Recommendations of the Arkansas Health Reform Legislative Task Force Committee on Human Development Centers
October 2016

Introductory Note

This report outlines recommendations related to the Human Development Centers (HDCs) operated by the Arkansas Division of Developmental Disabilities Services (DDS), a division of the Department of Human Services (DHS). The Committee heard testimony over the last several months from DHS and its staff who administers the care and support and maintain the HDC facilities across the state, the families of loved ones who are cared for in HDCs, and community providers and interested stakeholders, as well as visiting and touring the grounds of two HDCs. Additionally, the Committee received thorough research from our consultant The Stephen Group.

After its thorough review of all the information and testimony, as well as our own independent evaluation, the Committee first wants to recognize the fact that there was never an issue raised about the current quality of care in the HDCs. In fact, we heard and observed overwhelming evidence of high quality of care in all HDC facilities in Arkansas and for that reason, Arkansas should be proud of its state. When we looked at other states that have had issues with similar institutions and the care of individuals with disabilities, the same did not hold true here in Arkansas. The HDCs are home for many of our most vulnerable and our state DHS staff treat them with dignity, love, support, respect and quality.

According to testimony from the DDS Director, there are no present plans to close any of the HDCs, and the Committee is not recommending the closure of any particular HDC. These recommendations, however, seek to generate long-range system planning to inform the legislature about current and future needs of the system and to ensure that there is a commitment and focus to adequately funding the operations and maintenance of the existing HDCs in the future to ensure their continued quality of care for those individuals with intellectual and developmental disabilities who reside in such settings. The recommendations also take into account Arkansas' intent to improve the quality of care delivered across the broader continuum of services, including increasing future capacity and opportunities for persons with intellectual and developmental disabilities to live in a home and community based setting outside of HDCs.

Finally, the Committee would like to thank everyone for their efforts in bringing to our attention so many important issues dealing with the care and safety of many of Arkansas' most vulnerable citizens. We must do everything we can to ensure quality of life and quality of care for them in the setting of their choice and we hope that these recommendations go a long way in reaching that goal.

Long-Term Planning

Rationale:

DDS offers a continuum of Medicaid services for persons with intellectual and developmental disabilities. The Division operates five large intermediate care facilities known as Human Development Centers (HDCs). The HDCs served approximately 903 persons in fiscal year 2016 and are located at Arkadelphia, Booneville, Conway, Jonesboro, and Warren. Conway serves the largest total number of residents (466 in 2016) and the other centers each serve approximately an average of 114 people. The state previously operated a facility in Alexander that closed in 2010. The Division also serves persons in home and community-based settings using the Medicaid Home and Community-based Services (HCBS) waiver program. In 2016, 4,172 clients were enrolled in this program. Enrollment in the HCBS waiver has grown over time due to several factors, including the availability of increased funding to expand the program and the transfer of persons from institutional to community settings. DDS does not have a plan for the HDC system that includes a forecast of demand for HDC services statewide and regionally and a plan that outlines the most effective manner of providing HDC services based on demand (i.e., whether new construction, closure, or consolidation is appropriate, where facilities should be located, and at what critical census thresholds certain actions would be taken). DDS has an obligation to HDC residents to provide a safe physical environment that meets federal, state, and local Life and Safety Code requirements.

As with any facility physical plant (hospital, university, public schools, nursing home) the HDC campuses have ongoing maintenance needs. Each year, the facilities identify physical plant projects and the DDS central office physical plant manager prioritizes, in conjunction with the facility maintenance managers, which projects to complete based on available federal renovation funds. Renovation funds are renewable annually and are designated by federal regulations to solely be used for updating the human development centers, the Arkansas Health Center and Arkansas State Hospital. The funding is not transferable for other operational uses and is in addition to funds provided in the division's budgeting allocation process. Using the most recent fiscal year as an example, the HDCs identified $4.2 million in requested projects. However, funds will not enable these needs to be addressed resulting in the need to prioritize projects with Life and Safety Code projects receiving top priority. To put this in context, between 2013 – 2015, the facilities spent a total of $2.0 million in designated renovation funds to fund projects such as replacement/upgrade of heat and air systems, plumbing and sewer systems upgrade, roof repair/replacement. Currently, DDS does not have a central plan for preventive maintenance or a 5-year estimate of cost to replace all systems projected to reach end of life expectancy.

The absence of this information – in terms of system demand, ideal configuration, and facility needs – inhibits DDS planning for the future of the HDC system and legislative appropriations decisions. As demand shifts and maintenance costs of the aging infrastructure grow, there may

be a point at which a specific campus needs new construction, to be downsized, or to be closed, rather than continuing to replace or repair existing facilities. The agency does not currently have access to information about the appraised value of its land and buildings, due to the complexity of obtaining such, which may also inform decisions about whether to continue to invest in the HDC infrastructure or whether new construction is appropriate.

Recommendations:

DHS should create a long-term plan for the legislature that considers the following over the next five years:

- Forecasted demand for HDC services at state and regional level, assuming changes in resident acuity if applicable;
- Forecasted cost for operation of the HDC system (aggregated and per diem cost information);
- Analysis of how DHS can most effectively and efficiently meet forecasted need through existing HDCs or changes to the system (size, location); and,
- Cost estimate to meet forecasted demand (including estimated infrastructure needs).
- As part of the long-range planning, conduct an appraisal of any lands or properties not in use that could be sold that are not essential to current services that would create revenue for capital improvement projects.

This recommendation contemplates a different planning process than the annual strategic planning process used at each center and is not intended to supplant that process. HDC strategic plans outline current and future initiatives and center goals and are very client outcome-focused. They are developed by a multi-disciplinary group of local stakeholders. The center-level plans serve a different purpose and do not analyze long-term system needs.

Based on this planning process, the legislature should ensure availability of adequate funding for repair and maintenance of existing facilities and new construction, as needed.

Building a Continuum of Care and Ensuring Quality of Service Delivery

Findings:

DHS/DDS is responsible for the oversight of care and quality of service delivery across the continuum of long-term services and supports it offers. DHS has indicated its intent to enhance the capacity and opportunities for individual with developmental disabilities to remain in homes and communities and being cared for by a home and community based provider. There is a need for DDS to assess the capacity of the current Home and Community-Based Medicaid Waiver provider system to serve additional persons and to conduct a complete evaluation of the quality of life and quality of care delivered in community-based programs. If the evaluation reveals

concerns about capacity or quality, DDS must address those concerns in a timely manner and make any recommendations to the legislature to assure future capacity and quality.

Opportunities for improvement also exist in oversight and regulation of community-based providers. Several areas within DHS perform oversight functions related to DDS programs. Licensing is responsible for enrollment of eligible providers in the state's programs and ensuring the adequacy of service provision based on licensing standards. Licensing investigates complaints and matters related to rule compliance. Adult and child protective services investigate allegations of abuse/neglect/and exploitation of consumers served by DDS' programs.

Another area for possible improvement is in communication and making data relating to these investigative findings readily available to consumers and their families/legal guardians in an easily accessible online format. Another is that there are multiple investigations/licensing functions throughout DHS that may be using different tools and protocols.

Additionally, DDS has a transition process in place for every person moving from an HDC to another setting. The agency gained experience with the closure of the Alexander HDC in 2010, when over 100 residents transitioned to other settings. Each HDC employs a transition coordinator. Preparation begins months before the move, with family engagement and a preview shown of the setting. The transition coordinator performs follow-up visits over a two-year period, that are more frequent at the front-end. Visits are documented using a tool. These visits are done face-to-face. During the transition period, the rate structure provides extra support around the transition if needed. The person's rate may be adjusted to the highest available rate so that the provider has flexibility to do whatever needed to support the transition.

Overall, the agency reports few problems with its transition process and there are few "readmissions" to another HDC once a person has left an HDC. One gap is that DDS does not formally collect parent/guardian/resident feedback about this process. Another gap is that in the post-monitoring assessment visits, the tool DDS staff use is a check-list focused on ensuring certain services and supports for the person, including those in the person's discharge plan, are in place (i.e., transportation, case management, medication management). Other states, such as Tennessee, use similar tools that assess whether supports are in place, but also monitor for safety and risk, and a number of other important factors, such as whether the person's individual preferences are being honored, and whether there are any needs of the caregiver (i.e., training).

These more detailed transition checklists arise from standard operating procedures that Arkansas DDS should review to enhance its own efforts. These transition visits continue for 90 days in Tennessee, or on an as needed basis, and although the Arkansas transition model continues follow up visits for a more extended period of time (two years), there approach and focus is not

as detailed. Appendix A includes the tool used by DDS staff and the tool used by Tennessee for comparison.

Recommendations:

Conduct an evaluation of the current capacity and quality of the home and community based care system for serving those with developmental disabilities. The Task Force and this Committee has heard testimony concerning the future focus of the DHS to enhance capacity and opportunities for individuals with disabilities to live in homes and communities as part of the continuum of care. DHS should conduct a thorough evaluation of community provider current capacity and needs, and make recommendations to ensure adequate provider capacity, infrastructure, quality and support.

Publish data about licensing and maltreatment across programs
Making data about licensing violations and abuse/neglect/exploitation of consumers across DDS programs available online increases transparency about the quality of service delivery in those settings. It may inform decisions of consumers, their families, and legal guardians about whether to transfer to another program or aid in provider selection.

Centralize DHS investigations and licensing functions
Centralization of DHS investigations and licensing functions would allow DHS to gain additional efficiencies and organizational benefits, as well as enhance the rigor of investigations across programs by cross-pollinating some of the best practices and tools.

Continue to evaluate the capacity of licensing function
DHS should continue to monitor the ratio of licensing/oversight FTE resources to consumers served in its programs to ensure that the agency is providing an appropriate level of resources. While not a concern at present, if enrollment in community-based programs grows, it will be important for the agency to ensure that oversight resources keep pace with that growth.

Recommendations related to transitions from HDCs to community settings
DDS should review its current process of informing families/guardians of community waiver placement options to determine if additional methods are available to increase awareness of alternative placement options. The current system informs families/guardians alternative placement options prior to admission, during the admission process, and at a minimum, annually thereafter. Each facility also conducts a provider fair at least annually, in which community providers come to the facility campuses to visit with parents/guardians.

DDS should adapt its post-placement monitoring tool as needed to incorporate best practices from other states. The tool should prompt the worker to assess the person's safety and capture data in that area, as well as considered whether quality of life and person-centered care is

being delivered. DDS should establish a survey to measure parental/guardian/resident satisfaction with the transitions process. In reviewing the tool**,** DDS should also consider formalizing in a written policy or protocol its operating procedures and guidelines for post-placement monitoring for persons who transfer from an HDC to a community setting

Cost Containment

Findings:

DDS has used cost containment strategies across the HDCs including energy efficiency initiatives, reduced use of staffing/contracting where possible, and an increased priority on using bundled contracts and comparative shopping for commodities. Generally, however, each HDC operates its own budget and tends to engage in activities such as bulk purchasing on the campus instead of system level. This suggests some opportunity may exist for system-wide efficiencies (such as bulk purchasing across the system).

In addition, an analysis of unit costs across the facilities further underscores that some facilities may have achieved efficiencies in certain areas that other facilities could replicate. All the HDCs offer the same Medicaid client services at comparable quality. However, the facilities do not all spend the same amount per resident overall or when looking at certain categories of expenditures. Analysis of the cost reports for July 1 2014 – June 30, 2015 found that differences exist in unit costs across facilities. These unit costs were calculated by dividing total spending by category by the number of Medicaid patient bed days, which adjusts spending for the number of residents served.

Costs Per Medicaid Bed Day

	Conway	Warren	Arkadelphia	Jonesboro	Booneville
Room and Board	$22.81	$32.84	$25.79	$20.65	$23.31
Health Care	$263.38	$285.12	$225.63	$232.66	$203.72
Maintenance and Operations	$30.95	$48.93	$53.05	$39.80	$46.58
General Administration	$53.49	$81.15	$80.81	$89.30	$88.07
Provider Fee	$20.50	$20.57	$20.53	$20.69	$20.54
Comp. Administration	$0.78	$3.55	$2.24	$2.98	$2.26
All Costs	$391.12	$468.62	$405.81	$403.09	$382.23

Source: The Stephen Group.

While variations in unit costs may be due to several factors, including client acuity (facilities that serve residents with higher needs are expected to incur higher costs), wage differences of staff and/or need to use contractors, and differences in local budgeting practices, some may also be

due to efficiencies achieved by individual centers and those efficiencies offer opportunities for savings across the system if brought to scale.

Recommendation:

Cost Analysis

The DHS Office of the Chief Financial Officer, in conjunction with DDS, should conduct further analysis to understand cost variations across HDCs and identify efficiencies that can be replicated at other facilities. Examples to investigate include:

- Heath Care – This category comprises a large share of the total daily rate. It includes direct care staff. While most of the facilities are comparable here and maintain similar staffing ratios, Booneville's total cost per bed day is lower than the other HDCs and this should be explored.
- Room and Board – Warren's costs here are higher than its three other peers of a similar size. There may be practices it can replicate from its peers to bring down these costs.
- Maintenance and Operations – Conway has the lowest cost per bed day, which is likely due to efficiencies gained due to its larger relative size, but Jonesboro's cost is low relative to its peers of a similar size and its experience may be instructive.

Savings and efficiencies identified by DHS/DDS, as well as other DHS cost containment strategies such as use of bulk contracting and purchasing and identifying more efficient approaches to contracting for professional services (such as dental services) should be monitored and tracked by DHS.

Turnover

Findings:

DHS identified turnover as a main cost driver and challenge in the operation of HDCs. Three years of data on turnover across all position types are provided by HDC.

	2013	2014	2015
Arkadelphia	29.8%	45.8%	51.9%
Booneville	19.3%	34.2%	34.2%
Conway	20.2%	47.1%	47.5%
Jonesboro	52.1%	107.9%	77.6%
Warren	33.5%	26.0%	45.7%

Source: Arkansas Department of Human Services, Division of Developmental Disabilities Services.

Turnover is of concern in four direct care resident-facing position types. Data by facility are provided.

HDC Turnover for Direct Care Positions, Fiscal Years 2013 – 2015

Residential Care Assistant

	Conway	Jonesboro	Warren	Booneville	Arkadelphia
2013	46%	132%	63%	28%	66%
2014	67%	101%	67%	60%	74%
2015	165%	198%	158%	88%	200%
Residential Care Technician					
	Conway	**Jonesboro**	**Warren**	**Booneville**	**Arkadelphia**
2013	30%	53%	13%	22%	36%
2014	34%	40%	16%	19%	32%
2015	39%	55%	37%	16%	32%
Shift Supervisor					
	Conway	**Jonesboro**	**Warren**	**Booneville**	**Arkadelphia**
2013	51%	44%	20%	20%	30%
2014	16%	36%	30%	20%	23%
2015	29%	65%	40%	24%	33%
Residential Care Supervisor					
	Conway	**Jonesboro**	**Warren**	**Booneville**	**Arkadelphia**
2013	19%	45%	0%	16%	22%
2014	11%	36%	11%	16%	0%
2015	9%	20%	83%	0%	32%

Source: Arkansas Department of Human Services, Division of Developmental Disabilities Services.

DDS has implemented many strategies to address turnover including use of higher hourly wages in certain markets (mid-point of the approved salary range instead of the entry salary), use of a video and tour to provide a realistic job preview, and use of mass interviewing and continually advertised positions (positions are freeze exempt) as strategies to reduce the time to hire new employees. DDS also augments HDC staffing as needed using contractors and certain specialized staff that have a capped number of hours and no benefits. These recommendations offer guidance in new areas for the DDS to focus to avoid duplication with strategies already attempted.

Recommendations:

Establish a new supervisor development program

Quality supervision is important in the provision of services at HDCs and is critical to staff retention. Literature across disciplines suggests that a supervisor can be a key reason a worker leaves or stays at a job. The Department provides mandatory four days of policy and procedures

training and a mandatory three-day leadership training for new supervisors. There is also a mandatory supervisory update training that occurs after a person has been a supervisor for five years. The department does offer a menu of professional and personal growth training opportunities through its internal staff development section and its inter-agency training program, but most of these items are not mandatory. There is currently no mandatory, ongoing training program to strengthen the managerial and leadership skills of its supervisory workforce outside of those mentioned above. Exit interviews with workers suggest there are concerns with the quality of supervision in certain areas of the state and that some new supervisors may struggle with the role of manager. An on-going mandatory training and development program for supervisors throughout the course their career would not only improve the quality of supervision and strengthen supervisory skills, but would also provide supervisors with guidance on how to develop their staff. Such a program could include supportive features (such as mentoring) to provide personal and professional support to supervisors. It is expected that this program would aid in the retention of both supervisors and workers.

Explore feasibility and cost of establishing a career ladder for supervision/management

Absence of an extended career ladder/low pay is a factor contributing to supervisor turnover, especially in areas with direct competitors (i.e., a new healthcare facility). Direct care staff members advance from the entry-level position of Residential Care Assistant to the next level (Residential Care Technician) in a career ladder format but must apply, interview, and be selected for positions beyond that. There is currently no other career ladder mechanism outside the traditional interview/selection process that allows a direct services staff person to promote, though they are eligible for annual bonuses based on performance. Providing for an extended career ladder for staff could address a reason direct services personnel leave HDC employment.

Ensure adequacy of entry-level worker salaries

Each HDC operates in a local labor market and competes with other regional employers for staff. DHS staff has analyzed the salaries of other major employers in the markets where the HDCs are located and found DDS salaries to be less competitive in some areas (though benefits tend to be more robust at DDS compared to its competitors). In parts of state where economic opportunities result in the expansion of industry, HDCs may have an especially difficult time attracting and retaining staff. The state's Office of Personnel Management establishes the pay plan for the state. DDS has received permission previously to offer the mid-point of the salary range (instead of the bottom of the range as is typically offered) for certain positions in certain areas of the state and is currently in the process of implementing that salary adjustment. This recommendation is for a more generalized increase of salaries across the direct care staff positions to enable DDS to attract the best applicants for HDCs statewide and prevent loss of qualified staff to other employers.

HDC Campus Needs

Finding:
As discussed previously, the HDC campuses have a variety of facility and infrastructure needs and DDS has prioritized which needs to address each year based on the availability of renovation funding. One campus has vacant buildings with deteriorating quality, which could possibly pose potential risk and hazard to residents if not adequately secured.

Recommendation:

Ensure adequate funding for the demolition of vacant buildings on HDC campuses that produce potential risk to residents.

Demolition of such buildings has been prioritized by current DDS leadership and the process is underway to remove the buildings in question. Going forward, the legislature should ensure that adequate funding exists to ensure the timely demolition or repair of these buildings to mitigate any adverse resident impact. DDS should include such needs in its long-range plan to the legislature.

Appendix A – Post-Discharge Tools

Post Move Monitoring Checklist

_____ Human Development Center

Name of Individual:

Date of Birth:

Date of Discharge:

Date of monitoring contact:

1st, 2nd, 3rd, 4th, 5th & 6th Follow-up Contact:

Name of Receiving Program:

Guardian:

Phone Number:

Address:

Name of Monitor(s):

List all Essential and Non-Essential Supports from the Discharge Plan:

Type of Support	In Place	Needed	Comments
24-Hour Supervision			
Primary Care Physician			
Behavior Support Plan			
Dentist			
Assistance w/ Self-Help & Daily Living Skills			
Assistance Contacting Guardian/Friends			
Case Management			
Medication Management			

Transportation			
Assistance Shopping			
Recreational Activities			

PCSP	In Place	Needed	Comments

Notes from individual/staff interview:

.

Recommendations for follow up:

Protocol for Conducting Post Move Monitoring Visits:

1. Post Move Monitoring Visits will occur after discharge. (Approximately: 7 days, 45 days, 90 days, 6 months, 1 year & 2 years. Additional visits may be warranted depending on circumstances.)
2. The results of the monitoring will be shared with the receiving program and responsible DDS staff and JHDC Program Coordinator
3. The Post Move Monitoring will be conducted by one or more staff from DDS.

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

Area	Comments
I. Active Treatment	
A) Home	**<u>Home supports noted in the ISTP/ISP have been implemented.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
B) Day	**<u>Day supports noted in the ISTP/ISP have been implemented.</u>**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	Day of the move: Yes/No **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
C) Community (relationships)	**<u>Opportunities to be active in the community have been implemented as noted in the ISTP/ISP.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	60 Day visit: Yes/No **90 day visit: Yes/No** **Additional visit: Yes/No** **<u>Relationship building opportunities are evident.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	Additional visit: Yes/No **Additional visit: Yes/No**
D) Communication	**<u>Communication supports have been implemented as noted in the ISTP/ISP.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
E) Outcomes and Action Steps	**<u>Outcomes and action steps noted in the ISTP/ISP have been implemented.</u>** **Day of the move: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	5 Day visit: Yes/No **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
II. Health Care Services (Medical Conditions)	
A) Mealtime	**Mealtime supports (noted in the ISTP/ISP, dining plan or other assessments) are implemented.** **Day of the move: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	5 Day visit: Yes/No **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
B) Therapy	**Therapy plans are implemented as indicated in the ISTP/ISP or other assessments.** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	90 day visit: Yes/No **Additional visit: Yes/No**
C) Medical	**First PCP appointment?**
III. Safety	**Any issues?**
A) Environmental	**<u>The area is well maintained and free of potential safety concerns.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	Additional visit: Yes/No
B) Risks	**<u>Risk issues and supports are recognized and implemented as indicated in the ISTP/ISP or other assessments/reports.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
IV. Preferences, Choices (Decision Making), Non-negotiable	
A) Important to the person	**<u>Any notes related to 'important to' the person that has been implemented or is in process.</u>**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	Day of the move: Yes/No **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
B) Personal Finances	**<u>Personal funds are accessible.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	60 Day visit: Yes/No **90 day visit: Yes/No** **Additional visit: Yes/No** **<u>Personal funds are managed according to the information noted in the ISTP/ISP.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

V. Training issues	
A) TSNI (therapy, behavior and mealtime etc).	**<u>Staff is knowledgeable of medical diagnoses and how to provide.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No** **<u>Staff is knowledgeable of therapy needs and how to provide support.</u>**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	Day of the move: Yes/No **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No** **<u>Staff is knowledgeable of mealtime needs and how to provide support.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	60 Day visit: Yes/No **90 day visit: Yes/No** **Additional visit: Yes/No** **<u>Staff is knowledgeable of the supports included in the ISTP/ISP.</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	Additional visit: Yes/No **<u>ISP/ISTP is in the home?</u>** **Day of the move: Yes/No** **5 Day visit: Yes/No** **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
B) Other (any other issues that have surfaced since the move?)	**Day of the move: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	5 Day visit: Yes/No **30 Day visit: Yes/No** **60 Day visit: Yes/No** **90 day visit: Yes/No** **Additional visit: Yes/No**
VI. Other Transition Plan issues (before, during and after the move issues or additional QRP/Regional Office concerns).	
	Day of the move: Yes/No **5 Day visit: Yes/No** **30 Day visit: Yes/No**

Post Placement Monitoring Tool – All class members shall be transitioned in accordance with each Individual Support Transition Plan.

Name:

Move Date: Day 1, Day 5, Day 30, Day 60 and Day 90 (circle one): ISTP/ISP visit Date:

Site:

Reviewer:

	60 Day visit: Yes/No **90 day visit: Yes/No** **Additional visit: Yes/No**
Notes: Any contact with the ISC.	