

Transition Protocols



TRAINING SESSION 2: HOW TO DEVELOP AN ACTION PLAN

**NOVEMBER 5, 2015
MINNESOTA DEPARTMENT OF HUMAN SERVICES**

Introductions

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- **Greetings and Introductions**
- **Marquita Ryan and Dee-Ana Farness and their agencies, involved in development of the implementation plan and tools**
- **Some in attendance today have used the tools; for many they are new**
- **We will review and re-introduce**
- **If you have questions during the webinar, please email them**

Implementation Goals

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- All Lead Agencies to develop and implement their own action plans (based on their unique situations) to ensure Transition Protocols are consistently followed in their case management processes
- Provide support to Lead Agency supervisors for plan development and execution via a mentor program
- Ensure there is training available to all regarding the Olmstead Plan, Transition Protocols and person-centered principles and practices
- Integrate these new best practices into current work; minimize additional “administrative work”
- Align the planning and implementation efforts with other related initiatives

Today's Objectives

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- Review Olmstead and Transition Services in Minnesota
- Review the file documentation checklist and “Status Survey and Action Plan”
- Identify other tools available to support the planning process
- Walk through how to develop an action plan using the tool
- Describe the process and mentor program that will support follow-through
- Identify and collect questions from Lead Agencies

Today's Agenda

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- **Transition Protocols- background/progress** 15 minutes
- **The Process** 15 minutes
 - File Review Documentation Checklist
 - Outreach, Transition Planning and Follow up Protocols
 - Transition Summary
- **Supervisor Status Survey and Action Plan** 10 minutes
- **Creating your Action Plan** 25 minutes
- **What Next? How to Follow Through** 10 minutes
- **Mentoring** 5 minutes
- **Questions and Next Steps** 10 minutes

Guiding Protocol Principles

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Olmstead guidance -

- Involvement of the individual and family
- Use of person-centered principles
- Expression of choice and quality of life
- Life options and alternatives
- Provision of adequate services in community settings

Overview: Transition Services in MN

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- **Broad changes encompass moving persons in segregated settings in MN to integrated settings of their choosing**
- **Supported by Transition Protocols, Moving Home Minnesota and other DHS initiatives**
- **Implementation work group has developed an approach and timeline for full implementation of the Transition Protocols across the State**
- **The plan builds on and is integrated with what counties and lead agencies have in place**

Olmstead Plan

Transition Services Work Plan

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Executive Sponsor: Jennifer DeCubellis (DHS)

Lead: Erin Sullivan Sutton (DHS), Anna Mc Lafferty (DOC)

GOAL ONE:

- By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings will be 7,138.

GOAL TWO:

- By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting will be reduced to 30% (based on daily average).

GOAL THREE:

- By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month.

GOAL FOUR:

- By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person centered planning process that adheres to transition protocols that meet the principles of person centered planning and informed choice.

Transition Protocols Implementation

- DHS facilitated workgroups to develop best practices
- TP Tools tested by support planners; refined based on feedback
 - TP file review documentation requirements checklist
 - Transition Summary
 - TP Guidelines and Resources Directory
- 150 supervisors at TP training Session on best practices (Aug. 1)
- ~45 supervisors completed the “Situational Readiness Survey”
- DHS received approval for the Olmstead Plan on September 29, 2015
- November 4th - Support Planning Professionals Learning Community launched a series of monthly training sessions

What's to Come

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- ~200- 250 “lead agency supervisors” may not have seen the webinar and have not completed the “Situational Readiness Survey/Action Plan”
- Monthly sessions by the Support Planning Professionals Learning Community
- Mentor Program meeting in December to explore integrating Transition protocols support with MnCHOICES mentor program
- DSD Case Management Lead on board November 2015
- Compliance audits will begin by June 2016

Implementation Approach and Timeline

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- **Supervisors complete Status Survey and develop Action Plans**
 - Lead Agencies may use survey information to develop consolidated action plans
 - DSD Case Management Lead available to review and assist with action plans
 - SPP Learning Community provides monthly training on key elements
 - DSD Case Management Lead will monitor and support progress to plans
- **Tools developed and available** **December 1, 2015**
- **Case Management Lead available as Mentor** **December, 2016**
 - Potentially augment with local mentorship program
- **Supervisor/Lead Agency Action Plans** **January 31, 2016**
- **First Audits** **June 2016**
 - Audit for Transition Protocols documentation in files beginning in March

Tools for Implementation

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For Assessors, Case Managers, Care Coordinators, Relocation Service Coordinators, Transition Coordinators and other planners:

- **Guidelines and Resources Directory**
- **File Review Documentation Checklist**
- **Transition Summary**

For Supervisors/Lead Agencies:

- **Status Survey and Action Plan(s)**

Guideline Notes and Resources Directory

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- **Case-level tool**
- **Available to help case managers understand expectations and apply Transition Protocols**
- **Not mandatory or auditable**
- **Can be used to apply the five Olmstead guiding principles in unique situations**
- **Living document – Expect assessors and planners to add individualized resource information over time**

Transition Protocols Guidelines, Notes and Resources Directory



Transition Protocols Guidelines, Notes and Resources Directory

This document is for Case Manager's personal Reference Only. There is no requirement that it be used or kept on file. It describes key elements required to ensure compliance with the Olmstead Plan's Transition Protocols. It addresses the three protocols for which case managers, assessors, care coordinators and other supports planners are responsible. A resources directory is also provided to help planners address barriers to implementing the transition protocols.

OUTREACH PROTOCOL

At every assessment/ reassessment/care coordination meeting, find out if the client is open to moving- not opposed to moving:	Is it happening?			If no, why not?	Resources and Plan to address	When will this be in place?
	Yes	No	N/A			
1. Confirm a person centered plan is in place.						
1. If no plan, initiate the process						
1. Review goals identified, progress toward goals and confirm /adjust based on client feedback						
1. Find out what their interests are and introduce to options: visits to their friends who have moved; show examples, use tools etc.						
Outreach after an initial transition has occurred:						
1. Once the person is stable in their new environment, begin planning for the next transition- based on their person-centered plan						
1. Identify strengths and barriers as they move forward						

Transition Protocols Guideline Tool



Transition Protocols Guidelines, Notes and Resources Directory

DIRECTORY OF POTENTIAL RESOURCES

TOPICS	TECHNIQUES	TOOLS/SAMPLES	TRAINING	MENTORS/EXPERTS	MY NOTES
Outreach	<ul style="list-style-type: none"> Knowing when someone is ready Right questions to learn about wishes/goals Identifying options Discussing Options 				
Person Centered Planning	<ul style="list-style-type: none"> Right level of planning 				
Housing					
Employment					
Transportation					
SITUATIONS	TECHNIQUES	TOOLS/SAMPLES	TRAINING	MENTORS/EXPERTS	MY NOTES
Family/Guardians not aligned with individual's wishes	<ul style="list-style-type: none"> In PCP the focus person can choose a representative or spokesperson who is not the guardian 	<ul style="list-style-type: none"> 			
No/wrong housing options available					
Funding challenges					

The "Directory of Potential Resources" is a living document. Initial topics and resources are a starting point for each planner, who can/will likely add to the directory, building their personal "go to" reference list.

As new training and tools become available, the "common" document will be updated and each planner can update their working reference tool accordingly.

File Review Documentation Checklist

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- **Individual-level tool to ensure and document appropriate application of Transition Protocols**
- **“Auditable”, it is to be retained in Lead Agency case file**
- **Review and update at every assessment or planning meeting with client**

Transition Protocols Documentation



Transition Planning File Review Documentation Requirements – Checklist for Case File

Client Name:

Planner:

County/Geographic Location:

Date Completed/Updated:

In compliance with the State of Minnesota’s Olmstead Plan, the following checklist reflects documentation required to be kept on file related to individuals who are living or working in segregated settings. This checklist should be completed a minimum of once a year during an annual review, or as warranted when an individual is actively planning for a move to a more integrated setting. It is to be kept by the Lead Agency in the individual’s case file.

There is no requirement to copy the items listed and keep them with this checklist. Simply note if and where they are kept. (Most of these items are documented as part of the MnCHOICES CSP, CSSP, ITP or Care Plan.

The last four columns need not be completed unless a listed item is not currently kept and needs to be obtained.

Required information	Do you have?			If yes, where is this documented or kept?	If no, who will document?	If no, where will it be documented or kept?	If no, when will this be completed?	Barriers/ Resources to providing the service or meeting the need(s)
	Yes	No	NA					
General Information 1a. Client name 1b. Physical address 1c. Mailing address 1d. Phone number 1e. PMI	Indicate whether you have this item documented and if it does not apply to this person’s case, choose N/a			Note where this information can be found: CSP, CSSP ITP, etc.	Since this documentation is required, identify who will document and where it will be kept. And by what date one can verify it is there			Note barriers to documentation- and action taken to overcome them
2. Diagnoses including co- occurring								
3a. County of residence								
3b. Contact name								
3c. Contact information								
4a. County of financial responsibility								
4b. Contact name								
4c. Contact information								
5a. Guardian/conservator								
5b. Name								
5c. Contact information								

Transition Summary

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- **Creation of the Transition Summary document is mandated by the Transition Protocols**
- **This document is auditable and to be completed in preparation for the actual move**
- **To be developed by the Lead Agency or RSC who is leading the coordination of the move and reviewed by all who have a role in facilitating the move**
- **Includes information about the move, the person who is moving and their supports**
- **Can be used by the person, their designated family member or friend, and service providers at the new location**

Transition Summary - Information

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Sample Transition Summary elements (Based on the PP7 language in the Transition Protocols)

Move plan for (Name Here _____):

I am moving (Day/Date/Time):

I am moving to Destination and Address:

Who will take me there (name/ relationship)?

What time should I be ready:

Who will meet me to get me set up at my new home/job (Name):

Date/Time:

How to contact them if needed:

When will my belongings arrive?

How/Date/Time:

Where to find/how to contact:

How will I get my medication:

Name/Location:

Who will check in on me after arrival to make sure I am ok there?

Name/Relationship:

Date/Time:

Where to find/how to contact:

List of Appointments (dates/times):

Doctors' Name(s):

Address/Directions:

Family/Friend Contact

Name:

Relationship:

Where to find/how to contact:

Follow Up Support Contact (Relocation Services Coordinator, Case Manager, etc.)

Name:

Title:

Phone:

Description of what is important to _____:

From PCP Dated: 9/1/2015

_____ wishes that her/his brother be involved in all discussions, decisions and happenings. It is important for _____ to know that her/his parents will also be involved as part of their legal responsibility.

Description of what _____ wants provider supports to know:

(Example: _____ prefers to talk face-to-face whenever possible versus using the phone.)

(Example: _____ is not walking well and needs extra support.)

_____’s favorite things:

Things that upset _____:

Description of _____’s preferred place to live:

Location Type:

Possible place:

Barriers to achieving this move:

Date:

Description of Barriers:

Timeline and Plan for overcoming barriers:

Person monitoring the plan (name/title/phone):

Description of elements of plan:

Transition Summary - Information

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Signatures as appropriate:

Client: Signature _____ Date: _____

Parent/Legal Guardian Signature _____ Date: _____

Current Provider Signature _____ Date: _____

New Provider Signature _____ Date: _____

Current Case Manager: Signature _____ Date: _____

New Case Manager: Signature _____ Date: _____

Relocation Services Coordinator Signature _____ Date: _____

People with "Move day" responsibilities:

Name: _____ Signature _____ Date: _____

Once Move is Complete

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- **Follow ups occur per the plan**
- **New case manager or care coordinator transition has occurred and is communicated (if applicable)**
- **Continue working the person's plan as their needs and/or wishes evolve – circles back to the “Outreach protocol”**

Supervisor's Role

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Developing a plan to
ensure your team is in
compliance with
Transition Protocols

How to Develop the Action Plan

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- **Complete the Supervisor Status Survey to identify:**
 - Gaps in compliance to the protocols
 - Summary-level needs across your team to support compliance
 - ✦ Training, capacity, etc.
- **Identify resources needed/available to support the needs of your team**
- **Develop Action Plan**
 - Mentor available to help by December
 - Consider working with colleagues to develop a Lead Agency plan
- **Submit Action Plan in to DSD Case Management Lead (Mentor) (Submitted by 1/31/2016)**
- **Mentor will review your plan and follow up with you to help you update and track progress**

Developing a plan- Examples

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File Review Documentation checklist

Required information	Currently expect this information to be documented?	If yes, where is this kept or documented?	If no, who could document?	If no, where could it be kept or documented?	If no, by when could this be completed?	Barriers to providing the documentation described
23a. Plan approval	Yes / No / NA					
23b. Plan non-approval	Yes / No / NA					
23c. If Disagreement:						
C1. List differing opinions	Yes / No / NA					
C2. Document names of those agreeing with each opinion	Yes / No / NA					
24. Signature page:	Yes / No					
24a. Client	Yes / No					
24b. County Case Manager	Yes / No / NA					
24c. Legal Representative	Yes / No / NA					
24d. Designated coordinator	Yes / No / NA					
24e. Family	Yes / No / NA					
24f. Others	Yes / No / NA					
25. Transition (move) Summary	No		Case Manager	Case File	March 1	
25a. Reviewed in final mtg.	No		Case Manager			
25b. Reviewed by those responsible for providing services in new setting	No		Case Manager			
25c. Copy provided client	No		Case Manager			See Transition Planning Protocol, ## 5 and 6 below for action plans

Developing a plan- Examples

OUTREACH PROTOCOL

PRINCIPLE: At <i>every</i> assessment/screening/ reassessment/care coordination meeting, find out if the client is open to (not opposed to) moving to a more integrated home or work setting:	Expected part of practice?		What % of team is doing this?	What are the barriers to 100% of team doing this?	If not 100% in place, are there currently plans to get these practices in place? (Describe) If no, develop and describe a plan to get them in place	When will this be in place?
	YES	NO				
1. Check to see if the person is open to moving to a more integrated home or work setting		No	100% @ 50% perf.*	1. Not familiar with person-centered planning 2. Don't ask because no time to follow thru on planning	1. Find out where can get training 2. Budget and schedule 3. Spot check mtg notes/observe 4. Review case load & address imbalance	Nov. 15 Dec. 1 Dec.15 + Dec. 30
1. Confirm a person centered plan is in place.						
1. If there is no plan, determine what level of assessment/planning makes sense and initiate the process;						

Developing a plan- Examples

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FOLLOW UP PROTOCOL

PRINCIPLE: Regularly follow up to ensure the plan is being followed and is working well for the client	Expected practice?		What % of team is doing this?	What are the barriers to 100% of team doing this?	If not 100% in place, are there currently plans to get these practices in place? (Describe) If no, develop and describe a plan to get them in place	When will this be in place?
	Yes	No				
1. Person responsible for following up with person moving is part of the planning team		No	30%	Plan is not fully developed	<ol style="list-style-type: none"> 1. Set expectation for Transition (Move) Summary to be reviewed by Sup. Before every move. (This requires role Identification/communication) 2. Identify barriers to completing the Transition Summary 3. Address those to ensure compliance 	Jan 1 Feb 1 March 1

Other Comments regarding status/implementation of Transition Outreach, Planning and/or Follow up Protocols with your team:

*All ask the question at annual assessment- not regularly ensuring they understand options or conversing about what their interests are. Not checking at every meeting.

Developing a plan- Examples

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SITUATIONAL READINESS SURVEY

Element:	What % of your team?	Barriers?	If no, or less than 100% of the team, what action could be taken to address this?	When could this be completed?	What resources could/would you need to leverage?
1. Are planners aware of the expectations to follow Transition Protocols as part of Olmstead Plan requirements?	0%	I need information regarding what is expected	<ol style="list-style-type: none"> 1. Supv. Get copies of Transition Protocols; 2. Get/share SPP LC session 3. Walk through tools with Team 	<ol style="list-style-type: none"> 1. February 5 1. Nov. 15 1. Nov. 15 	<ol style="list-style-type: none"> 1. TP Mentor for info. 2. Share during monthly team meeting.

Developing a plan- Key Steps

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- Set time to do the Action Planning process
- Complete or update the Status Survey and clearly identify barriers to 100% compliance
- Compare with colleagues to identify common barriers and determine whether individual or group action plans make sense
- Identify action steps and estimate timing
- Check on resource availability and adjust steps and/or time
- Send questions and draft plans in to DSD Case Management Lead
- Once steps and times are confirmed, Send copy to Case Management Lead who will monitor progress and provide support

Next Steps



- **TOOLS EMAILED AFTER THIS PRESENTATION**
- **CASE MANAGEMENT LEAD AVAILABLE DECEMBER 1**
- **CONTINUE TO DEVELOP RESOURCES GUIDE**
 - Where to go for Training on Topics
 - Where to go to learn techniques in various situations
 - Roles and Responsibilities Guide to be developed

**ATTEND SUPPORT PLANNING PROFESSIONAL
LEARNING COMMUNITY EVENTS- NEXT ONE
DECEMBER 16**

Next Steps



QUESTIONS

Meeting Wrap

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Thank You !