

PBH Community Integration Plan for Developmental Disabilities (Olmstead Plan)

Guiding Principles:

“Supports for people with disabilities should be provided in a manner that recognizes people’s inherent competence; reflects the personal preferences of each individual; conveys that the person receiving services is a valued, respected community participant; and assists individuals to achieve self-determined lives of mastery, satisfaction, and meaning”. This statement taken from the 2004 *Community for All Toolkit* provides us a clear explanation of the need for community transition. The Supreme Court ruled that Title II of the Americans with Disabilities Act of 1990 requires states to provide services, programs, and activities developed specifically for persons with disabilities in the “most integrated setting appropriate” because “unjustified isolation or segregation of qualified individuals with disabilities through institutionalization is a form of disability discrimination prohibited by Title II of the Disabilities Act”.

PBH supports community integration and has begun undertaking tremendous efforts to provide individuals every opportunity to live within their communities. In order to promote community integration the following principles will be applied:

- ❖ Individuals and their families will be educated about opportunities for living options in the community.
- ❖ Individuals will have the opportunity to live in and contribute to their communities.
- ❖ Careful, individualized, and definitive planning to ensure individuals are transitioned only to quality and appropriate community services.
 - ❖ Comprehensive plans, consistent with the individuals needs should be developed to ensure that services are provided in accordance with the individual’s needs and requirements.

Vision of the plan:

PBH serves as the Local Management Entity overseeing Cabarrus, Davidson, Rowan, Stanly, and Union counties. Our mission is to establish and ensure best practice(s) for people with developmental disabilities who live in the PBH catchment area. This plan will reflect the uniqueness of local communities and be shaped by the choices of individuals and their families. We value the contribution of all stakeholders, and our actions will be based on the principles of respect, collaboration, fairness, shared responsibility, and mutual accountability. An integral piece to this integration plan will be to emphasize and support an approach specifically designed, tailored, and implemented to meet the individualized needs. Implementation of this plan should result in movement of individuals from institutional care to community based services. PBH will promote community acceptance and inclusion of people with disabilities; ensure the accommodation of cultural values in services and supports.

Community Integration Data:

In an effort to gain perspective on the number of individuals within the PBH area, we have begun to compile data on all consumers still in State Developmental Centers in regards to community viability; which is defined by an individual's request for community services or when an individual is determined appropriate for community services by the support team.

The grid below reflects the number of individuals residing in State Developmental Centers by which they and /or their guardians have expressed a desire to explore options of community placement.

<u>FACILITY</u>	<u>PBH INDIVIDUALS</u>	<u>PBH INDIVIDUALS ON THE COMMUNITY PLACEMENT LIST</u>
Murdoch	9	3
O'Berry	24	9
J. Iverson Riddle	31	2 *Both of these individuals have been accepted by a community provider for placement and will be utilizing DI funds.
Caswell Center	1	0

PBH will continue to assess the needs and wants of individuals who reside in community ICF facilities. *The grid below reflects the number of individuals residing in PBH contracted ICF facilities.*

ICF	<u>NUMBER OF PBH INDIVIDUALS RESIDING IN EACH FACILITY</u>
Monarch	30
PRDC	17
GHA	11
North Carolina MR, Inc	50
Howell Center, Inc	7
RHA/Howell Center, Inc	41
Carobell	1
ComServ	5
Lifespan, Inc	1
Autism Services of Meck	2
Peterkin and Associates, Inc	1
Residential Services, Inc	1
Skill Creation, Inc	1
T.L.C Home	1

Oversight and Funding

PBH currently functions as a managed care provider, overseeing the funding provided by Medicaid within the five county areas. Working as the managed care provider PBH has the responsibility to develop and maintain a network of providers. These providers not only provide quality services that reflect best practices, but also represent the goals and values that PBH promotes.

Currently PBH maintains a provider network of approximately 200 providers. PBH upholds a high standard of excellence that providers must meet and monitors them through the Quality Management Department. Providers are partners with PBH and provide both clinical interventions and support services that are essential for the achievement of positive individual and system outcomes. PBH providers share accountability for the effective use of public resources, and employs strategies which support empowerment, self determination, and choices of individuals. Within the PBH network there is an array of community based services that are utilized to provide comprehensive services to the individuals that are transitioning into the community.

PBH will provide case management services through People Driven Supports (PDS), a division of PBH. PDS, like all providers, is expected to adhere to best practices for each individual served through linkage, coordination, and monitoring of services.

PBH has the unique ability to provide individuals with additional services and supports through the PBH Medicaid B-3 services. B-3 services are offered through PBH's 1915 C Medicaid waiver as a result of effective management of Medicaid funding. Through this waiver PBH is able to utilize money for additional services that are not in the NC State Medicaid plan. Through *Deinstitutionalization Funding* or *DI funding*, individuals who are moving from State Developmental centers and community ICF settings to services within the community have access to services/supports that they otherwise would not have. These services mirror the Innovations services but do not require an Innovations slot. This is the main difference between *DI Funding* and *Money Follows the Person (MFP/State Demonstration Project)*. Children (over the age of three), and adults who meet the functional eligibility requirements for the Piedmont Innovations 1915 C waiver program but are not currently enrolled in a State Developmental center or community ICF or are being discharged from an ICF will meet criteria for DI Funding.

Available services include:

- ❖ Assistive Technology: Equipment and Supplies
- ❖ Communication Devices: Purchases, Repairs
- ❖ Community Guide: Individual
- ❖ Community Networking: Class and Conference
- ❖ Community Transition
- ❖ Crisis Services: Primary Responses, Behavior Consultation, Out of home
- ❖ Day Supports: Individual, Developmental Day
- ❖ Financial Support Services
- ❖ Home Modifications
- ❖ Home Supports: Individual, Group
- ❖ Individual Goods and Services
- ❖ Natural Supports Education: Individual, Conference
- ❖ Residential Supports: Level I and AFL, Level II and AFL, Level III and AFL, Level IV and AFL
- ❖ Respite: Individual, Group, Nursing Respite, B-3 Respite
- ❖ Specialized Consultative Services
- ❖ Supported Employment: Individual, Group
- ❖ Vehicle Adaptation

*Providers must meet the Piedmont Innovations waiver's provider requirements, state licensure requirements and certification requirements.

In addition to the above PBH has an access center that operates twenty-four hours a day, seven day per week to provide information, and/or referrals in a timely and efficient manner. This is maintained through a toll free number (1-800-939-5911) and is available to individuals, families, and providers for assistance with routine and crisis services.

In order to effectively implement and follow through with the community transition plan, PBH will utilize individual, family, and provider collaboration. Within PBH there are numerous departments that play an integral role in making this planning a success.

Accomplishments:

Some specific goals were addressed in FY 08-09 to assist in the overall attempt to meet the targeted deinstitutionalization rate of 10% for FY 08-09.

Below are goals that were accomplished:

- ❖ Five (5) Individuals are currently being served in the community utilizing DI funding.
- ❖ Background information was obtained on individuals who are currently on the community placement list in order to compare and match needs with community services.
- ❖ Hosted education/discussion groups, which included lunch and learns with providers, to brainstorm and develop partnerships
- ❖ PBH representation and participation was ensured for all PBH individuals who reside within the developmental centers as well as the state psychiatric facilities.
- ❖ Encouraged and engaged individuals and families in the planning process.
- ❖ Worked collaboratively with PBH departments and providers to identify and pursue services/providers to meet individual needs.
- ❖ Met with community ICF providers across the state to share information regarding DI funding.

Upon review and assessment the DI targeted goals for FY 09-10 have been revised to reflect the following:

- ❖ Currently, there are four (4) additional people who have expressed interest in community exploration. PBH's DD Olmstead Liaison is actively working with the State Developmental centers and community providers to coordinate transition plans with these individuals.
- ❖ Continue to encourage and engage individuals and families through the planning process.
- ❖ Continue to Work collaboratively with PBH departments and providers to identify and pursue services/providers to meet individual needs.

- ❖ Provide individuals/families/guardians with the opportunity to meet and greet with parents/guardians of individuals that have successfully transitioned into the community from the state facilities. We hope to capture both the positive and the negative experiences families have had with community transition in an effort to improve subsequent transitions into the community.
- ❖ Develop an Individual and Guardian Satisfaction Survey to be distributed annually to assess satisfaction with community placement and community providers.
- ❖ Continue to identify and meet the educational needs of the Individuals/Guardians and Community to further promote community integration.
- ❖ Continue to identify individuals who are ready to live in the community and work in conjunction with families and providers to make this happen.

Planning Process:

We recognize that many individuals residing in State Developmental centers and community ICF facilities receive quality services addressing all of their specific needs. A move into the community is full of unknown variables. In order to effectively plan, PBH reviews not only the individuals on the community placement list, but also the capacity to serve the needs of these individuals, and challenges to service provision within the catchment area.

Challenges that were noted include:

- ❖ Available funds to financially support the level of acuity for individuals with a primary diagnosis of a Developmental Disability.
- ❖ Availability of community professional staff including medical, behavioral, and other specialized services who accept Medicaid.
- ❖ Apprehension and reluctance from individuals and family members regarding movement into the community
- ❖ Public perception regarding individuals moving into communities.
- ❖ Identifying natural supports
- ❖ Exposure to and education about available community choices.
- ❖ A Different level of safety & security
- ❖ Transportation resources

As efforts continue, additional challenges will be identified and addressed. Through partnerships and collaboration with providers strategies have been identified as follows:

- ❖ Review available resources including providers and natural supports, quarterly meetings to match needs with resources creatively.
- ❖ Utilize resources such as Community Guide, provider networking, community resources, community outpatient clinics, and First Responder and community ER departments.
- ❖ Education, clear communication regarding all aspects of community living, peer to peer communication, family meetings and support groups
- ❖ Education, public forums, public service announcements, community integration, cultural awareness
- ❖ Relationship development, exploration of options, community networking and community/family education
- ❖ Development of a comprehensive transition plan and/or crisis plan to address all areas of health and safety prior to the person moving to the community, completion of a risk assessment to identify areas of supports needed, safety precautions in the home clearly identified
- ❖ Exploration of public transportation, and natural supports
- ❖ Education of individuals and their supports as to the process, to include the window for returning to the State Developmental Center if the individual so chooses
- ❖ Education of individuals and their supports on the transition and transition plan process

Transition Plan:

Planning is integral to a successful transition to a community placement. A comprehensive transition plan will be developed according to the specific needs of the individual. The transition planning team will consist of: the individual, supporting staff from the Developmental Center, community provider chosen by individual and family, LME representatives to include DD Olmstead Liaison and PDS Support Coordinator, guardian/family, and any other people significant to the individual. The transition planning process will begin as soon as the individual and his/her guardian have identified their desire for community placement. If a community provider has not already been chosen, the DD Olmstead Liaison will work with the individual and family to choose a provider. The team will meet to assess needs. A crisis plan will be developed from the identified needs.

This plan will state signs of decompensation for that person and strategies to address areas of concern. The State Developmental Center will update the Person Centered Plan to include: the individuals desire to move to the community, supports necessary for successful transition, what is motivating the move, how this move will occur, when the move will occur, who is involved, and the crisis plan. The plan will include a description of an introductory period where staff from the community provider visits the individual in their current placement and where the individual and their current staff visit the new home. Community staff will observe the individual's daily activities and, as much as possible, the community staff will incorporate the routine to minimize disruptions in daily activities.

The chosen community provider will identify the "physical" residential placement and appropriate supports for the individual with the input of the individual and their family. The community provider will find and train staff to support the individual in the home based on the previously developed crisis and transition plans.

The individual does have the option to move back into the State Developmental Center they were previously residing in typically within the first 90 days after community placement. An individual is not technically discharged from a State Developmental Center until after the previously agreed upon transition period is over. The Centers are also available for support and collaboration during this transition period in order to ensure a successful move.

Conclusion:

PBH supports the philosophy that all individuals who live in State Developmental Centers or Community ICF centers who would like to live in or near their home communities should have that opportunity available to them. PBH and their Providers are committed to developing, implementing, and maintaining a continuum of care in the community that will effectively support the individuals transitioned into the community.