The Self-Directed Support Coordinator and receiving Support Coordinator will assist the guardian/individual in the process to enroll in the Self-Directed Supports service system. All aspects of the transition process, which are applicable to the individual, shall be followed.

If the guardian/individual decides to pursue community transition to a residential provider, the Habilitation Center Social Service Worker or designee shall send the referral information to the Transition Coordinator/TCM Entity or the Community Living Coordinator at the Regional Office most closely associated with the Habilitation Center. The Community Living Coordinator from the sending Regional Office shall enter the individual's referral information into the Referral Database.

The Transition Coordinator/TCM Entity and Habilitation Center Social Service Worker or designee shall contact each provider that indicates interest in the referral to explore the supports the agency can provide. The Transition Coordinator/TCM Entity or the Community Living Coordinator from the sending Regional Office shall contact the Community Living Coordinators in the Regional Offices where the agencies of interest are located to inform them of the providers' interest in the referral. The Transition Coordinator/TCM Entity or the Community Living Coordinator from the sending Regional Office shall inform the team about the providers that respond through the Referral Database to express interest in supporting the individual.

The Transition Coordinator/TCM Entity and the Habilitation Center Social Service Worker or designee shall contact the guardian/individual to provide the guardian/individual with information regarding the providers that have responded, including the providers' contact information. The Transition Coordinator will encourage individuals and families to review profiles of potential support providers available on the Department of Mental Health website at <http://dmh.mo.gov/DDServiceDirectory.aspx>. The Transition Coordinator/TCM Entity shall facilitate contact between the guardian/individual and the provider, if that is in accordance with the guardian/individual's wishes. The Transition Coordinator/TCM Entity shall inform the guardian that they may invite family members, friends, or other advocates of their choosing to be a part of the transition process.

If the person has required behavioral supports in the form of strategies included in the Individual Support Plan or a Behavior Support Plan (BSP), psychotropic medications, or any crisis management techniques were utilized in the past year, the Habilitation Center Behavior Support Professional will ensure that there is a current functional assessment for the behaviors and the strategies or BSP is current and effective. Data for at least the past year will be summarized in graphic format, including any significant environmental events that may affect the behavior, medications, and changes in medications. The BSP, functional assessment, and data will be included in the information provided to chosen providers. In addition, the Transition Coordinator/TCM Entity or the Community Living Coordinator from the sending Regional Office will contact the Behavior Resource Team and if available the Regional Behavior Analyst at the receiving Regional Office to make a referral for Behavior Resource Team services if behavioral risk is anticipated or a behavior support plan was necessary at the Habilitation Center.

On-going career planning is expected to be addressed in the Person Centered Planning Process for all individuals who are of working age (ages 16 -64) so that career advancement opportunities are explored on a regular basis. Individuals should be provided sufficient information about the value and opportunities regarding work so that they are making an informed choice. If an individual requires supports around employment options the DMH Employment coordinator may be contacted to provide technical assistance. Tools such as the [Guide to Career Discovery](#) and [Disability Benefits 101](#) should be utilized to assist in supporting the individuals find an appropriate job match.

Upon guardian/individual approval, visits are set up for the guardian, individual, and anyone that the guardian or individual invites Transition Coordinator/TCM Entity, and Habilitation Center Social Service Worker or

designee, to visit the providers' homes. The Transition Coordinator or the Community Living Coordinator from the sending Regional Office shall notify the Community Living Coordinator of the receiving Regional Office that these visits are occurring.

The guardian/individual shall then make a decision as to which provider they want to support the individual in the community. If the guardian/individual does not choose any of the providers, then additional providers are sought through the Referral Database and the process of exploring potential providers continues until the guardian/individual selects a provider. The team may consider expanding the counties of preference in the Referral Database.

Once an agency has been chosen by the guardian/individual, the Transition Coordinator shall notify the receiving Regional Office Community Living Coordinator that the individual will be transitioning to an agency in the receiving Regional Office's area. The receiving Regional Office's Community Living Coordinator shall notify the receiving TCM Entity and the provider of the transition. Careful consideration must be given by the team to make sure the individual is compatible to potential housemates in the new placement. If the provider is offering a new ISL, at least one housemate must be identified. New ISL's will be inspected and approved by the receiving Regional Office. The Housemate Compatibility Tool (Appendix F) may be used in considering the compatibility of potential housemates.

The Transition Coordinator/TCM Entity shall schedule a transition meeting. The Transition Coordinator/TCM Entity shall inform the guardian and the individual that they may invite family members, friends, or other advocates to attend the meeting. The individual's interdisciplinary team includes, but is not limited to:

- The guardian and any other family member, friend, or advocate that the guardian or individual invites to attend.
- The individual (if team agrees this would be in his/her best interest)
- The Provider agency with their staff (DDP, lead staff at the home, agency RN)
- Receiving Regional Office staff as necessary (Community Living Coordinator, Support Coordinator, RN, Quality Enhancement staff assigned to the provider, and Behavior Resource Team Member)
- Habilitation Center staff (physician, RN, LPN, Social Service Worker or designee, Unit Manager, Program Supervisor, Habilitation Specialist, Quality Assurance staff, Recreation staff, Dietary staff, Psychologist/Behavior Support Professional, direct care staff)
- Transition Coordinator/TCM Entity
- Receiving Support Coordinator from SB 40 Board/TCM Entity (if applicable)
- Self Directed Supports Coordinator from receiving Regional Office if the individual/guardian has chosen self-directed supports.
- Behavior Resource Team Lead staff from the receiving Regional Office if behavioral risk is anticipated and if available the Regional Behavior Analyst
- DMH Employment and Youth Transition Coordinator for individuals from 16-64 who have expressed an interest in working after transitioning.

The Transition Coordinator/TCM Entity facilitates the transition meeting where detailed discussion is held regarding the supports that must be in place for the individual to be successful in the community. The Initial Transition Meeting Discussion Document (Appendix A) guides the transition planning process. The team shall also ensure that risk mitigation planning is part of the transition process, using the Risk Screening Guide (Appendix B) or a similar risk assessment tool. The behavioral support strategies will be reviewed with the provider and team and the Behavior Resource Team and if available the Regional Behavior Analyst and any adjustments necessary based on information from the team and new provider will be made by the Habilitation Center Behavior Support Professional.

During the initial transition meeting, the team shall schedule visits for the direct care staff from the provider agency to shadow the individual at the Habilitation Center during various times throughout the day and overnight if needed. Primary staff from the community provider agency should shadow the individual at the Habilitation Center. The care staff from the provider will receive competency-based training in the behavioral support strategies. The team shall also schedule visits for the individual and staff from the Habilitation Center to spend time in the individual's new residence with the receiving provider staff to offer suggestions and identify support needs for the individual in the individual's new environment. Extent and nature of the visits should be individualized, with the goal of helping the individual to feel as comfortable as possible in his or her new residence before the move. The Transition Coordinator/TCM Entity shall ensure that the proposed provider has a copy of the Individual Support Plan prior to an overnight visit. The Habilitation Center Social Service Worker or designee shall provide the provider with the Transition Visit Profile (Appendix C) which contains information regarding specific risk factors for the individual and emergency contact information. If overnight visits cannot be done for any reason, the team shall discuss other options to ensure the consumer has opportunities to become acquainted with staff and roommates, and become comfortable in the new location. Staff at the habilitation center shall help prepare the individual for his/her experience in the new environment. The Behavior Resource Team and, if available, the Regional Behavior Analyst will be involved in the planning for transition, visits to the new home and with ongoing support and consultation when the individual moves from the Habilitation Center. The Behavior Resource Team (and Regional Behavior Analyst) should assist in the evaluation of the needs in the new home environment to ensure successful supports and the best quality of life.

During the initial transition meeting, the Transition Coordinator/TCM Entity schedules and facilitates additional and/or final transition meetings for discussion of any issues that arise during the visits, and to firm up the Transition Plan. The number of transition meetings that are held will depend on the needs of the individual and whether any obstacles are encountered in setting up the supports in the community.

The Transition Coordinator/TCM Entity shall develop the Transition Plan from review of the Individual Support Plan, the individual's Placement Plan, and the team discussion at the transition meetings. The Transition Plan must identify all supports, services, accommodations, equipment, furnishings, etc. needed for the individual to be successful in the community, and shall be developed in accordance with the Division of DD Person Centered Planning Guidelines as well as Division Directive 4.060 Individual Support Plan and Level of Care.

At the exit transition meeting, the team confirms that all supports needed by the individual, including employment referrals, doctor's appointments, adaptive equipment needs, etc. are in place. The team sets a tentative move date with moving procedures as outlined in the Initial Transition Plan and Action Plan (Appendix A). Post-move review dates are set up for 30, 60, and 90 days

The Transition Coordinator/TCM Entity shall determine whether the individual qualifies for the Money Follows the Person Grant, and submit the Money Follows the Person documents to the Community Living Coordinator for those individuals who meet qualifications.

The Transition Coordinator/TCM Entity shall submit the Transition Plan, budget information, and all necessary waiver paperwork including the ICF-DD Level of Care Statement, service authorization documentation, the Medicaid Waiver, Provider, and Services Choice Statements to the receiving Regional Office's Utilization Review Committee (URC) for approval. The receiving Regional Office shall request a waiver slot for the individual. Once the URC and Regional Director have approved the Transition Plan and budget, the team confirms the final move date. The Transition Coordinator/TCM Entity shall complete the Health Inventory.

On the day of the move, the staff from the Habilitation Center and, when possible, the Transition Coordinator/TCM Entity, accompany the individual to the individual's new home. The current Medication Administration Record, current medications/and or medication orders to provide at least a 15 day supply of medication, current physician's orders, current lab results, current annual physicals, current Individual Support Plan, current Behavior Support Plan, and information regarding upcoming doctors' appointments go with the individual to the home. The Transition Coordinator/TCM Entity takes copies of these documents to give to the new provider if those have not already been provided. The Inventory Checklist (Appendix D) is completed by staff at the Habilitation Center and also accompanies the individual to the individual's new home.

The individual's record is transferred from the sending Habilitation Center to the receiving Regional Office. If the individual will receive support coordination from a TCM agency other than the receiving Regional Office, the Regional Office will transfer the record to the TCM agency per Division Directive 5.010 Transfer and Portability of Funds Policy. The receiving Support Coordinator makes weekly visits to the individual for the first 30 days. Thirty days after the individual's move, the transition team holds the 30 day post-move review on the prescheduled date at a location chosen by the individual/guardian. Any additional support needs and adjustment concerns are discussed and the frequency of future home visits is determined. The Transition Coordinator/TCM Entity facilitates this meeting, completes the Post-Habilitation Center Transition Review Form (Appendix E), and sends it out to all team members. The receiving Support Coordinator reviews and approves by signing the form or documenting approval via email to the Transition Coordinator/TCM Entity. The receiving Support Coordinator completes an addendum to the Individual Support Plan which includes objectives for implementation in the community. The date of the annual ISP does not change. If there are concerns at the 90 day post-move review, additional monthly review meetings may be scheduled by the team.

The Behavior Resource Team under the direction of the Regional Behavior Analyst will assist the Support Coordinator and support provider to utilize positive, proactive and preventative strategies that have the best chances of supporting the individual with a good quality of life. The Behavior Resource Team will provide at least weekly on site visits and consultation for the first month and at least bi-weekly on site visits and consultation for the next 60 days to assist with consistent utilization and adjustment of strategies of support recommended by the Transition Team.

TRANSITION RATE AND PROVIDER REIMBURSEMENT

The Division of Developmental Disabilities has developed a process to help promote community service expansion to meet the needs of individuals residing in Habilitation Centers who request community services. The combined daily transition rate includes residential and all other habilitation support services. Current rate information may be obtained from Transition Coordinator/TCM Entity. The rate shall be used to purchase all necessary community services determined by the individual support plan. Community services include residential services, transportation, employment and other necessary services. Individuals may choose a provider other than the residential provider for some of their community services. When this occurs, payment for the community service will be paid at the contract provider rate for the service within the total daily rate. No additional funding will be added to the daily rate unless the individual experiences a substantial change in behavior or medical needs requiring additional supports to be successful in the community. The Support Coordinator must immediately submit a written request for additional supports to the Utilization Review Committee.

If it is necessary for the combined rate to exceed the established daily transition rate for the individual to successfully transition to the community, the rate must be approved by the Regional Director. The Regional Director may approve a combined rate up to a set maximum daily rate in order to meet the extraordinary

residential and other habilitation support needs of an individual. The current maximum daily rate may be obtained from the Division's Management Analyst Specialist, or local Transition Coordinators.

The transition rate shall be in effect for 18 months after services begin. No later than 18 months following transition, the Provider Relations team member assigned to the provider will review the budget with the provider. If the individual continues to require services at the transition rate, the rate will continue. If the individual does not require the level of services covered by the transition rate, the Provider Relations team member will work with the provider to determine where the additional funds can be reallocated within the provider agency.

Flexibility to use the approved transition reimbursement rate will be offered to community providers to help providers expand capacity to serve additional individuals. For example, a provider may use some of the funds to move an individual living in a group home into another living arrangement more suitable to meet their needs and use the empty bed to meet the needs of an individual residing in a habilitation center requesting group home services. The process must not exceed the approved transition reimbursement rate per day in total.

Individuals moving into existing residential settings that have an established rate will be invoiced to the Department at the current residential daily rate plus an additional amount authorized as intensive residential habilitation to produce the established transition reimbursement rate per day.

Targeted Case Management services will be billable for individuals during the transition of their move into the community up to 180 days prior to the actual transition.

The Medicaid waiver service, community transition, may be authorized for individuals who are transitioning directly from a State Operated Habilitation Center and will be served through the DD Comprehensive Waiver. This service has a limitation of \$3,000 for one-time start-up expenses. Only start-up costs as per the service definition are covered when the specific needs are documented in the transition plan. Examples of expenses that may be covered include:

- Expenses to transport furnishings and personal possessions to the new living arrangement;
- Essential furnishing expenses required to occupy and use a community domicile;
- Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
- Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Waiver environmental accessibility adaptations/home modification services (up to \$7500) as well as Specialized Medical Equipment and Supplies (up to \$7500) may also be accessed in advance of a person moving to the community. Only adaptations as per the service definition are covered when the specific need is documented within the transition plan. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual, but shall exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. This service is not available for homes or vehicles owned by providers. No services are to be implemented without prior approval from Regional Office administration.

Since the services community transition and environmental accessibility adaptations, may not be billed to Medicaid until the person has moved to the community, Regional Offices may reimburse providers through POS for these services. Once the person begins waiver services, the Regional Office may bill Medicaid as the waiver provider under Organized Health Care Delivery System (OHCD) provisions.

Providers may be reimbursed for administrative costs necessary to the transition process including but not limited to:

- Staff training;
- Staff assessing individuals at the habilitation center;
- Staff costs associated with housemates becoming acquainted with each other (ie. overnight or day visits).
- Registered Nurse consultation;
- Locating housing; and
- Other staffing related costs necessary to successfully transition an individual into the community.

When new residential services are developed, planned and implemented the usual administrative fee for the first month may be increased by an amount not to exceed \$1,500 to reflect provider administrative costs required to develop new services. This increase shall be added as a line item to the ISL budget, or written in as a separate item on the shared living budget for the first month of service. Future ISL and shared living budgets must reflect the provider's usual administrative fee within ISL and shared living guidelines. The combined cost for residential and reimbursement for increased administrative costs is not to exceed the cap for the daily rate of ISL or shared living arrangement for that initial month.

If an individual is moving to a group home in which there is an existing vacancy, an existing ISL or shared living home, transition administrative costs may be negotiated up to an amount, not to exceed \$500 for that person. Approved administrative costs reimbursed to group home service providers will be paid as "res hab transition" code T2016 TG, for the first month of service only.

These administrative transition expenses will only be reimbursed to the provider after the person moves into the residential setting as an active waiver participant. Actual provider administrative expenses must be documented in detail and submitted to the Regional Office during the first month of service. Documentation must include dates of service, specific administrative activity(ies), actual cost of each activity, names of staff members, total cost, etc. This cost accounting must be signed and dated by the provider.

Authority

Division of DD **Person Centered Planning Guidelines**

Division Directive 4.060 Individual Support Plan and Level of Care

Division Directive [4.170 - Discharge Planning Process - Habilitation Centers](#)

Division Directive [5.010 - Transfer Policy](#)

Federal Standards ICF-MR W201 483.440(b)(4)(i), W202 483.440(b)(4)(ii), W203 483.440(b)(5)(i), W204 483.440(b)(5)(i), and W205 483.440(b)(5)(ii)

HCW Waiver Manual (<http://dmh.mo.gov/dd/manuals/waivermanuals.htm>)

Targeted Case Management Technical Assistance Manual (<http://dmh.mo.gov/docs/dd/TCMTAManual.pdf>)