



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

TEXAS PROMOTING INDEPENDENCE PLAN

**In Response to Executive Order GWB99-2 and the
Olmstead Decision**

January 9, 2001

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EXECUTIVE SUMMARY

Purpose

The Texas Promoting Independence Plan is a response to the US Supreme Court ruling in *Olmstead v. Zimring*, and the Governor's Executive Order GWB99-2. This plan includes the information as requested in the Executive Order which required a comprehensive review by HHSC of all services and supports systems available to people with disabilities in Texas. The focus for the review was to identify affected populations, improve the flow of information about supports in the community, and remove barriers that impeded opportunities for community placement in light of the Supreme Court ruling. A twelve member advisory board was appointed by the HHSC Commissioner to assist with the formulation of the state's plan in response to *Olmstead*. The board included representatives from provider, consumer and advocacy organizations. The board met ten times during 2000 and developed a series of recommendations for consideration by HHSC. These recommendations are reflected in this plan as ways to enable the health and human service agencies to address the requirements of the Governor's Executive Order. The input from the Promoting Independence Advisory Board (PIAB) identified opportunities to better support individuals with disabilities who choose to live in their home communities, as well as to help them understand their options and achieve better access to community supports.

The *Olmstead v. Zimring* Decision

The *Olmstead v. Zimring* case was brought forward in Georgia, on behalf of two individuals with mental and cognitive disabilities living in state operated institutions. They claimed a right to care in an integrated setting based on the guarantees under Title II of the Americans With Disabilities Act (ADA).

The Court ruled in June of 1999 that states must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when the:

- 1) States treatment professionals determine that such placement is appropriate;
- 2) affected persons do not oppose such treatment; and
- 3) placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services (119,S.Ct.2176, *2189).

The court further determined that nothing in the ADA condones the termination of institutional settings for persons unable to handle or benefit from community settings (119 S.Ct.2176, 2187) and that the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless (119.S.Ct.2176, *2188).

Under the ADA, states are obliged to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.” Fundamental alteration of a program takes into account three factors:

1. the cost of providing services to the individual in the most integrated setting appropriate;
2. the resources available to the state; and
3. how the provision of services affects the ability of the state to meet the needs of others with disabilities. (119,S.Ct. 2176, *2188, *2189)

The court suggested that a state could establish compliance with Title II of the ADA if it demonstrates that it has:

*A comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the state’s endeavors to keep its institutions fully populated. In such circumstances, a court would have no warrant effectively to order a displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions (119.S.Ct.2176, *2189, *2190).*

This plan is the beginning framework for the state’s response to the *Olmstead* decision. In the coming months through legislative appropriations and further agency work, HHSC will be able to identify and provide detailed accountability features, sequencing of expansion and implementation phases, and agency responsibilities in order to continue building our response to achieve comprehensive and effective plan implementation.

After careful review of all programs and services, consideration of the advisory board’s recommendations (See Appendix A for all PIAB recommendations and HHSC response), and consultation with the agencies under the HHSC umbrella, the following system improvements are needed for the state to continue it’s development of the comprehensive, effective working plan required by the *Olmstead* decision. These system improvements are detailed further in the body of this document, and are summarized here as necessary to the implementation of the Promoting Independence Initiative, and as basic to provide access for citizens of the state with disabilities to the current system of community services.

System Improvements to Better Support Persons with Disabilities

Identification & Assessment Related Funding Issues

TDMHMR Issues

- TDMHMR will continue implementation of the Community Living Options Process as initiated in March 2000 in state mental retardation facilities, and December 1, 2000 in community ICF-MR programs.
- TDMHMR will accommodate placement for individuals on state school waiting lists via the HCS waiver program. By August 31, 2001, the agency should move the remaining 118 individuals from the original referral list of 409. Effective September 1, 2001 provide opportunities for community alternatives within 180 days to any individual requesting and recommended for community placement.
- TDMHMR and HHSC will monitor the process for referral of individuals within state schools to community services.
- TDMHMR will continue the review and evaluation of the 16 persons residing in State Hospitals who were originally identified as having been residing in the state hospital longer than 12 months. When appropriate community based services are identified to meet their needs, the agency should move these individuals into the community.
- TDMHMR will continue review of all individuals residing in the state hospital for more than 12 months, and take appropriate action when they no longer require in-patient hospitalization under the Mental Health Code. Local community mental health authority staff should arrange discharge plans for community-reintegration as necessary.
- TDMHMR will monitor state hospitals for delays in community discharge and take the appropriate corrective action.
- TDMHMR's should offer opportunities in the HSC program within 12 months of determining that such services are appropriate for any ICF-MR resident living in a facility larger than 13 beds.
- To meet TDMHMR's commitment to the Promoting Independence Initiative additional funding is necessary. TDMHMR's Legislative Appropriations Request contains an exceptional item, which includes an additional 325 HCS slots for individuals leaving state schools and 864 HCS slots for community ICF-MR's in the next biennium (2002-2003).¹ A total of \$36,454,065 in general revenue funds is requested to assist in making community placement a reality for individuals currently in the ICF-MR program.

¹ A slot is an available placement in the HCS waiver program. The difference in the two sets of slots is 325 are being set aside to serve individuals within the state schools and 864 slots to be serve individuals in other ICF-MR programs.

- TDMHMR will continue on-going review and revision of the Community Living Options Instrument and process in relation to its application to children and families.

TDHS Issues

- TDHS will inform all MAO and SSI nursing facility residents of long-term care options, and their eligibility to bypass the waiting lists of the CBA program
- TDHS will inform new applicants, at the time of application, of long-term care options for which they may be eligible.
- TDHS will provide computer-based training for all TDHS staff to ensure their awareness of CBA programs, the Promoting Independence Initiative, and sensitivity to persons with disabilities.
- TDHS will train all long-term care staff on implementation procedures of the Phase I activities, which include: implementation of identification, application of the assessment instrument, data collection, community awareness and permanency planning.
- TDHS will implement a data collection system to develop a promoting independence consumer profile and to identify successful factors and barriers to transitioning of individuals in nursing facilities into community-based settings
- TDHS will implement community awareness activities to promote long-term care options
- TDHS will provide permanency planning to develop community placements for children. (RFP projected to be published in January 2001).

Funding the initiation and implementation of the TDHS plan and process for identification and assessment requires moving \$1.7 million dollars the agency received in enhanced matching funds. A request is pending before the LBB and Governor's Office to transfer the funds. The following steps are proposed by TDHS, dependent on approval to use the \$1.7 million dollars in enhanced funding in FY 2001:

- TDHS will hire, train and deploy 22 staff for six months of FY 2001 to provide intensive relocation and outreach activities at selected sites.
- TDHS will implement an identification process and assessment instrument to transition 50 individuals in nursing facilities.
- TDHS will develop an automation system to track data collected by the relocation specialist to build onto the baseline profiles from steps listed above.
- TDHS will pay for costs associated with moving and re-establishing a community residence for projected 50 individuals.

- TDHS will target community awareness activities
- TDHS will intensify permanency planning activities for 75 children in nursing facilities
- TDHS will submit an RFP for relocation activities including development of the identification process and assessment instrument. Site selection is dependent upon the entity awarded the contract; action plan is being developed for publication of the RFP.

Appendix F provides further information on the TDHS Identification and Assessment process. HHSC will continue to monitor the TDHS Identification and Assessment Process for timely implementation.

Access Issues

Local Access Plans

- HHSC will work with agencies to develop a system of access to services that will be local, user friendly, and provide the information necessary to consumers, family members, volunteers, and advocates to reduce the fragmentation of the current system of services.
- HHSC will complete the work of the Texas Long-term Care (TLC) Access Review Committee to review local plans and develop a state response to requests for assistance.

Consumer Assessment and Navigation Services

- HHSC and HHS agencies will study the current case management system and the possible development of specialists that can navigate the network of services on behalf of the consumer and their family, in order to reduce the fragmentation of services.
- HHSC will ensure that the system of access will incorporate development of the information and referral network and potential use of the 211-telephone number.
- HHSC will continue work on a single functional assessment, and the consolidated waiver pilot project and move forward with implementation if data indicates a successful system change.

Training and Information

- HHSC will coordinate with appropriate agencies to develop and implement training in the history, intent and scope of the Promoting Independence Initiative, development of community supports for people in transition from institutions to the community, contact information of service providers, and initiation of community-based services.
- HHSC will take the lead in developing one comprehensive information packet and video that can be used in all institutional settings to educate

residents/families/guardians about all available community services; using stakeholder focus groups for input regarding content, format, etc.

Technology

- HHSC will study the infrastructure issues between agencies related to varying computer systems, databases, and tracking of consumers.
- HHSC will continue the work in standardization and consistency in data systems across agencies.
- HHSC will continue the work of the technical architecture committee to assist in the development of a single data center where various agencies service tracking systems can be consolidated and data can be easily shared.
- HHSC will continue evaluation of products that will allow the current agency systems to share data.

System Capacity and Funding Issues

- General Revenue funding for HHS agencies' exceptional items related to Promoting Independence and Waiting Lists in the amount of \$119,547,256 accounts for approximately 4% or \$252,523,279 million of the \$6.1 billion All Funds exceptional items request for all HHS agencies for the FY 2002-03 biennium. Funding is necessary in order to increase the capacity of the system to accommodate those individuals currently in institutions, or who are in need of placement.
- HHSC supports the TDHS Legislative Appropriations Request for \$28,327,090 in general revenue to increase CBA Waiver slots by 1,061, CLASS waiver slots by 54, and MDCP waiver slots by 225 by FY2003.
- HHSC supports the TDMHMR Legislative Appropriations Request of \$36,454,065 in general revenue to phase-in 325 additional placements from state schools and 864 placements for persons moving from ICF-MR facilities.
- HHSC supports the TDHS transitional funding proposal for MDCP consumers in the amount of \$562,000 in general revenue. These funds would be used to make one-time modifications that would allow families to successfully transfer their child into community care.
- HHSC requests transitional funding for HCS consumers in the amount of \$500,000 in general revenue. These funds would benefit approximately 200 HCS consumers.
- HHSC Consolidated Budget requests \$3,345,139 in general revenue funds for the development of a new program that offers family based alternatives for children that are leaving institutions and cannot return home to their birth families. Because technical assistance is also

necessary for the recruitment and training of staff implementing the above foster care model, HHSC also requests \$151,650 in general revenue to ensure proper training and research of best practices.

- HHSC Consolidated Budget requests \$96,000 in general revenue to provide transitional funding and rent subsidies for approximately 25 individuals converting to community care through the Project choice pilot.
- Housing options should be expanded to assist individuals moving from institutions who desire and for whom appropriate community services are available. Temporary rent subsidies for consumers awaiting federal housing assistance will facilitate community integration. HHSC requests \$4,320,000 in general revenue for this purpose.
- Transportation has also been identified as a major issue for individuals attempting to transition from institutions into the community. HHSC has asked for \$780,000 in general revenue to provide non-medical transportation to these individuals.
- To reduce the long-term care waiting lists for community placement, which many times results in unnecessary institutionalization of individuals, HHSC supports the TDHS Legislative Appropriations Request for \$40,081,955 in general revenue to fund 3,740 consumers in FY2003 from community care waiting lists.
- In cooperation with the State Medicaid Office, TDMHMR should develop a Medicaid waiver or other options that provide services to those individuals on the waiting list who need only community supports. HHSC Consolidated Budget request supports TDMHMR's \$4,929,357 in general revenue to fund 750 individuals on the HCS waiting list and 400 placements on a new mid-range waiver.
- HHSC will work with TDMHMR to develop a plan which allows for community placement at a reasonable pace for those individuals identified through the Community Living Options process, should their numbers be greater than the allotted slots currently projected and set aside.
- Adequate funding to ensure a stable and well-trained workforce serving persons with disabilities is imperative. HHSC will work with appropriate long-term care agencies to explore and develop employee recruitment and retention incentives for providers of services.
- HHSC should ensure that coordinated planning between agencies is developed to address the need for availability and access to mental health services to compliment long-term care waiver services for people with mental illness leaving institutions.
- Sufficient mental health services in the community are needed to prevent the unnecessary institutionalization of individuals with mental illness.
- HHSC will examine and work with appropriate agencies to develop and encourage the foster care model in securing foster care placements,

adoptions, and family-based alternatives to institutional settings. Enhanced adoption subsidies and foster care rates are needed for families to adopt children who need higher levels of care.

Other Legislative Considerations

- Statutory relief issues such as rule changes within the Texas Administrative Code (TAC), and the elimination of riders lessening the percentages factored against cost neutrality for Medicaid waivers must be reviewed and specific steps developed to implement these changes.

Removing Service Barriers to Community Supports

Expand Medicaid Benefits

- HHSC should modify the existing State Medicaid Plan to include benefits for adults related to durable medical equipment, prosthetic and orthotic devices and their repair, as well as therapies needed to maintain the individual's functioning.
- HHSC should eliminate the homebound requirement under the Medicaid Home Health Benefits as directed by HCFA.
- HHSC should work towards ensuring timely provision of durable medical equipment.
- HHSC should collaborate with TDH to study and possibly implement the expansion of the Rehabilitation Option of the State Medicaid Plan to include acute and post-acute rehabilitation.

Meeting the Needs of Children and Their Families

- HHSC will work with TDHS on a proposed rule change to eliminate the need for children to reside in a nursing facility before they can enter the MDCP program.
- TDHS should establish an exception to allow for children who reside in an ICF-MR to bypass the CLASS interest list.
- HHSC should continue to work with the CLTCPC to implement the recommendations as appropriate in their report of 9/1/00.

Cost Neutrality Issues

- HHSC will study the impact of cost neutrality as it relates to individuals being unable to access community services due to the high cost of their individual plans of care.

- HHSC will study and develop resolutions to require individuals currently in institutions, desirous of and for whom appropriate community, services exist to be exempted from individual cost cap rules.
- HHSC will work with agencies to develop an appeal process beyond the existing processes required for Medicaid programs that is easily accessed and that will review the disapproval of the justified need for services that are over the individual cost caps.

Comprehensive Care Coordination System

- HHSC will work with appropriate agencies to develop adequate follow-up for individuals who move to the community. This follow-up must include criteria for successful transition and placement, measuring quality of services, measuring consumer satisfaction, and continued communication between agencies that ensure the basics of everyday life for consumers of services.

INTRODUCTION AND BACKGROUND

Purpose and Structure of Report

The Health and Human Services Commission (HHSC) embarked on a Promoting Independence Initiative in January of 2000, in response to the US Supreme Court ruling in *Olmstead v. Zimring*. At the direction of the Governor's Executive Order GWB 99-2, HHSC conducted a comprehensive review of all services and support systems available to people with disabilities in Texas. The review required analysis of the availability, application, and efficacy of existing community-based alternatives for people with disabilities. The focus for the review was to identify affected populations, improve the flow of information about supports in the community, and remove barriers that impeded opportunities for community placement in light of the Supreme Court ruling. To carry out the order, HHSC involved consumers, advocates, providers and relevant agency representatives in the review process.

The Executive Order requires HHSC to submit a report of its findings to the Governor, the Lieutenant Governor, the Speaker of the House, and the appropriate committees of the 77th Legislature no later than January 9, 2001. The order requires that the report make specific recommendations for how Texas can improve its community-based programs for people with disabilities by legislative or administrative action; and that HHSC use its statutory authority to effect appropriate changes.

A twelve member advisory board was appointed by the HHSC Commissioner to assist with the formulation of the state's plan in response to *Olmstead*. The board included representatives from provider, consumer and advocacy organizations. The board met ten times during 2000 and developed a series of recommendations for consideration by HHSC. These recommendations and HHSC's response are provided in Appendix A. These recommendations are reflected in this plan as ways to enable the health and human service agencies to address the requirements of the Governor's Executive Order. The input from the Promoting Independence Advisory Board (PIAB) identified opportunities to better support individuals with disabilities who choose to live in their home communities, as well as to help them understand their options and achieve better access to community supports.

The following sequence of events that led to the development of HHSC's Promoting Independence Initiative:

- Publication of the *Olmstead* Decision in June of 1999, encouraging states to develop plans for the timely movement from institution to community for individuals who qualify for and choose community supports;
- Promulgation of the Executive Order from Governor George W. Bush in September of 1999;

- Initiation of research into the existing services and initiatives of Health and Human Services agencies;
- Appointment of an advisory board in the fall of 1999;
- Development of the initial plan to guide the promoting Independence Initiative in January 2000; and
- Submission of a report to the Governor and the legislative leadership, by January 9, 2001

This report builds on the original plan developed by HHSC in January, 2000, entitled “The Promoting Independence Initiative: A plan to Expand Opportunities for Texas with Disabilities.” After discussing the *Olmstead* decision, this report provides:

- an overview of the current long-term system, including a discussion of limitations and deficits in the current system;
- an overview of the current status of institutional care and agency responses to the *Olmstead* decision and;
- a discussion of improvement needed to eliminate barriers in the existing system of services so the State can respond to the *Olmstead* decision in a comprehensive and structured manner.

The *Olmstead v. Zimring* Decision

To set the stage for the Promoting Independence Initiative, it is important to understand the state’s obligations as laid out in the *Olmstead* decision. This case was brought forward in Georgia, on behalf of two individuals with mental and cognitive disabilities living in state operated institutions. They claimed a right to care in an integrated setting based on the guarantees under Title II of the Americans With Disabilities Act (ADA).

The Court ruled in June of 1999 that states must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when the:

- 4) States treatment professionals determine that such placement is appropriate;
- 5) affected persons do not oppose such treatment; and
- 6) placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services (119,S.Ct.2176, *2189).

The court further determined that nothing in the ADA condones the termination of institutional settings for persons unable to handle or benefit from community settings (119 S.Ct.2176, 2187) and that the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless (119.S.Ct.2176, *2188).

The principles set forth in the Supreme Court's decision apply to all individuals with disabilities protected from discrimination by Title II of the ADA. The ADA prohibits discrimination against "qualified individual(s) with a disability". The ADA defines "disability as: a) a physical or mental impairment that substantially limits one or more of an individual's major life activities; b) a record of such an impairment; or c) being regarded as having such an impairment. Examples of major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks and learning, as well as basic activities as thinking, concentrating, interacting with others, and sleeping. Age alone is not equated with disability; however, if an elderly person has a physical or mental impairment that substantially limits one or more of his or her major life activities, has a record of such impairment, or is regarded as having such impairment, he or she would be protected under the ADA. To be a "qualified" individual with a disability, the person must meet the essential eligibility requirements for receipt of services or participation in a public entity's programs, activities, or services (119,S.Ct. 2176, *2188/ 42 U.S.C. Subchapter. 12132, Subchpt.12131 (2)).

Under the ADA, states are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity." Fundamental alteration of a program takes into account three factors:

4. the cost of providing services to the individual in the most integrated setting appropriate;
5. the resources available to the state; and
6. how the provision of services affects the ability of the state to meet the needs of others with disabilities. (119,S.Ct. 2176, *2188, *2189)

The court suggested that a state could establish compliance with Title II of the ADA if it demonstrates that it has:

*A comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated. In such circumstances, a court would have no warrant effectively to order a displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions (119.S.Ct.2176, *2189, *2190).*

This plan is the beginning framework for the state's response to the *Olmstead* decision. In the coming months through legislative appropriations and further agency work, HHSC will be able to identify and provide detailed accountability

features, sequencing of expansion and implementation phases, and agency responsibilities in order to continue building our response to achieve comprehensive and effective plan implementation. HHSC believes its on-going Promoting Independence Initiative applies to individuals of all ages with disabilities, in institutions such as nursing facilities, state schools, ICF-MR facilities, state hospitals, and other institutions licensed by TDPRS. Recognizing the nature of human services, the state's response must be fluid and flexible to meet the system's service demands and those of citizens with disabilities of the state. Successful implementation requires that time and resources are available in order to move forward with the initiative.

THE CURRENT LONG-TERM CARE DELIVERY SYSTEM

State law defines long-term care services as...

The provision of personal care and assistance related to health and social services given episodically or over a sustained period to assist individuals of all ages and their families to achieve the highest level of functioning possible, regardless of the setting in which the assistance is given (Sec. 22.0011 of the Human Resources Code).

This definition encompasses a range of services, including nursing facility care, community-based services for adults and children with physical disabilities, and services to persons with mental retardation and mental illness. Based on this definition, long-term care services in Texas are currently funded by four agencies: Texas Department of Human Services (TDHS), Texas Department of Mental Health and Mental Retardation (TDMHMR), Texas Department on Aging (TDoA) and the Texas Department of Health (TDH).

Historical Perspective

The Promoting Independence Initiative is not the first time the State of Texas has addressed the issue of how to increase services in the community. During the mid-1970s the Joint Advisory Committee on Government Operations: Subcommittee on Health and Welfare of the Texas Legislature prepared a "Background Report on the Nursing Home and Alternate Care Programs Administered by the Department of Public Welfare." The purpose of the report was to examine the reasons for the dramatic increase in nursing facility costs during a period in which there has also been a dramatic increase in the scope and costs of alternate care service. The report looked at a number of administrative issues related to costs in the programs and processes for accessing the programs. The conclusion was that the nursing facility admission process did not facilitate the consideration of community alternatives since the application for admission frequently came after the individual had moved into a nursing facility.

During the late 1970s, the 65th Texas Legislature appointed a Joint Committee on Long-term Care Alternatives to study the scope and effectiveness of the state programs that provide care for the aged and disabled, including evaluation of the existing programs and alternatives to those programs. Questions for evaluation included:

- Are community care programs a substitute for some forms of nursing facility care?
- What is their effect on number of persons receiving nursing facility care?
- Is community care a suitable substitute for some forms of nursing facility care?
- Is there a continuing need for a minimum-level nursing care such as the ICF-II?

The study concluded that community care programs are effective but limited in scope and reach. Consequently, they were not an effective substitute for nursing facility care due to lack of service options. It was determined that initial expansion of community care would not reduce nursing facility populations, but the ICF-II level of nursing facility care could in the long run be eliminated if community care was expanded since potential residents in this lowest level of care could be served in the community. Other recommendations included providing all Medicaid applicants for nursing facility care with a pre-admission assessment, expanding the array of services included in Medicaid home health, encouraging development of congregate housing and establishing adult day care services.² The state subsequently eliminated the ICF-II level of care, expanded services options in the community and developed more controls over nursing facility admissions.

In response to this and other studies Texas continued to expand community-based long-term care services throughout the 1980s and 1990s. The expansion was primarily funded through Medicaid services, such as the Frail Elderly program, Personal Care Option, Community-based Alternatives (CBA) and Medically Dependent Children waiver programs at TDHS and the Home and Community-Based Services (HCS) waiver program at TDMHMR.

Declining Rates of Institutionalization

As Texas has increased community-based service options for the elderly and individuals with disabilities, especially through the Medicaid program, there has been a population decline within institutional settings. Most striking is the 48% reduction of the average daily census in state mental hospitals. In 1986, the average daily census in these facilities was 4,500 compared with 2,350 today. Currently, state hospitals are providing care with a greater emphasis on acute treatment and shorter lengths of stay. Similarly, for the same period, state

² Joint Committee on Long-term Care Alternatives, Final Report, Late 1970s.

schools for the mentally retarded experienced a census decline from approximately 8,700 to approximately 5,400, representing a 38% decrease.

The proportion of elderly in nursing facilities has decreased in Texas. Although the Medicaid average nursing facilities census has increased by 21.7% from FY 1986 to FY2000, the number of nursing facility residents has remained fairly constant for the past six years. Through the growth of the community programs for the elderly and people with disabilities, Texas has realized a 121.7% increase in persons receiving community services. Some 117,500 Texans are now receiving community services through these programs compared to the 53,000 fourteen years ago.

State agency budgets also reflect the shift from institution to community. In fiscal year 1989, approximately 65% of the service budget for TDMHMR was expended on institutional services; community services accounted for the remainder. Eleven years later, the balance has shifted, with 68% of the budget spent on community services with institutional services representing only 32%. A similar trend is found in services operated through TDHS, where community services spending has increased to 35.4% of the long-term care budget. Even with these changes, Texas continues to have one of the largest institutionalized populations in the nation. This requires the state to have a determined and systematic approach to the *Olmstead* decision, and the population to which it applies, in its assistance in providing community care. Expanded resources are necessary to a successful initiative, which promotes independence for individuals in institutional care.

Overview of the Current Long-term Care System

Texas has developed a long-term care system structured around population groups -- mental health/mental retardation, aging, children, and adults with physical disabilities -- using the federal funding streams associated with programs that serve these populations. This long-term care system provides a range of service alternatives, from institutional care in nursing facilities and state facilities to a wide variety of home and community-based services. Medicaid is the predominant funding source for this system, primarily through eight 1915 (c) waivers.

The following charts provide an overview of the current system of services. Table 1 compares funding and service levels between community and institutional care. Table 2 provides a brief description of the target populations served by these agencies and of the separate systems for accessing services at the local level. Table 3 provides information on the long-term care programs by agency.

Table 1
Texas Long-term Care Programs¹
FY 2000 Budgeted Financial and Performance Data

| | Institutional | Community | Both | Total |
|---|----------------------|----------------------|-------------|--------------|
| Budget (in millions) | | | | |
| Federal Funds | \$1,258.527 | \$967.012 | \$375.601 | \$2,601.140 |
| General Revenue | \$901.301 | \$956.840 | \$237.086 | \$2,095.227 |
| Other | \$50.915 | \$36.997 | \$0 | \$87.912 |
| Total Funds | \$2,210.743 | \$1,960.849 | 612.687 | \$4,784.279 |
| Total Persons Served² | | | | |
| Monthly | 71,798 | 362,302 | 56,563 | 490,663 |
| Annually | N/A | 323,181 ⁴ | N/A | 362,104 |
| Waiting List ³ | 0 | 62,200 | 0 | 62,200 |

Notes:

¹ Includes only strategies that at least partially meet the statutory definition of long-term care; consequently, not all programs providing services to elderly or disabled are included.

² Some programs count consumers monthly, others annually.

³ May include duplication of persons among programs; number valid as of Winter, 2000.

⁴ Includes only TDH strategies. See footnote 2 in Table 3 for further information on persons served by these programs. .

Sources:

Agency Operating Budgets and other data collected by the Texas Health and Human Services Commission.

Table 2
Target Populations and Service Delivery Systems of
Agencies Participating in the Long-term Care System

| Agency | Target Population Served | Service Delivery System |
|--------|---|--|
| TDoA | Over age 60, targeting services to those most in economic and social need, but without eligibility requirements | 28 regional contractors (area agencies on aging) provide access and assistance (I&R, benefits counseling, case management, etc.) and contract for a variety of home and community-based supports, such as home-delivered meals and transportation. |
| TDHS | Adults and children with physical disabilities who meet income and other criteria, primarily for Medicaid funded programs | Regional and local state offices provide eligibility determination and service authorization; services are provided through local contractors |
| TDH | Children with physical disabilities who meet income and other criteria, primarily for Medicaid funded programs | Regional and local state offices contract for services with local providers |
| TDMHMR | Adults and children with mental disabilities, with varying other eligibility requirements | Over 40 regional contractors (TDMHMR Authorities) provide access to services for the general population, authorize and contract for services for those most in need, and provide limited direct services |

Numerous studies of the long-term care system have been conducted in recent years. Most of the studies are program or population specific. Appendix B provides a table summarizing the findings from various studies, beginning with the HHSC Long-term Care Task Force in 1994.

Table 3
Long-term Care Financial and Performance Data by Agency
FY 2000 Budgeted Financial and Performance Data

| | TDHS | TDMHMR | TDoA | TDH |
|--|-------------------|-------------------|-----------------|--------------|
| # Of LTC Strategies ¹ | 12 | 12 | 1 | 3 |
| FY 2000 Funding by Source (in millions) | | | | |
| General Revenue | \$1,065.722 | \$943.161 | \$3.956 | \$82.388 |
| Federal Funds | 1,743.777 | 724.115 | 32.458 | 100.789 |
| Other | <u>0.805</u> | <u>86.788</u> | <u>0</u> | <u>0.319</u> |
| Total | 2,810.304 | 1,754.064 | 36.413 | 183.496 |
| # of Persons Served | 236,047/ month | 253,844/ month | 72,182/ year | See note 2. |
| # of Persons on Waiting List ³ | 34,561 | 26,196 | NA | 1443 |
| Notes: | | | | |
| <p>¹Does not include all agencies and all strategies that provide services to persons with disabilities, but those that at least partially meet the statutory definition of long-term care. Includes the following: all TDMHMR strategies, all TDHS community and nursing facility strategies, the TDOA nutrition strategy and the TDH strategies listed in the following note.</p> <p>² The Medically Dependent Children's program serves 872 persons per month; the Chronically Ill and Disabled Children's program serves 4578 per year (excluding case management recipients); and the Comprehensive Care Program serves around 250,000 individuals per year, which includes Medicaid case management as well as long-term and acute services.</p> <p>³ May include duplication of persons among programs; number valid as of Winter, 2000.</p> | | | | |
| Sources: | | | | |
| Agency Operating Budgets and other data collected by the Texas Health and Human Services Commission. | | | | |

The Long-term Care Task Force Report is perhaps the most instructive of these reports since it established a general definition, framework and vision that have been supported through legislative actions. There are a number of general themes apparent from this and other studies, including:

- Texas has been responsive to the call by consumers to develop an array of community-based services, however long waiting lists exist for these services.
- These services are generally an effective alternative to institutional services when individuals are able to access.
- Texas system for accessing services is fragmented and, therefore, confusing to consumers.
- Texas system for accessing services often results in persons entering institutions even though community services may be preferable.
- Texas has undertaken numerous initiatives in recent years to improve access and service integration.
- Disparities and inconsistencies exist across agencies and programs based on diagnostic rather than functional differences.

Limitations and Deficits in the Current System of Services

Assessment Processes

Currently, there is no single, comprehensive survey indicating the number of institutionalized individuals who may meet the conditions for community services as stipulated in the *Olmstead* decision. There is no single uniform means of identifying and informing those individuals for whom community services are appropriate, who prefer to be served in a community setting, and for whom affordable and effective supports can be provided.

Individuals who live in privately operated ICF-MR facilities, in most cases, have not been evaluated as appropriate for the HCS program by the state. Although they have an assigned Level of Care and are known to be Medicaid-eligible, further evaluation is necessary using the Community ICF-MR Living Options Instrument prior to final consideration for community placement. The Community Living Options process (see Appendix C for rule) was implemented December 1, 2000 in community ICF-MR programs and includes guidelines that are used to evaluate consumers' living arrangements in the context of the Promoting Independence Initiative. Effective March 1, 2000 the Community Living Options process was implemented in state mental retardation facilities. Eventually this process will influence the number of individuals recommended for community placement from state schools.

Unlike the Community Living Options Instrument used by TDMHMR, there is no assessment instrument for individuals residing in nursing facilities that will assist their treatment professionals in determining the appropriateness of placement in community-based services. Individuals receiving services in

TDHS nursing facilities do not have a single case manager or professional identified who could make a referral for these individuals, or provide them the information on available community services necessary for them to make an informed choice, or perform intensive case management to transition the individual back to the community.

Capacity Issues

If individuals in community ICF-MR programs wish placement in a more integrated community environment, and their inter-disciplinary team has referred them as appropriate for placement, their name is placed on the HCS Medicaid waiver waiting list. TDMHMR has projected that 10,720 individuals will be on the waiting list. TDMHMR has also found that 32%, or 3,425 individuals, currently on the waiting list will request out-of-home placement, the majority of these in four person or smaller residential settings. Individuals on this current waiting list have waited as long seven years or more for placement.

The CBA waiver program currently has a waiting list of 21,366. The Community Living Assistance and Support Services waiver (CLASS) has 5,897 individuals waiting for services. The Medically Dependent Children's Program waiver (MDCP) has a waiting list of 1,905.

These figures clearly illustrate the need for expanded capacity in the community Medicaid waiver programs.

Varying Eligibility Requirements

The current system of community-based services has a variety of eligibility requirements for each Medicaid waiver or general revenue funded service. These varying requirements add to the confusion of professionals and consumers in their attempts to access the appropriate services that will meet the needs of a person with disabilities. Individual funding caps are placed on plans of care related to Medicaid waiver services. These funding caps are enforced in such a manner that individuals with the most severe needs, residing in institutions and to whom *Olmstead* applies, may have difficulty in accessing community-based waiver services. While it is recognized that there are federal and state Medicaid requirements for budget neutrality and that cost controls are necessary, the caps illustrate the need to find new ways to manage the overall community-based program services costs to increase access to services for individuals in institutions for whom community placement is appropriate. Specifically riders in HB 1 of the 76th Legislature, TDMHMR Rider 7, TDHS Rider 7B, require community Medicaid waiver programs to be below neutrality and cost percentages less than the institutional care these programs waive.

Children in Institutions

In Texas, there are currently more than 1200 children under the age of 21 residing in institutions. Over half of these children are under the age of 17, many are under the age of 10, and some are only months old. There are 9,608 children waiting for community services through the CLASS, HCS, Home and Community-based Services – OBRA (HCS-O), Mental Retardation Local Authority (MRLA), and Medically Dependent Children's Program (MDCP) Medicaid waiver programs. Because of the lengthy wait for community-based services, many families are forced to consider institutional placement for their child to obtain the needed services. Texas currently has no specialized system for recruiting and developing family-based alternatives for children with disabilities residing in institutions.³

Other Issues

The Promoting Independence Advisory Board assisted HHSC in further identifying system issues that limit access and availability of community services. The Board has stated that housing availability, affordability, and accessibility is a major issue. The United Cerebral Palsy Association/Texas' Supported Living Demonstration Project (1989-1992) found that the lack of affordable, accessible housing was a "substantial barrier" to individuals with disabilities moving into the community from institutional settings. Homes that lack ramps, accessible bathrooms and accessible kitchens pose a serious and life-threatening situation in every day lives of individuals with disabilities. A 1994 United States Department of Housing and Urban Development report to Congress entitled "Worst Case Housing Needs" states that people with disabilities typically have multiple housing problems and are among the people most likely to live in severely inadequate housing. Individuals who have been residing in institutions for any number of years may no longer have a home in the community in which to return and receive home-based services. The wait for affordable housing through Section Eight can be as long as two to seven years. HHSC agencies must work better with federal and state housing entities to reach solutions to this barrier. Federal and state housing laws should be enforced. Another problem for individuals attempting to transition into the community is transportation. Lack of transportation for non-medical services, such as grocery shopping, paying bills and recreation limits a person's integration into their community and presents barriers to the success of their transitioning efforts. Supports for people to learn or re-learn basic life skills to function outside an institutional setting, lack of strong informal supports, and transition costs also present challenges to accessing community care.

³ For further discussion, please refer to the Children's Long Term Care Policy Council report, September 1, 2000 entitled "Moving to a System of Supports for Children and Families" and to Appendix D for recommendations supported by the PIAB related to children's services.

Critical to long-term care is an adequate supply of direct care staff. Across the nation, states are suffering a shortage of trained and qualified staff. The healthy economy has created a situation where recruitment and retention of qualified staff is difficult, given the current funding rates. The long-term care system in Texas has significant issues related to responding to the service, support, and health needs of people with disabilities. Issues around training of staff and caregivers, licensure of providers, nurse delegation, and availability of professional staff exist as current barriers to individual's accessing community services.

With the assistance of the Promoting Independence Advisory Board, HHSC has identified various system recommendations in the areas of access, capacity, legislative and funding requirements that should be implemented to ensure a coordinated, comprehensive system of services and supports. These recommendations are discussed in more detail in the section on System Improvements Needed.

STATUS OF INSTITUTIONAL CARE AND SYSTEM RESPONSE

As of September 1, 2000, state and federal funding supports approximately 76,350 people living in institutional settings in Texas. This includes 66,200 people living in nursing facilities, approximately 2,400 living in large ICF-MR settings and 5,400 enrolled in state schools for persons with mental retardation, and 2,350 receiving inpatient services in state hospitals for persons with mental illness, on an average day. The current status of individuals in the various types of institutions and how the system responds to individuals desiring and appropriate for community care varies by type of institution, as follows:

State Schools

As of September 1, 1999, there were approximately 409 individuals residing in the 11 state schools and El Paso and Rio Grande State Centers, operated by TDMHMR, who were recommended for and had expressed an interest in community placement. By October 31, 2000, 118 of the original 409 remain in facilities and continue to request community placement. Another 198 individuals have expressed an interest in and been recommended for community placement, bringing the current total of state school residents awaiting community care to 316.

TDMHMR has committed to making community placement options available to each of the remaining 118 individuals by August 31, 2001, provided that they want to return to the community and can be appropriately served there. Effective September 1, 2001 the agency commits to provide opportunities for community alternatives within 180 days of any individual's request and recommendation for placement.

The Community Living Options process, discussed above, will influence the number of individuals recommended for community placement from state schools. Individuals who reside in a state school continue to make their request for community services known through their Inter-disciplinary Team Process and the Qualified Mental Retardation Professional acting as their case manager. If they reside in a state school, there are existing slots set aside within the HCS services for those individuals desiring these services and whose teams feel these services are appropriate.

ICF-MR Facilities

TDMHMR implemented the Community Living Options process in December 2000 to inform all individuals residing in ICF-MR residential facilities, no matter the size, of potential alternative living arrangements. Current data from the agency indicates that there are 228 persons⁴ living in “large ICF-MR facilities”, on the waiting list for community placement through the HCS Medicaid waiver program. The TDMHMR designation for “large ICF-MR facility” is 14 beds and above.⁵ The number of persons waiting for community placement through the HCS Medicaid Waiver program should rise as a result of the Community Living Options process.

Currently the consumers who indicate a desire to pursue an alternative living arrangement are referred to the local Mental Retardation Authority (MRA). If services are not available within 30 days, the MRA will add the individuals to their waiting list. However, the agency, with appropriations, has now committed to placing these individuals within twelve months of the date they were determined to be ready for community placement.

State Hospitals

At the end of fiscal year 2000, the eight state hospitals averaged a daily census of 2,350 with approximately 15,800 admissions during the year. For most residents, inpatient psychiatric care is a relatively brief intervention, lasting no more than a few weeks. However, for those individuals whose treatment needs are the most severe, longer lengths of stay may be indicated. As of October 1, 1999, 54 individuals had been in state hospitals for longer than 12 months and are considered ready for discharge into a community-based living arrangement. Since that time, 38 of those individuals have been discharged, leaving 16 persons from the original 54 remaining in the state hospitals due to identified barriers preventing discharge from the hospital. At any given time there are between 30 and 50 individuals who have been in state hospitals for longer than 12 months and are considered ready for discharge into a community-based living arrangement. There are additional persons who have been in state hospitals longer than 12 months, but are not recommended for discharge by treatment

⁴ Information from the TDMHMR waiting list study completed December 1, 2000.

⁵ See Appendix A recommendation 2.

professionals and continue to meet commitment criteria for in-patient hospitalization under the Mental Health Code.

Nursing Facilities

TDHS implemented a new rule that allows nursing facility residents increased access to the CBA program. Individuals who request CBA services and have resided in a nursing facility within the last six months automatically move to the top of the CBA interest list for a determination of CBA eligibility. Other Medicaid programs may serve individuals desiring and appropriate for community-based programs, including the CLASS, MDCP, HCS, and MRLA waivers. Individuals desiring community placement would have their names placed on interest or waiting lists for these programs. As previously stated, no current identification and assessment process for individuals residing in nursing facilities who desire community services and for whom appropriate community services may be available exists. TDHS nursing facilities do not have a single case manager or professional identified who could make a referral for these individuals, or provide them the information on available community services necessary for them to make an informed choice, or perform intensive case management to transition the individual back to the community.

SYSTEM IMPROVEMENTS TO BETTER SUPPORT PERSONS WITH DISABILITIES

To fully support Texans with disabilities in their efforts to lead productive and meaningful lives in the community, basic improvements that are needed for access must be made to the current system. With the assistance of the PIAB, the following areas for improvement have been identified.

Identification & Assessment Related Funding Issues

TDMHMR Issues

As recommended by the PIAB, TDMHMR has developed the assessment tools to determine persons eligible for community placement. TDMHMR is committed to expanding service opportunities in the community through the HCS program, both for current and future individuals residing in institutions and potential new consumers. TDMHMR's goal is to offer opportunities in the HCS program within 12 months of determining that such services are appropriate for any ICF-MR resident.

However, to meet the agency's commitment to the Promoting Independence Initiative additional funding is necessary to increase the capacity of the HCS program. TDMHMR's Legislative Appropriations Request contained an exceptional item, which included an additional 325 HCS slots for state schools and 864 HCS slots for community ICF-MR's in the next biennium

(2002-2003).⁶ A total of \$36,454,065 in general revenue funds was requested to assist in making community placement a reality for individuals currently in the ICF-MR program. The basis of the estimate for HCS expansion is a statistical analysis by TDMHMR taking into consideration all children in ICF-MR facilities, 60% of individuals in community ICF-MR programs, not on the waiting list, with a Level of Need 1, and 35 % of individuals in community ICF-MR programs, not on the waiting list, with a Level of Need 5. This totaled 1278 person who would be likely to choose alternative services. TDMHMR then requested a portion of this number for their Legislative Appropriations Request for the next biennium. (Appendix E provides further information on this analysis).

TDMHMR will review the Community Living Options process in relation to its application to children and families and continue to revise as necessary.

As individuals residing in state hospitals progress to the point of discharge readiness, local community mental health authority staff arrange discharge plans for community re-integration. With few exceptions, this provides community transition at a “reasonable pace”. TDMHMR will monitor state hospitals for delays in community discharge and will respond accordingly.

TDHS Issues

The PIAB believes TDHS must develop an identification and assessment process in which people in nursing facilities can be informed as to the options for community support and evaluated for re-integration once there is an expression of interested in leaving the nursing facility setting. This process must be developed with concern and sensitivity to the needs of all nursing facility residents. Timelines for community placement will be established based on data generated through the identification process. Efforts to effect community placement for people with disabilities who live in nursing facilities, and for whom affordable supports can be provided, will move forward independent of the efforts to offer community alternatives to other institutional settings.

TDHS has proposed the following steps for Phase 1 within existing resources:

- Inform all MAO and SSI nursing facility residents of long-term care options, and their eligibility to bypass the waiting lists of the CBA program
- Inform new applicants, at the time of application, of long-term care options for which they may be eligible.
- Provide computer-based training for all TDHS staff to ensure their awareness of CBA programs, the Promoting Independence Initiative, and sensitivity to persons with disabilities.

⁶ A slot is an available placement in the HCS waiver program. The difference in the two sets of slots is 325 are being set aside to serve individuals within the state schools and 864 slots to be serve individuals in other ICF-MR programs.

- Train all long-term care staff on implementation procedures of the Phase I activities which include: implementation of identification, application of the assessment instrument, data collection, community awareness and permanency planning.
- Implement a data collection system to develop a promoting independence consumer profile and to identify successful factors and barriers to transitioning of individuals in nursing facilities into community-based settings
- Implement community awareness activities to promote long-term care options
- Provide permanency planning to develop community placements for children. (RFP projected to be published in January 2001).

In addition to these steps in Phase 1 funding the initiation and implementation of the TDHS plan and process for identification and assessment requires moving \$1.7 million dollars the agency received in enhanced matching funds. A request is pending before the LBB and Governor's Office to transfer the funds. The following steps are proposed by TDHS, dependent on approval to use the \$1.7 million dollars in enhanced funding in FY 2001:

- Hire, train and deploy 22 staff for six months of FY 2001 to provide intensive relocation and outreach activities at selected sites.
- Implement an identification process and assessment instrument to transition 50 individuals in nursing facilities.
- Develop an automation system to track data collected by the relocation specialist to build onto the baseline profiles from steps listed above.
- Pay for costs associated with moving and re-establishing a community residence for projected 50 individuals.
- Target community awareness activities
- Intensify permanency planning activities for 75 children in nursing facilities
- Submit an RFP for relocation activities including development of the identification process and assessment instrument. Site selection is dependent upon the entity awarded the contract; action plan is being developed for publication of the RFP.

Appendix F provides further information on the TDHS Identification and Assessment process. HHSC will continue to monitor the TDHS Identification and Assessment Process for timely implementation.

Access Issues

In the current system, stakeholders have reported that access to services is fragmented, programs have differing and conflicting eligibility requirements, and

that system is not easy to understand. The PIAB and others have identified the following steps to improve access to services across the system.

Local Access Plans

SB 374, 76th Texas legislature, provides local communities with the opportunity to submit local access plans for long-term care services and requires that the state support local efforts. Thus far, 22 plans have been submitted. These plans describe barriers to improving access at the local levels, request assistance from HHSC and outline improved systems of local access. HHSC has established a Texas Long-term Care (TLC) Access Review Committee to assist with reviewing the local plans and developing a state response to requests for assistance. Through this process, the Commission will work with agencies to develop a system of access to services that will be local, user friendly, and provide the information necessary to consumers, family members, volunteers, and advocates to reduce the fragmentation of the current system of services.

Consumer Assessment and Navigation Services

An important component of the local access plans is the need for a more centralized case management or navigator type function. This same need was identified by the Promoting Independence Board and by other analyses of the long-term system.⁷ HHSC and the HHS agencies will study the current case management system and the possible development of specialists that can navigate the network of services on behalf of the consumer and their family, in order to reduce the fragmentation of services and the frustration of consumers and families in accessing needed services. The system of access should also incorporate development of the information and referral network and potential use of the 211- telephone number and build on existing systems in order to reduce cost and duplication.

The PIAB recognizes, as did the local access plans, that another component of improved local access may be the use of a single functional assessment. Currently, HHSC has developed and will be piloting the use of a single functional assessment for long-term care services, through the new consolidated waiver pilot project. HHSC will study the pilot data, and move forward with implementation if data indicates a successful system change.

Training and Information

In order to effectively implement the Promoting Independence Initiative, it is critical that staff and agencies receive training in the history, intent and scope of the initiative, development of community supports for people in transition from institutions to the community, contact information of service providers,

⁷ HHSC, prepared by Susan Stone, J.D.M.D. "Long-Term Service and Supports Initiative: Rate Setting, Service Design, Access"

and initiation of community-based services. HHSC should coordinate with appropriate agencies to develop and implement this training.

HHSC should take the lead in developing one comprehensive, but family-friendly information packet and video that can be used in all institutional settings to educate residents/families/guardians about all available community services. Within the process of development, the HHSC should convene a focus group of consumers/families to gain input regarding content, format, etc.

Technology

A final component of improved local access recognized by both the local access plans and by the PIAB is information technology. The PIAB recommends HHSC study the infrastructure issues between agencies related to varying computer systems, databases, and tracking of consumers, which is similar to the recommendation of the TLC Access Review Committee. Under the HHSC expanded authority provided in SB2641 of the 76th Legislative Session, HHSC is beginning to move forward in creating some standardization and consistency in data systems across agencies. This particular step will require increased effort and new focus to be placed on those data systems related to consumer care. HHSC envisions a single data center where the various agencies' service tracking systems can be consolidated and data can be easily shared. Toward that end, HHSC has appointed a technical architecture committee charged with selecting an automation approach that will be used by all the HHS agencies as they develop new systems. The committee is also evaluating products that will allow the current agency systems to share data.

System Capacity and Funding Issues

HHSC could not move forward with the Promoting Independence Initiative without studying issues related to the capacity of the system to serve those individuals currently in institutions desiring and appropriate for community placement. To prevent the unnecessary institutionalization of individuals, inroads must be made into the existing waiting lists and movement of resources necessary to provide placements. HHSC also studied recommendations related to gaps in existing services. In addition to the previously discussed steps that will require funding, the following actions are necessary for success with the Promoting Independence Initiative:

- Funding for HHS agencies' exceptional items related to Promoting Independence and Waiting Lists account for approximately four percent or \$252.5 million of the \$6.1 billion All Funds exceptional items request for all HHS agencies for the FY 2002-03 biennium. Funding is necessary in order to increase the capacity of the system to accommodate those individuals currently in institutions, or who are in need of placement.

- HHSC should work with TDMHMR to develop a plan which allows for community placement at a reasonable pace for those individuals identified through the Community Living Options process, should their numbers be greater than the allotted slots currently projected and set aside.
- In cooperation with the State Medicaid Office, TDMHMR should develop a Medicaid waiver or other options that provide services to those individuals on the waiting list who need only community supports. This is necessary due to the lengthy wait for HCS community services. Although the HCS waiver provides non-residential services, individuals wait for years to come to the top of the list and only then are the type and amount of services determined after their eligibility is approved. With a new Medicaid waiver that provides only non-residential supports, it is anticipated that significant numbers of individuals waiting could move off the existing list and possibly access these services more quickly. Therefore, HHSC supports the TDMHMR Legislative Appropriations Request of \$4,929,357 general revenue, which includes a mixture of HCS waiting list slots, and placements on a new mid-range waiver.
- Housing is a necessary component to assisting individuals from institutions who desire and are appropriate for community placement. The HHS Consolidated Budget has requested \$4,320,000 for rent subsidies for consumers moving out of institutions who are waiting for federal housing assistance.
- The service delivery system has been undermined in recent years by a high turn over rate of direct care employees. HHSC should work with appropriate long-term care agencies to explore and develop employee recruitment and retention incentives for providers of services. Within Tier II of the HHSC Consolidated Budget, under the Promoting Independence, HHSC supports the TDHS requests for \$89,073,319 in general revenue-funding inflation for community care, nursing facilities, and STAR-Plus programs. Along these lines, the Commission supports the TDMHMR Legislative Appropriations Request for \$24,910,550 in general revenue for a rate increase for HCS and ICF-MR, and rehabilitation service providers. This may allow providers to increase pay rates of direct care employees, and fund community services to ensure a fiscally healthy community provider base. The Commission also supports the TDHS LAR request for \$150,247,149 in general revenue to increase wages and benefits to attract and retain qualified community care attendants and nursing facility aides. TDMHMR also has an exceptional item request in their LAR for \$23,991,228 for salary increases to direct care staff in TDMHMR facilities.
- HHSC should ensure that coordinated planning between agencies is developed to address the need for availability and access to mental health services to compliment long-term care waiver services for people with mental illness leaving institutions. Sufficient mental health services in the community are needed to prevent the unnecessary institutionalization of individuals with mental illness. HHSC supports the funding request of

TDMHMR for \$83,891,720 in general revenue for service expansion of mental health community supports.

- HHSC will examine and work with appropriate agencies to develop and encourage the foster care model in securing foster care placements, adoptions, and family-based alternatives to institutional settings. The HHS Consolidated Budget requests \$3,345,139 in general revenue funds for the development of a new program that offers family based alternatives for children that are leaving institutions and cannot return home to their birth families. Because technical assistance is also necessary for the recruitment and training of staff implementing the above foster care model, the Consolidated Budget also requests \$151,650 to ensure proper training and research of best practices occurs.
- HHSC supports the TDPRS Legislative Appropriations Request ⁸ for \$8,565,981 in general revenue to create a 2-tiered rate system for adoption assistance as an incentive for families to adopt children who need higher levels of care. This is needed for the state to move forward, support the needs of children, and ensure that children in Texas are not unnecessarily institutionalized.
- HHSC also supports the TDPRS request for \$11,755,184 in general revenue⁹ to increase rates for foster care providers and adoptive parents of special needs children by 5%. This should provide incentives to serve special needs children in foster and adopted family environments.
- HHSC supports a series of funding requests related to transitioning individuals to whom *Olmstead* applies out of institutions and into the community. The funding requests address both children and adults. Within Tier II of the HHSC Consolidated Budget, HHSC supports the TDHS transitional funding proposal for MDCP consumers in the amount of \$562,000 in general revenue. These funds would be used to make one-time modifications that would allow families to successfully transfer their child into community care. Transitional funds within the agencies appropriations requests was requested for CBA and CLASS programs, but not for MDCP. HHSC also requested transitional funding for HCS consumers in the amount of \$500,000 in general revenue. These funds would benefit approximately 200 HCS consumers.
- Because of the long wait for services in community Medicaid waiver programs, the state needs to increase capacity within the existing community services to meet the needs of the population residing in institutions and meet the requirements of the *Olmstead* decision. HHSC supports the TDHS' Legislative Appropriations Request for \$28,327,0900 in general revenue to increase CBA Waiver slots by 1,061, CLASS waiver slots by 54, and MDCP

⁸ These items represent a portion of TDPRS' LAR biennial request

⁹ Same as above.

waiver slots by 225 by FY2003. HHSC also supports the TDMHMR Legislative Appropriations Request of \$36,454,065 in general revenue to phase-in 325 additional placements from state schools and 864 placements for persons moving from ICF-MR facilities. Additionally, to reduce the long-term care waiting lists for community placement, which many times results in unnecessary institutionalization of individuals, HHSC supports TDHS Legislative Appropriations Request¹⁰ for \$40,081,955 in general revenue to fund 3,740 consumers in FY2003 from community care waiting lists.

- Transportation has also been identified as a major issue for individuals attempting to transition from institutions into the community. Within the Promoting Independence request of the Consolidated Budget, HHSC has asked for \$780,000 in general revenue to provide non-medical transportation to these individuals.

Other Legislative Considerations

In addition to the funding requests outlined above, Appendix G provides a funding summary and has additional information on the Promoting Independence section of the TIER II of the HHSC Consolidated Budget. The total funding for exceptional items related to Promoting Independence and addressing waiting lists account for approximately 4% or \$252.5 million of the \$6.1 billion All Funds exceptional item requests by HHS agencies. Statutory relief issues such as rule changes within the Texas Administrative Code (TAC), and elimination of riders¹¹ lessening the percentages factored against cost neutrality for Medicaid waivers will be reviewed and specific steps developed to implement these changes as appropriate by the continued Promoting Independence Advisory Board and its work groups.

Removing Service Barriers to Community Supports

The Promoting Independence Advisory Board meetings have provided HHSC with specific information regarding service barriers to de-institutionalization. The following recommendations address these service barriers, as well as recognize the importance of a continuum of care and the role for the consumer and family choice in the system of services and supports for Texans with disabilities. These steps are essential to moving the system that supports persons with disabilities to one that fosters independence and productivity and provides meaningful opportunities for individuals to live in their home communities.

Expand Medicaid Benefits

In its role as the single State Medicaid Agency, HHSC should modify the existing State Medicaid Plan to include benefits for adults related to durable

¹⁰ TDHS partial LAR exceptional item request.

¹¹ TDMHMR - HB 1 76th Legislature (Art.11-73) Rider 7; TDHS - HB 1 76th Legislature (Art.II-58) Rider 7b

medical equipment, prosthetic and orthotic devices and repair of such devices, as well as therapies needed to maintain the individual's functioning. As directed by the Health Care Financing Administration states should eliminate the homebound requirement under the Medicaid Home Health Benefits.¹² Another system improvement needed would be to determine a way to ensure timely provision of durable medical equipment. HHSC anticipates that this will have significant fiscal impact to the Medicaid budget by the addition of the above benefits to adults and the removal of the Homebound restriction. Therefore, this recommendation must be implemented in a cautious, systematic and immediate manner to provide a long-range plan for system changes to service delivery.

HHSC will partner with TDH to study and possibly implement the expansion of the Rehabilitation Option of the State Medicaid Plan to include acute and post-acute rehabilitation. This expansion would lead to a potentially significant increase in costs for TDH. The inclusion of these services may prevent unnecessary institutionalization of individuals in need of these services.

Meeting the Needs of Children and Their Families

HHSC will work with TDHS on a proposed rule change to eliminate the need for children to reside in a nursing facility before they can enter the MDCP program. The CBA waiver has this exception currently. Additional work should be done with TDHS to establish an exception to allow for children who reside in an ICF-MR to bypass the CLASS interest list. Issues around this recommendation that need to be studied are related to fairness to those families who have waited years to advance on the interest lists for community service, and prevention of people being institutionalized to access community Medicaid waiver slots. Immediate access to these waiver slots will allow the state to meet the *Olmstead* decision requirements around "reasonable pace".

The Commission will continue to work with the Children's Long-Term Care Policy Council to implement the recommendations as appropriate in their report of September 1,2000, entitled "Moving to a System of Supports for Children and Families." This report was developed in response to SB374 76th Legislature. The Commission will continue this work so that services within the State of Texas:

- 1) are applicable to the special needs of children with disabilities,
- 2) are in alignment with the overall system of care,
- 3) promote the principles of family support, the development of alternative families for children with disabilities, and
- 4) incorporate service and delivery system changes that make these services available and user friendly to children and families.

¹² HCFA Letter, July 25,2000, Attachment 3-g

This will allow all children with disabilities to receive the appropriate care necessary to serve them in family settings in their home communities.

Cost Neutrality Issues

The HHSC State Medicaid Office will study the impact of cost neutrality as it relates to individuals being unable to access community services due to the high cost of their individual plans of care. Currently individual plans of care may not exceed a certain percentage of the cost of the institutional care and caps are placed on certain devices or equipment to contain waiver program costs. HHSC will study and develop resolutions to require individuals currently in institutions, desiring and appropriate for community services, to be exempted from individual cost cap rules. Additionally, all Medicaid waiver services must have an appeal process beyond the existing processes required for Medicaid programs that is easily accessed and that will review the disapproval of the justified need for services that are over the individual cost caps.

Comprehensive Care Coordination System

FINALLY, HHSC recognizes the need to work with appropriate agencies in the continuing development of a comprehensive care coordination system for all persons with significant physical and /or cognitive disabilities and their families. This system must include adequate follow-up for individuals who move to the community. Part of this system of follow-up must include criteria for successful transition and placement, criteria for measuring quality of services including a measurement of consumer satisfaction, and continued communication between agencies to ensure that the basics of everyday life are in place (food, clothing, utilities, attendant care if necessary, etc.). This may require additional funding to ensure the provision of follow-up services. The Promoting Independence Advisory Board, in its implementation phase, will assist with the development of this type of comprehensive care coordination.

CONCLUSION

In light of the *Olmstead* decision, HHSC has committed to a continuing relationship with the Promoting Independence Advisory Board. To move various HHSC agencies and services towards actions in support of *Olmstead*, HHSC has moved to an implementation phase with the PIAB. Re-appointed membership will focus on a higher level of accountability and policy decision-making. Recognizing the need for continuity, HHSC has re-appointed members from the original Board who represent a broad array of stakeholders.

HHSC will continue to work diligently to evolve a response from this framework that will provide detailed accountability with agencies involved. A further identification and sequencing of expansion and implementation steps will also be

developed during the legislative appropriations process and work with agencies on current recommendations within the framework of this plan. HHSC is dedicated to collecting data on all aspects and steps of its Promoting Independence Initiative. HHSC will track the progress on the initiative and report back to stakeholders regarding the status of its various phases. HHSC intends to hold public stakeholder meetings around the state to publicize its efforts and accomplishments related to the initiative. HHSC would like to thank all members of the initial Promoting Independence Advisory Board,¹³ who dedicated much of their time, resources, knowledge, and abilities in the development of the steps of this initiative. HHSC believes that the Promoting Independence Initiative will further enhance the ability of Texans with disabilities to live and receive services in their communities. HHSC welcomes the opportunity to continue its work with consumers, advocates, providers, and agencies to improve the system of services and support for individuals with disabilities. Together, we can and will make a difference.

¹³ See Appendix H for members and agency representatives



**Texas Health and Human
Services Commission**

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Appendix A

Recommendations

Adopted at the PIAB Meeting - 10/24/00

Adopted at the PIAB Meeting - 11/28/00

HHSC Response

RECOMMENDATIONS ADOPTED BY THE PROMOTING INDEPENDENCE ADVISORY BOARD

Identification and Assessment

1. PIAB recommended that DDPC, the University Affiliated Program, and Advocacy, Inc. should coordinate project activities with the agencies, including HHSC, to address identification and assessment processes, capacity enhancement, and other activities supportive of the implementation of the Promoting Independence Plan. HHSC should direct appropriate agencies TDHS, TDMHMR, TDPRS to collaborate and provide assistance to this project. The project should explore various institutional settings; develop a plan of action including outcomes, responsible parties, and a fiscal note.
 - HHSC believes that project activities, as proposed in the “Collaboration Project” will need to build on the existing authority structure for people with mental retardation. Partners in the “Collaboration are encouraged to work with TDMHMR to develop a project plan that strengthens the existing system. With respect to information dissemination and referral to appropriate community care for individuals who reside in nursing homes, the Commission supports the joint development of a project plan between TDHS and the partners in the “collaboration”, with the appropriate input from the nursing home industry.
2. TDHS, TDMHMR, and TDPRS should work with the Promoting Independence Advisory Board and in cooperation with the project funded by the DDPC to develop an identification process to identify those individuals in nursing homes, state schools, ICF-MR’s and state hospitals who choose community-based services. A plan of action with outcomes, responsible parties and a fiscal note should be developed, include the creation of a model, lower the qualifier of large facilities to six bed, and begin incorporating the Community Living Options and the role of the MRA The PIAB disagrees with applying the instrument to only 14+bed institutions.
 - HHSC understands that a process for identifying people in institutional settings who may match the criteria in Olmstead was developed by the end of June 2000 by TDMHMR and by August for TDHS. HHSC applies the TDMHMR definition of “large facilities” to those ICFs-MR that are 14 or more beds. However, TDMHMR as of December 1, 2000 applied the Community Living Options Instrument to all individuals residing in ICF-MR facilities, no matter the size.
3. TDMHMR, TDHS, TDPRS, and TDH should each contribute resources to match and enhance the identification project funded by the Developmental Disabilities Council, in order to ensure that the resources are available so that the project includes a comprehensive and appropriate identification and assessment process

- for children and families. Resources could be staff and other non-monetary resources.
- HHSC expects requirements to be identified in the project plans for the identification process developed by the agencies listed.
 - HHSC supports the movement of 1.7 million in enhancement funds to begin the DHS identification and assessment process. Preliminary verbal approval to move these funds has been granted to the agency by the legislature.
4. The PIAB approved and accepted the TDMHMR Community Living Options Tool and agency process for identification and assessment.
 - HHSC supports the implementation of this tool as TDMHMR has presented, and will continue to check the progress and rule adoption related to the CLO Assessment. HHSC continues to support the implementation of this document through existing structure in the ICF-MR program.
 5. The PIAB approved and accepted the DHS Plan and process for Identification and Assessment.
 - HHSC continue to monitor DHS progress in relation to their identification and assessment process. HHSC supports the use of internal staff at DHS, or the contracting with an independent unbiased party to perform their assessment. HHSC supports the stakeholder process to determine the five sites for first implementation.
 6. PIAB recommends that the state include strong and clear language asserting that individuals on waiting lists for community services (or at least the subset of individuals who are expected to require services within a year) are “ at risk” of inappropriate institutionalization and are, therefore, covered under the Olmstead mandates.
 - HHSC believes the Olmstead Decision applies to all individuals currently in institutions identified as waiting for placement in the community. HHSC recognizes the need to make sizeable inroads into the waiting list, in order to prevent the unnecessary institutionalization of individuals desirous of community care.
 7. The LBB should move the 1.7 million dollars (1.3million of state enhanced food stamp monies and 472,000 of federal monies) requested by DHS to start immediate implementation on the Identification and Assessment Process of individuals living in nursing homes who wish to move to a community setting. The PIAB, the Commission, and the Agency involved have all supported the movement of the 1.7 million dollars for this purpose, which is critical to the initiation of the state’s response to the Olmstead Decision.
 - HHSC supports this recommendation, and has demonstrated its support through various meetings with the legislature. Preliminary verbal approval to move these funds has been granted to the agency by the legislature.

8. PIAB recommends that the Community Living Options Instrument be reviewed for specific use with children and their families.
 - HHSC supports the implementation of this tool as TDMHMR has presented and will continue to check the progress and rule adoption related to the CLO Assessment. The tool itself is for use with all individuals regardless of age, but HHSC would support any changes the agency would make in their continuing review of the tool to accommodate this recommendation.
9. PIAB recommends that individuals, who choose, have access to independent third party who is thoroughly conversant with the resources of the community and the realities of living independently should be used in conjunction with the identification and assessment functions.
 - HHSC does not support the use of choice counselors. The commission supports the DHS process of internal staff and supports the use of an independent third party, without bias, to perform the identification and assessment process should TDHS not have internal capacity do so. HHSC continues to support the implementation of the Community Living Options Assessment Tool through the existing ICF-MR structure to avoid duplication. HHSC expects those individuals who perform this function to be trained in the identification and assessment tool and have the necessary knowledge to perform the tasks assigned.
10. PIAB recommends that agencies and staff implementing the Promoting Independence Initiative receive training in: the history, intent and scope of the promoting independence initiative, development of community supports for people in transition from institutions to community, contact information for ILC's and other community groups, and initiation of community based services.
 - HHSC supports this recommendation.

Capacity

(Infra-structure, is the service delivery system sufficient to provided services and in a timely manner)

11. PIAB recommended that housing assistance recommendations be a necessary component of the State's response to the Olmstead decision.
 - HHSC supports this recommendation. The HHSC Consolidated Budget Request includes \$4,320,000.00 for rent subsidies for consumers waiting for federal housing assistance.
12. PIAB recommends exploration and development of employee recruitment and retention incentives for all providers of long term care (LTC) services.

- HHSC supports this recommendation.
13. PIAB recommends that HHSC recognize that TDOCJ is being used to institutionalize individuals with mental illness, TBI, and other disabilities due to a lack of available community services. (Trans-institutionalization)
 - HHSC does not apply the Olmstead decision to the population served through the Texas Department of Corrections. HHSC recognizes the need for increased capacity in services to persons with mental illness in the community. HHSC supports the agency's LAR in regards to their request for diversion programs.
 14. PIAB recommends that HHSC work with the TDMHMR to develop a plan which allows for community placement at a reasonable pace for those individuals identified through the Community Living Options tool, should their numbers be greater than the allotted slots available.
 - HHSC will work with the legislature to achieve maximum flexibility in addressing the states obligations under the Olmstead decision.
 15. PIAB recommends that TDMHMR in cooperation with other stakeholders investigate, evaluate, and develop a waiver or other options that provides services to those individuals on the waiting list who only need community supports that do not include residential services. (The light waiver)
 - HHSC supports any waiver development that would better suit the needs of individuals on the waiting list.
 16. PIAB recommends that case management services be included in the CBA waiver.
 - HHSC would prefer to study the impact on consumers of adding case management to the CBA waiver. The addition of this service would be included in a person's individual plan, which would lessen the amount of funding for other needed services. The use of targeted case management as a mechanism to provide this service may be an alternative. HHSC should work with TDHS and its stakeholders to formulate a plan in response to this recommendation.
 17. PIAB recommends that HHSC study infrastructure issues between agencies around computer systems, databases, tracking of consumers.
 - HHSC supports this recommendation, and is currently studying this issue as it relates to its obligations in SB2641, and our Systems Operations Division

Service Barriers
(Including such items as regulatory barriers, rules, policies, etc.)

18. PIAB recommends that the state change the Medicaid State Plan to include benefits for adults related to durable medical equipment, prosthetic and orthotic devices and the repair of such devices; and therapies needed to maintain their functioning and eliminate the homebound requirement under the Medicaid Home Health Benefits; as well as study and develop resolutions that ensure timely provision of durable medical equipment.
 - HHSC would need to study the fiscal impact before supporting this recommendation. HHSC will work with appropriate agencies to develop resolutions to the issues of timely provision of durable medical equipment.

19. PIAB recommends that coordinated planning between agencies be developed to address the need for availability and access to mental health services to compliment long term care waiver services for people with mental illness leaving institutions.
 - HHSC supports this recommendation and made it part of its overarching Texas Promoting Independence Initiative by ensuring that implementation of the initiative will study and address issues related to mental health services. HHSC has supported TDMHMR's request for additional mental health community services funding.

20. PIAB Recommended that the concept outlined in the TACIL proposal to HHSC and that any Requests for Offer (RFO) are developed by the agencies include the components of the TACIL proposal.
 - HHSC supports the use of independent and objective contractors to perform identification and assessment functions when no resource exists within the state agency. The current Local Mental Retardation Authority at TDHMHR is the preferred structure for Identification/Assessment of the population with mental retardation. The DHS proposal for outside contractors is preferable for nursing home populations, as they have no current resources to perform these tasks.

21. PIAB recommends that a change in the CLASS rules be developed to allow for children who leave nursing homes to be served in the CLASS waiver and be at the top of the waiting list for the CLASS waiver.
 - HHSC supports working with appropriate agencies to ensure that individuals who are eligible for waiver services will have access to the appropriate waiver.

22. PIAB recommends that HHSC take the lead in developing one comprehensive, but family-friendly information packet and video that can be used in all institutional settings to educate residents/families/LAR's about all available

community services. The process should include convening a focus group of consumers/families to gain input re: content, format, etc.

- HHSC supports this recommendation, and is working through accomplishing this recommendation through the implementation of the Texas Promoting Independence Plan.

23. PIAB recommended that the recommendations in the CLTCPC Report Chapter: Promoting Independence and Permanency Planning for Children in Texas be adopted, this includes the major recommendations 1 through 8 be with the subsequent recommendations under each of the eight. (See Appendix D)
 - HHSC has responded in detail to the Children's Long Term Care Policy Council on each of its recommendations. The Commission has asked the CLTCPC for recommendations on how to initiate and implement effective systems change. The Commission has also requested the CLTCPC to prioritize their recommendations and assist with identifying those areas that don't require new appropriations or legislative authorization.
24. PIAB recommends that HHSC fully study and examine the issues of difficulty in recruiting quality foster care families, inadequate reimbursement rates, federal tax code inequities, and the lack of available training programs for providers and foster families; and develop resolutions to the barriers identified.
 - HHSC supports studying the issues around foster care, and will look to the CLTCPC for guidance and further recommendations.
25. In light of the Olmstead Decision the HHSC has assembled a stakeholder board to provide guidance and input to the Commission in the development of its response to the Olmstead Decision. The Board, in it's efforts to comprehensively study the issues related to the Olmstead Decision; to move various agencies and services under the HHSC umbrella towards actions in support of Olmstead; and to ensure appropriate response based on stakeholder recommendation proposes the following:

That the HHSC develop a mechanism that will begin by 3/1/00 to collect data on approved recommendations of the PIAB, involving other agencies' responsibilities, track the progress and lack of progress on these recommendations, and publish this information to all stakeholders in a timely fashion.

 - HHSC supports this recommendation, but will use the Promoting Independence Advisory Board in the implementation phase to develop the system, tracking, and mechanisms to publish information to all stakeholders.
26. PIAB recommends that appropriate agencies develop a mechanism to allow those individuals who reside in institutions, identified as wanting and needing community placement, for any existing waiver services for which they are eligible, to receive a waiver slot without going to the bottom of a waiting list.
 - HHSC supports this recommendation.

27. PIAB recommends that HHSC develop with appropriate agencies a comprehensive care coordination system for persons with traumatic brain injury and other significant physical and/or cognitive disabilities and their families including the expansion of the Rehabilitation Option in the Medicaid State Plan to include acute and post-acute rehabilitation and to educate and train policy makers and service providers.
 - HHSC will need to study this recommendation further with reference to fiscal implications on Medicaid services within the state. Additionally, HHSC will study the results from piloting the single functional assessment and the consolidated waiver in regards to its efforts for a comprehensive care coordination system for all persons with significant physical and/or cognitive disabilities.

28. PIAB recommends that we not restructure the existing system, but build on what we have such as allowing for nurse delegation in the primary home care program, to allow for presumptive eligibility in the community waiver services as is done in the nursing home care services, etc.
 - HHSC would need to study this recommendation further before it could fully support implementation. There is no presumptive eligibility in nursing facility services. Facilities get a prepayment up-front. If they don't and someone is ineligible the facility is not paid by TDHS. There is however, retroactive coverage in nursing facilities that does not exist in waivers, and would require federal approval to do. Retro coverage (three months prior) is not the same as presumptive eligibility. Expansion of nurse delegation for the primary home care program would require legislative appropriations.

29. PIAB recommends that adequate follow-up for individuals who move to the community be provided. This would include criteria for successful transition and placement, quality of services including a measurement of consumer satisfaction, communication between agencies, and ensuring that the basics of everyday life are in place (food, clothing, utilities, attendant care if necessary, etc.)
 - In general, HHSC supports this recommendation. However, HHSC recognizes that it carries a fiscal implication to build the follow-up services listed.

30. PIAB recommends that the state include within its promoting independence plan workable and useable solutions that consumers, family members, volunteers and advocates can put into place for individuals and that the state address the fragmentation of the current system through a process that allows for individuals to know where to go to get the services they need.
 - HHSC supports this recommendation.

31. PIAB recommends that services be provided on functional need, eliminating unnecessary medical and professional services, rather than categorical funding sources.
 - HHSC is currently piloting the use of an instrument to measure functioning that can be used for all long-term care populations. Results from this functional assessment will assist the Commission in future directions for ensuring functional needs is an essential element in determining what services an individual receives.
32. PIAB recommends that HHSC examine and develop resolutions to barriers related to the utilization of the foster care model in securing long term foster care placements and adoptions.
 - HHSC has asked that the CLTCPC prioritize their recommendations and assist us in identifying those steps that can be taken immediately. HHSC supports this recommendation, and will work with appropriate agencies to identify barriers and develop resolutions to those barriers related to foster care.
33. PIAB recommends that HHSC evaluate the adequacy of the reimbursement rate for both the Supervised Living model and the Residential Supports model under the HCS program.
 - HHSC supports this recommendation.
34. If funding formulas and payment types prevent Medicaid waivers being factored on an aggregate waiver cost, the PIAB recommends that all Medicaid Waivers have a mechanism to allow for individual appeal, review, and approval of the justified need for services over the individual cost cap.
 - HHSC supports this recommendation. HHSC supports the identification of cost caps for waiver programs that assure budget neutrality and conformance with legislative requirements

Funding

35. PIAB recommends that the state provide the necessary funds, dollar for dollar, in the community to support the individual's community placement, as they move from an institutional setting.
 - HHSC supports a funding formula that allows services to be matched to the individuals needs. Funding for community care must be based on individual need for community supports and not simply the previous expenditures for institutional care.
36. PIAB recommends that HHSC develop a long-range infrastructure budget to support the PI Plan, which goes beyond and complements the program/service budgets developed by the individual agencies.

- The HHSC has developed a consolidated budget that requests funding related to the PI initiative. Future budget considerations will continue to manifest themselves in requests of the legislature related to funding the implementation steps of this initiative. HHSC will also work with appropriate agencies to identify funds, and infrastructure necessary to carry out the Texas Promoting Independence Plan.

- 37. PIAB recommends application of annual inflationary rate increases for all LTC Medicaid providers to support the increased costs of providing quality services and meet increased regulation and oversight demands.
 - HHSC responds that rate setting, per se, is not directly related to the Promoting Independence Initiative.

- 38. In light of the number of individuals with mental illness that are currently being served through the Criminal Justice System, and recognizing the study done by the TDOCJ regarding the number of people with mental illness being served in this system the PIAB strongly supports the exceptional item housed in the Texas Department of Mental Health and Mental Retardation's LAR for \$85,000,000 for community services for persons with mental illness.
 - HHSC does not support applying Olmstead to the population served by the Criminal Justice system. HHSC supports TDMHMR's request for increased funding community mental health services.

- 39. PIAB recommends Transitional Funding for MDCP clients of \$562,500 in General Revenue and all funds. These funds would serve all 225 children transferring to waivers from institutions.
 - HHSC supports this recommendation.

- 40. PIAB Recommends Transitional funding for approximately 200 HCS clients of \$500,000 in GR and all funds.
 - HHSC supports this recommendation.

- 41. Family Based Alternatives for Children coming out of institutions that cannot live with their birth families is limited. The PIAB recommends funds to provide Technical Assistance of \$151,650 in GR funds are requested to assist state agencies with the problems faced of an insufficient trained provider base. And GR funds of \$5,336,84 are requested to establish alternative family options for children coming from institutions that cannot return to their birth family. (This figure includes 28.1 FTE support/case management positions with a caseload size of 10, and 13.5 FTE recruitment specialist positions)
 - HHSC supports the request for Technical assistance for Foster Care. HHSC supports the need to establish alternative family options for

children coming from institutions that cannot return to their birth families. It has requested, \$3,345,139.00 in order to develop a new alternative family options program.

42. Housing Subsidies are a crucial need for many indigent persons leaving institutions. The PIAB recommends GR funds of \$96,000 for FY01 to provide housing subsidies and housing assistance for approximately 25 people. And biennial funds of \$4.32 million in GR for 400 slots in FY02 and 800 slots in FY03. The approximate per person cost of \$3,600, will serve as a temporary rent subsidies and other housing assistance while individuals apply for federal housing subsidies from the section eight program. Total all funds request for housing is \$4,416,000.
 - HHSC supports this recommendation.

43. PIAB recommends transportation funding for non-medical trips such as grocery or clothing errand is recommended. An estimated cost of \$780,000 in GR and all funds would be required to fund approximately 120,000 trips at \$6.50 per trip.
 - HHSC supports this recommendation.

44. PIAB recommends permanency planning for children with an independent case manager, for individuals not in the DHS proposal. \$2,912,000(34 Children under the age of 18 in the ICF-MR program, and 330 individuals between the age of 18 and 21 currently in the ICF-MR program.)
 - HHSC supports the development of alternative family options for children. HHSC does not support specific funding for independent case managers to perform permanency planning for children in the ICF-MR program, as this is a duplication of services provided by the existing structure of the ICF-MR program. Currently ICF-MR does not require permanency planning for individuals over the age of 18.

45. The PIAB recommends that direct care staff in long term care services, in addition to the amounts identified within all agencies LAR's be given a competitive living wage consistent with the prevailing wage for all direct care service attendants. (Approximate cost of this bullet raising the DHS 1.7% increase for community care programs to 3%, -\$160,000,000.)
 - HHSC's support for agency spending does not extend beyond levels requested by the agencies.

46. PIAB recommends a Salary Increase of 10 percent for community care staff is being requested at DHS for \$87.5 million in General Revenue and \$204.1 million all funds.

- HHSC supports this item as it appears in the DHS Legislative Appropriations Request.
47. PIAB recommends an Inflation Increase for DHS community care programs of 1.7 percent each year for \$9.5 million General Revenue and 20.8 million in all funds.
- HHSC supports this recommendation.
48. In light of recent litigation in numerous states related to Olmstead and waiting lists, the PIAB strongly supports a funding approach, which includes waiver slots for those individuals currently in institutions and funding for reduction of waiting lists. The PIAB also supports rate and salary increases and a number of ancillary items such as transitional funds, foster care funding, housing subsidies and transportation funds to be necessary to ensure successful community placements.
- HHSC supports an approach that will fund both individuals in institutions waiting for community placement, and a plan to make sizeable inroads in the reduction of existing community waiting lists.
49. PIAB recommends that HHSC require that all Medicaid waivers be factored on an aggregate waiver cost mechanism as opposed to individual cost caps within waivers.
- HHSC supports the identification of cost caps for waiver programs that assure budget neutrality and conformance with legislative requirements. Individuals whose care exceeds these caps should have access to appeal and prompt review. This appeal and review would have to be at a higher level than the typical Medicaid Fair Hearing. This appeal and review would require the ability to waive the eligibility rules or cost caps.
50. PIAB recommends that the state shall provide sufficient transitional funding for voluntary downsizing or conversion in a planned, organized manner for specific increased per capita costs incurred by the provider.
- HHSC supports the concept of transitional supports to phase out large community ICF-MR facilities in favor of smaller home-like alternatives. Such a transition must be made in full and voluntary partnership with the provider community.

Resolution: This resolution was adopted at the Promoting Independence Advisory Board Meeting on 11/28/00.

The state has an obligation to fund appropriate community services for individuals who choose to live in the community unless it becomes a fundamental alteration of a state's program; given this resolution the PIA Board recommends that the Health and Human Services Commission work with the appropriate agencies to implement the Texas Olmstead plan with the above statement included.

- HHSC will be governed by the direction of the governor and the Texas legislature.

Appendix B

Recent Long-term Care Studies and Reports

| Year | Author | Findings |
|------|--|--|
| 1994 | HHSC, Long-term Care Task Force: Final Report and Recommendations | Task Force charged with making recommendations and developing a broad vision to guide all of the state's long-term care services, irrespective of the ages or disabilities of the consumers to whom those services are directed. Adopted a long-term care vision (subsequently passed into state law), definition of long-term (also adopted into law), and made a plethora of recommendations in the areas of Resources and Funding, Choice, Risk and Regulations, Service Array and Care Setting, Access and Delivery, and Organizational Structure. |
| 1994 | Institute for Quality Improvement in Long Term Health Care, Medically Fragile Children: A Comparison of State Programs | The report provides state comparisons on availability of waiver programs. It discusses the issues of children in nursing homes. The report describes Texas' system of services as appearing confusing, fragmented and overlapping to parents and professionals attempting to access the system. Recommendations include: Ask what is needed (i.e., give the consumer what they need); eliminate duplication; implement independent case management; listen to parents and guardians; implement and publicize a single statewide point-of-contact; establish data base tracking mechanism; improve nursing home care. |
| 1995 | Texas Department of Health: Children's with Special Health Care Need Services Committee, Title VI Futures Project: Long Term Recommendations | Define the role of TDH in the overall state health care deliver system for CSHCN, to set priorities for the types of services to be provided, and to make recommendations about how TDH can assure quality, efficiency and effectiveness of services. Very detailed report that discusses problems and issues, describes the target population, draws conclusions and issues based current service needs and current initiatives, recommends a model for service delivery, identifies basic priority funding needs. |
| 1996 | Texas A&M University, Health Policy for Medically Fragile Children: An Analysis of Factors Impacting Care in Texas | A telephone survey was conducted with the parents of medically fragile children in MDCP, in institutions, and on the MDCP waiting list, with questions about costs, incentives and outcomes for families, communities and government associated with current Medicaid policy. No significant demographic differences were observed between families with children in the MDCP program and those with children in institutional care; |

Appendix B

the program is effectively offering an in-home alternative to institutionalization.

1996 MHMR, The Mental Retardation System of the Future

The recommendations describe a future system in which resources are combined and managed by local mental retardation authorities, which serve as the single point where consumers/families access all available services. A person-centered planning process is used to determine each consumer's/family's desired outcomes and available resources are used to support them in achieving their desired outcomes. The LRMA should be the single access point where people obtain information about all service and support options in the systems, alternatives to the system, and eligibility for the system. Recommends resources that should be included in the system (federal, state, local). Persons currently defined as the MHMR priority population should be eligible for services and supports. Persons with other developmental disabilities should be considered for eligibility with the exception of persons for whom chronic mental illness is their only developmental disability. Evaluate LMRA based on outcomes.

1996 Richard C. Ladd, with assistance of Robert and Rosalie Kane, State LTC Profiles Report, 1996

Texas is listed as one of 10 states that "stand out in terms of their commitment to HCBS and their control over the growth of nursing homes." Texas qualifies as having High/Very High Potential Demand for Public LTC and Very High/High Control over nursing home expenditures and Very High/High control of nursing home utilization. Texas is ranked 5th in progress in balancing the LTC system, 17th in control of nursing home utilization, 15th in the control of nursing home expenditures, 21st in commitment to HCBS utilization and 4th in commitment to HCBS expenditures. Texas is 1st in nursing home percent of occupancy.

1996 Ladd and Associates, State Strategies and Methods Used to Balance Long-term Care Systems

Texas has a high percentage of care for clients in the community, but nursing facilities have a much higher percentage of the funding. Texas nursing facilities are characterized by large numbers of low care residents and long lengths of stay. This is the result, according to the author, of no pre-admission screening mechanism, no relocation mechanism, and no requirement for functional disabilities.

Mid-1990s Richard C. Ladd (LBJ School), Long-Term Care in Texas

Texas has done an excellent job of controlling the community base care services, such as home care. Texas would, most likely, be spending considerable more dollars on long-term care if this had not been done. The report points out that 27.3 percent of nursing facility

care if this had not been done. The report points out that 27.3 percent of nursing facility residents are in the lowest levels of the case mix system and that many of these clients appear to be inappropriate for nursing home care. The report discusses methods of long-term care reform that emphasize a managed long-term care system, with recommendations to: institute pre-admission screening for all applicants for state supported LTC services, make functional impairment a criterion for all LTC services, review each client in the lower three nursing facility reimbursement categories and similar clients in HCBS to ascertain if these services need to continue, increase case managers at DHS or privatize the function to non-providers, increase the housing option at DHS and enhance the Options program at TDoA, obtain a waiver to assign clients levels of care appropriate to their impairment needs, allow for client-direct in-home services, and better coordinate the local service delivery system.

1998 TDHS, A Look at LTC Waiting List Approaches in Texas & Other States

The concept and application of needs-based approaches to waiting lists appears to be more common in the area of MR/DD services than in systems primarily focused on elder care. Despite obvious differences in service population, the similarities in basic LTC issues are significant. For this reason, if a needs-based system is to be considered, careful exploration of the sophisticated needs-based models used by states for MR/DD services is essential.

Late 1990s TDHS, Oregon Long-Term Care Compared to Texas

The Oregon model is attractive, but would be difficult for Texas to emulate directly due to differences in population, provider base, service delivery system and political situation. Texas could emulate Oregon by adopting three strategies: (1) An integrated assessment and admissions system would divert people from nursing homes and increase the use of HCBS. Texas would need to establish a set of agencies to act as the point of entry for LTC, which would include pre-admission screening for both public and private pay recipients. (2) Texas could expand the use of licensed facilities other than nursing homes, including use of foster care in the CBA program, while encouraging private pay use. (3) Removing the limits from the CBA waiver would make it a more viable alternative to nursing facilities.

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| 1998 | HHSC, Permanency Planning for Children in Texas | HB 855, 75 th , directed HHSC and appropriate HHS agencies to develop procedures to ensure that a permanency plan is developed for each child residing in an institution or for whom institutional care is sought. Four local family collaborative sites are developing systems to provide coordinated service planning for children at risk or in out-of-home placement. A progress report is provided for the sites. Challenges: no additional funding; lack of funding stream flexibility; difficulty of permanency planning for children with dual or multiple diagnoses. Additional recommendations are made. |
| 1998 | Mary G. McCarthy, On the Right Track Project: Focus Group Study Preliminary Findings | Examine through focus groups the service and support needs of people with disabilities and provide this information as a starting point from which to develop a state-wide strategic plan to alleviate the formation of secondary conditions. Central theme was “acquiring basic services was an ongoing and frustrating process called ‘the qualifying game.’” Service delivery system is seen as fragmented, disorganized and inconsistent. Families need a functioning team to help them. |
| 1998 | HHSC, A Status Report on An Assessment of the Design and Delivery of Long-term Services and Supports | The number of persons with disabilities is expected to increase significantly; residential/institutional services are more expensive per client; many programs offer the same service (e.g., related supports, personal assistance, case management) as other programs; degree to which consumers control their services varies by program; agencies did not identify measurable consumer outcomes for many programs; rates vary across programs for similar services; and access to long-term care services is population based and 16 programs provide some type of case management or service coordination. |
| 1999 | State Medicaid Office, HHSC, Combining Community-Based Waivers: A Feasibility Study | Recommended certain functions (rate setting, procurement, definitions, data collection and waiting list maintenance) of existing waiver programs should be made more consistent, regardless. Pilot-test a consolidated waiver program. Have full participation and input of stakeholders. |

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| 1999 | MHMR: Access to Services Workgroup, Access to Services Work Group Report: Long-term Services and Supports | <p>Recommends a single point of access for all services provided by or contracted for the Department and that local authority be the single point of access based on the model at the MRLA pilot sites. Specific processes to accomplish this were recommended. Defined single point of access as: The LMRA will be the sole entity which determines persons eligible for MR services provided by or contracted for MHMR, provides information about services, supports and providers, and facilitates the person directed planning process.</p> |
| 1999 | DHS, Needs-Based Waiting Lists for Community Care Services | <p>Research waiting list approaches in other states and conducted a study comparing the risk of nursing facility placement of individuals on the CBA interest list with active CBA clients. Three town hall meetings were held to discuss issues. The report concludes the concept is good, but “very problematic to implement.”</p> |
| 1999 | DHS, Long-term Care Costs Literature Review | <p>Many studies have found that community care did not reduce overall long term care costs; more recent studies have shown that community care can produce overall savings if it is properly targeted. States that make a significant commitment to shifting from institutional to community based care have been shown to have reduced overall costs, allowing for inflation and population growth. For the last 20 years, Texas has used growth in community care as a part of its strategy to restrict growth in long term care costs. There is no evidence that expanding community care in Texas has increased caseload or cost.</p> |
| | | <p>Texas’ reduction of nursing home use has stalled since about 1990. It is not clear whether further increases in community care expenditures will result in further overall savings. If community care is not increased, more persons may choose to enter nursing homes. Successful use of community care to control total long-term care costs depends on several factors: Accurate targeting, including pre-admission screening; adequate flexibility in available services; controlling the costs of services; and other constraints on nursing home entry. Even under the best of circumstances, community care is likely to serve some people who would never enter a nursing home. Texas should conduct research to learn more about the dynamics of the long term care population.</p> |

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|------|--|--|
| 2000 | HHSC, Children’s Long-term Care Policy Council Recommendations | <p>Many of the 500,000 families of children with disabilities find navigating the health and human services system daunting and exhausting. Services extend across many programs administered by numerous Texas agencies, each with different criteria and procedures for eligibility and enrollment. Many thousands of families are put on waiting lists for years to receive home-based services. For some, the home-based services come too late—their child is placed in an institution—the only place where some needed services in Texas are entitled. Recommendations are made in the following areas: Access and case management (develop an independent case management function); develop seamless transition between programs; coordination and collaboration (use a family-directed planning model); promote independence and permanency planning; support choice, control and self-determination by families; and increase funding.</p> |
| 2000 | HHSC, Achieving Integrated Access and Service Delivery for the Elderly and Persons with Disabilities | <p>This report defines and describes an integrated system of services; briefly reviews efforts in Texas to achieve integration; provides a feasibility analysis of what it will take to achieve integration; and makes recommendations on how to better achieve integration. Recommendations focus on the process for implementing local access projects proposed as a result of SB 374.</p> |

Appendix C



TEXAS ADMINISTRATIVE CODE

Rules of the Texas Department of Mental Health and Mental Retardation Title 25, Part II

Revised Subchapter Governing

Additional Facility Responsibilities Chapter 406, Subchapter G

EFFECTIVE DATE: December 3, 2000

Please replace the copy of Chapter 406, Subchapter G, with an effective date of December 13, 1999, in your files with the attached copy of the revised subchapter.

Reason for Revision

A new §406.311 has been added which requires a provider in the ICF/MR Program to discuss living options at least annually with each resident or the resident's legally authorized representative (LAR). The facility must use the Community ICF/MR Living Options instrument developed by the department as the basis for the discussion. A copy of the Community ICF/MR Living Options instrument is attached at the end of the subchapter. The facility must notify the local mental retardation authority (MRA) about each resident who expresses a preference for an alternative living arrangement or whose LAR expresses a preference on the resident's behalf. After the MRA is notified, the MRA must contact the individual or LAR to discuss alternative living arrangements, enter the resident's name in the department's Client Assignment and Registration (CARE) system if the service requested is not available, and assist the resident in accessing the service when it becomes available. The new section is responsive to a recommendation from the

Promoting Independence Advisory Board to the Texas Health and Human Services Commission that the department develop procedures to identify each resident of an ICF/MR who prefers, or whose LAR prefers, an alternative living arrangement. The new section does not apply to state mental retardation facilities (state schools and those state centers with a residential component) because they are already required by department policy to discuss alternative living arrangements with residents and LARs on an annual basis.

Process

The new section was published in the August 11, 2000, issue of the *Texas Register* for public review and comment. The Texas MHMR Board adopted the section at its October 2000 meeting with changes to the text as proposed. The adoption appeared in the November 24, 2000, issue of the *Texas Register*.

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FOR USE BY

- State Hospitals
- State Schools
- Central Office
- ICF/MR Providers

PERTAINING TO

- Mental Health
- Mental Retardation
- Management and Support
- Administration

PROVIDING SERVICES IN

- Service Coordination
- ICF/MR
- HCS
- HCS-O
- IMD
- Rehabilitative Services
- Diagnostic Services

APPROVED BY

- Commissioner
- Deputy Commissioner, Community Programs
- Director, Long Term Services and Supports

Questions

Please direct technical questions about this subchapter to Long Term Services and Supports at 512/206-4708.

Comments and recommendations for future revisions of this subchapter should be directed to Linda Logan, director, Policy Development, TDMHMR, P. O. Box 12668, Austin, Texas 78751, faxed to 512/206-4750, or e-mailed to policy.co@mhm.state.tx.us.

ADDITIONAL FACILITY RESPONSIBILITIES
CHAPTER 406, SUBCHAPTER G

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§406.301. Agreements with Local School Districts.

(a) As a condition of contracting to participate in the Title XIX Texas Medical Assistance Program, a facility that serves individuals between the ages of three and 21, inclusively, must meet the following requirements.

(1) The facility must establish a written agreement with the local school district. The agreement must contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

(2) The facility must develop written policies and procedures to ensure that each eligible individual between the ages of three and 21, inclusively, is enrolled in an education program approved by the Texas Education Agency (TEA), unless the individual has already successfully completed or graduated from the required program.

(3) The facility must abide by the Memorandum of Understanding Relating to School-Age Residents of Intermediate Care Facilities for the Mentally Retarded as published by the Texas Education Agency under 19 Texas Administrative Code §89.243.

(b) To provide and administer its own educational program(s), a facility must secure and maintain TEA certification as a nonpublic school.

(c) In accordance with the requirements of 42 Code of Federal Regulations §483.410(d)(3) and §483.440(a), each facility must ensure that each individual's educational services are integrated with the other components of his treatment program.

§406.302. Day Services.

(a) In accordance with the requirements of 42 Code of Federal Regulations (CFR) §483.410(d)(3) and §483.440(a), each facility must ensure that day services furnished by an outside source meet the needs of each client and are integrated with the other components of the client's active treatment program.

(b) When an outside source furnishes services to a client, the client's facility must establish and maintain a written agreement with the outside source in accordance with 42 CFR §483.410(d)(1)-(3).

(c) If subminimum wages are paid to a client, the service provider must maintain the appropriate certification required by the United States Department of Labor.

(d) Day services include day habilitation and supported employment.

(1) Day habilitation assists individuals in the acquisition, retention, and/or improvement of self-help, socialization, cognitive, and adaptive skills necessary to be successful in the community. Day habilitation provides individuals with opportunities to participate in activities that increase attendance to task, elicit appropriate social and emotional interaction, relieve isolation, and encourage independent utilization of community resources. These opportunities may include enclaves, mobile crews, and other congregate training sites. Day habilitation services include individual assessments, career development, other person-centered services, transportation to and from day services, and attendant care for individuals who are unable to manage their personal care needs away from the residential setting. Whenever possible, public transportation will be utilized. Day habilitation must be designed to provide individuals with opportunities for meaningful

ADDITIONAL FACILITY RESPONSIBILITIES
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activities that enhance their self-esteem, maximize their functioning level, and increase their level of independence.

(2) Supported employment is individualized employment in an integrated setting with ongoing support services. Employment is work performed by the individual for which the individual is compensated by an employer in accordance with the Fair Labor Standards Act. An integrated setting is a job site away from the individual's place of residence, in which generally no more than one employee or three percent of the employees, whichever is more, have mental retardation or a related condition. Supported employment includes activities that are necessary to sustain paid work by an individual with developmental disabilities. Supported employment is intended to assist individuals in maintaining employment in the community.

(A) Reimbursement for supported employment services is available only if documentation verifies that supported employment services have been denied or are otherwise unavailable to the client through either the Texas Rehabilitation Commission or the public school system.

(B) All clients receiving supported employment services must have an identified need and desire for employment.

§406.303. Facility Capacity.

The number of individuals that a facility admits must not exceed its rated capacity or its programming capabilities.

§406.304. Release from the Facility.

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) **Emergency release** – The individual is absent from the facility for more than 24 hours for reasons specified in subsection (d)(1) of this section. The nature of the release

prevents the facility from accomplishing prerelease planning.

(2) **Mental retardation authority (MRA)** – The Texas Department of Mental Health and Mental Retardation (TXMHMR) entity that directs, operates, facilitates, or coordinates services required by state law and TXMHMR for persons with mental retardation in a local service area. A local service area consists of one or more counties.

(3) **Permanent release** – The individual moves from the facility to another residence and the facility does not intend that the individual return for continued services, or the individual is absent from the facility for more than 30 days. TXMHMR state schools comply with permanent-release requirements when an individual is placed on extended furlough status (a furlough longer than 30 days).

(4) **Temporary release** – The individual is absent from ICF/MR care for more than 24 hours but no longer than 30 days from the date of departure. The absence is for reasons other than a therapeutic visit, or for a therapeutic visit that exceeds the allowed length of stay. The facility intends that the individual return for continued services and provides a bed upon his return.

(5) **Therapeutic visit or extended therapeutic visit** – An individual's absence from the facility meets the criteria stated in §406.211 of this title (relating to Payment for Absences from the Facility).

(b) Requirements for temporary release are as follows.

(1) The facility may temporarily release an individual if:

(A) the individual, parent, if individual is a minor, or legal guardian requests the release;

(B) the interdisciplinary team plans or approves the absence;

(C) the individual transfers to an acute care medical setting; or

(D) the individual's absence is not authorized. This includes, but is not limited to, an individual who leaves without permission or is being held by legal authorities.

ADDITIONAL FACILITY RESPONSIBILITIES
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(2) The facility must notify the individual's family, parent, if individual is a minor, or legal guardian about the release.

(3) The facility must document the temporary release in the individual's record, including the date of departure, the circumstances causing the absence, and the date of return.

(4) Upon the individual's return, the facility must conduct an interdisciplinary team meeting attended by the QMRP and any other appropriate team member. The purpose of the meeting is to review the individual program plan, identify new needs, and make necessary changes to the plan.

(5) If the individual's absence from the facility exceeds 30 days, the facility must permanently release him.

(c) Requirements for permanent release are as follows.

(1) The facility must complete permanent-release requirements in any of the following situations.

(A) The individual makes a planned move to an alternate living arrangement, including, but not limited to, another facility, apartment, foster home, or home.

(B) The individual, parent, if individual is a minor, or legal guardian requests the release.

(C) The individual loses financial (Medicaid) eligibility for ICF/MR services, and the facility chooses to release him.

(D) The facility stops operating or voluntarily withdraws from the Medicaid program.

(E) The individual does not pay allowable fees including but not limited to applied income and bed-hold charges, and the facility chooses to release him.

(F) The individual's temporary release exceeds 30 days.

(2) Except in cases when an individual's temporary release exceeds 30 days, the facility must meet the following requirements before release. When an individual's temporary release exceeds 30 days, the facility must complete the

following items within seven calendar days after the individual's permanent release.

(A) Except in cases when an individual makes a planned move as described in paragraph (1)(A) of this subsection, the facility must notify the individual, parent, if individual is a minor, legal guardian, or other family members about the proposed release. When an individual makes a planned move, the facility must provide the notification at least 30 days before release.

(B) The facility must counsel the individual, parent (if the individual is a minor), or legal guardian about the advantages and disadvantages of the release. These persons should participate in release planning whenever possible.

(C) The facility must notify the mental retardation authority (MRA) of the catchment area in which the individual will live regarding the release and the reason for it.

(D) The facility must develop a plan for providing appropriate services, including protective supervision and other follow-up services. The facility must ensure that the individual's record contains the following documentation from service agencies identified in the plan as responsible for providing after-care services:

(i) letters of intent to provide the services identified in the plan; or

(ii) signatures of service-agency representatives verifying their attendance at the interdisciplinary team meeting in which the plan is developed; or

(iii) letters of attempts to secure such services, if service agencies have not provided documentation described in clauses (i) and (ii) of this subparagraph.

(3) When the facility must release an individual because of maladaptive behavior(s) that the facility is unable to address successfully, the facility must provide evidence, in the individual's record, of the interdisciplinary team's attempts to manage the behavior(s). These attempts must include active participation of the facility's psychologist or psychiatrist and

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review by the facility's specially constituted committee.

(4) Within seven calendar days after the individual's release, the facility must ensure that the individual's record contains a release summary including the following:

(A) the reason for permanent release. If the individual is released to another residence, the facility must include an explanation of why the facility is no longer appropriate or no longer able to provide services;

(B) a description of findings, events, and progress of the individual during residence. If the individual is released because of behaviors or active treatment needs the facility is unable to address, the facility must ensure that the summary describes the actions taken by the interdisciplinary team to meet those needs before discharge planning was initiated;

(C) a comprehensive statement of the individual's service needs, the plan for addressing those needs, and the agency(ies) and other service providers responsible for providing the services.

(5) The facility must send a copy of the release-summary to the individual, parent, if individual is a minor, or legal guardian; to the local MRA in whose catchment area the client will live; and to any alternative residence, if requested and legal consent is obtained.

(6) The psychologist must participate in the release planning if the reason for release is the individual's display of maladaptive behavior that the facility is unable to address successfully.

(7) If the facility voluntarily withdraws from the Medicaid program or ceases to operate, the facility implements a release plan for each individual, in cooperation with TXMHMR.

(8) If the individual dies, the facility must complete a release-summary as described in paragraph (4)(A) and (B) of this subsection.

(d) Requirements for emergency release are as follows.

(1) The facility may release the individual on an emergency basis for any of the following reasons.

(A) The individual, parent, if individual is a minor, or legal guardian requests an immediate permanent release. The facility must counsel the party(ies) about the advantages and disadvantages of the release.

(B) The individual's physician determines that failure to release the individual will threaten the individual's health and safety or the health and safety of others.

(C) The individual requires an acute-care medical setting.

(2) The facility must notify, at least orally, the individual's family, parent, if individual is a minor, or legal guardian before the release unless the individual's well-being will be jeopardized. If the individual's well-being will be jeopardized, the facility must attempt to contact the family, parent, or legal guardian within 24 hours of the release. The facility must document in the individual's record all contacts or attempted contacts.

(3) If the release is temporary, the facility must comply with subsection (b)(3)-(5) of this section.

(4) If the release is permanent, the facility must comply with subsection (c) of this section. The facility must notify the local MRA within 72 hours of the individual's release.

(e) When an individual is absent from the facility for 24 hours or more, except for purposes of a therapeutic visit, the facility must meet the requirements for termination of state reimbursement for services as described in §406.212 of this title (relating to Discharge and Transfer).

§406.305. Health and Hygiene Services.

(a) The facility must:

(1) weigh each individual quarterly;

(2) measure the height of each individual quarterly until the individual reaches the age of maximum growth; and

(3) maintain weight and height records for each individual.

(b) An individual who is incontinent must be bathed or cleaned immediately upon voiding or soiling unless specifically contraindicated by the

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training program; and all soiled items must be changed.

(c) If a facility requires a licensed vocational nurse (LVN) to practice the techniques of venipuncture or of insertion of a naso-gastric tube or a gastrostomy tube, the facility must:

(1) verify that the LVN has received sufficient instructions in the techniques and is qualified to perform the specific procedures needed; and

(2) maintain documentation of the qualifying training in the LVN's record.

§406.306. Requirements for Self-administration of Medication.

(a) The facility must develop policies and procedures governing the self-administration of medication. The policies must ensure adequate supervision of the individual and describe the facility's training program for self-administration of medication.

(b) Individuals who meet the requirements stated in 42 Code of Federal Regulations §483.460(k) may remove medications from their pharmacy-labeled containers and place the selected medications in an individual container that holds a seven-day supply or less.

(c) A container that holds transferred medications as specified in subsection (b) of this section must be labeled with:

(1) the name of the individual;

(2) the name and strength of the medications;

(3) the name of the physician; and

(4) the address of the facility.

(d) Authorization to transfer medications as permitted in subsection (b) of this section must be included in the individual program plan.

§406.307. Medical Transportation.

(a) The facility must provide each individual with normal transportation to medical services outside the facility when the attending physician orders the services.

(b) Throughout this section, the term "normal transportation" refers to transportation

to and from the medical care provider of an individual's choice, as long as the provider is generally available and used by residents of the locality for medical care covered by the Texas Medical Assistance Program. When there is no Title XIX provider in the locality, the term "transportation" refers to transportation to and from the nearest appropriate Title XIX provider that the individual chooses. The term "locality" refers to the service area surrounding the facility from which individuals ordinarily come or are expected to come for inpatient or outpatient services.

(c) The facility is responsible to pay transportation charges, including non-emergency, routine ambulance services, related to an individual's certification or recertification.

(d) The facility must not charge the Texas Department of Human Services' (TDHS's) insuring agent, the Medicaid client, his family, or any other party responsible for the Medicaid client for normal transportation as defined in this section. Normal transportation charges are covered in the monthly vendor rate. The facility is not permitted to use TXMHMR's community-based Title XIX Medical Transportation Program.

(e) The facility is not responsible for charges for medically necessary ambulance services when they are properly documented with a physician's authorization and when they conform to TDHS's health insuring agent's guidelines for payment of ambulance services. These services are payable by TDHS's insuring agent as Medicaid benefits. The services include:

(1) emergency ambulance services; and

(2) nonemergency ambulance services (except for certification or recertification) for individuals who must be transported by litter or who require a life-sustaining support system. This group includes severely disabled individuals who must be transported by ambulance and individuals who are unable to use other means of transportation for stated medical reasons.

(f) Ambulance services that are reimbursable by TDHS's health insuring agent are not the

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responsibility of the Medicaid client, his family, or any other party responsible for the Medicaid client.

§406.308. Record Retention and Other Related Record Requirements

(a) Without prior notification or consent, the agencies listed in paragraph (1) of this subsection must be provided prompt access to and copies of facility records and supporting documents.

(1) The agencies which may request access to and copies of facility records and supporting documents are:

(A) the United States Department of Health and Human Services;

(B) the Texas Health and Human Services Commission;

(C) the Texas Department of Mental Health and Mental Retardation;

(D) the Texas Attorney General's Medicaid Fraud Control Unit;

(E) the Texas Department of Human Services; and

(F) the Comptroller General of the United States.

(2) Records and supporting documents which are immediately available must be produced by the facility for review by the requesting agency within 24 hours of the agency's request. If the records and supporting documents have been archived, they must be produced for review within 72 hours of the request. If copies of the records and supporting documents are requested and the facility does not have immediate access to photocopy equipment, the copies must be provided within 72 hours of the request for copies.

(3) When an agency listed in paragraph (1) of this subsection requests and receives copies of facility records and supporting documents, the agency will issue an acknowledgement to the facility for those records and supporting documents.

(b) The contractor must keep financial and supporting documents, statistical records, and any other records pertinent to the services for

which a claim or cost report was submitted to the department or its agent. The records and documents must be kept for a minimum of three years and 90 days after the end of the contract period or for three years after the end of the federal fiscal year in which services were provided (if a provider agreement/contract has no specific termination date in effect). If any litigation, claim, or audit involving these records begins before the three-year period expires, the provider must keep the records and documents for not less than three years and 90 days or until all litigation, claims, or audit finds are resolved. The case is considered resolved when a final order is issued in litigation, or the department and contractor enter into a written agreement. The contractor must keep records of nonexpendable property acquired under the contract for three years after the final disposition of the property. In this section, contract period means the beginning date through the ending date specified in the original agreement/contract; extensions are considered separate contract periods.

(c) After medical services end, the contractor must keep the recipient's medical records for five years as stated in the provider agreement/contract. The facility must keep the records of an individual under age 18 for three years beyond his 18th birthday even if this retention period exceeds the five-year retention period.

(d) The facility must retain financial records in their original form during the applicable retention period. Microfilming and other methods of data storage are not acceptable.

§406.309. Abuse and Neglect Reporting Requirements.

In accordance with 42 Code of Federal Regulations §483.420(d)(2), the facility must immediately report to the facility administrator, and to other officials, all allegations and suspected incidents of mistreatment, neglect, or abuse, as well as injuries of unknown source, in accordance with state law and through established procedures, as follows.

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(1) Facilities licensed by the Texas Department of Human Services (TDHS) must report each allegation and suspected incident of mistreatment, abuse, or neglect to TDHS in accordance with Texas Civil Statutes, Article 4442(c). Additionally, allegations of physical, verbal, or sexual abuse shall be reported immediately to the local law enforcement agency. The facility must have a current copy of TDHS's procedure for reporting abuse and neglect and must make this procedure known to appropriate staff. TDHS's reporting procedure is available from TDHS, Bureau of Long Term Care, Complaints Management and Public Disclosure Section, 1100 West 49th Street, Austin, Texas 78756-3199.

(2) Texas Department of Mental Health and Mental Retardation (TXMHMR) facilities must report investigative findings about each suspected incident of abuse or neglect to Texas Department of Protective and Regulatory Services, P.O. Box 149030, Austin, Texas 78714-9030.

§406.310. Consent to Treatment by Surrogate Decision-Makers

The facility must comply with Chapter 405, Subchapter J of this title (relating to Surrogate Decision-Making for Community-Based ICF/MR and ICF/MR/RC Facilities).

§406.311. Living Options.

(a) The following words and terms, when used in this section, shall have the following meanings:

(1) **Facility** – An intermediate care facility for persons with mental retardation or a related condition, as described in 42 Code of Federal Regulations, §440.150, other than a state mental retardation facility operated by the department.

(2) **Individual** – A person enrolled in the ICF/MR program and residing in a facility.

(3) **IDT (interdisciplinary team)** – A group of people assembled by the facility who possess the knowledge, skills, and expertise to

develop an individual's Individual Program Plan, including mental retardation professionals and paraprofessionals and other concerned persons whose inclusion is requested by the individual or LAR.

(4) **LAR (legally authorized representative)** – A person authorized by law to act on behalf of an individual with regard to a matter described in this section, and may include a parent, guardian, or managing conservator of a minor individual, or the guardian of an adult individual.

(5) **MRA (mental retardation authority)** – An entity to which the Texas Mental Health and Mental Retardation Board delegates its authority and responsibility within a specified region for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental retardation services to persons with mental retardation in one or more local service areas. A local service area consists of one or more counties.

(b) At least annually or upon the request of an individual or the individual's LAR, the IDT must discuss living options with the individual or LAR using the Community ICF/MR Living Options instrument, copies of which are available on the department's website www.mhmr.state.tx.us/CentralOffice/Medicaid/i.html or by contacting Office of Medicaid Administration, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711.

(1) During the discussion, the facility must use information obtained from the MRA in whose local service area the facility is located to inform the individual or LAR of the different types of alternative living arrangements.

(2) The facility must document the discussion in the IDT summary and file the summary in the individual's record.

(3) If the individual or the individual's LAR expresses interest in an alternative living arrangement, the facility must send a copy of the IDT summary to the MRA in whose local service area the facility is located.

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(c) If an MRA receives an IDT summary, the MRA must:

(1) contact the individual or the individual's LAR to discuss the alternative living arrangements in which the individual or LAR has expressed an interest; and

(2) determine if the individual or the individual's LAR is interested in seeking an alternative living arrangement in another MRA's local service area and, if so, notify the MRA for that local service area.

(d) The MRA for the local service area in which the individual or LAR is interested in seeking an alternative living arrangement must:

(1) enter on the Client Assignment and Registration (CARE) system the individual's name and the specific type of service requested if that service will not be available within 30 calendar days of the date of request; and

(2) assist the individual in accessing the service requested when it becomes available.

COMMUNITY ICF/MR LIVING OPTIONS INSTRUMENT

Purpose

The Community ICF/MR Living Options instrument was designed to standardize criteria and objectify the process of making living option recommendations upon admission into the ICF/MR program, at the annual planning conference, or any time interest is indicated in an alternative living arrangement by an individual or legally authorized representative (LAR).

Instructions

1. The Living Options Instrument must be utilized by the Interdisciplinary Team as a guide to planning conferences with the individual/LAR when living options are discussed.
2. Prior to using the Living Options Instrument, the ICF/MR provider will ensure that facility staff participating in planning conferences with the individual/LAR have received adequate training on the use of the instrument.
3. Items on the Living Options Instrument will be incorporated as an essential element of interdisciplinary team policy and procedure at each facility, and will serve as the basis for all planning conferences with the individual/LAR at which living options are discussed.
4. Staff at each facility will coordinate monitoring of planning conferences to assure the process is being utilized as designed.
5. Staff at each facility will coordinate monitoring of record documentation (on a random basis) to evaluate the written product for a specified period of time.

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Questions

Staff is encouraged to obtain this information using an approach that is focused on the preferences of the individual/LAR. Each of the factors below should be addressed by the IDT. Documentation in the IDT staffing summary will include: a) source of the information; b) relevant deliberation; and c) outcome of the discussion. Final recommendations will address individual/LAR preferences regarding living options. Information obtained from this instrument should be used to update the individual's program plan for the ICF/MR program. Additionally, when an alternative living arrangement is requested, the information will be used by the MRA to identify appropriate community resources and to develop the individual's service coordination plan.

| FACTORS | <i>ESSENTIAL ELEMENTS</i> |
|--|--|
| Person's Preference | <ul style="list-style-type: none"> • Does the latest planning conference with the individual indicate a clear preference of where the individual wishes to live? If so, where? • What information has been provided to the individual related to living options? • What is the source of this information? Where is this documented? • What was the individual's preference in his/her last planning conference? • Is there a noted change in his/her preference compared to the previous planning conference? If so, why? |
| LAR/Family Preference | <ul style="list-style-type: none"> • Does the individual have a legally authorized representative (LAR)? • If there is no LAR, does the individual have family involvement and/or other natural supports? • What information has been provided to the LAR and family/natural supports related to living options and permanency planning? • What is the LAR and family/natural support's stated preference? • What is the source of this information? Where is this documented? |
| Medical Issues | <ul style="list-style-type: none"> • Does this individual have medical/nursing needs? If so, what are they? • What would enable these needs to be met in an alternative living arrangement? • What can facility/MRA staff do to support/facilitate these needs being met in an alternative living arrangement (e.g., in-service training, extended trial visits, professional consults, provision of adaptive equipment, respite, etc.)? |
| Behavioral/Psychiatric Issues | <ul style="list-style-type: none"> • Does the individual have behavioral/psychiatric treatment needs? • If so, what are the treatment needs (e.g., behavior management plan, psychoactive medication, etc.)? • What would enable these needs to be met in an alternative setting? • What can facility/MRA staff do to support/facilitate these needs being met in an alternative living arrangement (e.g., in-service training, extended trial visits, psychiatric/psychological consultation, respite, etc.)? |
| Quality of Life | <ul style="list-style-type: none"> • If the individual is a minor, has permanency planning been incorporated in the minor's service plan and reviewed as required? • If the individual is a minor, what efforts have been made to ensure LAR/family participation in service planning activities (including permanency planning issues)? • If a minor, have educational issues been addressed, including contact with the local school district? • What factors are most important to this person in choosing a place to live (e.g., family, friends, employment, special communication needs, leisure, living arrangements, daily routine, privacy, eating, community integration, etc.)? • What would enable these factors to take place for the individual in an alternative living arrangement? • What can facility/MRA staff do to support/facilitate these factors being met in an alternative living arrangement? |
| MRA Recommendations & Input <i>(required when an individual/LAR requests an alternative living arrangement)</i> | <ul style="list-style-type: none"> • What alternative living arrangements are available to meet the individual's needs? • Within what timeframe could placement in an alternative living arrangement occur? • Was an MRA representative present at the planning conference? • If not, what was the source of the MRA input? |
| Other Issues | <ul style="list-style-type: none"> • Were other factors (issues) discussed at the planning conference? If so, explain. |

Appendix D

Promoting Independence and Permanency Planning for Children in Texas

Introduction

There are approximately 1,253 children under age 21 currently residing in various Texas institutions including state schools, intermediate care facilities for people with mental retardation (ICF-MRs), and nursing homes. A breakdown of these numbers shows that the number of children being institutionalized in large facilities such as state schools has in fact increased from 1998 to 2000. In 1998 there were 234 children in state schools; in 2000 this number had increased to 302 children under the age of 21 years. This indicates that while Texas has begun supporting people in their communities, the state should aggressively pursue new methods to support families and expand options for children whose birth families are not able to care for them.

As a result of the Supreme Court ruling, *Olmstead v. L.C.*, as well as Governor Bush's Executive Order GWB-99-2, Texas Health and Human Services Commissioner Don Gilbert appointed the Promoting Independence Advisory Board (PIAB). This twelve-member board was charged with developing recommendations for systems changes that would enable individuals with disabilities living in institutions, who prefer community-based services, to receive quality supports and services in their communities. Prior to Supreme Court decision, the 75th Texas Legislature passed HB 885 and SB 118 which addressed the issue of Permanency Planning for children with disabilities residing in institutions or at risk of institutionalization. Permanency planning is a process undertaken on behalf of children with developmental disabilities with the anticipated outcome of ensuring that every child grows up in a family, benefiting from an enduring relationship with an adult.

"It is the policy of the state to strive to ensure that the basic needs for safety, security and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. The state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible." House bill 885, 75th Texas Legislature.

Best Practices

Best practices in permanency planning include:

- Adherence to the value that all children belong in families.
- Family-like alternative community options such as alternative family options, including shared parenting, and opportunities for adoption.
- Support services and options that facilitate the return of children to their birth families.
- Permanency planning that is family and child centered and directed, and includes wrap around approaches to services.
- Strong family support services to help families care for their child at home.
- Texas Family Support Principles adopted by the Council illustrate best practices (see page 6).
- Operationalizing family support principles (see page 6) in policies, guidelines and practices.

The Texas Family Support Initiative goals include:

- expansion and enhancement of continuous and seamless family support throughout the life-span for Texans,
- demonstration of public/private partnerships for family supports which incorporate community and faith based organizations,
- establishment of local family support councils which model after the state council in the aspects of public/private partnerships and family representation, and
- conducting a policy analysis regarding family supports.

Barriers

- Lack of sufficient community alternatives and supports for the family.
- Extensive waiting list for the existing community alternatives.
- Funding structure supports funding for programs instead of a continuum of individualized services for people.
- Absence of standardized rules, regulations, policies, and monitoring criteria among health and human service agencies.
- Insufficient staff training in permanency planning and family centered practices.
- Community services are not often available, whereas institutional services are entitlements.
- Inability to access community based case managers that are knowledgeable about resources available in the community.

Issue 4: Promoting Independence and Permanency Planning

In response to the Olmstead v. L.C. court case (June 1999), Governor George W. Bush signed Executive Order GWB 99-2, dated September 28, 1999, affirming the value of community supports for persons with disabilities. This Executive Order along with the charge of SB 374 to pursue opportunities for improvements to the current system of long-term care services and supports led to HHSC implementing a Promoting Independence Initiative. A 12-member advisory board has been appointed by the HHSC Commissioner to advise in the implementation of this initiative. The Promoting Independence Advisory Board (PIAB) requested the Children's Long-term Care Policy Council (Council) to make recommendations on ways to expand and enhance community-based services for children with disabilities and special health care needs.

Recommendations

PI 1.0: Ensure permanency planning implementation

- PI 1.1: HHSC must continue to lead a workgroup that studies issues and creates policies related to permanency planning for statewide implementation. This workgroup must include the active participation of individuals, family members, and other advocates for children;
- PI 1.2: Develop uniform standards across all health and human services agencies and TEA. Include all health and human services agencies and TEA when developing these measures;
- Include in these standards the expectation that the permanency goal for each child is to live with a family.
- PI 1.3: Develop standardized monitoring and accountability measures based on specific personal outcomes and family satisfaction to ensure compliance with permanency planning requirements;
- PI 1.4: Ensure training efforts to ensure that everyone in the health and human services field, especially those responsible for developing permanency plans, have the knowledge, value base, tools, and resources to effect change for these children; and
- PI 1.5: Ensure families receive training about permanency planning and other family living alternatives. The information should include the positive outcomes that can be achieved by connecting or reconnecting a child with the birth family or alternative family. Discuss family supports, and tools to keep the family together.

Rationale: *More than 1,200 Texas children reside in ICF-MRs, nursing facilities and state schools. The Promoting Independence Initiative applies to children residing in all of these facilities. Making available alternative community options would allow for families to keep their children at home or reunite with their child who has been placed in an institution.*

PI 2.0: Develop alternative family options

PI 2.1: Develop alternative family options, such as community training homes (specialized foster care for children with disabilities), shared parenting and adoption opportunities, outside of the CPS system for institutionalized children who are unable to return to their birth families and for those at risk of institutional placement.

- The alternative family options program works closely with birth families to ensure that the child's well-being remains paramount and focuses on the unique circumstances and needs of children with disabilities and their families;
- Recruitment of alternative families is approached as an employment opportunity. This effort requires staff whose sole responsibility is to recruit foster families through a broad range of marketing and public awareness initiatives; and
- Recruitment of alternative families is based on basic qualifications required to do the job and not as a charitable act. These families are considered paraprofessionals who are required to carry out habilitative plans for the child. They are expected to help the child achieve personal outcomes/habilitative goals that are part of the child's service plan.

PI 2.2 Create a community-based model through which children in crisis situations will be placed with a temporary host family instead of in an institution.

Rationale: *It is estimated that 70 to 90 percent of children residing in institutions will be unable to return to their birth families. Creating a program outside CPS foster care allows families to make decisions regarding alternative family options for their child without the stigma associated with CPS, which presumes abuse and neglect. In such an environment, extended/alternative family choice can be made without the adversarial intervention of the court system. The new alternative/foster family will be responsible for the in-home training and skill development of the child, in addition to her/his daily care.*

Alternative family options will help ensure that children grow up in nurturing families where relationships, bonds, and skills are developed and maintained. Children returning to their birth or extended families, or to alternative families in their home communities, gain access to local schools, relationships, and community service organizations. Expanding and enhancing the circle of support to the child in his or her home community benefits the child, the community in which the child becomes a valued member, and supplements the available state resources.

PI 3.0: Develop community permanency planning case managers (relocation or support specialists) for children in institutions

PI 3.1 Develop a system of on-going community-based case-management (or relocation and support preparation) for children in institutions that has as its primary focus the responsibility of ensuring that available supports are in place for birth families. Or, if birth families are not an option, finding or developing an alternative family for the child to “go home to.”

***Rationale:** Currently, once a child is placed in a nursing facility or ICF-MR, case management services from community providers stop and the provider/facility is responsible for development of the child’s permanency plan. This presents a potentially significant conflict of interest. Comprehensive case-management can help to ensure the continuance of active efforts to place these children in families.*

Frequent home visits and continuing contact from the case manager, once the child returns to a family, are needed to ensure ongoing training and support for the birth family and/or alternative family as well as quality program outcomes for the child.

PI 4.0: Develop system of accountability and monitoring for institutional placements

PI 4.1: On going permanency-planning efforts to ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible, are to be identified and documented in the child’s permanency plan at least every 30 days.

PI 4.2: All institutional placements of children are to be considered as temporary emergency placements. Relevant agency Commissioners must approve all institutional placements, which must be limited to no more than 60 days. Approval for extended placement time must document the efforts to unite children with families and must be reviewed and approved by the appropriate commissioner at least every 60 days.

PI 4.3: Require the HHSC Commissioner to review and approve any placement of a child who has been in a Texas institution for 6 months and at any subsequent 6 month interval.

PI 4.3: Require the HHSC Commissioner to report child institutional placements to the Governor and appropriate legislative committees every 6 months.

- Any institutional placement of a child on an emergency or temporary basis should be one of last resort and efforts to move the child into a family arrangement must be

diligently sought. Meanwhile, the development of capacity for emergency or temporary crisis intervention must be vigorously pursued as a high priority.

Rationale: *Requiring agency Commissioners to approve all placements of children into institutional care, will act as a safe-guard to ensure that all efforts to maintain the child at home have been exhausted, including access to blended funding from multiple public and private sources. Agency Commissioners are in the best position to hold accountable those to whom they have delegated the responsibility for developing the capacity to serve children in families. The Commissioners can also bring to bear previously unidentified resources at the agency and interagency level to prevent institutionalization.*

PI 5.0: Provide training and support to families and/or alternative families

PI 5.1: Provide training and support to families/alternative families including but not limited to the following elements:

- Ensure that trainers are individuals who understand the unique needs of children with disabilities/special health care needs and families must provide this training;
- Ensure the training is unique to the different needs of children from 0 to 17 years and 18 to 21 years, including early childhood, school age, and transition to adulthood;
- Focus training efforts on preparing the family to work with the individual, not preparing the child to move to the community.

PI 5.2: Provide alternative families with access to on-going assistance and support when they need it (i.e. someone on call).

Rationale: *Birth and alternate families must be prepared emotionally and intellectually to accept the child from the institution. Skill training of birth and foster parents is essential for successful in-home training, and should be targeted to the specific needs of the child. In addition, the home environment may require modifications in order to maintain the child's health and mobility in the home.*

PI 6.0: Remove nursing home stay requirement for access to Medically Dependent Children's Program (MDCP) emergency slots

PI 6.1: Remove the requirement in the Texas Department of Health deinstitutionalization rule that children have to stay in a nursing home for four months before receiving MDCP waiver services under the deinstitutionalization option.

Rationale: *This requirement forces parents to institutionalize their child against their will when it need not be necessary to do so. Four months can be a very long time in the development of a child. This time could also take away from the bonding that occurs between children and parents when the children are young.*

PI 7.0: Create an emergency fund

- PI 7.1: Create a flexible, easily accessible and responsive (with-in 24 hours) emergency fund, by blending financial resources from all health and human services agencies, to prevent institutionalization.

Provide services such as specialized 24-hour care nursing care, day treatment, specialized day care, emergency crisis intervention, equipment needed to monitor children with significant special health care needs, and in-home attendant services. In case of an emergency, easy access must include a one-person authorization process between the family/case manager and the local funding source(s).

***Rationale:** This emergency fund will prevent the undue institutionalization of a child in a crisis situation. Parents will gain added peace of mind, by not having to be separated from their child during a crisis. This allows parents to continue to closely monitor the quality of care provided to their child.*

PI 8.0: Evaluate the status of children with mental health needs or traumatic brain injury residing in facilities

- PI 8.1: Identify the number of children with long-term mental health needs in facilities (in-patient).

- PI 8.2: Evaluate the extent to which their support needs are long-term.

***Rationale:** There is evidence that children cycle through mental health facilities multiple times in a 12 to 24 month period. There are indications that some children with mental health needs require long-term supports in the community yet are unable to access the needed services. Mental health services have traditionally been thought of as acute care, but the incidence of multiple re-admissions is evidence that these children need different care than currently available.*

Likewise, there are indications that the needs of children with traumatic brain injury are not being adequately addressed. Identification of these children should be a priority. Once identified, efforts should be made to ensure that specialized treatment and services are made available depending on the specific needs of the child.

Appendix E

**TDMHMR Proposal for the
Identification and Assessment of
Consumers in Community
ICF/MR Programs**

**Promoting Independence Advisory Board
June 19, 2000**

A. IDENTIFICATION PROCESS

1) Short-Range Projection

For purposes of projecting how many persons may request an alternate community option, analysis began with adult consumers who are in nine beds or more community based ICF/MR programs *and* on the HCS waiting list. For children, analysis included children in all sizes of facilities.

Based on analysis, it is projected that **1278** persons would choose alternate services, if made available, and also would be eligible (compared with a current HCS waiting list of **402**). The proposed number of 1278 is based upon:

- a) baseline number of adults in ICF/MR (nine beds or more) and children (regardless of facility size), both on the HCS waiting list as of 6/9/00

= **402**

*See explanation of baseline number below**

- b) 100% of children (0-17) in the entire ICF/MR program, currently not on the waiting list

= **269**

This is considered a starting point which is consistent with TDMHMR board policy; it is acknowledged that for some number of consumers the LAR will not choose an alternate community option.

- c) 60% of Level of Need (LON) 1 consumers not already on the waiting list

= an additional **195** (for a total of 251 with a LON 1)

The % was increased to 60%, based on the assumption that more persons with a Level of Need 1 would be likely to choose alternate community services plus be able to meet eligibility requirements.

- d) 35% of Level of Need 5 consumers not already on the waiting list

= an additional **412** (for a total of 550 with LON 5)

The % was increased to 35%, based on the assumption that more persons with a Level of Need 5 would be likely to choose

alternate community services plus be able to meet eligibility requirements.

**Explanation of baseline number:*

Level of Need 1.....Adults = 56; Children = 0

Level of Need 5.....Adults = 138; Children = 17

Level of Need 6.....Adults = 42; Children = 54

Level of Need 8.....Adults = 53; Children = 31

Level of Need 9.....Adults = 1; Children = 4

Unknown LON.....Adults = 4; Children = 2

Total = 402

Additional Assumptions

- 402 is the most valid number we have at this time and therefore, is the most appropriate starting point from which to project future appropriations needs.
- Consistent with the TDMHMR Board Policy on Family Support Services for Children and Youth, special focus on children is required.

2) Refinement of Projection

The information produced by data analysis should be refined as soon as possible, and then on an ongoing basis, in order to account for the difference between the current 402 and projected 1278. It is believed that the following activities, in combination, will help accomplish this:

- a) Beginning in September 2000, ICF/MR providers will be asked to use the Community Living Options instrument in discussions with consumers who are part of the current HCS waiting list of 402.

For individuals who indicate a preference for alternate community services, information obtained through the use of the Community Living Options instrument will serve as a "profile" and the provider will submit this information to the MRA. Upon receipt of this information, and in conjunction with the ICF/MR provider, the MRA will establish contact with the consumer/LAR and initiate discovery activities limited to general preferences regarding alternate community options.

Although this activity may be somewhat redundant to the MRA waiting list activity described in item (b) below, it does offer the opportunity to provide the MRA with additional information about each of the consumers on the waiting list. Additionally, this voluntary activity will help inform the system before implementation of the Community Living Options instrument is required for all ICF/MR consumers.

- b) In September 2000, revisions to the MRA's performance contract will be in effect which will require the MRA to validate HCS waiting list information (which includes the 402 on the current HCS waiting list and living in community ICFs/MR), as well as types of services desired and current status, on a systematic basis. Review of the current backlog will be completed by August 31, 2001 with continued annual review required thereafter.

Assumptions:

- 402 is an underestimate of the number of consumers who would request HCS services if provided current information about their choices.
- Formal rule changes are not required to accomplish the items above. Cooperation with the first item is anticipated due to the providers of the 402 and either their involvement with the Promoting Independence Initiative and/or their status as an MRA. The second item will be managed through the performance contract process already in place between TDMHMR and community centers.
- The consumers identified in this proposal would be targeted in a waiver amendment by the criteria used to define this population.
- Working relationships between MRAs and private ICF/MR providers will need to be further developed and/or enhanced through regular meetings and other mechanisms.
- It is anticipated that resources may be required for (including but not limited to):
 - Validating waiting list information (by the MRA);
 - Training on the Community Living Options instrument and conducting discussions in which the instrument is used (by the ICF/MR); and
 - Contacting consumers who choose an alternate living option and conducting preliminary discovery process (by the MRA).

B. ASSESSMENT

Assessment processes are required in order to determine appropriateness for alternate community services. Discovery of a consumer's preferences through a person focused process is considered the centerpiece of a valid assessment process.

1) Role of the Community ICF/MR Provider

Community ICF/MR providers will utilize a person focused planning process as much as possible, within any limitations that may be imposed by current federal regulation. It is anticipated that future revisions to the regulations will be more focused on outcomes, thereby offering better support to the use of a person focused planning process. Minimally, the Community Living Options instrument will be used by private ICF/MR providers for each consumer on an annual basis. Outcomes regarding consumer preferences will be documented in the consumer record. The instrument will be used with each consumer upon admission and thereafter, on at least an annual basis.

For consumers who indicate a preference for an alternate community living option, information will be forwarded to the MRA.

2) Role of the MRA

Upon receipt of information regarding consumers who prefer an alternate living option, the MRA will establish contact with the consumer and initiate a discovery process regarding general preferences of alternate community living options. Once resources to move to an alternate community living option are identified, the MRA will make contact again to continue the discovery process to determine the consumer's more specific preferences.

The MRA's role is one of access, information sharing, and continuity. This role as it relates to state schools is described in TAC 4021 *Movement of Individuals with Mental Retardation from Department Facilities*. This proposal intends to replicate the primary features of that role in the community ICF/MR program.

Assumptions

- Due to changes in process being required, a formal rule will be necessary to require community ICF/MR providers to use a person focused planning process and/or the Community Living Options

instrument and document annual verification of consumer/LAR preferences.

- Implementation of person focused planning in the community ICF/MR program will represent a paradigm shift, requiring the investment of time and training resources.
- Rule development is considered a priority. Adoption is considered possible 90 days after a draft is completed, possibly requiring specially called meetings by the MCAC and Board. At this time, implementation is targeted for Fall 2000.
- Placing requirements into a rule will allow for stakeholder input (consumers, providers, MRAs, etc.) prior to adoption and opportunity for training of providers and MRAs prior to implementation.
- A monitoring system may be required in order to ensure that consumer preferences are documented by community ICF/MR providers.
- Resources may be required once a consumer selects an alternate living option, including but not limited to:
 - Community ICF/MR providers - transportation of consumers for pre-placement visits and/or moves to an alternate living option; training staff at the alternate site regarding consumer preferences and needs; physician to physician exchange of information;
 - MRAs - completion of a person focused planning process for each consumer and determination of specific preferences; transition activities as resources become available (beyond the 30 days prior to leaving the facility which currently are funded through Targeted Case Management); assistance to consumers for pre-placement visits and/or moves to an alternate living option; development of additional responsibilities as the Local Authority role evolves due to statewide roll-out of MRLA
 - State Authority – implementation activities related to waiver program expansion (enrollment activities; survey, oversight and utilization review activities, etc.); provision of technical assistance, etc.
 - System – resources for the development of some type of statutorily endorsed assistance for persons who are unable to give legally adequate consent.

Appendix F

PROMOTING INDEPENDENCE INITIATIVE

December 2000

The July 19, 2000 version of TDHS' Promoting Independence Plan (PI) is the current version.. Implementation of Phase I will be effective 12/00. Notification to nursing facility residents, responsible parties or guardians will be retroactive to September 2000 as indicated in the July 2000 PI plan.

PHASE 1 IMPLEMENTATION - 12/00

CURRENT PI ACTIVITIES WITH EXISTING RESOURCES

- ◆ Inform all MAO and SSI nursing facility residents, including children, of Long Term Care Options and their eligibility to bypass the waiting lists of Community Based Alternative (CBA) programs via Long Term Care Options Notice and brochures
- ◆ Inform new applicants, at time of applications, of Long Term Care Options that summarizes an array of Long Term Care programs available through DHS.
- ◆ Information letter to providers to inform of Phase I PI Activities
- ◆ Computer Based Training (CBT) for all TDHS staff to ensure awareness of CBA programs, PI initiative, and sensitivity to persons with disabilities. The CBT course is available to all interested parties via Internet
- ◆ Training on Implementation Procedures for LTCS staff
- ◆ Data collection system to develop PI client profile; identify successful factors and barriers to transitioning of NF clients into community-based settings
- ◆ Community awareness activities to promote Long Term Care options
- ◆ Permanency planning to develop community placements for children (RFP will be published by January 2001)

PHASE I - CONTINGENCY PLAN 09/2001 (Dependent on additional resources in FY 2001)

PI ACTIVITIES WITH REQUESTED FUNDING

- ◆ Hire, train and deploy 22 staff for six months of FY 2001 to provide intensive relocation and outreach activities at selected sites
- ◆ Implement an identification process and assessment instrument to transition 50 NF clients
- ◆ Development of automation to track data collected by the relocation specialist to build onto the baseline profiles from Phase I
- ◆ Pay for costs associated with moving and re-establishing a community residence for projected 50 clients
- ◆ Target community awareness activities
- ◆ Intensify permanency planning activities for 75 children in NFs
- ◆ Submit an RFP for relocation activities including development of the identification process and assessment instrument.
- ◆ Site selection is dependent upon the entity awarded the contract.
- ◆ Action Plan is being developed for publication of the RFP

TDHS Plan to Address Promoting Independence in Nursing Facilities

Introduction

The Texas Department of Human Services (TDHS) is committed to maximizing choice by developing more opportunities for individuals with disabilities through accessible systems of cost-effective community-based services. The department's commitment can be fulfilled over time with planning, funding, resources and management.

Overview of proposed approach

In support of achieving the goals of Promoting Independence, TDHS is proposing a multi-phased approach in maximizing choice for current and potential nursing facility residents.

Phase I involves a written notification to authorized representatives of all current nursing facility residents, as well as new applicants and SSI recipients, explaining the CBA option. People seeking to bypass the CBA interest list are referred for eligibility determination for CBA. Baseline profiles of clients seeking transition will begin. Community awareness activities promoting choice and community options will also begin. This phase of the plan can be implemented September, 2000, with existing staff and funding.

Phase I Contingency Plan (Dependent on Additional Resources in FY 2001)

Should additional resources be allocated to the department for FY 2001, relocation and community awareness activities could begin in the five urban areas. In addition to the statewide activities described in Phase I above, the department proposes as a contingency to hire, train and deploy 20 staff for six months of FY 2001. This proposal is dependent upon allocation of additional funding. The new staff would begin relocation and outreach activities in the five urban areas. TDHS intends when possible to use contracts with Area Agencies on Aging, Independent Living Centers or other interested organizations to fill the relocation and public service coordinator's positions. A specific staffing concern is the FTE cap which applies to contracted positions as well. The nursing facility clients identified for transitioning to the community would bypass the CBA interest list. In addition, permanency planning activities for children in nursing facilities could be intensified and accelerated if additional funds were allocated for developing community placements for children.

Phase II involves building an infrastructure similar to the MRA concept for placement of individuals, and includes funding for relocation specialists to transition residents from the nursing facility. This phase could be implemented over a two year period beginning September 1, 2001. If money is appropriated, the first year of Phase II would address the hiring and training of relocation specialists and public service coordinators, development of an identification process and assessment instrument, development of automation to track data collected by the relocation specialist to build onto the baseline profiles from Phase I and conduct community awareness activities. The first year of Phase II would be a pilot of the process in five urban counties. Year two would be full statewide implementation.

Phase III is the long-term goal to take a preventive approach that leads to diversion from institutionalization. While community awareness activities can begin during Phase I, placement of additional staff in hospitals and pre-admission/admission screening activities would not be operationalized until the 2004-2005 biennium.

Overview Timeline – Phase I, II and III

| TASK | FY00 | FY01 | FY02 | FY03 | FY04 | FY05 |
|---|-------------|-------------|-------------|-------------|-------------|-------------|
| Phase I | | | | | | |
| Planning | | | | | | |
| Resident Notification | | | | | | |
| Training | | | | | | |
| Evaluation | | | | | | |
| Community Awareness | | | | | | |
| Phase II | | | | | | |
| Planning | | | | | | |
| Pilot Urban Relocation and Community Awareness | | | | | | |
| Statewide Relocation and Community Awareness | | | | | | |
| Evaluation | | | | | | |
| Phase III | | | | | | |
| Diversion | | | | | | |

Fiscal Year (FY) - begins September 1 and ends August 31. For example, FY 2001 begins September 1, 2000, and ends August 31, 2001.

PROMOTING INDEPENDENCE
PHASE I: Utilization of Existing Resources

Scope

The scope of Phase I is multifaceted. The implementation of Phase I will begin an informational and educational process for Texas Department of Human Services (TDHS) staff and nursing facility residents and their authorized representatives. They will be made aware of Community Care options and the exception allowing nursing facility residents to bypass the Community Based Alternatives (CBA) interest list. In addition, department staff will continue to gain knowledge and experience by working with the two Project CHOICE sites. Grant initiatives to develop processes and infrastructure for transitioning individuals from nursing facilities to the community can be pursued. During this phase there are opportunities to work with pilot sites selected by the Texas Community Integration Collaboration (TCIC). The TCIC is a collaborative effort of three developmental disability programs in the state. Proposals for housing options are currently being considered, and if realized, may be added to the process during Phase I in working with residents indicating interest in relocating. Community awareness activities promoting choice and community options will begin. A Request For Proposal will be released to solicit community entities and other interested parties for the development of community placements for children.

Outcomes

A number of individuals who currently reside in nursing facilities will be able to transition into the community.

Data will be collected to assist in identifying the circumstances and barriers that result in both successful and unsuccessful transitions into the community. This collection of statistical information will enable the department to more accurately profile individuals for future planning and funding. This information does not currently exist.

Although Phase I can be implemented with existing funding and staff, it will cause a shift in workload responsibilities from other client care services. However, it is anticipated that resources currently allocated to training, automation support, and evaluation activities may be reallocated to focus efforts on this initiative. Further, there is a potential cost for evaluation efforts if contracted services are utilized. Without historical information or direct contact with the clients and/or their authorized representative, it remains speculative as to the number of requests the department will receive from individuals wishing to transition into the community.

Targeted population

Phase I will target statewide the authorized representatives of Medicaid nursing facility residents, applicants for Medicaid in nursing facilities, SSI recipients, and STAR + PLUS clients. It is important to note the target population includes children.

Process

The process begins when TDHS Medicaid Eligibility staff conduct an annual review of the nursing facility clients' eligibility. At the time a nursing facility resident's annual review is due, a letter will be sent to the nursing facility residents authorized representative informing them of community options and the ability of the nursing facility resident to bypass the CBA interest list. The CBA bypass applies to all nursing facility residents including residents who have lived in the nursing facility within the last six months. The letter instructs interested parties to respond to the Medicaid eligibility staff members who sent the letter or to a 1-800 number.

Any nursing facility resident who self declares to transition into the community will be included in the process.

The TDHS staff will refer the names of the interested individual to the Community Care intake staff. Having been identified as a nursing facility resident bypassing the CBA interest list, a CBA case manager will determine eligibility for CBA and either authorize or deny CBA services for the client. Individuals denied CBA services are afforded a fair hearing through the appeal process, and will continue to receive services in the nursing facility. Should the circumstances resulting in a denial change, the case can be brought back to the attention of TDHS; otherwise the individual case will be reviewed in the following year. New applicants for Medicaid will also be reviewed as part of this process for potential CBA eligibility.

In instances when the families of children have indicated to the Medicaid Eligibility staff that they are interested in community options, a referral will be made to the Texas Department of Health for determination of eligibility for the Medically Dependent Children's Program.

SSI recipients residing in nursing facilities will receive notices informing them of community options and the ability to bypass the CBA interest list. This mailing may be handled through a central mailing since annual reviews are not done by TDHS staff for SSI recipients. A contact name or number will be given to direct individuals to Community Care staff. **(See Draft Attachment #1)**

Data Collection

Data will be collected at the time an individual is authorized or denied CBA service. The purpose of the data is for profiling and includes but is not limited to: demographics, housing arrangements, formal and informal support, care needs, transportation needs, costs, and reason for denial of service. Examples of specific information to be collected include:

- The number of existing nursing facility Medicaid clients and Medicaid nursing facility applicants receiving notification letters
- The number of respondents and nursing facility residents self declaring to bypass the CBA interest list
- The number of nursing facility residents who are authorized to receive CBA services and those who are denied CBA services, with specific reason for denial
- The number of respondents for children seeking transition to the community
- The number of nursing facility residents referred to other state agency programs

The additional automation needed to collect, track and report the information will include modification to existing systems.

Permanency Planning

The TDHS staff will release a Request for Proposal to solicit community entities and other interested parties experienced in developing community placements for children to work with the children and families of children residing in nursing facilities. The department intends to contract for this activity.

Nursing Home Transition 2000 Grant

TDHS is working with HHSC regarding development of a proposal in response to this grant initiative. The proposal is to transition young adults and children from nursing facilities back to the community.

Training

To ensure the successful outcome of Phase I, a key component is to raise the staff's consciousness regarding transitioning individuals with disabilities, including children. Training will be conducted for affected staff and new staff regarding persons with disabilities. The training may include segments such as disability awareness, Olmstead overview and permanency planning. The department training effort should provide a better level of understanding about a significant and important population we serve. Training would begin by September 2000.

Planning Activities (For FY 2001 Contingency Plan and/or 2002-2003 LAR)

Staff – Preparatory work can begin for job descriptions and job audits of relocation specialists, public service coordinators, state office and support staff. Accomplishing the upfront paper work will expedite posting, interviewing and hiring should additional funding be made available for FY 2001 and/or appropriated for FY 2002/2003.

Training – Planning a preliminary outline and timelines of essential training materials for the proposed new staff can begin. Preparing for training will enable the department to orient new

staff to their responsibilities should additional funding be made available for FY 2001 and/or appropriated for FY 2002/2003.

Assessment Tool – Research can be completed of other agencies and states assessment processes. Preliminary development and testing of an assessment tool can occur for the nursing facility population.

The testing could occur should TDHS be awarded the Nursing Home Transition 2000 Grant. The collection of other assessment processes has already begun.

Public Service Material – Preliminary planning, timelines, strategies and suggested design related to informational materials, target groups, and outreach activities can begin. Although community awareness activities will have already begun, the planning is related to developing a systematic statewide outreach and community awareness program.

Automation – Preliminary system planning will be conducted for purposes of conceptual design of the proposed automated system.

Timeframes

Beginning in September 2000, Medicaid Eligibility staff will send out annual review letters with information about the CBA alternative. Approximately 4,000-5,000 letters will be sent each month. It will take approximately one year to notify all residents. The notice of community options will be provided on an ongoing basis to all nursing facility residents applying for Medicaid. **(See Draft Attachment #1)**

Prior to September 1, 2000, the nursing facility association and providers will be informed of the notification letters which will be mailed throughout the year to the authorized representative of nursing facility residents. The department is committed to working with nursing facility providers to further the process of identifying nursing facility residents appropriate for community placement.

Community awareness activities regarding choice and community options will begin in September 2000. Also in September 2000, the permanency RFP will be released. In October 2000, the SSI recipient notification will begin.

Evaluation

The evaluation of Phase I will establish a base line which has not existed previously. The information and results of Phase I efforts can be used for future planning and funding. The data on the number of people seeking to transition into the community and the circumstances which lead to successful or unsuccessful placement in the community will be valuable. An evaluation

of the staff training can be done by a questionnaire. An evaluation of the department's involvement in the Project CHOICE sites, any pilots of the TCIC, housing proposals, or grant initiatives could be included in the respective evaluations or done separately.

Community Awareness

It is difficult to identify and reach people who are at risk of entering a nursing facility. An effective nursing facility diversion and relocation program must be designed to reach a range of groups who may make or influence decisions about long-term care use. To increase community awareness of long term alternatives, TDHS will use three major tactics:

1. Provide information to groups of elderly, disabled and families to raise their general knowledge about long term care options.

TDHS staff, trained volunteers, and persons associated with programs serving the elderly can make presentations and provide printed materials to community groups. Targeted groups might include faith-based groups, civic organizations, leisure groups and senior centers. TDHS staff will be involved to the extent feasible. To carry out a thorough job, TDHS will need to obtain funding for additional staff or contracts, obtain the support of committed community volunteers, or both.

The purpose of this tactic will be to increase the number of people who, when faced with a need to consider long term care, will have a least a general idea that alternatives to institutionalization are available. We expect that word of mouth will reinforce these efforts, although the details of the information passed by word of mouth may be incomplete.

2. Ensure that information about long term care services (TDHS and otherwise) is available from sources where people will seek help for long-term care issues.

We know that physicians and hospital discharge planners are involved in long term care decisions. In addition, clergy, attorneys, and certain electronic and media sources are trusted and influential sources of information. TDHS will provide brochures, Internet links and editorial content to these sources to enable them to pass information on to people seeking help with long term care decisions.

TDHS will take a variety of steps to ensure that medical professionals have current, accurate information to guide patients who need long term care. Some of the professional groups to be considered are:

- Physicians, including TMA, and specialty groups such as those for Family Practice, Internists, Physical Medicine and others
- Nurses at all levels
- Professional social workers
- Therapists
- Mental health professionals
- Hospitals, THA and certain groups of hospital staff such as discharge planners and chaplains

We will try to ensure that these professionals understand that long-term care options exist, that they can meet the needs of many patients, and that services are available, often with public funds. It may be especially important that they understand how home based services can make long stays in a nursing facility unnecessary.

If possible, TDHS will work with other organizations to make information about long-term care options available as professional continuing education. If the information is convenient, low in cost and meets part of the CE obligation for licensure, it is more likely to be reviewed and understood by the target audience. TDHS will work with the various professional licensure boards and professional associations to meet the requirements for accredited or accepted CE.

The information may be present through several methods. Presentations at professional conferences and meetings will reach some professionals. Written materials, perhaps set up as self-guided CE courses, will reach others. We may also use the Internet, possibly offering a self-guided online course. Information, whether as CE or not, can be made available through the internet, using links from sites such as professional associations and possibly commercial sites like WebMD.

This strategy will be reinforced by other research into the long term care decision making process. The purpose of this strategy is to ensure that medical, and other, professionals are willing and able to help patients consider a range of options for long term care.

A range of other groups may have influence on long term care decisions, or be seen as potential sources of information by families facing a decision. Some examples include:

- Clergy
- Attorneys and estate planners
- Advocacy and special interest groups

- Associations concerned with stroke, arthritis or other conditions likely to result in a need for long term care
- Employee assistance programs
- Community support groups

TDHS will also offer Internet links from the pages of such groups as AARP, drkoop, and other advocacy and special interest groups. TDHS will work with groups, professional associations and governing bodies to develop this strategy. In each case, we will ask to what extent the group or its members are asked about long term care issues, and what kinds of information will be most helpful. This strategy will expand over time, and be reinforced by other efforts to learn more about the long-term care decision-making process.

The purpose of the strategy is to ensure important sources of advice on long term care have accurate and current information and written material about long-term care services.

3. Develop and provide a brochure about community service options.

In addition, TDHS will prepare a brochure or other public information materials, similar to those used in Washington or other states, to encourage persons entering a nursing facility to plan for leaving and going home. The brochure will point out that CBA services may be available without a waiting list and offer advice on retaining home and household goods, making practical arrangements and maintaining an expectation of recovery. The brochure will be made available in hard copy and electronically through a variety of channels, including:

- Hospital discharge planners
- The TDHS web site
- Web sites of other public and advocacy groups
- Nursing facilities

TDHS will work with HCFA, nursing facility associations and the Texas Hospital Association to ensure that such information is provided at every nursing facility admission. We will place particular emphasis on those who are entering the facility with Medicare or private pay funding.

The purpose of this brochure, which will be reinforced by other aspects of the TDHS plan, is to encourage individuals and families to think about nursing facility care as a temporary measure. Those who enter a nursing facility because of a health crisis may not have completed the emotional or practical processes that can make return to the community difficult. This brochure may prevent breaking up personal possessions and delay the hardening of a decision about permanent nursing facility residence.

4. Learn more about how Texans make long term care decisions and find about their options, then modify information and outreach strategies to reflect the new information.

We know that the use of community care and nursing facility services varies widely across Texas. Although there are a number of theories, there is no hard information about why community care is used more heavily in the Rio Grande Valley than anywhere else in the state.

TDHS can acquire some information about consumer knowledge of long term care through existing efforts. The HB374 assessment of long term care, survey efforts by TDoA and the evaluation of the CARE project will all provide insights on the process of long term care decision-making. Private organizations or universities may also be able to provide research on effective marketing and information strategies for the elderly.

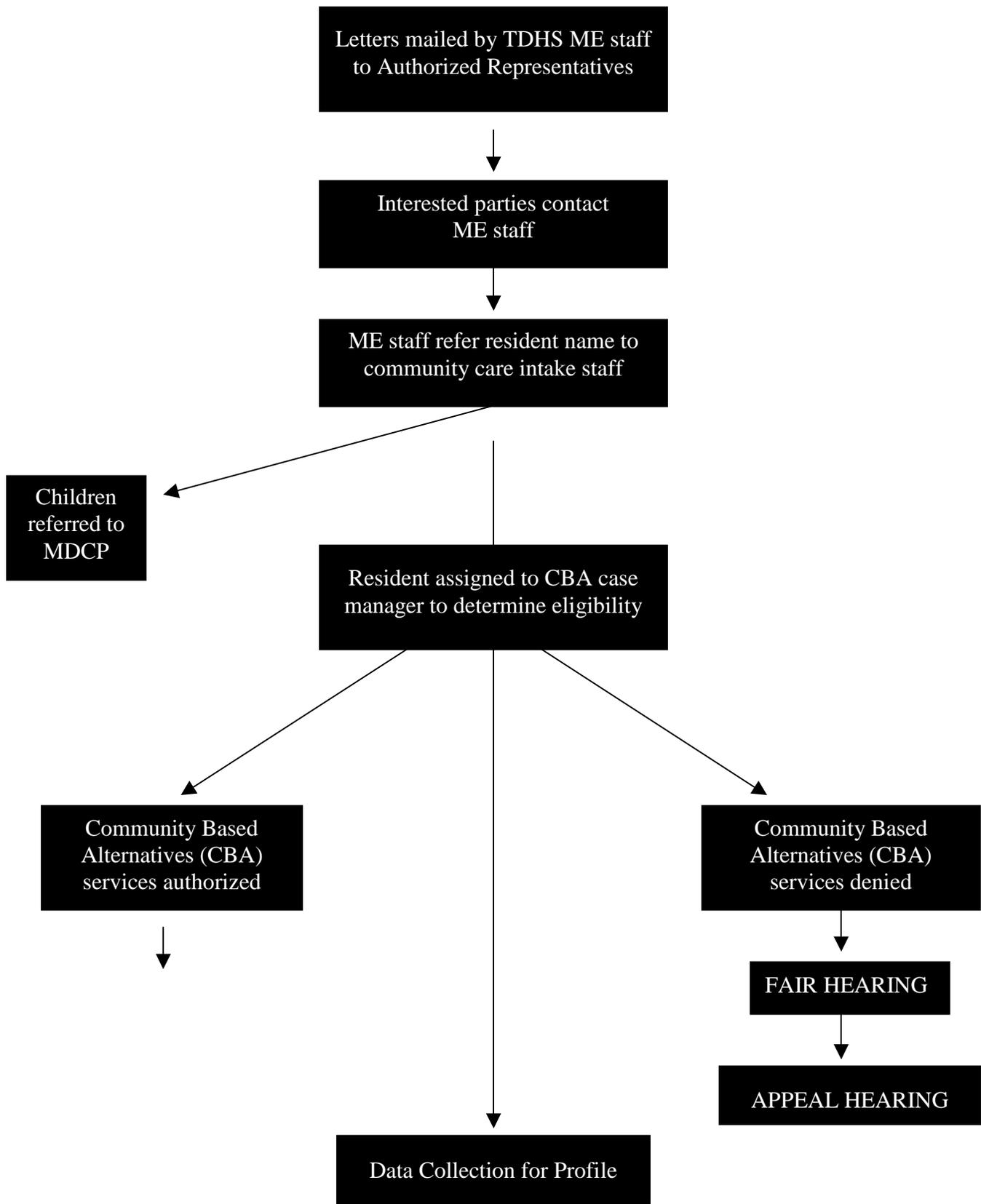
If resources are available, TDHS and other organizations could undertake further research. For example, we could ask persons using community care services how they learned about them.

As more information about public knowledge of long-term care develops, TDHS can modify its printed materials, outreach strategies and other techniques. Research may suggest new groups to contact, new media to use or new ways of packaging information.

The purpose of this tactic is to ensure that TDHS outreach techniques reflect our best understanding of the needs, expectations and wishes of the individuals and families we are trying to reach.

TDHS will combine research and public information in a mutually reinforcing cycle. We will build systematic knowledge about people who use long term care, their families, their resources and their needs. We will use that information to build a public and professional information system that ensures that their elderly, their families and their doctors know that there are alternatives besides living alone without help and going into a nursing facility.

As further information is acquired, other strategies will be implemented that reflect new information about the long-term care decision making process. Information for new strategies will come from reviews of research by other groups and by analyses of data collected by TDHS. For example, the SB374 assessment and the evaluation of the CARE program may yield information about the extent to which caregivers and families are aware of long term care options and the ways they learn about those options. Other groups and organizations continue to conduct and publish the results of their own research and we will take advantage of that information as it becomes available. Finally, TDHS will collect a significant body of information while implementing the early stages of Promoting Independence. That information will be used to shape the public and professional outreach efforts of the future.



Promoting Independence Phase II : LAR Dependent

Phase II will expand on the efforts of Phase I and the Phase I contingency plan should resources be allocated. Phase II will identify affected populations, improve the flow of information about supports in the community, and remove barriers that impede opportunities for community placement. Through contracts to provide intensive relocation efforts and community awareness activities, Phase II will be statewide in two years. In addition, Phase II will use systematic collection and analysis of data to improve our understanding of the best methods of avoiding institutionalization, and raise community, family, and professional awareness of community care options.

Phase II is dependent on approval of a legislative appropriations request, and to be fully successful, should be supported by other appropriations requests being made by TDHS.

Scope

Phase II will focus on several important groups, who will be provided relocation services without regard to income or funding source for their nursing facility care. The major target groups are:

- Persons newly admitted to a nursing facility
- New admissions whose Medicare eligibility is about to expire
- Children
- Individuals identified in Phase I who expressed interest in relocation but could not have a plan of care developed to adequately meet their needs

Persons requesting relocation services but who do not qualify for Medicaid will receive assistance in arranging community based services to be paid for with their own resources or other non-Medicaid funds.

Phase II will be implemented in a two year period. At the end of that time, services will be available statewide

Expected Outcomes

Anticipated outcomes from implementation of Phase II include:

- Use permanency planning to begin reducing the number of children in nursing facilities
- Decrease the number of Medicare admissions who remain in the facility after Medicare benefits expire
- Relocate groups targeted but not moved in Phase I
- Relocate new admissions who do not use Medicare

- Increase community and professional awareness of community-based alternatives, leading to fewer applications for nursing facility care
- Increase knowledge about the most effective methods of diverting or relocating persons from nursing facility care
- Increase local capacity, paid and voluntary, to provide services in the community to children, persons who are elderly and persons with disabilities.

Another important aspect of Phase II will be community outreach activities which will raise awareness about community care options. Target groups will include: physicians and medical professionals, persons who are elderly and persons with disabilities and their families, hospital discharge planners and social workers, and civic, faith-based and community groups and public schools.

Limitations

Effectiveness will vary based on a variety of factors, some of which are outside agency control. Additionally, it must be remembered that successful relocation will not be effective with all nursing facility residents. Following is a list of specific limitations:

- Persons who have been resident in a nursing facility for several years, especially the elderly, cannot be easily relocated.
- Relocation of individuals who have no or weak community networks, or certain health conditions, may require the participation of housing, transportation, and local community entities to build community supports.
- There is an insufficient provider base in settings such as assisted living and adult foster care.
- Phase II will not be effective if TDHS does not have sufficient funding and authority to carry it out.
- In the current economic conditions, it may be difficult to find enough staff to carry out the Promoting Independence initiative. Relocation Specialists, Public Service Coordinators, support staff and home care aides may all be scarce in a tight job market.

Proposed Process

A multi-pronged approach consisting of personal interview, self-guided interview, along with other informal approaches will be considered. At a minimum the process is going to have to take the form of two distinct steps: a preliminary screen followed by a more intensive assessment process. The objectives of the preliminary screen will be to determine:

- Individual's/family's choice
- Capability of relocating
- First level assessment of community supports
- Housing opportunities.

TDHS will require all nursing facilities to send notification of all new admissions, regardless of funding source. The notification will include information describing the resident's condition and needs.

A face-to-face contact will be made with nursing facility residents, family members, and authorized representatives by the relocation specialist .

Upon notification, the relocation specialist with the contract agency will contact the resident and nursing facility. The relocation specialist will arrange a meeting with the resident and a family member or friend chosen by the resident. The meeting will occur within a few days of the resident's admission to the facility.

At the meeting, the relocation specialist will use a standardized interview guide/assessment tool to discuss the resident's wishes, expectations and needs concerning relocation. The needs and concerns of family and other support networks will also be considered. The interview guide/assessment tool is to capture information; the tool will not be a decision document on feasibility of relocation.

If the resident wishes to relocate, the relocation specialist, resident and family will develop a plan, involving whatever resources are necessary. For example, family, the resident's personal funds, Medicaid eligibility, publicly funded programs and voluntary services may all be involved. In many cases, a formal staffing with the resident's medical providers will be needed. The plan will include responsibilities, timeframes and expectations for each participant.

Relocation may be to resident's own home, the home of a family member, an assisted living or adult foster care facility or other accessible and affordable housing. Assisted living provides 24-hour living arrangements in licensed homes in which personal care, home management, escort, social and recreational activities, supervision/assistance with medications and transportation are

provided. Adult foster care also provides 24-hour living arrangements in other individual homes for persons who need services such as meal preparation, home-keeping, personal care, help with activities of daily living, supervision, and transportation. Accessible, affordable housing means a residential setting that meets the requirements of the Americans with Disabilities Act and is within the financial means of low-income individuals. Relocation may take place a few days after admission to the nursing facility or be delayed for several months while the resident is stabilized or rehabilitated.

Even when the resident faces several months of rehabilitation, it is important to develop a plan early. With the plan in place, the resident and family operate toward a goal of independence. The resident's home and possessions remain available, so the re-establishment of the home is feasible.

The initiative includes CBA and Community Living Assistance and Support Services (CLASS) slots dedicated for FY 2002 and 2003 specifically for residents transitioning from the nursing facility back to the community. If the resident appears to qualify for CBA, CLASS or other community care services through TDHS, TDHS staff will become involved with eligibility, care planning and other usual responsibilities. If other resources (private pay or voluntary, for example) are involved, the relocation specialist will remain more involved with the case. In any case, the relocation specialist will make a follow-up visit, beginning at about 6 months after relocation.

Identification of an Assessment Process

The goal of this process is to identify individuals who have expressed an interest and/or have a high probability of successfully transitioning from a nursing facility placement to a less restrictive environment. In order to identify a practical assessment process, the TDHS is reviewing:

- the activities that have been done in other states
- a process proposed by the Texas Department of Mental Health and Mental Retardation (TDMHMR) with their population, and
- activities associated with Project CHOICE.

TDHS is in communication with the states of Colorado, Oregon, New Jersey, Washington, Pennsylvania and Maine and will be evaluating their materials (along with TDMHMR's) to determine:

- Ease of administration
- Ease of evaluation
- Fiscal impact
- Overall effectiveness

The issue of a singular assessment tool will also be considered.

Preliminary research has indicated that the more intensive screening process must focus on:

- Functional needs as identified through assessment of activities of daily living
- Need for assistive devices or home modifications
- Psychosocial needs
- Cognitive functioning
- Medication supervision
- Extent of required nursing services

Community Outreach and Awareness

The intent of this effort is to improve processes for informing decision makers about long term care options. It is widely accepted that relocating people from nursing facilities is more difficult than diverting them. Once a person has entered a nursing facility, two processes, both hard to reverse, may have been completed. The resident and family have been through the painful decision process, and often are unwilling to revisit the guilt, grief and difficulties associated with that decision. Family resistance to re-opening the question was a significant problem for TDHS in past efforts to prevent or avoid institutionalization. Furthermore, the resident's household goods and home may also be broken up and sold, making re-establishment of a new home especially difficult.

When an individual or family faces a health crisis that requires long term care, they frequently are unaware of any options except nursing facilities. A nursing facility will meet the need, they know it exists, and beds are usually available. Programs like CBA are not as well known, and neither the family, their friends or the medical professionals involved are likely to know how to access the program.

TDHS will develop and implement a systematic program of public information, targeted at groups who are most likely to be involved in long term care decisions. The aim of the program will be a change in public and professional expectations about long term care, and a change in the decision making process for many families.

The proposed method is to form a task force of consumer, provider, advocate and agency staff to develop materials for promoting community awareness of options for people to continue residing in the community and access needed services and supports. Presentations should be done by community members, in order to create a community familiarity about who to contact and may help build a network of ongoing community supports. These may be done with faith-based organizations, senior centers, PTA meetings, service organizations, business organizations, hospital discharge planners etc. In addition to community presentations, information needs to be presented to professional organizations.

In order to reach professionals who often have a role in long term care decisions, TDHS will work with professional associations, church governing bodies and trade groups. If possible, information about long term care options will be incorporated in accredited professional continuing education.

The content and focus of the community awareness efforts will be modified over time as TDHS acquires more information about decisions processes through the on-going research effort.

The initial timeline would begin task force meetings in September 2000, targeting for materials and training by March 2001. Rollout could begin in April 2001 with statewide covered by September 2001.

Staffing

TDHS intends wherever possible to use contracts to carry out the relocation planning process and public service activities. In most cases, the contracts are expected to be with the Area Agencies on Aging, Independent Living Centers or other interested organizations. If a suitable agency can be identified, a special child-placing or advocacy organization may be involved with the relocation of children.

The contract agency will hire a relocation specialist to carry out two functions: Relocation outreach and relocation case management. The same individual may handle both functions, or different persons may be assigned the tasks, depending on local preferences and circumstances. The work will be intensive, with a caseload of only 10-15 clients at a time.

Relocation will place additional demands on TDHS staff involved with the CBA and CLASS programs. Additional staff will be needed in the areas of Medicaid Eligibility Determination, Community Care Case Management, and Contract Management. As Phase II progresses, there may be an increase in the number of licensed assisted living and adult foster care facilities. If so, TDHS may also need to increase Long Term Care Regulatory staff.

TDHS can also contract for the Public Service Coordinator's positions. The staff will be responsible for implementing a systematic statewide program of public information. Activities can involve local community presentations, establishing and building community networks, targeting professional and public groups, and working with families, clients and others who frequently interact with the elderly and disabled persons. In addition, the public service coordinators will collect information about public knowledge of long-term care. This information will be used to modify educational materials, outreach strategies and other techniques.

Timeline

Phase II will be implemented over a two year period beginning in FY 2002.

- **Year One**—Planning and Capacity Development

During Fiscal 2002, TDHS and other staff will conduct contract procurement, staff hiring and training and the development of working relationships with contract partners.

Data collection and analysis will begin in Fiscal 2001, but will become more intense in 2002. Staff and contractors will collect baseline data on current nursing facility and community care utilization and movement patterns and the characteristics of persons using various systems. Literature and survey research will be used to help shape the community awareness program.

- **Piloting in Five Diverse Urban Counties**

TDHS will select several urban counties with diverse demographic and economic characteristics. The Department on Aging and other groups will participate in the selection. In these counties, Phase II will be implemented during FY 2002.

Continued data collection and analysis will support program improvements. The community awareness program will ensure that more and more Texans are aware of long-term care options.

- **Year Two**—Statewide Implementation

All counties will be served with full relocation services in FY 2003.

The community awareness program will be implemented fully statewide in FY 2003.

Data Collection, Analysis and Evaluation

There is little recent, formal information about the best ways to prevent nursing facility placement or relocate residents from nursing facilities. While many states, including Texas, have shifted the emphasis in their long-term care programs from institutional to community based services, information is insufficient for accurate planning at this time.

By building on the information collected from each phase, Texas will have the opportunity to collect, analyze and make use of a wealth of information about a large number of current and potential persons in need of long term care. Systematic data collection and analysis will allow better targeting of resources and better understanding of resident needs. The proposed data collection and analysis effort will focus on the five areas listed below, and assumes the utilization of contracted services where needed.

Program Participation Data

This information will be collected during routine service delivery and reported monthly and annually. We will use it for basic program description and to identify geographic and other patterns in service use. Examples of information to be collected include:

- Characteristics of those contacted, including demographic information, diagnoses and medical and functional needs
- Number of relocation plans developed
- TDHS and other publicly funded services used in relocation plans

Client Outcome Data

For persons using TDHS services, this information will be gathered from routine service reports. Follow-up letters will be used for others. If resources are available, a sample of non-TDHS clients will be contacted by telephone. We will use this information to describe the cycle of service usage and to calculate costs and savings associated with relocation. Examples of information to be collected include:

- Living arrangement (nursing facility, assisted living, own home, with family, etc)
- Use of long term care services
- Change in health or functional status

Client Satisfaction and Service Quality

Information about client satisfaction with services and quality of life will be collected during planning meetings and periodic follow-ups. The outside evaluator will also collect more detailed information in interviews with a sample of clients. We will use this information to evaluate service quality and to improve and refine services. Examples of information to be collected include:

- Client satisfaction with services
- Client self-described quality of life

Community Resources

Information about community resources will be collected through the case planning and follow-up process, and will be supplemented by data gathered by the independent evaluator. Relocation specialists will have a specific format to use in describing community resources, to facilitate analysis and comparison of the data. We will use this information to guide resource development efforts and possible legislative changes for program improvements. Examples of information to be collected include:

- Formal and informal resources available in each county
- Barriers encountered to using those resources

- Gaps in resources by county

Community and Professional Awareness

- Survey and other market-research techniques will be used to determine the extent to which professionals and the community at large are aware of options in long term care. We will use this information to evaluate and strengthen community and professional outreach programs

Costs for LAR

Staff costs: Additional staffing/positions include:

- Relocation specialists/relocation case managers,
- Public Service Coordinators,
- Medicaid Eligibility Determination caseworkers,
- Community Care Case Managers,
- Contract Managers
- Licensing/regulatory staff

A specific staffing concern is the FTE cap which applies to contracted positions as well. If the Relocation Specialist/Case Manager and Public Service Coordinators functions are contracted, the TDHS cap would need to be increased to accommodate these additional positions.

Other costs

- We may need to pay for the involvement of nursing facility staff in the relocation planning process, especially if there is a formal staffing involving various professionals.
- Costs for contracted evaluation and analysis efforts, especially data collection.
- Automation tracking system, laptop computers for relocation specialists, and interface to existing long term care and Medicaid eligibility systems
- Increased travel costs/cap
- Infrastructure/support

Other TDHS LAR initiatives that aid in this effort

Funding to eliminate or reduce LTC Interest Lists.

Funding to provide prescription drugs for individuals in 1929b

CCAD Case Management and CCAD Workload Improvement

Increased funding for Alzheimer's Program

Expand the Deaf-blind waiver to include children

Community Care Services

Promoting Independence Initiative

Description of Item

This initiative will increase community awareness about community based services, identify affected populations within nursing facilities (NFs), and will assist in relocating identified nursing facility residents who are willing and able to transition to community living arrangements. The identification activities will include improving the flow of information to residents of NFs and their families about available supports in the community, identification of specific NF residents interested in transitioning, community outreach activities to raise awareness of community care options, and systematic collection and analysis of data to improve our understanding of the best methods of avoiding institutionalization and removing barriers to community placements. For individuals who are willing and able to transition to community living arrangements, this initiative will provide intensive relocation services, development of the supports needed for community placement, and the provision of one-time grants to pay for costs associated with moving and re-establishing a community residence. The grant funds are necessary because NF residents often do not have the financial resources to re-establish community residences. This financial need and the lack of accessible, affordable housing have been identified as barriers to transitioning. This initiative will be implemented in stages with the identification, relocation and community awareness activities beginning in FY 2002 and the implementation of these activities statewide in FY 2003.

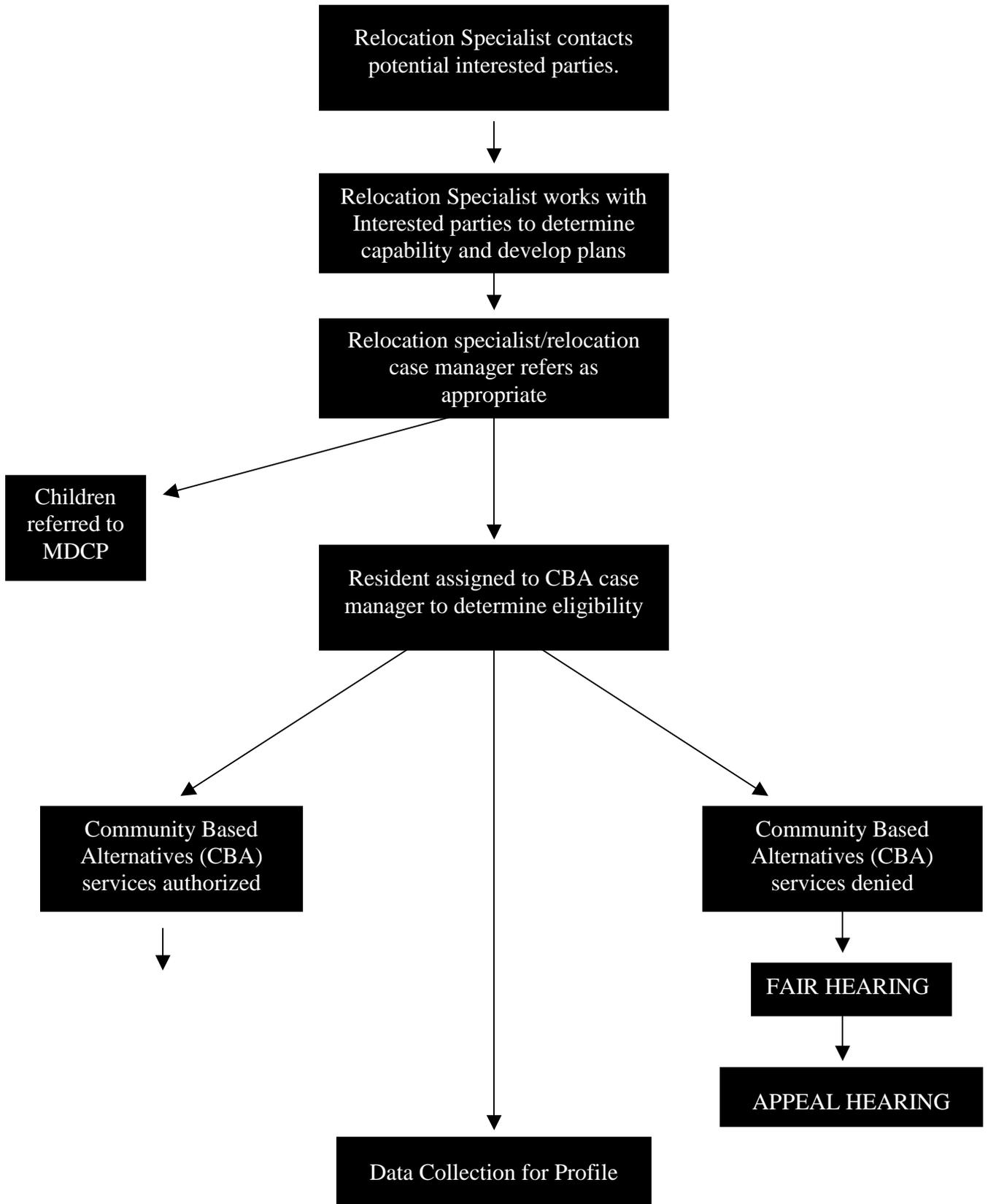
Estimated Cost:

| FY 2002 | | | FY 2003 | | |
|-------------|--------------|-------|--------------|--------------|-------|
| State | Total | Staff | State | Total | Staff |
| \$7,193,272 | \$12,766,505 | 44.6 | \$18,911,769 | \$32,343,995 | 197.4 |

Cost Benefit Analysis:

Anticipated outcomes:

- Promote permanency planning to begin reduction in the number of children in nursing facilities.
- Decrease the number of Medicare admissions who remain in the facility after Medicare benefits
- Increase knowledge about the most effective methods of diverting or relocating persons from nursing facility care.
- Increase local capacity, paid and voluntary, to provide services in the community to individuals who are elderly or have disabilities.
- Increase individuals who could be transitioned into community because of start-up grant funds.
- Increase knowledge of community care options in target groups, including people who are elderly or who have disabilities and their families, physicians and medical professionals, hospital discharge planners and social workers, civic, community and faith-based groups.



Promoting Independence - Phase III. Diversion

The focus for Phase III is to establish ongoing processes that ensure early knowledge of options for care by decision-makers and to divert individuals from inadvertent institutionalization. Based on initial discussions, the proposed approach involves several different options, which are described below. Implementation of this phase would be dependent upon analysis and evaluation of the information and results from the previous two phases, as well as additional funding. The projected timeframe to begin this phase is 2004.

Out-stationed Staff

Increase the number of staff out-stationed at hospitals and rehabilitation centers on a full time and part time basis. Include in the contracts the function of upon admission client/family informing about community services and supports and brokering or working with the discharge planning staff to set up access. This may even involve discharge to a nursing facility (NF) for a rehabilitative stay and while the community services are being arranged.

Data Collection efforts include client tracking information input by hospital based staff. Other agency caseworkers will need access to enter client choice of care setting and to periodically update the choice to track length of community placement, transition time for rehabilitative institutional stays, reasons for continued or returns to institutional stays. Information would be used to determine if clients assisted by the out-stationed staff remain in the community or return to the community.

Potential costs include: funding for additional staff as the hospitals may not realize any payback from this and may be unwilling to fully fund positions, infrastructure and support costs, automation support, and evaluation contract .

Pre-admission/Admission Screening

Another approach involves screening of individuals before allowing admission or promptly upon admission to a NF, similar to the relocation specialist function described in Phase II. The process would identify functional needs, medical needs, community supports and the availability of community services and supports to remain or return to the community, and involve intense individual planning.

Facility Funding

Another consideration is incentive payments to nursing facilities. This would involve basing facility rates on the cost of care in the community (waiver ISP), but provide incentive payments if:

- During the first three to six months of the initial nursing facility stay, facility staff work on transitioning individuals back to the community.
- Nursing facility staff identify and successfully transition individuals who are residing in the facility for more than six months.

All of these proposed approaches will require further development, much of which should be based upon results and information from the previous two phases, especially to accurately design effective processes and plan for staffing and cost projections.

Conclusion -- Challenges and Risks with Implementation

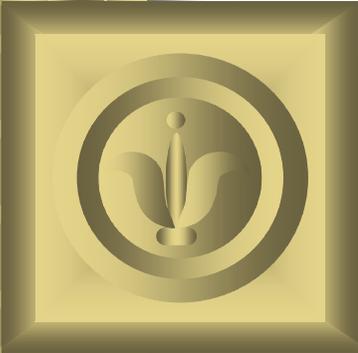
As the department enters into improving community-based programs for individuals with disabilities it is important to recognize the challenges/risks that must be addressed in order to successfully achieve the goal.

- A specific concern that was raised during research and discussion related to the development of the proposed plan was that this effort will expand the existing interest list for Community Based Alternatives. Although TDHS has an LAR initiative to eliminate the interest lists and waiting time, if that initiative is not funded, the reality will be insufficient
- Closely related to this issue was another concern about increasing the expectations of residents with hope of leaving a facility for home or community-based services. In some cases, residents will simply not be able to achieve this transition, for a variety of reasons.
- Unlike Mental Health and Mental Retardation (MHMR), TDHS does not have an existing infrastructure such as the Mental Retardation Authority (MRA) to arrange for the placement of the individuals. A similar infrastructure will need to be designed, funded and operationalized for TDHS to achieve MHMR's level of sophistication. Steps for achieving this are addressed in this plan, but several of them are dependent upon additional funding.
- The lack of an existing identification process is another important factor. Using the Minimum Data Set (MDS) or the Form 3652 as identification instruments for nursing facility residents are not appropriate solutions because neither specifically addresses information necessary to determine a resident's discharge capability or desire to return to the community. The MDS was developed as an assessment and care planning instrument for use in nursing facilities, and the information gathered is geared towards meeting medical and nursing needs in the setting.

In our research, we found that the state of Kansas does not recommend using the MDS as an identification instrument based on their experience with using specific MDS data in a project similar to Promoting Independence. They found that the MDS is an ineffective tool for this purpose; therefore, Kansas developed their own system.

The Form 3652 is currently used to determine medical necessity for nursing facility placement and Texas Index of Level of Effort (TILE) payment. The medical necessity determination is proof that an individual is appropriate for nursing facility care, but would provide no useful information regarding a resident's ability to live in the community. A TILE level also provides no indication of an individual's appropriateness for community placement.

Although challenges exist, TDHS will continue demonstrating the commitment to ensure Texas fosters independence and acceptance of people with disabilities in the community, through the Promoting Independence initiative.



PROMOTING INDEPENDENCE

Texas Department of Human Services

Long Term Care Services

November 13, 2000



PROMOTING INDEPENDENCE INITIATIVE

◆ BACKGROUND

In June of 1999, the U.S. Supreme Court ruled in *Olmstead vs. L.C.* that states are obligated to allow access into integrated community-based alternatives for people in institutional settings.

On September 28, 1999, Governor George W. Bush issued Executive Order GWB 99-2, ordering the Health and Human Services Commission (HHSC) to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. In response to the Executive Order GWB 99-2, the HHSC created the Promoting Independence Advisory Board (PIAB). The PIAB is charged with providing guidance to the HHS agencies in recommendations regarding a written plan that evaluates and implements a system of community based services and supports for people with disabilities.

◆ TDHS PROMOTING INDEPENDENCE (PI) PLAN

In response to the Executive Order GWB 99-2 and a directive from the Health and Human Services Commission (HHSC), the Texas Department of Human Services (TDHS) developed the Promoting Independence (PI) Plan. The TDHS PI Plan was approved by HHSC on August 2000. Phase one of the PI Plan will be implemented effective December 1, 2000. Phase one activities involve training; client and provider notification; community awareness; data collection; and permanency planning.



COMMUNITY AWARENESS

◆ STATEWIDE KICK OFF 12/00

- Campaign Material

- . Brochure/Posters
- . PI Overview
- . Fact Sheet
- . Community Services Overview
- . Public Service Announcements
- . Press Releases
- . Feature Articles



COMMUNITY AWARENESS

◆ REGIONAL PUBLIC INFORMATION DIRECTORS (PIDs) 12/00

- Take lead in community awareness activities
- Convene regional speakers bureau
- Report on community awareness activities to state office



COMMUNITY AWARENESS

◆ **SPEAKERS BUREAU** **12/00**

Help inform other agencies/community of long term care options

- Regional Speakers Bureau

- State Office Speakers Bureau

◆ **VIDEO** – working with ADAC member to develop a video to use as an educational tool.



NOTIFICATION LETTERS

◆ **NURSING FACILITY RESIDENTS/ARs** 12/00

- **MAO:** Field staff will mail out at annual review. Notice will include a local contact name and number or a 1800#
- **SSI:** State office will mail out all at once. Notice will include a 1800#

◆ **PROVIDER LETTER** 11/00

Notify provider of PI and NF residents notification letter.



TRACKING SYSTEM

◆ EXPANDED DATA BASE

- Track Responses
- Track Outcomes
- Create a client profile for future planning

◆ REPORTING SYSTEM

- State Office will generate PI reports to monitor and track outcomes



TRAINING

- ◆ **GENERAL TRAINING** *11/00*
 - CBT's general awareness training for TDHS staff
- ◆ **INTERNET ACCESS** *11/00*
 - CBT general awareness training for other agencies, stakeholders, and the general public
- ◆ **SPECIFIC TRAINING** *11/00*
 - Procedures for LTCS staff on:
 - .Intake/application
 - .eligibility determination
 - .data collection/reporting



PERMANENCY PLANNING

◆ RFP Workgroup

- Complete by 12/00
- Publish by 1/2001
- Project to have Contractor on board by early 2001



Appendix G

PROMOTING INDEPENDENCE

This recommendation enhances community services that are administered through MHMR and DHS. The request includes:

- Increasing community care slots to address the implications of the Supreme Court Olmstead decision from June 1999, which is known as “The Promoting Independence Initiative”
- Reducing the current waiting lists for community services that have approximately 40,000 names
- Implementing several HHSC recommended initiatives to ensure successful transitioning of people in institutions to the community

The total request is \$252.5 million, of which \$119.5 million is General Revenue. The majority of this request creates 2,529 new community care Medicaid waiver slots, of which 397 are for children, at a cost of \$138.9 million All Funds (\$64.8M GR). These slots are specifically requested for individuals currently residing in institutions.

Approximately four percent of this request includes seven items, totaling \$9.8 million in General Revenue, that HHSC is requesting based on recommendations of the Promoting Independence Advisory Board, to assist in transition for individuals leaving institutions and going into community care. These items have not been requested in any HHS agency LAR.

The waiting list component of the Promoting Independence Initiative, which totals \$103.8 million All Funds (\$45.0M GR), includes approximately 25 percent of what MHMR and DHS requested in exceptional funding to address persons on the current waiting list. (The remaining 75 percent is recommended in tier 6). This 25 percent will fund approximately 288 HCS/MHMR slots and serves 3,740 people in one of six DHS community care programs. Many states face litigation due to the length of time and number of individuals on waiting lists for services. This recommendation allows for a reasonable attempt at lessening both number and time on waiting lists.

TIER 2: REIMBURSEMENT INCREASES/PROMOTING INDEPENDENCE

Table 5

| | Biennial Totals | | Item description |
|--|-----------------|---------------|---|
| | GR/GR Dedicated | All Funds | |
| Promoting Independence (DHS) | \$ 28,327,090 | \$ 50,825,647 | In response to the Olmstead ruling DHS would increase awareness about community-based services, identify affected populations within nursing facilities, and assist in relocating identified nursing facility residents who are willing and able to transition to community living arrangements. Waiver slots would be increased for CBA (1,061 slots), CLASS (54 slots), and MDCP (225 slots) by FY03. |
| Expansion of HCS (MHMR) (1 of 3) | 36,454,065 | 88,103,172 | Requested funding would phase-in 325 additional placements from state schools and 864 placements for persons moving from ICF-MR facilities. |
| Transitional funding for MDCP clients (HHSC recommendation) | 562,000 | 562,000 | DHS has included 225 MDCP waiver slots by FY03 for the children currently in nursing facilities. However, transitional funds to help families with one-time modifications are needed so these families can successfully transfer to community care. Transitional funding is being requested for individuals entering CBA and CLASS programs, but not the MDCP program. This funding would provide the same resource for MDCP clients. |
| Transitional funding for HCS clients (HHSC recommendation) | 500,000 | 500,000 | Funds provide the HCS program with comparable transitional funds as requested for CLASS, CBA and MDCP. This funding would benefit approximately 200 HCS clients. |
| Foster care for children leaving institutions (HHSC recommendation) | 3,345,139 | 3,345,139 | HHSC recommends development of a new program that offers foster care homes for children that are leaving institutions and cannot return home to their birth families. Currently children who cannot return to their birth families have no alternative but to remain institutionalized. These funds would support approximately 300 placements and outreach for up to 400 families. |
| Technical Assistance for Foster Care Initiative (HHSC recommendation) | 151,650 | 151,650 | Since the recruitment and training for the 'no fault' foster care program would be significantly different from the current foster care homes in Texas, funding for proper training and research of best practices is requested. |
| Project Choice (HHSC recommendation) | 96,000 | 96,000 | Project Choice is a pilot project that began with HCFA funding. The funding has expired and a new funding stream is required to continue this project. This program provides transitional funding and rent subsidies for approximately 25 individuals converting to community care. |

| | Biennial Totals | | Item description |
|---|--------------------|--------------------|--|
| | GR/GR Dedicated | All Funds | |
| Housing subsidies (HHSC recommendation) | 4,320,000 | 4,320,000 | Many individuals transferring from institutions to community care do not have the means to cover monthly rent for housing. Federal programs provide housing subsidies, but currently have waiting lists. These funds would provide rent subsidies while clients are waiting for federal housing assistance. Clients served in waiver programs at DHS and MHMR would increase by 400 each year of the biennium. |
| Transportation (HHSC recommendation) | 780,000 | 780,000 | Clients living in community settings are provided medical transportation through Medicaid; however, non-medical transportation is not available. For successful transition to community care, individuals need access to transportation for grocery or clothes shopping or other non-medical necessities. |
| Reduce LTC Interest Lists (DHS) (1 of 2) | 40,081,955 | 91,554,353 | Funding, which includes 25% of DHS' exceptional item request, would serve approximately 1,768 clients in FY02 and 3,740 clients in FY03 from community care waiting lists. Programs affected include CBA, CLASS, MDCP, Non-Medicaid Community Care, In-Home and Family Support, and Deaf-blind with Multiple Disabilities waiver. |
| Expansion of HCS (MHMR) (2 of 3) | 4,929,357 | 12,285,318 | Approximately 25% of the MHMR's request to fund 750 clients on the HCS waiting list and 400 placements on a new mid-range waiver would be covered through this item, thus approximately 288 slots would be filled. |
| Promoting Independence Total | 119,547,256 | 252,523,279 | |

Appendix H