

**Living Choice Project  
Transition Coordination  
Standards**

**May 2009**

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# Introduction

The following Transition Coordination Standards are applicable to funds administered by the Oklahoma Health Care Authority for the Living Choice Project.

## Living Choice Project Transition Coordination / Case Management Standards

The Institute of Medicine (1992) defines practice guidelines as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for special clinical circumstances.”

Guidelines refer to general objectives or principles for action, rather than identify how specific performance or procedures are related to specific Participant outcome.

They are generally broadly stated, and, because they are not established on the basis of empirical research, do not include criteria for measurement, and do not include any projects of health benefits or harmful consequences.

Living Choice Project Transition Coordination / Case Management Standards are:

- A set of parameters used to determine what is acceptable.
- A level of expectations designed to bring out the best.
- A realistic, consistent guideline set to help attain goals.
- A set of expectations.
- An adaptable goal set at a challenging, but achievable, level in which a framework can be developed to assist in reaching that goal.
- A guideline used to measure accomplishments and levels of ability to encourage progress.
- A guideline to an acceptable performance level.

The standards are minimal and intended to provide administrative and programmatic direction on Living Choice Project Transition Coordination / Case Management service delivery specification and timelines.

Service provider agencies are required, at a minimum, to incorporate the following programmatic standards and components into their agency policies and procedures.

When a timeline has been specifically designated, it is a timeline that must be incorporated within the agency policies and procedures.

# **Transition Coordination / Case Management Philosophy**

The Commission for Case Management Certification (CCM) defines Case Management (Transition Coordination in the Living Choice Project) as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the Participant's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

Transition Coordination is an area of specialty practice within one's health and human service profession. Its underlying premise is that everyone benefits when Participants reach their optimum level of wellness, self-management, and functional capability including the Participants being served, their support systems, the health care delivery system, and the various payer sources.

Transition Coordination facilitates the achievement of Participant wellness and autonomy through advocacy, assessment, planning, communication, education, resource management, and service facilitation. Based on the needs and values of the Participant, and in collaboration with all service providers, the Transition Coordinator / Case Manager links Participants with appropriate providers and resources throughout the continuum of health and human services and care settings, while ensuring that the care provided is safe, effective, Participant-centered, timely, efficient and equitable. This approach achieves optimum value and desirable outcomes for all—the Participant, their support systems, the providers and the payers.

The Living Choice Project Transition Coordinator works within the following principles to meet the needs and desires of the Participants served:

- Each Participant has the capacity for growth and development.
- Each Participant should have access to services and opportunities that enhance his or her development, autonomy, independence, productivity, well-being, and capacity for social interaction with others.
- Each Participant should have access to his or her preference of the least restrictive cultural, social and physical environments.
- Each Participant's services should be provided, as far as possible, in settings that are integrated into the community and promote interaction with family, friends, and other persons.
- Each Participant's services are delivered in accordance with a single Participant plan that is developed, monitored, coordinated, and revised by members of a care planning team, of which the Participant (and/or his or her designee(s) or legal representative, as appropriate) is a participant.

Philosophically, the Living Choice Project is designed to support, not replace, family or other informal support or assistance, and to aid and enhance the family or caregiver's ability to provide care for a person.

# Transition Coordination Standards Summary

**Standard 1 Participant Orientation and Education Page 6**

Transition Coordinators provide an orientation of the Living Choice Project philosophy and purpose to the potential Participant. They also educate the potential Participant on their rights and responsibilities associated with the Living Choice Project.

**Standard 2 Participant Assessment Page 9**

Transition Coordination requires a comprehensive, systematic and standardized assessment of the Participant's functional and cognitive capacity and limitations, and other needs, strengths, abilities and resources. Transition Coordinators draw on their experience, expertise, observations and judgment to analyze and synthesize the information obtained in the assessment to determine a Participant's needs for services, supports and resources.

**Standard 3 Transition Planning Process Page 12**

Transition Coordination requires that the Participant be an active member in the planning process, meeting their desired preferences, needs and desires.

**Standard 4 Community Plan Development and Submission Page 14**

Transition Coordination requires a community plan for each Participant. The community plan is based on the findings from the Participant's comprehensive assessment, reflects the Participant's values and preferences, including a written list of problem-oriented goals which describes services from paid and unpaid sources.

**Standard 5 Community Plan Implementation and Monitoring Page 20**

Transition Coordination requires a community plan be implemented and that the Participant receives all services on the Community Plan.

**Standard 6 Community Plan Addendum Development and Submission Page 23**

Transition Coordination requires a community plan addendum be submitted each time there is a change in service or the Participant has a major life change.

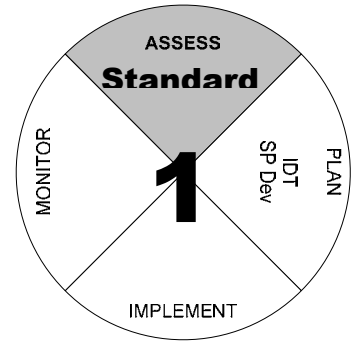
**Standard 7 Change in Participant Transition Coordinator or Home Care Provider Page 25**

Transition Coordinators are required to submit documentation to the Administrative Agent of any request for Transition Coordination / Case Management or Provider changes.

**Standard 8 Change in Participant Event Page 27**

Transition Coordinators are required to inform the Administrative Agent when a Participant has had an event change that may or may not affect the status of their Living Choice Project services.

# Standard 1: Participant Orientation and Education



## Expected Outcomes

Participants receive support to exercise their rights and in accepting personal responsibilities.

Information and support is available to assist Participants to freely choose among qualified providers.

Participants are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.

Participants receive training and support to exercise and maintain their own decision-making authority.

Participants are informed of and supported to freely exercise their Medicaid due process rights.

Participants are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.

## Transition Coordinator Performance Expectations

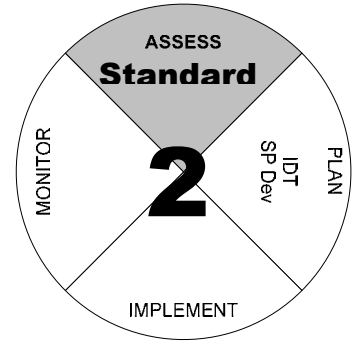
- A.** The Transition Coordinator receives an Initial Transition Planning Authorization (LCP3) from the Transition Coordinator Supervisor to contact the potential Participant to arrange for an orientation to the Living Choice Project.
- B.** The Transition Coordinator provides the Participant with an initial orientation to the Provider Agency and the Living Choice Project in a written, oral, audio or electronic media compatible with the Participant’s desired form and/or communication abilities.

- C.** The Transition Coordinator reviews the orientation packet with the Participant including, but not limited to the following:
- 1)** Participant Assurances, including due process rights and constitutional, federal and state statutory rights
  - 2)** Abuse, neglect and exploitation investigation and how to report any such incidents
  - 3)** Provider's grievance process and procedure
  - 4)** Provider's emergency contact information
  - 5)** Living Choice Project Careline at 1- 866-230-5276
  - 6)** OKHCA Complaint/Grievance, form LD-1
  - 7)** Request for a Fair Hearing, OKHCA form LD-1
  - 8)** Education materials related to health and safety procedures
  - 9)** Rights and Responsibilities, including rights to freely choose providers
  - 10)** Nursing Facility Resident Rights, as related to transition
  - 11)** Provider contact information
- D.** The Transition Coordinator explains the Living Choice Project philosophy, purpose and services.
- E.** The Transition Coordinator verifies Participant's decision to participate or not to participate in the Living Choice Project by obtaining a signed statement of Participant Consents and Rights (LCP1). If the Participant chooses to participate, a Release of Information (LCP5) is also completed and signed.
- F.** The Transition Coordinator verifies the Participant's understanding by obtaining the provider's signed statement of Participant Orientation and Understanding.
- G.** The Transition Coordinator supports the Participant in choosing transition team members.
- H.** The Transition Coordinator discusses the benefit of a nursing facility medical chart review.
- I.** The Transition Coordinator requests permission to invite the nursing facility RN and the Home Care Provider/LTCA RN to participate in the nursing

facility medical chart review and other associated activities.

- J.** Prior to discharge from the nursing facility, the Transition Coordinator educates the Participant in identification of critical incidents and how to notify the transition coordinator in the event of a critical incident.
- K.** The Transition Coordinator documents all contacts and meetings with or on behalf of the Participant.

# Standard 2: Participant Assessment



## Expected Outcome

Comprehensive information concerning each Participant’s preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan.

Participant is supported in identifying risk and safety considerations that may need to be addressed.

The safety and security of the Participant’s living arrangement is assessed and risk factors are identified.

## Transition Coordinator Performance Expectations

- A.** The Transition Coordinator conducts a comprehensive assessment, using multiple tools annually or at major life change occurrences, for each Living Choice Project Participant according to the following schedule:

<b>Tool/Document</b>	<b>Responsible Party</b>	<b>Timeline/Action</b>
<i><b>NURSING FACILITY</b></i>		
<b>NF Chart Review</b>	LTCA RN, Participant and the Transition Coordinator reviews nursing facility medical chart in collaboration with nursing facility RN to obtain information relevant to transition to community.	Prior to the Transition Assessment Meeting
<b>RN Assessment (LCP6)</b>	<b>Home Care Provider/LTCA RN</b> RN Assessment assesses current health and welfare	Can be initiated prior to Transition Assessment Meeting with information from chart review
<b>Transition Assessment Tool (LCP23)</b>	<b>Transition Coordination Provider</b> Gathers comprehensive information concerning a Participant to facilitate transition to community	Within 5 business days of initial meeting
<b>Geriatric Depression Scale</b>	<b>Transition Coordination Provider</b> Administers to Participants who are age 65 years and older or who will be 65 within 6 months	Completed along with Transition Assessment Tool

<b>Initial UCAT</b>	<b>Transition Coordination Provider</b> Verifies program appropriateness and develops 1st year Community Plan with team	Prior to development of the Community plan and Participant's transition to the community.
<b>Optional Assessment Tools (such as the Nutritional Health Self Assessment )</b>	Determined by Tool	As necessary
<b>Update UCAT</b>	<b>Transition Coordination Provider</b> Changes in Services or Major Life Change	As necessary
<b>COMMUNITY</b>		
<b>UCAT</b>	<b>Transition Coordination/ Case Management Provider</b> Verifies program appropriateness and develops 1st year Community Plan with team	Prior to development of the Community Plan
<b>RN Assessment (LCP6)</b>	<b>Home Care Provider/LTCA RN</b> RN Assessment assesses current health and welfare	Prior to development of the Community Plan
<b>Update UCAT</b>	<b>Transition Coordination Provider</b> Changes in Services or Major Life Change	As necessary
<b>ANNUALLY</b>		
<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

**B.** Throughout the year the Transition Coordinator updates or completes a new UCAT, continually assessing in response to a major life change or as needed to reflect current status.

**C.** The Transition Coordinator assures:

- 1)** The Participant, Transition Coordinator and the Home Care Provider/LTCA RN with collaboration from the nursing facility RN, complete the Participant's nursing facility medical chart review prior to the Transition Assessment meeting.
- 2)** The Home Care Provider/LTCA RN completes the initial RN Assessment prior to development of the Community Plan, conducts a new RN Assessment in conjunction with annual Plan development, updates or completes a new RN Assessment if needed in response to changes in the Participant's health status, and includes health and welfare, functional services, medication and disease management recommendations.

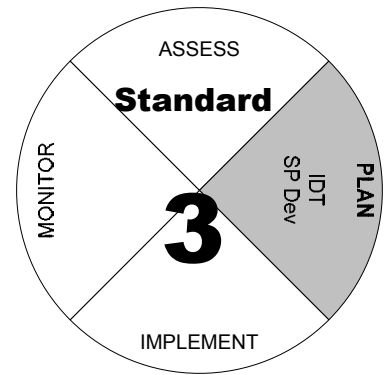
**D.** The Transition Coordinator facilitates with the Participant and team to:

- 1)** identify and assess health and welfare including risk and safety

considerations.

- 2)** assess Participant's needs, abilities, resources and supports.
  - 3)** identify his or her preferences and personal goals.
- E.** The Transition Coordinator documents all contacts and meetings with or on behalf of the Participant.
- F.** Within two business days of completing the Transition assessment tool (LCP23) the Transition Coordinator submits to Program Administration the following documents:
- 1)** Transition Assessment Tool (LCP 23)
  - 2)** Release of Information (LCP5)
  - 3)** Participant Consents and Rights (LCP1)
- G.** If program appropriateness issues are identified or if the Participant declines any part of the assessment process, the Transition Coordinator documents the Participant's response, consults with the Transition Supervisor who can contact TA if needed.

# Standard 3: Transition Planning Process



## Expected Outcomes

Services and supports are planned and effectively implemented in accordance with each Participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.

Information and support is available to help Participants make informed choices among service options.

Medications are managed effectively and appropriately.

The service planning process effectively supports Participants of diverse cultural and ethnic backgrounds.

Participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with the informed involvement of the Participant.

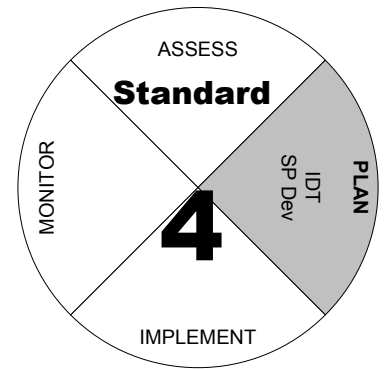
The safety and security of the Participant’s living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.

## Transition Coordination Performance Expectations

- A.** The Transition Coordinator utilizes and maintains linkages (formal and informal) with resources and agencies that can enhance or contribute to meeting the Participant’s needs, preferences and goals.
- B.** The Transition Coordinator obtains accurate, current and comprehensive information and is responsible for providing information to the Participant to assure informed choice.
- C.** The Transition Coordinator assures the team supports the Participant’s cultural and ethnic practices and preferences.

- D.** The Transition Coordinator supports the Participant in:
- 1)** selecting members for the Transition Planning Team for the purpose of developing the transition plan using the Transition Planning Tool (LCP24).
  - 2)** meeting with the transition team to complete the Transition Planning Tool (LCP24).
  - 3)** reviewing the Transition Planning Tool when it is complete.
  - 4)** obtaining the Participant's signature on the agreed upon Transition Planning Tool (LCP24).
  - 5)** assuring that the services outlined in the Transition Planning Tool are implemented as directed by the Participant.
  - 6)** scheduling on-going meetings as needed to revise and implement the Transition Planning Tool
  - 7)** informing all Transition Planning Team members that they may call a meeting whenever the Participant experiences a major life change or when needed.
- E.** The Transition Coordinator facilitates all transition activities on the actual date of transition to assure that all services are in place as needed to meet the Participants expressed preferences, decisions and health and welfare.
- F.** The Transition Coordinator obtains the Participant's permission (or the legal representative, when applicable) to share assessment and transition planning information with specified team members on the Release of Information (LCP5).
- G.** The Transition Coordinator documents all contact and meetings with or on behalf of the Participant.

# Standard 4: Community Plan (Service Plan) Development and Submission



## Expected Outcomes

Services and supports are planned and effectively implemented in accordance with each Participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

Each Participant's plan comprehensively addresses his or her identified need for Home and Community Based Services, health care and other services in accordance with his or her expressed personal preferences and goals.

Information and support is available to help Participants make informed choices among service options.

Medications are managed effectively and appropriately.

The service planning process effectively supports Participants of diverse cultural and ethnic backgrounds.

There are safeguards in place to protect and support Participants in the event of natural disasters or other public emergencies.

Participants have the authority and are supported to direct and manage their own services to the extent they wish.

Participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with the informed involvement of the Participant.

The safety and security of the Participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.

## **Transition Coordinator Performance Expectations**

### **Community Planning**

- A.** The Transition Coordinator supports the Participant in selecting members for the Interdisciplinary Team (IDT) for the purpose of developing a Community Plan.
- B.** The Transition Coordinator assures that the Provider/LTCA RN has received a copy of the UCAT, the Geriatric Depression scale and other relevant assessment information prior to the Community Planning IDT meeting.
- C.** Once the transition date has been determined, the Transition Coordinator, with support of the Participant, arranges for the Home Care Provider/LTCA RN to complete the initial RN Assessment, if it has not previously been completed
- D.** The Transition Coordinator obtains the Provider/LTCA RN Assessment (LCP6) prior to Community planning IDT meeting.
- E.** The Transition Coordinator reviews the UCAT, RN Assessment (LCP6) and other assessment information to identify possible Participant needs.
- F.** The Transition Coordinator convenes the initial IDT meeting, composed of, at a minimum, the Participant, and/or legal representative, Transition Coordinator, and the Provider/LTCA RN.
- G.** The Transition Coordinator informs all Transition Planning Team members that they may call a meeting whenever the Participant experiences a major life change or when needed.
- H.** The Transition Coordinator facilitates the IDT members through the planning process to reach consensus on goals, outcomes and action steps.
- I.** The Transition Coordinator submits necessary documentation for approval of spouse or legal guardian to be the paid caregiver when applicable.
- J.** The Transition Coordinator facilitates development of medication

management outcome and action steps.

- K.** The Transition Coordinator facilitates development of disease management outcomes and action steps.
- L.** On the day of transition, the Transition Coordinator facilitates an IDT and includes if applicable, the Home Care Provider RN, Community Transition Coordinator (if different than current Transition Coordinator) and any other team members the Participant requests. This IDT may be conducted prior to moving day if the Provider RN agrees.

### **Community Plan Development and Submission**

- A.** The Transition Coordinator utilizes and maintains linkages (formal and/or informal) with resources and agencies that can enhance or contribute to meeting the Participants needs, preferences and goals.
- B.** The Transition Coordinator obtains accurate, current and comprehensive information and is responsible for providing information to the Participant to assure informed choice.
- C.** The Transition Coordinator assures that the team supports the Participant's cultural and ethnic practices and preferences.
- D.** The Transition Coordinator completes a risk assessment with the Participant by completing the Risk Analysis and Planning Tool (LCP27) that includes the following:
  - 1)** Health/Medical/Nutrition
  - 2)** Safety/ADL's
  - 3)** Behavioral/Lifestyle Issues
  - 4)** Medications
  - 5)** Family Home/Caretaker
  - 6)** Living Environment
- E.** The Transition Coordinator assures that the Community Plan goals, outcomes and action steps correspond to the Participant's expressed preferences, decisions and abilities identified in the UCAT, RN Assessment (LCP6), Risk

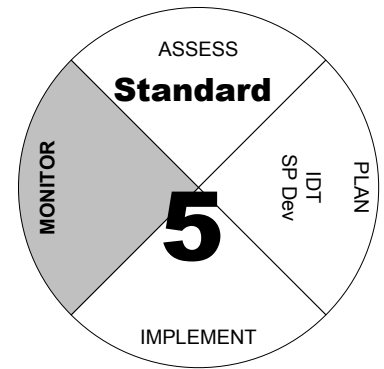
Analysis and Planning Tool (LCP27) and other assessment information.

- F.** The Team assists the Participant in writing a long term goal relative to how the Participant describes his/her quality of life and personal goals for a period of three to five years.
- G.** The Transition Coordinator collaborates with the Participant and team to write anticipated outcomes relative to the long-term goal that are achievable and measurable.
- H.** The Transition Coordinator collaborates with the Participant and team to write each action step specific to achieve each outcome, within the time frame of the outcome. The Transition Coordinator specifies the frequency of each action step and clearly states who is responsible for each task, including the Participant, family, friends and community members as applicable.
- I.** The Transition Coordinator collaborates with the Participant and team to writes outcomes, action steps and monitoring activities. Areas may include the following:
  - 1)** Physical and Mental Health
  - 2)** Daily Living Personal Assistance and Assistive Technology
  - 3)** Transportation
  - 4)** Social – Faith – Recreation
  - 5)** Self-Determination and Advocacy
  - 6)** Housing
  - 7)** Employment – Volunteering
  - 8)** Financial
- J.** The Transition Coordinator completes the Back Up Plan (LCP25) with the Participant that addresses the following:
  - 1)** Direct Care Assistance
  - 2)** Critical Health – Supportive Services
  - 3)** Equipment Maintenance Options
  - 4)** Transportation
  - 5)** Unpaid Provider of Critical Services

- K.** The Transition Coordinator and Participant revise the Community Plan as necessary.
- L.** After the Participant or legal representative reviews and approves the Community Plan (LCP6e), the Transition Coordinator completes the Plan Authorization Request Packet (LCP6f) and submits the Community plan to the Transition Coordinator Supervisor for final approval, including:
- 1)** Plan Authorization Request Packet Checklist (LCP6f)
  - 2)** Copy of signed Community Plan (LCP6e)
  - 3)** Copy of the RN Assessment (LCP6)
  - 4)** Copy of the Geriatric Depression Scale
  - 5)** Copy of the Back up Plan (LCP25)
  - 6)** Copy of the Release of Information (LCP5)
  - 7)** Other documentation when necessary, such as:
    - Environmental Modification (EM) Decision Tool (LCP6d1) and supporting documentation;
    - Nutritional Supplement Request Form (LCP6a1b);
    - PERS Request Form (LCP6e3)
    - Grab Bar Request Form (LCP6e2)
    - Risk Analysis and Planning Tool (LCP27);
    - Any additional documentation requested for service authorization.
- M.** The Administrative Agent sends an electronic copy of the Authorized Plan (LCP6g) to the Transition Coordinator, and an electronic copy of the Authorized Plan for Single Provider (LCP6g-SP) to all other authorized Providers listed on the Plan. The Transition Coordinator confirms the other Providers received their plan authorization.
- N.** The Transition Coordinator assures the home care provider receives a copy of the Community plan (LCP6e).
- O.** The Transition Coordinator distributes a copy of the Community Plan (LCP6e) and Authorized Plan (LCP6g) to the Participant and/or Legal Representative.
- P.** The Transition Coordinator assists the Participant in completing a disaster preparedness plan that at a minimum includes:

- 1)** a designated safe place to go in case of home evacuation;
  - 2)** an accessible, current list of emergency contact numbers;
  - 3)** a fire evacuation plan;
  - 4)** a designated safe place within the Participants home that is equipped with emergency equipment/supplies necessary for sheltering in place.
- Q.** If program appropriateness issues are identified in the IDT meeting or the Participant declines any part of the Community Plan development process, the Transition Coordinator collaborates with the Transition Coordination Supervisor.
- R.** The Transition Coordinator documents all contact and meetings with or on behalf of the Participant.

# Standard 5: Community Plan Implementation and Monitoring



## Expected Outcomes

Services and supports are effectively implemented in accordance with each Participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.

Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

Participants are satisfied with their services and achieve desired outcomes.

Services are furnished in accordance with the Participant’s plan.

Services and supports lead to positive outcomes for each Participant.

Regular, systematic and objective methods—including obtaining the Participant’s feedback—are used to monitor the Participant’s well being, health status, and the effectiveness of HCBS in enabling the Participant to achieve his or her personal goals.

Medications are managed effectively and appropriately.

Participants and the Participant’s family members, as appropriate, express satisfaction with their services and supports.

## Transition Coordinator Performance Expectations

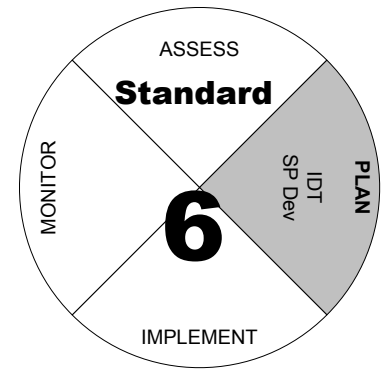
**A.** At a minimum, the Transition Coordinator conducts monitoring contacts to assure Participant’s well being and health status, and assesses the effectiveness of HCBS in supporting the Participant in achieving his or her personal goals.

**1)** The Transition Coordinator uses the outcomes and action steps recorded on the Participant's Community Plan (LCP6e) to monitor:

- 2)** Delivery of services as authorized on the Plan Authorization (LCP6g),
  - 3)** Adequacy of services to meet the Participant's needs/goals,
  - 4)** Participant satisfaction with each service provided,
  - 5)** Measures of progress toward, or achievement of, anticipated outcomes, and
  - 6)** Participant health and welfare.
- B.** The Transition Coordinator evaluates implementation, adequacy, and progress toward outcomes detailed in Community Plan (LCP6e). If any service identified on the Authorized Plan has not been implemented as planned, the Transition Coordinator immediately consults with the provider or person responsible for the service to determine and resolve the reason(s) for delay.
- C.** During all monitoring activities, the Transition Coordinator continues to assess for program appropriateness and the health and welfare of Participant.
- D.** The Transition Coordinator submits documentation, at least quarterly, of expenditures and the health, safety and welfare of Participants whose spouse is the paid caregiver.
- E.** The Transition Coordinator documents all contacts and meetings with or on behalf of the Participant.

<b>Minimum Transition Coordination Monitoring Standards</b>	
<b>Type of Monitoring</b>	<b>Purpose</b>
Day of transition to community and week of transition to community (for those coming out of a Nursing Facility)	Monitor to assure all services are in place as needed to meet the Participants expressed preferences, decisions and health and welfare.
5 days after any service implementation	Monitor transition into implementation and determine if an interim health and welfare plan needs to be developed by team.
30 calendar days after Service Plan or Service Plan Addendum implementation	Monitor transition into implementation and determine if an interim health and welfare plan needs to be developed by team.
Monthly  Can be conducted by phone only if the Participant demonstrates cognitive and communication ability to provide valid information	Monitor health and welfare, progress toward Community Plan goals and outcomes, Participant satisfaction, and identification of any major life changes.
Minimum Quarterly Home Visit	At a minimum, a quarterly Face-to-Face visit occurs with the Participant to monitor health and welfare, progress toward Community Plan goals and outcomes, Participant's satisfaction with services, and identification of any major life changes.
Minimum Monthly Home Visit (With family as paid caregiver)	At a minimum, a monthly home visit occurs when a Participant's family member, spouse or legal guardian serve as paid caregiver. The Transition Coordinator provides additional personal care attendant oversight and monitoring of Participant's health and welfare; Participant's satisfaction with services, and identification of any major life changes.
Minimum Weekly Telephone Visit (when unstaffed)	At a minimum, a weekly telephone visit occurs when a Participant is unstaffed for personal care services. Transition Coordinator contacts the Participant and Home Care Provider weekly to provide increased monitoring of Participant's health and welfare, major life changes, possible need to change providers; and to monitor the recruiting activities of the Provider to determine when and if a change of Provider is indicated.  Weekly phone call monitoring occurs until all personal care hours are fully staffed.

# Standard 6: Community Plan Addendum Development and Submission



## Expected Outcome

Services and supports are planned and effectively implemented in accordance with each Participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.

Significant changes in the Participant’s needs or circumstances promptly trigger consideration of modification to his / her plan.

## Transition Coordinator Performance Expectations

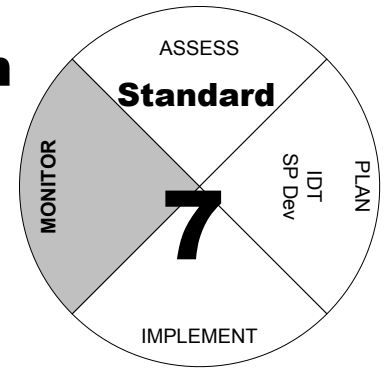
- A.** The Transition Coordinator and team revise the Community Plan (LCP6e) in response to changes in the Participant’s needs and/or resources.
  - 1)** The Participant, Transition Coordinator or team members identify service needs and modifications necessary to support the Participant’s health, welfare and quality of life.
- B.** The Transition Coordinator assures that the outcomes, actions steps and monitoring activities detailed in the Community Plan Addendum (LCP6e1) correspond to the Participant’s identified needs in the existing Community Plan.
- C.** The Transition Coordinator submits the Community Plan Addendum (LCP6e1) within ten business days of identifying the need for change.
- D.** The Transition Coordinator may temporarily submit the Community Plan Addendum (LCP6e1) without the Participant’s signature to add or increase an immediate service.
  - 1.** The Transition Coordinator provides written justification for submitting the Community Plan Addendum without the Participant’s signature.

- 2.** The Transition Coordinator schedules a home visit prior to or no later than the quarterly visit to obtain the Participant or legal representative's signature on the Community Plan Addendum (LCP6e1).
- E.** When the Participant's or legal representative's approval is given on the Community Plan Addendum (LCP6e1), the Transition Coordinator completes the Community Plan Authorization Request Checklist (LCP6f) and submits the Packet to the Transition Coordination Supervisor. The supervisor approves and the provider agency sends the following to the Administrative Agent for authorization:
- 1.** Community Plan Authorization Request Checklist (LCP6f);
  - 2.** Copy of signed Community Plan Addendum (LCP6e1);
  - 3.** Other documentation when necessary, such as:
    - a.** Environmental Modification (EM) Decision Tool (LCP6d1) and supporting documentation,
    - b.** Nutritional Supplement Request Form (LCP6a1b)
    - c.** PERS Request Form (LCP6e3)
    - d.** Grab Bar Request Form (LCP6e2)
    - e.** Updated or new UCAT (if applicable)
    - f.** Updated Copy of Back Up Plan (LCP25)
    - g.** Risk analysis and planning tool (LCP27)
    - h.** Release of Information (LCP5) (if applicable)
    - i.** RN Assessment (LCP6) (if applicable) and
    - j.** Any additional documentation requested for service authorization.
- F.** The Administrative Agent sends an electronic copy of the Authorized Plan (LCP6g) to the Transition Coordinator, and an electronic copy of the Authorized Plan for Single Provider (LCP6g-SP), to all other authorized Providers listed on the Plan. The Transition Coordinator confirms the other Providers received their plan authorization.
- G.** The Transition Coordinator assures the home care provider receives a copy of the Community plan (LCP6e).
- H.** The Transition Coordinator distributes a copy of the Community Plan (LCP6e) and Authorized Plan (LCP6g) to the Participant and/or the Legal

Representative.

- I.** The Transition Coordinator documents all contacts and meetings with or on behalf of the Participant.

# Standard 7: Change in Transition Coordinator or Home Care Provider



## Expected Outcomes

Services and supports are planned and effectively implemented in accordance with each Participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.

Significant changes in the Participant’s needs or circumstances promptly trigger consideration of modification to his or her plan.

Information and support is available to assist Participants to freely choose among qualified providers.

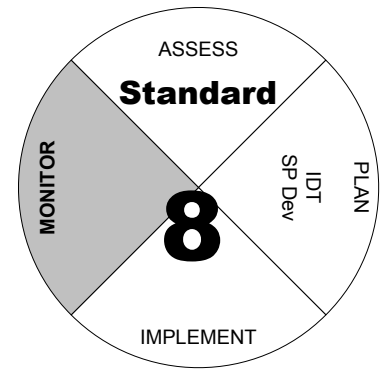
## Transition Coordinator Performance Expectations

- A.** When a Participant is transferred from one Transition Coordinator to another within the same agency, the agency:
  - 1.** Notifies the Administrative Agent of Transition Coordinator changes using the Provider Communication (LCP9) form.
  - 2.** Convenes a meeting of the current and new Transition Coordinator prior to reassignment to plan transfer activities. When possible, the current Transition Coordinator introduces the new Transition Coordinator to the Participant.
  
- B.** When a Participant requests a change of Transition Coordination provider, the Transition Coordinator notifies the selected Provider Agency to coordinate transfer.
  - 1.** The Transition Coordinator educates the Participant regarding available Transition Coordination providers and documents Participant’s choice of Transition Coordination provider by obtaining the Participant’s or

legal representative's signature on the Participant Change of Provider (LCP10) form, and sends the LCP10 to the new Transition Coordination Provider Agency.

- 2.** The Transition Coordinator contacts the new Transition Coordinator to collaborate and assure continuity of Participant services.
  - 3.** If the Participant has not transitioned, the Transition Coordinator completes and submits a signed Change of Provider form (LCP 10) to the new Transition Coordinator. The new Transition Coordinator submits a copy of the signed Participant Change of Provider (LCP10) to the Administrative Agent for authorization.
  - 4.** If the Participant has transitioned, the new Transition Coordinator completes the Community Plan Addendum (LCP6e1), and obtains the Participant's signature or legal representative signature, and submits along with the copy of the signed Participant Change of Provider (LCP10) to the Administrative Agent for authorization.
- C.** When a Participant requests a change of home care provider the Transition Coordinator notifies the selected Provider Agency to coordinate the transfer.
- 1.** The Transition Coordinator educates the Participant regarding available home care providers and documents Participant's choice of home care provider by obtaining the Participant or legal representative's signature on the Participant Change of Provider (LCP10) form and submits to the Administrative Agent.
  - 2.** The Transition Coordinator contacts the new home care provider to collaborate to assure continuity of Participant services.
  - 3.** The Transition Coordinator coordinates completion of new RN Assessment.
  - 4.** The Transition Coordinator assures that the previous home care provider agency is notified of the end date prior to actual transfer to new provider.
  - 5.** Submits to Administrative Agent.
- D.** The Transition Coordinator documents all contacts and meetings with or on behalf of the Participant.

# Standard 8: Change in Participant Event



## Expected Outcome

Services and supports are planned and effectively implemented in accordance with each Participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.

Information and support is available to help Participants make informed selections among service options.

Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.

## Transition Coordination Performance Expectations

An event is defined as any change in Participant’s status, including: a temporary stop of services, voluntary withdrawal and/or closure.

- A.** Immediately upon notification, by the Participant or Participant’s family, of the change in events, the Transition Coordinator temporarily stops Living Choice Project services. The Transition Coordinator immediately notifies the Living Choice Project and all current service providers, via the Provider Communication (LCP9), under the following circumstances:
  - 1.** The Participant has been hospitalized or admitted for temporary nursing facility services.
  - 2.** The Participant is on vacation, therapeutic leave, or will be temporarily out of the service area.
  - 3.** Or other reasons that are Participant driven or health and welfare related.
  
- B.** When HCBS services are to resume, the Transition Coordinator sends a

Provider Communication (LCP9) to notify all suspended service providers and the Administrative Agent that services are being resumed.

- C.** The Transition Coordinator plans with the Participant and team for the resumption of all Plan services as appropriate to the situation.
- D.** If the Participant wishes to voluntarily withdraw from the Living Choice Project, the Transition Coordinator completes a Voluntary Withdrawal form (LCP2). If the Participant wishes to voluntarily withdraw, but refuses to sign the LCP2, the Transition Coordinator submits an LCP2 to the Administrative Agent. Supporting documentation must be submitted with an LCP2 without the Participants signature.
- E.** The Transition Coordinator completes and submits a Living Choice Project Discharge Summary (LCP15) within 5 days of notification of a Participant's death, permanent nursing facility placement, placement in another type of institution or out of state residence.
- F.** In the event that the Transition Coordinator is unable to locate the Participant, the Transition Coordinator submits a completed Living Choice Project Discharge Summary (LCP15) with supporting documentation indicating contact attempts.
- G.** The Transition Coordinator immediately notifies all Living Choice Project authorized service providers of Participants discharge from the Living Choice Project.
- H.** If it is questioned that the Participant does not meet program appropriateness or level of care at any time during the plan year, the Transition Coordination Supervisor notifies the Living Choice Project Contract Administration Department for consultation.
- I.** The Transition Coordinator follows the critical incident reporting requirements established by the Living Choice Project.
- J.** The Transition Coordinator documents all contacts and meetings with or on behalf of the Participant.