# Annual Report:

# Obstacles to Community Referral and Transition

# Texas Department of Aging and Disability Services

# State Supported Living Centers

## Fiscal Year 2014

**Data as of 8/31/2014**

## I. Purpose of Report

The state of Texas' settlement agreement with the Department of Justice regarding the 12 state supported living centers (SSLCs) and the Intermediate Care Facility (ICF) component of Rio Grande State Center (collectively, the "SSLCs") requires, in Section II.T.1.g., that each SSLC gather and analyze information related to identified obstacles to individuals' movement to a more integrated setting that is consistent with their needs and preferences.

This section further requires that on an annual basis, each SSLC shall use such information to produce a comprehensive assessment of obstacles and provide this information to the Department of Aging and Disability Services (DADS) and other appropriate agencies. Based on each SSLC's assessment of obstacles to individuals' movement to more integrated settings, DADS has produced this consolidated report on behalf of the SSLCs to satisfy this requirement.

## II. Identification of Obstacles

Obstacles are defined as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting. The individual's interdisciplinary team (IDT) identifies obstacles during its discussion of living options and documents those identified obstacles in the Individual Support Plan (ISP) or ISP Addendum.

When identifying obstacles, IDTs will:

- determine the supports/services currently in place at the SSLC and decide whether or not these supports and services can be easily transitioned into the community setting;
- identify the supports/services that are currently in place in the community setting and decide whether or not these will meet the needs of the individual;
- identify the supports/services currently in place at the SSLC that cannot be easily transitioned into the community setting; and
- identify strategies to secure needed supports/services currently provided at the SSLC in the community setting.

Any supports/services that cannot be readily secured in the community setting will be identified as an obstacle. The SSLCs will use the categories of obstacles divided into subcategories for consistent identification and data collection. On a quarterly basis, information collected at the center level will be reviewed by center management for analysis and development of specific action plans to address identified trends and/or patterns of issues.

## III. Conducting the Comprehensive Assessment

The SSLCs are charged with the collection of data based on the categories described below.

**Obstacles to a Referral for Community Transition** – These obstacles are identified during the annual ISP or at the conclusion of a living options discussion outside of the annual ISP. If the IDT makes the decision not to refer an individual for community transition, the obstacle(s) to a referral will be identified. More than one obstacle category can be identified for an individual if there are multiple factors leading the IDT to the decision not to refer the individual for transition. For the categories of individual's reluctance to community placement and legally authorized representative's (LAR's) reluctance for community placement, at least one subcategory is identified to better delineate the obstacle. More than one subcategory can potentially be identified for the IDT's decision to not refer the individual. For each obstacle identified, the IDT must develop a plan to overcome or minimize the obstacle to referral.

| Category | Subcategories |
|---|---|
| **Individual's reluctance for community placement** | • Lack of understanding of community living options<br>• Individual has been provided information and exposure to community living options, but is not interested in community placement<br>• Individual is not interested in being provided information and exposure to community living options<br>• Mistrust of providers<br>• Unsuccessful prior community placement(s) |
| **Legally authorized representative's (LAR's) reluctance for community placement** | • Lack of understanding of community living options<br>• LAR has been provided information and exposure to community living options, but is not interested in community placement<br>• LAR is not interested in being provided information and exposure to community living options<br>• Mistrust of providers<br>• Unsuccessful prior community placement(s) |
| **Medical needs requiring 24-hour nursing services/frequent physician monitoring** | |
| **Behavioral health/psychiatric needs requiring frequent monitoring by psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff** | |

| | |
|---|---|
| **Evaluation period (Ch. 55/46B only)** | |
| **Court will not allow placement (Ch. 55/46B only)** | |
| **Lack of funding** | |

**Obstacles to Transition** – These obstacles are identified after an individual has been referred for community transition. Obstacles to transition will be identified at any time during the transition process and plans to overcome the obstacle should be developed. If the individual does not transition within the 180-day timeframe set forth as a goal for all transition processes to be completed, then the IDT must identify which obstacles below are preventing the individual from a successful transition, develop a plan to overcome the obstacle, and then meet on a monthly basis to review the status of the obstacle and as appropriate, adjust the plan to overcome the obstacle. These meetings will continue until the individual transitions to the community or the referral is rescinded. More than one category of obstacles to transition can be identified by the IDT as primary reasons for the delay in the individual's transition to the community.

| Category | Comments |
|---|---|
| **Lack of supports for people with significant challenging behaviors** | • Reimbursement rates insufficient to hire and retain direct care and professional staff able to meet the challenging needs of individuals<br>• Trained and qualified professional staff (e.g., behavior analysts to develop and assure appropriate implementation of successful behavior support plans) not available |
| **Lack of specialized mental health supports** | • Specialized evaluation and treatment for individuals with co-occurring IDD and mental illness not available in the community<br>• Easily accessible psychiatric crisis support not available |
| **Need for services and supports for individuals with forensic needs/backgrounds** | • Lack of specialized counseling services related to prior offense (e.g., drug abuse counseling, sex offender counseling)<br>• Lack of opportunities for employment for individuals who cannot pass a criminal history background check |
| **Need for environmental modifications to support the individual** | • Architectural changes to the living environment are needed<br>• Geographic location of the identified placement area does not allow easy access to medical/behavioral/habilitation/etc., supports and services |

| Category | Comments |
|---|---|
| **Need for transportation modifications to support the individual** | • Public transportation vehicle/assistance is not currently available to meet the individual's mobility/translocation needs<br>• Viable transportation to accommodate the individual's mobility/transportation needs is not currently available (e.g., customization of the vehicle is needed to safely and appropriately transport the individual) |
| **Lack of availability of specialized medical supports** | • Staffing adequacy and training competency to meet the medical needs of the individual may not be readily available<br>• Frequent interventions from direct support staff to assist with medical needs, catheterizations, etc., which may require higher levels of staff support in the home<br>• Immediate and/or frequent attention by nursing staff, etc., is needed in the home/day program environments |
| **Lack of availability of specialized therapy supports** | • Staffing adequacy and training competency to meet the therapy needs of the individual may not be readily available<br>• Frequent interventions from direct support staff to assist with positioning, dining assistance, etc., which may require higher levels of staff support in the home<br>• Immediate and/or frequent attention by physical and occupational therapists, speech therapists, etc., is needed in the home/day program environments |
| **Lack of specialized educational supports** | • Local school district does not have the supports in place to serve individuals with mental health, challenging behaviors, and/or specialized medical needs |
| **Need for meaningful employment and supported employment** | • Assistance to obtain meaningful employment in identified geographic area is not readily available<br>• Continuation of supported employment services to maintain employment<br>• Transportation assistance to and from employment site |
| **Individual/LAR indecision** | • Individual/LAR have not reached a decision regarding provider selection |
| **Limited residential opportunities** | • There are limited residential opportunities in the preferred area and individual/LAR is unwilling to consider other areas. |
| **Medicaid/SSI funding** | • Individual is not eligible for SSI funding |
| **Other** | |

## IV. Process

For the past year, obstacles were identified by the interdisciplinary teams during the living options discussion, as well as during the community transition process. Each center's assistant director of programs (ADOP), quality assurance director, admission/placement coordinator, qualified intellectual disabilities professional (QIDP) coordinator, and data analyst are charged with working collaboratively to produce the center annual obstacles report. These reports are gathered and combined in this report.

## V. Obstacles to Referral Statewide Data

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral | 1,511 | 48.5% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 531 | 17% |
| Individual's reluctance for community referral | 494 | 15.9% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 466 | 15% |
| Lack of funding | 57 | 1.8% |
| Evaluation period (Ch. 55/46B only) | 39 | 1.3% |
| Court will not allow transition (Ch. 55/46B only) | 17 | 0.5% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for referral FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 897 |
| Individual is not interested in being provided information and exposure to community living options | 266 |
| Lack of understanding of community living options | 201 |
| Unsuccessful prior community transition(s) | 98 |
| Mistrust of providers | 72 |

**Table 3. LAR reluctance for referral, 4th Quarter, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 337 |
| LAR has been provided information and exposure to community living options, but is not interested in community transition | 119 |
| LAR is not interested in being provided information and exposure to community living options | |
| Unsuccessful prior community transition(s) | 22 |
| Mistrust of providers | 10 |

## VI. Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

- DADS has submitted a legislative appropriations request to the 84th Texas Legislature for funding for intensive service coordination for each individual moving from a SSLC, including enhanced transitional services and supports prior to and following the transition, for one year after transition. More intensive coordination from the Local Authority is expected to address some LAR concerns regarding community services.

- DADS has established a workgroup to review and revise the Community Living Options Information Process (CLOIP) materials used by Local Authorities to provide information and education about community living options, to ensure the materials are current and accurate. The materials will be revised using Money Follows the Person (MFP) Demonstration funding and will be utilized to increase awareness of LARs.

- SSLC management identified the need to add social workers at each SSLC to increase and improve communication and coordination of services with legally authorized representatives, family members, actively involved persons and other agencies. The social worker positions could be particularly beneficial in educating, alleviating concerns, and reducing the reluctance of LARs to make referrals of individuals for transition. Each facility is currently in the process of establishing these social worker positions.

### Medical needs requiring 24-hour nursing services/frequent physician monitoring

- DADS, in conjunction with HHSC, has developed a pilot program to create an add-on rate for up to four small (i.e., four to six beds) community-based Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to compensate those facilities for the higher costs of services for individuals moving from SSLCs with high medical/nursing needs who are determined eligible for the add-on rate. The four ICF homes will be located in the Austin area and are expected to be available by March 2015.

- DADS submitted an appropriations request to the 84th Texas Legislature to request funding for increased rates in both the community-based ICF/IID program and the Home and Community-based Services (HCS) waiver to compensate providers of HCS and ICF/IID services for the higher costs of services for individuals moving from SSLCs with high medical needs who are determined eligible for the add-on rate.

- DADS has submitted a request to the Centers for Medicare and Medicaid Services for additional Money Follows the Person (MFP) Demonstration funding for Local Authorities to provide, on a statewide basis, regional medical technical assistance teams to provide education, consultation and peer review services to service planning teams and community providers to support individuals who move from

SSLCs and have complex medical needs. DADS has also submitted a legislative appropriations request to the 84th Texas Legislature for funding for these teams.

- DADS will establish a toll-free, 24-hour-a-day, seven-day-a-week, nursing crisis hotline to provide individuals who moved from a SSLC, their families, and providers with support from the State's care management organization, information regarding local resources, including resources for current crises and potential crises (i.e., situations that may become urgent without intervention) and assistance with referrals to local providers. DADS expects the hotline to be operational by May 1, 2015.

**Individual's reluctance for community referral**

- DADS has submitted a request to the Centers for Medicare and Medicaid Services for additional Money Follows the Person (MFP) Demonstration funding for Local Authorities to provide, on a statewide basis, enhanced community coordination and transition services for individuals at SSLCs to explore and visit community programs to increase their awareness of living options; ensure services are delivered as planned, or modified as needed; and support individuals through a person-centered process.

- DADS has submitted a legislative appropriations request to the 84th Texas Legislature for funding for intensive service coordination for each individual moving from a SSLC, including enhanced transitional services and supports prior to and following the transition, for one year after transition. More intensive supports and coordination from the Local Authority is expected to address some individuals' concerns regarding community services.

- SSLC management identified the need to add social workers at each SSLC to increase and improve communication and coordination of services with legally authorized representatives, family members, actively involved persons and other agencies. The social worker positions could be particularly beneficial in educating individuals in the transition process and community living options, alleviating concerns, and reducing their reluctance for moving to the community. Each facility is currently in the process of establishing these social worker positions.

- DADS has established a workgroup to review and revise the Community Living Options Information Process materials, used by Local Authorities to provide information and education about community living options, to ensure the materials are current and accurate. The materials will be revised using Money Follows the Person (MFP) Demonstration funding and will be utilized to increase awareness of individuals.

**Lack of supports for individuals with significant challenging behaviors**

- DADS continues to collaborate with Local Authorities in the implementation of Delivery System Reform Incentive Payments (DSRIP) projects under an 1115 demonstration waiver. Seventeen of the 39 Local Authorities have received funding through 2016 to implement DSRIP projects to provide crisis intervention services for

individuals, including those moving from SSLCs, who have complex behavioral needs. DADS has also submitted a legislative appropriations request to the 84th Texas Legislature for funding for expansion of behavioral intervention and crisis respite services to augment existing DSRIP projects and expand coverage across the State.

- DADS has submitted a request to the Centers for Medicare and Medicaid Services for additional Money Follows the Person (MFP) Demonstration funding for Local Authorities to provide, on a statewide basis, regional behavioral/psychiatric technical assistance teams to provide education, consultation and peer review services to community providers to support individuals who move from SSLCs who have complex behavioral health needs. DADS has also submitted a legislative appropriations request to the 84th Texas Legislature for funding for these teams.

- DADS will establish a toll-free, 24-hour-a-day, seven-day-a-week, behavioral health crisis hotline to provide individuals who moved from a SSLC, their families, and providers with support from the State's care management organization, information regarding local resources, including resources for current crises and potential crises (i.e., situations that may become urgent without intervention) and assistance with referrals to local providers. DADS expects the hotline to be operational by May 1, 2015.

- DADS will develop behavioral health stabilization teams at each SSLC to provide on-site (*i.e.*, at the individual's home or other location in the community) stabilization support to individuals who move from a SSLC following a crisis or facing a potential crisis. Intervention from the team may range from telephonic consultation with the provider to onsite technical assistance.

- DADS has established an internal workgroup to explore options to provide additional funding to HCS waiver providers to successfully serve individuals, including those who move from a SSLC, who require more than one to one staff support for behavioral health needs.

**Lack of funding**

- DADS Legal Division has compiled a list of immigration resources in the Austin area to assist individuals, LARs and families with citizenship issues. The list will be expanded to include resources statewide and will be shared with each SSLC and maintained on the statewide data system.

**Evaluation period (Ch. 55/46B only)**

- Individuals committed to the SSLC following the restoration period are eligible for referral for transition.

**Court will not allow placement (Ch. 55/46B only)**

- DADS Legal Division will now request a hearing to address the court's opposition and concerns with an individual's proposed move to a community setting. The DADS

attorney will use the hearing to provide education to the court regarding DADS community services to include monitoring by the SSLC, the Local Authority and oversight by DADS regulatory division.

**General Strategies and Actions to Overcome or Reduce Obstacles to Referral**

DADS SSLC Division continues to provide technical support and assistance to the SSLCs as it relates to the identification and reporting of obstacles to referral. In addition, DADS SSLC Division has developed the following initiatives:

- DADS received approval from the state auditor's office to reclassify the QIDP position series to a higher pay group and has submitted a legislative appropriations request to the 84th Texas Legislature LAR to provide the additional funding to support the reclassification. The overall turnover rate for QIDPs at the SSLCs is very high and costly and significantly compromises the SSLCs' ability to develop and monitor services to residents, and maintain continuity and consistency of services. The upgrade in classification and salary will provide a career ladder and opportunities for advancement for SSLC employees in the QIDP series to support recruitment and retention of QIDPs.

- During FY 2015, the ISP process, from assessments to ISP development to implementation of the resulting action plans for services and supports, will be reexamined and refined. This will include the living options discussion and determination of services and supports that an individual would need to live in a community setting. This process will include revising the Preferences and Strengths Inventory to better identify preferences for living, working, relationships, leisure activities and greater independence to enhance the living options discussion. Once the ISP process is revised, statewide training will be implemented. The training will be provided by two consultants and state office staff.

**VII. Obstacles to Transition Statewide Data**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 116 |
| Limited residential opportunities | 72 |
| Need for environmental modifications to support the individual | 68 |
| Lack of supports for individuals with significant challenging behaviors | 49 |
| Lack of availability of specialized medical supports | 30 |
| Lack of availability of specialized therapy supports | 13 |
| Need for services and supports for individuals with forensic needs/backgrounds | 12 |
| Medicaid/SSI funding | 8 |
| Lack of availability of specialized mental health supports | 7 |
| Need for meaningful employment and supported employment | 5 |
| Need for transportation modifications to support the individual | 3 |
| Other | 63 |

## VIII. Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Individual/LAR indecision (116)

- DADS has submitted a legislative appropriations request to the 84th Texas Legislature for funding for intensive service coordination for each individual moving from a SSLC, including enhanced transitional services and supports prior to and following the transition, for one year after transition. More intensive coordination from the Local Authority is expected to address some LAR and individuals' concerns regarding community services.

- DADS has established a workgroup to review and revise the Community Living Options Information Process (CLOIP) materials used by Local Authorities to provide information and education about community living options, to ensure the materials are current and accurate. The materials will be revised using Money Follows the Person (MFP) Demonstration funding and will be utilized to increase awareness of LARs and individuals.

- SSLC management identified the need to add social workers at each SSLC to increase and improve communication and coordination of services with legally authorized representatives, family members, actively involved persons and other agencies. The social worker positions could be particularly beneficial in educating, alleviating concerns, and reducing the reluctance of LARs to make referrals of individuals for transition. These positions could also be beneficial in educating individuals in the transition process and community living options, alleviating concerns, as well as reducing their reluctance in moving to the community. Each facility is currently in the process of establishing these social worker positions.

- DADS has submitted a request to the Centers for Medicare and Medicaid Services for additional Money Follows the Person (MFP) Demonstration funding for Local Authorities to provide, on a statewide basis, enhanced transition services and supports for individuals at SSLCs to explore and visit community programs to increase their awareness of living options.

### Limited residential opportunities (72)

- DADS anticipates that the strategies to overcome or reduce obstacles to referral and transition will potentially encourage expansion of residential opportunities in areas with limited options.

### Need for environmental modifications to support the individual (68)

- DADS, in coordination with HHSC as the state Medicaid agency, worked with CMS to amend the HCS waiver to allow pre-approval for environmental modifications when a provider is selected for transition. This pre-approval for funding will allow modifications

to be completed prior to the individual's move from a SSLC. The pre-approval process is expected to be operational by July 1, 2015.

**Lack of supports for individuals with significant challenging behaviors (49)**

- DADS continues to collaborate with Local Authorities in the implementation of Delivery System Reform Incentive Payments (DSRIP) projects under an 1115 demonstration waiver. Seventeen of the thirty-nine Local Authorities have received funding through 2016 to implement DSRIP projects to provide crisis intervention teams to support individuals, including those moving from SSLCs, who have complex behavioral needs. DADS has also submitted a legislative appropriations request to the 84th Texas Legislature for funding for the expansion of behavioral intervention and crisis respite services to augment existing DSRIP projects and expand coverage across the State.

- DADS has submitted a request to the Centers for Medicare and Medicaid Services for additional Money Follows the Person (MFP) Demonstration funding for Local Authorities to provide, on a statewide basis, regional behavioral/psychiatric technical assistance teams to provide education, consultation and peer review serves to community providers to support individuals who move from SSLCs who have complex behavioral health needs. DADS has also submitted a legislative appropriations request to the 84th Texas Legislature for funding for these teams.

- DADS will establish a toll-free, 24-hour-a-day, seven-day-a-week, behavioral health crisis hotline to provide individuals who moved from a SSLC, their families, and providers with support from the State's care management organization, information regarding local resources, including resources for current crises and potential crises (i.e., situations that may become urgent without intervention) and assistance with referrals to local providers. DADS expects the hotline to be operational by May 1, 2015.

- DADS will develop behavioral health stabilization teams at each SSLC to provide on-site (i.e., at the individual's home or other location in the community) stabilization support to individuals who move from a SSLC following a crisis or facing a potential crisis. Intervention from the team may range from telephonic consultation with the provider to onsite technical assistance.

- DADS has established an internal workgroup to explore options to provide additional funding to HCS waiver providers to successfully serve individuals, including those who move from a SSLC, who require more than one to one staff support for behavioral health needs.

**Lack of availability of specialized medical supports (30)**

- DADS, in conjunction with HHSC, has developed a pilot program to create an add-on rate for up to four small (i.e., four to six beds) community-based Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facilities to compensate those facilities for higher costs of services for individuals moving from SSLCs with high

medical/nursing needs who are determined eligible for the add-on rate. The four ICF homes will be located in the Austin area and are expected to be available by March 2015.

- DADS submitted an appropriations request to the 84th Texas Legislature to request funding for increased rates in both the community-based ICF/IID program and the Home and Community-based Services (HCS) waiver to compensate providers of HCS and ICF/IID services for the higher costs of services for individuals moving from SSLCs with high medical needs who are determined eligible for the add-on rate.

- DADS has submitted a request to the Centers for Medicare and Medicaid Services for additional Money Follows the Person (MFP) Demonstration funding for Local Authorities to provide, on a statewide basis, regional medical technical assistance teams to provide education, consultation and peer review services to service planning teams and community providers to support individuals who move from SSLCs and have complex medical needs. DADS has also submitted a legislative appropriations request to the 84th Texas Legislature for funding for these teams.

- DADS will establish a toll-free, 24-hour-a-day, seven-day-a-week, nursing crisis hotline to provide individuals who moved from a SSLC, their families, and providers with support from the State's care management organization, information regarding local resources, including resources for current crises and potential crises (i.e., situations that may become urgent without intervention) and assistance with referrals to local providers. DADS expects the hotline to be operational by May 1, 2015.

**Lack of availability of specialized therapy supports (13)**

- DADS is exploring the addition of orientation and mobility services to the HCS waiver to better support individuals, including those moving from a SSLC, who are deaf and/or blind or have significant hearing and/or visual impairments.

**Need for services and supports for individuals with forensic needs/backgrounds (12)**

- DADS will establish a toll-free, 24-hour-a-day, seven-day-a-week, behavioral health crisis hotline to provide individuals who moved from a SSLC, their families, and providers with support from the State's care management organization, information regarding local resources, including resources for current crises and potential crises (i.e., situations that may become urgent without intervention) and assistance with referrals to local providers. DADS expects the hotline to be operational by May 1, 2015.

**Medicaid/SSI funding (8)**

- State office will continue to provide assistance on an as needed basis to address Medicaid/SSI issues including coordination with HHCS and other agencies.

**Lack of availability of specialized mental health supports (7)**

- DADS will establish a toll-free, 24-hour-a-day, seven-day-a-week, behavioral health crisis hotline to provide individuals who moved from a SSLC, their families, and providers with support from the State's care management organization, information regarding local resources, including resources for current crises and potential crises (i.e., situations that may become urgent without intervention) and assistance with referrals to local providers. DADS expects the hotline to be operational by May 1, 2015.

**Need for meaningful employment and supported employment (5)**

- DADS participates on the Interagency Employment Workgroup which promotes engagement, sharing of resources, and positive problem solving with the Department of Assistive and Rehabilitative Services (DARS), the Department of State Health Services (DSHS), the Department of Family and Protective Services (DFPS), and the Texas Workforce Commission (TWC). The First Steps to Employment pilot initiated through the workgroup provided positive steps toward improvement of the interagency referral process and coordination for DARS employment services. The San Antonio and Richmond SSLC vocational departments were selected to participate in the pilot for recommendations. As an additional result of the pilot, the DARS and SSLC workgroup representatives continue to work as liaisons as necessary with staff at regional levels.

- The DADS Employment Services Workgroup implemented in November 2014 consists of internal DADS divisions for agency wide development of supported employment initiatives. The SSLC division is represented in this workgroup by the state office vocational services/active treatment coordinator and two SSLC facility vocational directors.

- DADS has made the decision to allow individuals to maintain their current paid employment opportunities when transitioning to the community. In an effort to support an individual's work preferences, employment opportunities may continue at the facility if the individual desires or opportunities are not readily available in the community at the time of transition.

**Need for transportation modifications to support the individual (3)**

- State office will provide assistance on an as needed basis to address transportation issues including coordination with other agencies.

**Community Referrals and Transitions from State SSLCs, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 135 | 41 | 206 | 11 | 4789 |
| **2009** | 312 | 40 | 252 | 11 | 4541 |
| **2010** | 224 | 76 | 330 | 8 | 4207 |

| | | | | | |
|---|---|---|---|---|---|
| **2011** | 221 | 90 | 204 | 3 | 3994 |
| **2012** | 267 | 65 | 207 | 5 | 3787 |
| **2013** | 243 | 110 | 287 | 16 | 3547 |
| **2014** | 240 | 137 | 261 | 9 | 3362 |

Data Source: HHS CARE System

## SSLC Obstacle Reports

# Abilene State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral & Transition Report

## A. Center Profile

The Abilene State Supported Living Center (AbSSLC) opened in 1904. The center is on 200 acres and, at the end of fiscal year (FY) 2014, was serving 356 residents. AbSSLC employs approximately 1,450 people and serves 18 counties in its catchment area: Brown, Callahan, Coleman, Comanche, Eastland, Erath, Hood, Johnson, Jones, McCulloch, Mills, Palo Pinto, Parker, San Saba, Shackelford, Somervell, Stephens, and Taylor.

AbSSLC is located in Taylor County which has the greatest number of Home and Community-Based Services (HCS) and Intermediate Care Facility (ICF) providers available in the 18-county catchment area. Although 130 HCS providers are listed as providers for Taylor County, only eight currently provide services locally. For HCS and ICF providers in Taylor County, only one HCS and one ICF provider have their own vocational services. While vocational services can potentially be provided via referral to Texas Department of Assistive and Rehabilitative Services (DARS), vocational services continue to be limited. Other counties in the AbSSLC catchment area have even more limited community resources available to individuals with intellectual disabilities.

The center continues to transition individuals to the community at a steady rate; however, a decrease in referrals and transitions for fiscal year 2014 is noted. This is most likely due to the sudden increase in referrals and transitions in FY 2013 when the Transition Specialists were added to the Admission and Placement Department. AbSSLC hired two transition specialists in July 2012. The transition specialists have been attending ISP meetings in an attempt to make contact with LARs and offer additional education on community living options. With the Transition Specialists in place for past two years, the pace of referrals and transitions has become steady, but there was a significant increase in rescinded referrals during FY 2014. Of the 10 rescinded referrals, five were able to verbalize their desire to remain at AbSSLC at this time after pre-placement visits. Four of the five simply stated they like where they live now and don't want to move; however, one was experiencing medical issues and asked to have her referral rescinded until she was healthier and could fully participate in the process. The Interdisciplinary Team (IDT) continues to work with this individual and plans to make another community referral in FY 2015. Action Plans were developed to continue to expose these individuals to community options in an attempt to address their reluctance to community living options. The other four individuals had their referrals rescinded after becoming medically unstable and requiring more intensive medical interventions than are available in the community at this time. The tenth individual had his referral rescinded after beginning to exhibit behavioral concerns which led to him needing more intensive psychiatric services. The IDTs will continue to review living options at least annually to determine if these individuals have reached levels of medical and psychiatric stability which could lead to another community referral in the future.

**Community Referrals and Transitions from the AbSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 9 | 5 | 5 | 0 | 508 |
| **2009** | 22 | 2 | 14 | 0 | 486 |
| **2010** | 4 | 10 | 20 | 2 | 454 |
| **2011** | 15 | 1 | 11 | 0 | 442 |
| **2012** | 18 | 7 | 18 | 1 | 412 |
| **2013** | 26 | 1 | 33 | 1 | 386 |
| **2014** | 21 | 10 | 26 | 0 | 356 |

Data Source: HHS CARE System

## Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from AbSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 164 | 49.2% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 99 | 29.7% |
| Individual's reluctance for community referral* | 55 | 16.5% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 15 | 4.5% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 33 |
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 19 |
| Unsuccessful prior community transition (s) | 2 |
| Mistrust of providers | 1 |

**Table 3. LAR reluctance for referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community transition | 106 |
| LAR is not interested in being provided information and exposure to community living options | 30 |
| Lack of understanding of community living options | 14 |
| Unsuccessful prior community transition(s) | 9 |
| Mistrust of providers | 7 |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

Legally Authorized Representative (LAR) reluctance continues to be the greatest obstacle to refer for community transition at AbSSLC and the most difficult one to overcome. Education of LARs is most often addressed through the Community Living Options Information Process (CLOIP) that occurs before each annual Individual Support Plan (ISP) meeting. LARs are contacted by staff at Betty Hardwick Center (local authority) and offered information on community living options. This process does not appear to be uniformly effective as some LARs decline to receive information from the CLOIP workers. LARs and other family members are encouraged to attend the educational community tours provided through the local authority that occur twice a month, but a review of tour attendees reveals that no LARs or family members have attended these tours during fiscal year 2014. The annual Community Provider Fair was held on 06/06/2014 in conjunction with the annual Cultural Diversity Fair. Letters were mailed to all LARs and primary correspondents informing them of the opportunity to receive information from local community providers; however, no family members attended the provider fair. Many LARs are parents or siblings of residents who have resided at AbSSLC for extended periods of time. These LARs frequently state that AbSSLC is the only home their loved ones have known, and they do not want to disrupt their lives after so many years of living in the same place. LARs also frequently state that they do not believe community providers can care for their loved ones as well as AbSSLC. Although the majority of LARs state that they have received information about community living options and are not interested in learning more, their reluctance appears to be more a mistrust of community providers due to the belief that they cannot provide the same level of supports as AbSSLC.

With the hiring of transition specialists, the center began to see some LARs show interest in learning more about what is available in their area. The transition specialists have had more LARs request tours of providers in their home areas. This approach appears to be more successful in providing education on community living options to LARs that might otherwise turn down offers from the local authority for information on community living options during the CLOIP process each year. Articles about individuals who have had successful transitions to the community are published in the bi-monthly center publication, The Maple Street Messenger, which is sent to families and correspondents with addresses

on file. These articles provide an opportunity for LARs to learn about positive outcomes from community transitions and also appear to be a positive step in providing information to LARs and other family members.

### Medical needs requiring 24-hour nursing services/frequent physician monitoring

Medical needs became the second greatest obstacle to community transition during FY 2014, passing individual reluctance. There are individuals whose medical needs are such that they require 24-hour nursing services which are often only available in a nursing home or other medically oriented setting in the community at this time. The Admission and Placement Department will continue to work with the QIDP Department and the various disciplines to provide training to teams to ensure that those individuals who are identified as needing 24-hour nursing services actually have nursing needs that require 24-hour nursing coverage and cannot be typically met in a community setting. The Admission Placement (AP) department will also provide teams with information on how their medical needs can and are being met in community settings.

### Individual's reluctance for community referral

Individual reluctance continues to be an obstacle to community referral but dropped to the third most common reason for individuals to not be referred for community placement. The facility, as well as the local authority, has provided different ways to present community group homes to individuals at AbSSLC. The local authority's twice-monthly educational community tours continue to offer individuals an opportunity to learn more about the options available to them in the community. IDTs continue to ask the transition specialists for help in setting up tours for some individuals who the team feels would be served well in a less restrictive setting. Some individuals have also visited peers who have successfully transitioned to the community in their new homes. Holding the annual Provider Fair in conjunction with the Cultural Diversity Fair increased individual attendance significantly and provided an opportunity for more individuals to meet different community providers and learn more about the options available to them. The "Provider in the Diner" program also continues as a way for individual providers to spend time at the AbSSLC and meet residents who may be interested in receiving more information on services available in the community. The transition specialists continue to attend the monthly self-advocates meetings on campus to be available to talk to attendees and give them more information on community living options. All of these strategies have been effective in reaching out to the residents of AbSSLC and will continue in fiscal year 2015.

### Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff

For the individuals identified as those whose behavioral needs prevent them from moving to a less restrictive setting at this time, interventions through behavior support plans and psychiatric services will continue to address their challenging behaviors. As individuals are determined to be psychiatrically and behaviorally stable, the IDTs will consider them for community placement through living options discussions.

**In fiscal year 2015, AbSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

- A list of the 55 individuals identified by IDTs during the living options discussions in FY 2014 as having no other obstacle to referral other than their own reluctance has been given to the transition specialists. These individuals will be the primary focus of attempts to provide education on community options available in an effort to reduce the individuals' reluctance to consider the community as a viable living option. The transition specialists were given the names of these individuals and began to work with the IDTs to help address this obstacle. This has proven to be one of the most successful strategies up to this date and will continue in FY 2015.
- A list of the 90 individuals identified by the IDTs during the living options discussions in FY 2014 as having no other obstacle to referral other than LAR reluctance has been given to the transition specialists. The transition specialists will continue to make contact with these LARs and offer tours or other information to help educate them on the options available in the community. The transition specialists will also continue to make contact with LARs through attendance at annual ISP meetings. While the number of LARs who have become more open to community living options is still small, the facility believes that personal contact with the transition specialists should continue as this appears to be the most effective way to establish a positive relationship with LARs and provide personalized education on community living options.
- Transition specialists will continue to attend annual ISP meetings to provide LARs and individuals with information on services in the community. This strategy has been effective in establishing contact with family members as well as providing information on how supports can be met in the community. The transition specialists try to attend at least four ISP meetings each week. Individuals that have been identified by the IDT as not having any obstacle other than individual or LAR reluctance are given priority when deciding which meetings to attend. The transition specialists also attend meetings at the request of the IDT.
- A provider fair will be held at least once during fiscal year 2015 to provide an opportunity for individuals and AbSSLC staff to meet community providers in this area and to learn more about the options available to them. LARs and family members will continue to be notified of the provider fair and invited to attend, but the focus will be on education to the individuals and their IDT members. Holding the annual provider fair in conjunction with the Cultural Diversity Fair resulted in an increase in the number of individuals and staff who attended. This will be repeated during fiscal year 2015.
- "Provider in the Diner" has been successful and will continue as a way for individuals to meet community providers and receive information on services they provide. The goal of the Admission Placement (AP) Department is to have at least one provider visit the campus monthly to meet residents and staff.
- A transition specialist will continue to attend the monthly self-advocates meetings to provide information on community living options to meeting attendees. Every six months, a representative from the Admission and Placement Department will make a presentation at the meeting on community living options. A Power Point presentation on community living options was given at the June 2014 meeting and was well-received by the attendees. Plans are to continue to have some kind of Power Point presentation

to provide a visual aid in communicating information as well as to try to have some former residents come speak about their experiences living in the community.

- Articles on successful community transitions will continue to be submitted for publication in The Maple Street Messenger. This appears to be effective in providing family members with positive community living experiences. Plans are in place to try to expand the articles to include more information on frequently asked questions regarding community living and supports available.
- Current residents will continue to be provided opportunities to visit with former residents who have successfully transitioned to the community through visits to community providers. This strategy appears to be effective for individuals who are more comfortable on community visits when they see people they recognize at the day programs and homes.
- Training will continue to be provided to IDT members on properly identifying individuals who require 24-hour nursing services. This is an ongoing issue due to the high turnover rate in most of the departments at AbSSLC. The Admission Placement Coordinator (APC), Post Move Monitor (PMM), and transition specialists provide informal training as questions arise and formal training will continue to be provided at the annual training with the local authorities.
- Data regarding obstacles to referral will continue to be shared with State Office in order to assist them with developing plans to address obstacles at the statewide level.

## B. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from AbSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Need for environmental modifications to support the individual | 8 |
| Individual/LAR indecision | 7 |
| Limited residential opportunities | 5 |
| Lack of supports for individuals with significant challenging behaviors | 4 |
| Lack of availability of specialized medical supports | 1 |
| Other | 10 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

Obstacles to transition continue to be due to the circumstances which are typically beyond the control of the IDT and not due to lack of involvement from the IDT. During fiscal year 2014, there were 24 individuals that did not transition to the community within 180 days of their referral. Nine of these individuals had two obstacles to transition identified while one individual had three obstacles identified accounting for the 35 identified obstacles to transition noted in Table 4. Twelve individuals with obstacles to transition did transition to the community during fiscal year 2014 and four others should transition within the first few months of fiscal year 2015. Seven individuals who had obstacles identified in fiscal year

2014 eventually had their referrals rescinded. While one other individual passed away during the referral process.

The Admission/Placement Coordinator maintains a spreadsheet of referred individuals and the number of days since the opening of the referral. If an individual reaches the 120-day mark and does not have a CLDP meeting scheduled, the APC meets with the transition specialist handling that referral to determine if an obstacle to transition needs to be identified by the IDT. If an obstacle is identified, the APC works with the transition specialist and the IDT to develop strategies to overcome the obstacle. The Admission and Placement Department will continue to monitor individuals who exceed the 180-day timeframe to ensure that obstacles to transition are addressed and they can move to their selected community provider as soon as possible.

**Need for environmental modifications to support the individual**

Seven of the individuals with this obstacle utilized wheelchairs and needed homes that could accommodate their wheelchairs as well as modifying bathrooms to address their bathing needs. The other individual needed environmental modifications to address low vision needs. Finding providers who had homes with these modifications caused a delay in their transition, but six transitioned successfully to the community before the end of fiscal year 2014. One individual is waiting for a provider to complete modifications on a home at the end of the fiscal year in order for a pre-placement visit could be scheduled. The other individual passed away during the referral process.

**Individual/LAR indecision**

Six individuals took an extended amount of time to identify a preferred provider after making visits. Four of these individuals eventually requested that their referrals be rescinded due to reluctance to transition to the community while one individual transitioned to the community after settling on a provider. The IDT has developed action plans for these four individuals though continuous access and education of their community and living options. The other individual continues to visit providers with the support of his newly appointed LAR.

One LAR took extra time to decide on the type of placement they preferred. The CLDP was finalized as soon as the LAR settled on the preferred placement type and the individual transitioned to the community.

**Limited residential opportunities**

The five individuals with the obstacle of limited residential opportunities were looking at providers near their families. The transition specialists worked with the individuals and families to find appropriate placements for three of the individuals. One individual eventually requested that his referral be rescinded because he was uncomfortable with moving to the community. This individual had behavior plans in place and also visited a home which specialized in accommodating those with tough behaviors; however, he shown staff that he didn't want to move. The other individual passed away during the referral process.

**Lack of supports for individuals with significant challenging behaviors**

Of the four individuals with this obstacle, two eventually had their referrals rescinded. One individual indicated to staff that he did not want to move to the community after some difficult visits to a provider that had historically been able to offer behavioral supports to individuals with difficult behaviors. The other individual continued to be unstable psychiatrically and behaviorally and underwent several unsuccessful psychiatric medication trials before having his referral rescinded. The third individual successfully transitioned to the community with added behavioral support from AbSSLC during the transition period. The fourth individual continues to actively search for a provider with the help of the transition specialist and his LAR.

**Lack of availability of specialized medical supports**

The individual who had this obstacle required extra medical support due to issues related to the mickey button of her g-tube. The transition specialist worked with the IDT to identify providers with enough nursing support to be able to address this need. The IDT will continue to search for providers who can meet the required nursing supports in fiscal year 2015.

**Other:**

**Illness during transition period (7)**

Four of the individuals who had this obstacle to transition identified eventually had their referrals rescinded when they could not be medically stabilized. One individual's health issues improved that pre-placement visits were starting to be scheduled again at the end of fiscal year 2014. This individual should transition during the first few months of fiscal year 2015. The IDT for another individual had considered rescinding the referral due to concerns with medical stability but decided to give the individual more time to see if medical issues improve. Unfortunately, one individual passed away during the referral process.

**Provider delay in opening home (2)**

The two individuals who had this obstacle were delayed in moving when the providers selected ran into issues with homes that were newly purchased. Both successfully transitioned to the community as soon as their homes were ready.

**LAR reluctance to choose provider (1)**

One individual had this obstacle identified prior to it being added to the obstacle list. The LAR was actively involved in the referral process and visited many different providers with the transition specialist before settling on one that she felt could meet the needs of her sister. When the LAR chose a provider, the individual transitioned to the community in a timely manner.

**In fiscal year 2015, AbSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

- Beginning in fiscal year 2015, the Admission Placement Coordinator will ask IDTs to meet and identify obstacles to transition for all individuals who have reached the 120-day mark in the referral process and do not have a provider selected. If an individual does not move within 180 days of their referral, the IDT will meet monthly to identify and address obstacles to transition.

- Transition specialists will continue to work with the IDTs to identify providers that can meet the needs of individuals who need specialized supports such as home modifications, extra nursing support, and behavioral support.

- Data related to obstacles to transition will continue to be shared with State Office to assist them in developing statewide strategies to address issues related to supports needed in the community but not readily available such as additional staffing at group homes for individuals with behavioral needs, increased nursing care for individuals with medical needs, and environmental modifications needed but not available due to funding not being available until after the individual moves to the community and Medicaid funding is changed over.

# Austin State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral & Transition Report

## A. Center Profile

The Austin State Supported Living Center (AuSSLC) is a 95-acre facility opened in 1917. As of August 31, 2014, AuSSLC is serving 266 individuals and employed approximately 1,100 staff.

The Austin area, including Travis, Williamson and Hays counties has a variety of providers that offer services including: three and four bed Home and Community-Based Services (HCS) group homes, host home/companion care and supported home living through the HCS program, Intermediate Care Facility (ICF) group homes, respite care, day habilitation, and sheltered workshops. The catchment area for AuSSLC consists of a 28-county area: Bandera, Bastrop, Blanco, Burnet, Caldwell, Comal, Edwards, Fayette, Gillespie, Gonzales, Guadalupe, Hays, Kendall, Kerr, Kimble, Kinney, Lee, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Travis, Uvalde, Val Verde, and Williamson. In June 2014, it was announced that because there is so much turnover at the Austin State Supported Living Center, seven homes on campus were slated to close in order to improve services and decrease overtime. Homes were chosen based on individuals who are more independent and thought to transition to the community more successfully. Since that time there has been a drastic increase in community referrals in order to keep loved ones close to Legal Authorized Representative (LARs)/family members in the Austin area, rather than transferring to another State Supported Living Center (SSLC) in other locations across the State.

**Community Referrals and Transitions from AuSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 10 | 0 | 5 | 0 | 431 |
| **2009** | 17 | 1 | 19 | 0 | 401 |
| **2010** | 15 | 4 | 15 | 0 | 377 |
| **2011** | 16 | 4 | 14 | 0 | 355 |
| **2012** | 33 | 3 | 16 | 0 | 328 |
| **2013** | 27 | 16 | 25 | 0 | 288 |
| **2014** | 48 | 15 | 15 | 0 | 266 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from AuSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 146 | 68.5% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 35 | 16.4% |
| Individual's reluctance for community referral* | 17 | 8% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 12 | 5.6% |
| Lack of funding | 2 | 1% |
| Court will not allow transition (Ch. 55/46B only) | 1 | 0.5% |

Data Source: HHS CARE System

**Table 2. Individual's Reluctance for Referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 12 |
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 5 |

**Table 3. LAR's Reluctance for Referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community transition | 110 |
| Lack of understanding of community living options | 21 |
| LAR is not interested in being provided information and exposure to community living options | 9 |
| Unsuccessful prior community transition(s) | 5 |
| Mistrust of providers | 2 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

LAR reluctance continues to be the greatest obstacle to referral for community transition at AuSSLC and the most difficult to overcome. Education of LARs is most often addressed

through the Community Living Options Information Process (CLOIP) that occurs before each annual ISP. LARs are contacted by Local Authority (LA) CLOIP staff and offered information on community living options. This process does not appear to be uniformly effective as some LARs decline to receive information from the CLOIP staff or opportunities to tour community options. The Qualified Intellectual Disability Professional (QIDP) Department and Admission and Placement Department continue to work alongside the LA CLOIP staff to help communicate, educate, and discuss living options with LARs, family members and the individuals. This is to ensure that information is being communicated consistently, as well as to improve the relationship between AuSSLC and the LA. LARs and other family members are encouraged to attend the educational community tours provided through the LA that occur twice a month; however, a review of tour attendees reveals that no LARs or family members have attended these tours during fiscal year 2014. In FY2015 the facility will work closely with the LA CLOIP staff to ensure that family members and LARs are invited on the tours. Many LARs are parents or siblings of individuals who have resided at AuSSLC for extended periods of time. These LARs frequently state that AuSSLC is the only home their loved ones have known and they do not want to disrupt their lives after so many years of living in the same place. In addition they state they are satisfied with the services and supports that AuSSLC continue to provide. LARs also frequently state that they do not believe community providers can care for their loved ones as well as AuSSLC. While we appreciate the confidence that LARs have in the facility, the Admission and Placement Department and LA continue to discuss at the ISP meeting, the positives regarding community living. The Admission and Placement Department schedule at least two provider interviews a year in order to provide more education about community options with individuals and their families/LARs. With the increase in provider interviews, IDT members have the opportunity to learn more about community providers and options, which can then be offered as examples in the ISP meetings.

The AuSSLC QIDP Department utilizes the facilitator model for all annual ISPs; there are currently 3 facilitators with another scheduled to start on December 1st. This allows for more consistency in the facilitation and documentation of the living options discussion. These ISP facilitator QIDPs received specialized training that specifically focuses on improving the living options discussion in the ISP. Through the training, the facilitator has an increased knowledge base of community options and can provide individualized information and recommendations related to the person's needs, which might alleviate an LAR and IDT's reluctance to open a community referral. Admission and Placement staff attends the majority of ISP meetings to support the QIDP facilitator and ensure that the living options discussions are thorough and supportive of the individual's needs.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

There are individuals whose medical needs are such that they require 24-hour nursing services which often can only be accessed in a nursing facility or other medically oriented setting in the community. This is the second greatest obstacle for community referral at the AuSSLC. The Admission and Placement Department will work with the QIDP Department and the various disciplines to provide training to teams to ensure that those individuals who are identified as needing 24-hour nursing services actually have nursing needs that require this level of services and cannot be met in a community setting. They

will also provide teams with information on how medical needs can be met in a community setting.

**Individual's reluctance for community referral**

Individual reluctance has decreased as an obstacle for referral since last year. This decrease is attributed to the QIDP Department, Residential Services Department, and Admission and Placement Department working together to improve the planning and execution of the CLOIP tours scheduled with the LA. A process in which CLOIP representatives contact QIDP, Residential, and Admission and Placement departments to schedule individuals with upcoming ISPs on a tour is currently being employed and shown to be effective. The team feels that a CLOIP tour closer to the individual's ISP provides a fresh memory of the experience for the individual and any AuSSLC staff that attended. The LA's twice-monthly educational community tours continue to offer these individuals an opportunity to learn more about the options available to them in the community. In order to provide a thorough experience, there are usually no more than 5 individuals scheduled for a CLOIP tour. This has also proven to decrease anxieties for some of the individuals entering into a new environment when there aren't so many people around. IDTs are also beginning to ask the LA for help in setting up tours for some individuals who the team feels would be served well in a less restrictive setting. Provider fairs held on campus give additional opportunities for individuals to meet different community providers and learn more about the options available to them. A provider fair was held in March 2014 to coincide with Disability Awareness month. The day was filled with a parade and recreational activities along with the provider fair. A second provider fair was held in July 2014 after the home closures were announced in order to provide more information about community options to individuals and their families. There were about 20 providers in attendance and around 15 family members. The provider fair was held on a Saturday which allowed for more family attendance as there are usually only 1-5 family members that attend. All of these strategies appear to be effective in reaching out to the individuals served at AuSSLC and will continue in fiscal year 2015.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

For the individuals identified as those whose behavioral needs prevent them from moving to a less restrictive setting at this time, interventions through behavior support plans and psychiatric services will continue to address their challenging behaviors. Austin Travis County Integral Care has implemented the Systemic Therapeutic Assessment Resources and Treatment (START) program to provide more intense crisis intervention for individuals moving into community living options in Travis County. LARs has been receptive to this program and have expressed reassurance that individuals and community providers are better prepared for more intense psychological and psychiatric needs.

**Lack of funding**

Efforts to secure funding for the two individuals who are not currently citizens of the United States and not eligible for Medicaid funding will continue in fiscal year 2015. One

individual currently has a Resident Alien Card, but the LAR has historically refused to sign the Medicaid application to determine what benefits she would be eligible for. The facility was recently informed that the LAR has been in contact with an attorney and the Medicaid office to initiate the process of obtaining citizenship and determining her qualifications for Medicaid. The home QIDP is continuing to follow up with the LAR to assist throughout the process. The other individual's LAR started the process but there are some discrepancies in her registered name. The LAR is working on corrections with the attorney prior to the paperwork being filed with immigration.

**Court will not allow transition (Ch. 55/46B only)**

There is one individual who is not eligible for community transition due to court orders. We will continue to educate the committing court regarding community services in fiscal year 2015. His team is in the process of working with an attorney to gain eligibility for community transition and plan on referring him after he is cleared.

**In fiscal year 2015, AuSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

With the announcement of the home closures in June 2014, the affected LARs have been more open to the option of community living and have chosen that route rather than transferring their loved ones to alternate SSLCs. Particularly, individuals who would rather not move out of the Austin area have also expressed more interest in community options. With the home closures, community providers have been more motivated to expand community capacity in order to keep individual's close to their loved ones and still have their needs met appropriately.

The QIDP and Admission and Placement Departments will continue to work closely with the LA CLOIP staff in order to continue the pattern of at least two CLOIP tours per month. There will also be more of a focus on providing individualized CLOIP tours for individuals who have more focused needs such as environmental, medical and/or behavioral.

LA CLOIP staff continue to attend ISPs and will provide information to the LAR, individual and IDTs regarding the various aspects of the START program. Adjacent local authorities including Bluebonnet Trails and Hill Country Mental Health and Developmental Disabilities (MHDD) also have crisis intervention programs and speak to these services during an individual's ISP. Both local authorities, plan on presenting their programs to Family Eldercare, which is the guardian for many individuals at the AuSSLC.

Both provider fairs were successful this year with about 150-200 individuals attending each time. The Admission and Placement Department plans on continuing the spring event to coincide with Disability Awareness month.

Provider interviews have become an integral part of the community transition process for individuals that have been referred, but this has also provided team members with a better working knowledge of community providers and options which they can speak about during annual ISP meetings.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from AuSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Need for environmental modifications to support the individual | 13 |
| Limited residential opportunities | 10 |
| Lack of supports for individuals with significant challenging behaviors | 6 |
| Individual/LAR indecision | 6 |
| Lack of availability of specialized medical supports | 4 |
| Lack of specialized mental health supports | 1 |
| Need for services and supports for individuals with forensic needs/backgrounds | 1 |
| Medicaid/SSI funding | 1 |
| Other | 2 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

Obstacles from FY 2014 compared to FY 2013 are very similar. Several of the individuals on the community referral list from 2013, carried over to 2014. AuSSLC is working to be more proactive in identifying obstacles prior to the 180-day referral milestone and developing strategies to address the obstacles as soon as they are identified.

### Need for environmental modifications to support the individual

There are numerous individuals referred for transition that utilize a wheelchair. A limited number of providers have available homes which fully accommodate individuals who use wheelchairs. Some homes have a ramp but may not have wide enough doorways or a bathroom large enough to accommodate a wheelchair. Initially there were three individuals on the community referral list who required a bathing trolley. Since that time, two of the referrals have been closed because the IDT and Admission and Placement department were unable to locate a home that had or could accommodate a trolley. These individuals had been assessed by an occupational therapist to identify alternative bathing equipment that could be used but it was determined that the trolley was the only apparatus that would keep them safe during bathing. The other individual's referral was closed due to health concerns, but finding a home with a trolley had been a long term struggle. Providers and LAs have been made aware of the need for wheelchair accessible homes. A waiver amendment has been approved which would allow providers access to pre-approval of funds for minor home modifications once an individual has made a provider choice. The goal is for this waiver amendment to be effective in FY 2015. There have been several instances where the team identified a provider who proposed making modifications to a home, but because the home was leased, the modifications did not occur. Initially, teams were reluctant to consider ICF group homes due to concerns that they might not be accepted or at higher risk of being discharged if the provider determines

they can no longer meet the individual's needs. The Admission and Placement Department and LA have provided more education regarding ICF homes as they are larger and better equipped to accommodate larger wheelchairs and the need for bathing trolleys. For one of the ladies that required a trolley, her LAR only wanted to focus on HCS and closed the referral because she was not open to ICF and there were no HCS options with trollies available. For the other individual, the LAR only wanted her moving to Hays County and there were not any openings in an HCS or an ICF home. Due to the lack of availability of homes, the referral was closed. In FY 2014, two people who had an identified obstacle of environmental modifications have moved.

**Limited residential opportunities**

Due to the home closures at AuSSLC along with the Sunset Review reports that may recommend closure of the facility, providers have been proactive about contacting the Admission and Placement department to regarding the possibility of opening new homes to accommodate the influx of individuals moving into the community. Currently in Travis County, the housing market is extremely competitive, so it has been difficult for providers to purchase homes. Providers have had more success purchasing homes outside of Travis County, including Williamson and Hays County. Many LARs/IDTs would like individuals to remain in Travis County so they can have access to the START program which provides intense crisis intervention in the community. The Admission and Placement department has been working with Bluebonnet Trails (Williamson County) and Hill Country MHDD (Hays County), to educate LARs and IDTs about their respective crisis intervention programs. Despite these efforts, LARs and IDTs continue to push for finding homes in Travis County. Many LARs, whose family members live on the homes that are slated to close, have chosen the community rather than an alternate SSLC due to not wanting to limit visitation related to distance. This has increased the concentration of individuals looking in the Austin area that are not open to other geographical locations. In FY 2014, two people who had an identified obstacle of limited residential opportunities have moved.

**Lack of supports for individuals with significant challenging behaviors**

There have also been limited community options for individuals who at times need more intense staffing related to aggressive behaviors and non-compliance with attending medical appointments off campus. There is currently not a mechanism in the HCS program to fund more than 1:1 staff. State Office has been made aware of these concerns and is in the initial phases of addressing the need. It continues to be difficult to locate providers who are prepared to serve individuals with pica related behaviors. Concerns have been related to the level of supervision that the provider can provide as well as locating a day habilitation or work environment that is safe for the individual. To address these concerns, AuSSLC has approached providers regarding the possibility of engineering or structuring group homes and day sites to be pica safe environments and to provide protocols for environmental checks. One provider was open to this idea but has since struggled to maintain staff including administration and direct support professionals (DSP), so the team no longer wanted to pursue that provider. The team is looking into other providers that would be open to this idea. Providers continue to be invited to come to the center to shadow staff that is familiar with the individual and familiar staff will remain

at the group home or day habilitation site for a predetermined amount of time when the individual goes for an overnight visit. One individual went on two overnight visits to a home; AuSSLC staff remained in Lubbock and provided additional supports and on-call services to the community provider. The individual has since moved and is doing well and closer to family. As appropriate, packets will be submitted for utilization review at state office for consideration of an increased level of need to provide additional funding. In FY 2014, two people who had an identified obstacle of behavioral supports have moved.

**Individual/LAR indecision**

Many LARs are concerned about the limited oversight and smaller staffing ratios of the available community options. The Admission and Placement department and LA have continued to provide education related to options and how it looks for other individuals living in the community with similar needs. Providers have also given information in both provider interviews and tours on how they monitor homes as well as information about their annual surveys. The LA continues to inform families, individuals and teams about their monitoring process to include the weekly monitoring for the first 90 days and monthly service coordination for the remainder of the time that the individual is in the HCS program. It continues to be difficult to coordinate with some LARs to arrange meetings, tours, and provider interviews, and this has delayed the progression of individuals' transition. We have utilized e-mail, phone calls, certified letters, and the LA to assist with making contact with the LAR. One individual's LAR has since made a final provider selection. The other two individuals are in the process of going on an overnight visit and will most likely be making a final provider selection if all goes well.

One individual's LAR had several deaths in the family and has been unable to participate in the transition process for many months. The LAR has since reinitiated the process, worked with the IDT to choose a provider and a move date is scheduled in January 2015. In FY 2014, two people who had an identified obstacle of individual/LAR indecision have moved.

**Lack of availability of specialized medical supports**

Throughout the FY 2014, there have been several individuals on the community referral list who have a diagnosis of hypothermia which have more intense protocols related to taking temperature multiple times a day, not going outside during certain temperatures and different warming methods. Several providers have been concerned about their DSP taking rectal temperatures three times a day despite the ability to be delegated for this procedure. IDTs have been concerned that a nurse would not be facilitating the process as well as DSPs not being professionally trained to see signs and symptoms of hypothermia and address in a timely manner. At this time, there is only one individual on the community referral list who has a diagnosis of hypothermia that requires these intense measures; the other two individual's referrals have since been closed This individual also requires a two person transfer, at all times, due to a diagnosis of Osteoporosis. It has been difficult to identify a provider that can provide two staff at night. At this time, the IDT will be looking into ICF options, but if one is not identified, the team has discussed closing the referral.

**Lack of specialized mental health supports**

The individual where a lack of specialized mental health supports was a barrier to transition last FY, moved into the community. Unfortunately, this transition was not successful due to increased aggression and SIB which contributed to the need for more intense staffing. The LAR chose for the individual to be admitted to another SSLC. Austin Travis County Integral Care (ATCIC) does have their START program up and running to include a Psychiatrist and Psychiatric RN. Their respite home is currently being remodeled and should be up and running in the spring, which could be a resource for individuals needing more intense short-term supervision and treatment. Positive Enlightenment, a group of BCBAs, has a contract with ATCIC to develop and facilitate Transition PBSPs for individuals with more intense maladaptive behaviors with transitioning to the community. Positive Enlightenment starts this process after an individual has been identified for the need at their 14 day meeting. They review charts, consult with their Behavioral Health Specialist, shadow the individual on their home/day program and speak with DSP. Once the individual is ready to transition, Positive Enlightenment trains and monitors the provider staff on implementation. The AuSSLC Behavioral Department is working with Positive Enlightenment, to incorporate aspects of the Transition Positive Behavior Support Plan (PBSP) into their current PBSP to start better preparing the individual prior to transition.

**Need for services and supports for individuals with forensic needs/backgrounds**

The individual who had forensic needs successfully transitioned into the community over the summer. Individual counseling began prior to the individual moving and continued after his transition to the community. Positive Enlightenment developed a Transition Plan for the individual and his current living situation continues to be positive. He has also obtained employment in the community, which he is extremely proud of.

**Medicaid/SSI funding**

The individual, whose transition was delayed to funding, successfully moved into the community. There continues to be a protocol with the reimbursement staff and QIDP Department to identify these concerns early in the transition process.

**Other:**

**Family chose to pursue guardianship to prevent transition (1)**

The individual's family did not feel that there were the appropriate supports in the community related to intense staffing and the need for more services directed towards individuals with visual impairments. This individual is currently living on one of the homes slated to close and will be transferring to an alternate SSLC, closer to his family's home.

**Illness during transition period (1)**

This individual's weight continued to fluctuate just under his Estimated Desired Weight Range (EDWR). The team was still in the process of addressing his weight loss and was

concerned that a major transition would cause anxiety for the individual, causing more weight loss and possibly the need for a g-tube. The team chose to close the referral due to his medical condition, but will reconsider opening a referral at his ISP in April 2015, if his weight has stabilized.

**In fiscal year 2015, AuSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

The Admission and Placement Department will continue to work with the LA to educate individuals, families and teams about their options in the community, to include smaller ICFs. This will especially be important for individuals who might need more supports related to medical and environmental modifications. State Office has a pilot program in the works for several ICF homes to have a higher reimbursement rate for individuals who have more intense medical needs. The hope is that this will not only be a benefit for individuals currently referred to the community, but will also allow for LARs and IDTs to feel more secure about opening a community referral.

The Admission and Placement Department started utilizing provider interviews during the last FY in order to provide more information to the provider related to the individuals preferences and needs as well as increase the teams' knowledge of the provider and community supports. This has continued to be beneficial for all parties and will continue to be in place in the upcoming FY. Provider shadowing was also a major focus of last FY and continues to be beneficial and shown improvements in developing the relationship between the individual/IDT and provider, prior to the move, thus creating a smoother transition.

The Admission and Placement Department will continue to work and follow up with State Office regarding the need for more intense staffing ratios for individuals with significant challenging behaviors.

The Admission and Placement Department is working with Residential, Hab Therapies and Behavioral Health to create a "hot sheet" that provides an initial brief overview of essential supports to providers and SSLCs when trying to identify appropriate options to choose from. This form is called the Residential Individualized Information Sheet.

The Admission and Placement Department is working with ATCIC to send out de-identified case studies of individuals currently referred to the community. A follow up meeting is held several weeks later to allow the providers an opportunity to ask questions and determine if they might have an appropriate home or feel that they can meet the needs of the individual. This has proven to be effective in identifying placement options and narrowing down appropriate choices for individuals and their LAR. This process has also allowed for Transition Specialists to get a more accurate list of current openings with providers, due to the frequent contact.

The Admission and Placement Department and LA will continue to educate LARs and teams regarding crisis intervention programs outside of Travis County to safeguard that an individual's transition is not held up due to concerns of limited behavioral supports outside of the provider.

# Brenham State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral & Transition Report

## A. Center Profile

Brenham State Supported Living Center (BSSLC) was opened in January 1974. At the end of fiscal year (FY) 2014, BSSLC was serving 283 individuals, and employing approximately 1,100 staff. The center serves a 10-county area including Brazos, Burleson, Grimes, Leon, Liberty, Madison, Montgomery, Robertson, Walker, and Washington counties.

BSSLC is located in Washington County which has five active providers, the greatest number in the 10-county catchment area. The majority of group homes in the 10-county area are Home Community-Based Services (HCS) with only two Intermediate Care Facility (ICF) homes. In Washington County, there are 32 HCS group homes and one ICF. Counties outside of Washington are more limited in residential options available to individuals with intellectual disabilities.

In Washington County, all five providers have their own vocational services. BSSLC contracts with two providers to provide vocational services to the individuals they serve. Both providers utilize the BSSLC off-campus workshop plus help BSSLC fulfill a contract at their own workshops. Although BSSLC is working with Department of Assistive and Rehabilitative Services (DARS) for vocational services, there are still limited opportunities for individuals to work in the community.

The number of transitions remained the same for fiscal years 2013 and 2014. The Center is taking steps to increase the number of transitions to the community by educating interdisciplinary teams on identifying specialized services and supports that are needed in the community and locating providers that can provide such specialized services.

**Community Referrals and Transitions from BSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 8 | 2 | 19 | 2 | 385 |
| **2009** | 36 | 5 | 13 | 1 | 378 |
| **2010** | 27 | 5 | 39 | 0 | 340 |
| **2011** | 14 | 7 | 28 | 0 | 315 |
| **2012** | 18 | 3 | 12 | 0 | 298 |
| **2013** | 11 | 6 | 16 | 3 | 288 |
| **2014** | 12 | 7 | 16 | 0 | 283 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from BSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral | 204 | 84% |
| Individual's reluctance for community referral | 15 | 6.2% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 12 | 4.9% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 10 | 4.1% |
| Lack of funding | 2 | 0.8% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for community referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 8 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 4 |
| Unsuccessful prior community placement(s) | 3 |

**Table 3. LAR reluctance for community referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 153 |
| LAR is not interested in being provided information and exposure to community living options | 29 |
| Lack of understanding of community living options | 12 |
| Mistrust of providers | 6 |
| Unsuccessful prior community placement(s) | 4 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

Legal Authorized Representative (LAR) reluctance continues to be the greatest obstacle to referral for community transition at BSSLC and the most difficult one to overcome. Currently, of the 283 individuals who reside at the center, 88 percent have a guardian. Education of LARs is most often addressed through the Community Living Options Information Process (CLOIP) that occurs before each annual ISP. LARs are contacted by staff at Brazos Valley Mental Health and Mental Retardation Authority (MHMRA), the local authority (LA), and offered information on community living options. LARs and other family members are encouraged to attend the weekly educational community tours provided

through the LA. Review of tour attendees reveals that two LARs or family members attended these tours during fiscal year 2014. The center's Admission and Placement Department gave one individual a tour in the community with LARs and family members.

The Center hosted three additional community provider fairs this year to accommodate individuals that work off campus or have difficulties leaving their home due to medical issues. Community provider fairs occurred in December 2013, January 2014, March, 2014, July 2014, and August 2014. Letters were mailed to all LARs and primary correspondents informing them of the opportunity to receive information from local community providers. For the past two years, BSSLC has been inviting individuals and their families who have transitioned to the community to attend the provider fairs to speak to current BSSLC individuals and their families about their successful transition. This has proven positive for individuals who have not been at the center for an extended period of time as well as for children at the facility. Many of the LARs are parents or siblings of individuals who have resided at BSSLC for an extended period of time. These LARs frequently state that BSSLC is the only home their family members have known, and they do not want to disrupt their lives after so many years of living in the same place. LARs also frequently state that they do not believe community providers can care for their family members as well as BSSLC. The majority of LARs state, they have received information about community living options and are not interested in learning more. LAR reluctance appears to be a mistrust of community providers due to the belief that they cannot provide the same level of supports as BSSLC.

The transition specialist continues to attend Individual Support Plan (ISP) meetings in an attempt to make contact with LARs to offer additional education on community living options. Through this effort, the center has seen some LARs show interest in learning more about what is available in their area. The transition specialist has seen some LARs start to request tours of providers in their home areas. This approach appears to be successful in providing education on community living options to LARs that might otherwise turn down offers for information from the LA.

**Individual's reluctance for community referral**

Individual reluctance is the second greatest obstacle for referral at BSSLC. The main reason is a lack of understanding of community options available. The center continues to provide individuals with information about the LA's weekly educational community tours in an effort to provide an opportunity to learn more about the options available to them in the community. The number of individuals who have participated in tours doubled in FY 2014. This past fiscal year, the Admission and Placement Department began attending Self-Advocacy meetings as another means of educating individuals on options in the community. IDTs are also beginning to ask transition specialists for help in setting up tours for individuals and family members who the team feels would be served well in a less restrictive setting. Some individuals have been able to visit peers, who have successfully transitioned in their new community homes. In some cases, when a peer makes a pre-selection visit, the individual is invited to go along to gain exposure to their peer's choice of community transition. Provider fairs held on campus give additional opportunities for individuals to meet different community providers and learn more about the options available to them. A provider fair was held at the Center's off-campus workshop for

individuals who did not want to miss work to attend a fair and 100 percent attendance rate was achieved for this fair. All of these strategies appear to be effective in reaching out to individuals and will continue in fiscal year 2015.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

In an effort to reach out to the center's medically fragile and geriatric populations, the Admission and Placement Department began holding special provider fairs during the past two years. This fair is for individuals whose medical needs require access to 24-hour nursing services which often can only be provided in a medically oriented setting in the community at this time. The individuals in two units, along with their families and staff, are invited to visit with providers of these services for individuals with special, complex needs. This provider fair is held semi-annually at the units in order for the individuals to gain better access to the providers and the information being offered. This has been successful in which a 98 percent attendance rate was achieved for this provider fair.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

For the individuals with behavioral needs that prevent those from moving to a less restrictive setting are provided interventions through behavioral support plans and psychiatric services which will continue to address their challenging behaviors. Seven out of the ten people who have behavioral needs came to BSSLC from unsuccessful community settings. The three other individuals receive 2:1 supervision or continue to exhibit signs of psychiatric distress. The individuals who came from unsuccessful community settings are currently being monitored through action plans developed by their teams to address their behavioral needs. The three other individuals teams continue to review their medications and levels of supervision in hopes that a referral to a less restrictive setting can be secured in the future.

**Lack of funding**

Efforts to secure funding for the two individuals who are currently not citizens of the United States and ineligible for Medicaid funding in the community will continue in fiscal year 2015. The BSSLC Social Worker will continue to work with their families to gain citizenship.

**In fiscal year 2015, BSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

A list of the 15 individuals identified by IDTs during the living options discussions as having no other obstacle to referral other than their own reluctance will continue to be provided opportunities to attend provider fairs, community excursions for education purposes, and link them with peers that have already transitioned. These individuals will be the primary focus of attempts to provide education on community options available in an attempt to reduce the individuals' reluctance to consider the community as a viable living option. The transition specialist, along with the Admission and Placement team will attend as many of

these individuals' ISP/ISPA meetings related to living options as possible to assist in living options discussions.

- A list of the 153 individuals identified by the IDTs during the living options discussions as having no other obstacle to referral other than LAR reluctance, but are not interested in community transition will continue to be encouraged to participate in providers fairs and CLOIP tours, and provided CLOIP information by mail.

- BSSLC will continue to offer up to five provider fairs per fiscal year to provide opportunities for individuals, LARs, and families to meet community providers in the area and to learn more about available options to them in the community.

- Provider fairs for medically fragile and geriatric individuals will continue on a semi-annual basis as a way for individuals to meet community providers and receive information on services they provide.

- The admission and placement team, along with the transition specialist, will attend self-advocacy meetings quarterly to provide information on community living options to meeting attendees.

- Individuals will continue to be provided opportunities to visit with former peers who have successfully transitioned to the community through visits to community homes. The number of individuals who may visit their peers in the community will vary from year to year. The visits are individualized and coordinated with their peers and the peer's team/LAR.

- Training will continue to be provided to IDT members on properly identifying individuals who require 24-hour nursing services versus needing available nursing services. This training will be for the two units who have medically involved individuals.

- Individuals, along with their families, who have successfully transitioned to the community, will continue to be invited to provider fairs to share their success stories with other individuals and their families.

- The admission and placement team, along with the transition specialist, will continue to offer individualized community visits for family members and individuals. This will be achieved by providing one-to-one individualized tours looking at specific locations and any other needs requested by the family.

- The admission and placement team will begin mailing the quarterly newsletter (BSSLC Admissions and Transitions Department Newsletter) to families in an effort to educate them on community options.

- Due to the younger population served at BSSLC, BSSLC would like to see more specialized therapies, programs, and specialists to work with children prior to them being placed at an SSLC. It would be beneficial to all to allocate more resources for programs geared towards individuals with IDD and dual diagnosis. SSLCs need more

guidance on the 30-day initial ISP meeting whereby living options are discussed to guide teams on the community referral process at that point.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from the BSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 5 |
| Limited residential opportunities | 3 |
| Lack of supports for individuals with significant challenging behaviors | 2 |
| Lack of availability of specialized medical supports | 1 |
| Medical/SSI funding | 1 |
| Other | 3 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Individual/LAR indecision

All five individuals and/or their LARs experiencing this obstacle took an extended amount of time to identify a preferred provider after making visits. Three of these individuals had their CLDPs developed in a timely manner once the provider was selected, while two individuals have had their referrals rescinded by the LAR. Of these two individuals, one LAR made a promise to the deceased parent to make sure this individual remained at BSSLC as they have a mistrust of private providers. The family knows another family member who had a very bad experience in a group home. The other is also a family decision in which the individual has resided at BSSLC for numerous years and the family has heard of negative comments from other friends and family regarding private providers. Two individuals have moved and the third individual is scheduled to move in December.

### Limited residential opportunities

One individual with the obstacle of limited residential opportunities has an LAR who has very specific parameters for group home location which has made it difficult to locate a provider. The second LAR is in a very remote area with no providers within a 50-75 mile radius requested. The third family member has strict home specifications and locations which makes it difficult to find a provider. Out of the three, the individual with strict home specifications and locations has transitioned to the community.

### Lack of supports for individuals with significant challenging behaviors

There are two individuals under this obstacle in which their IDTs had developed action plans to address their behaviors. One referral was rescinded by the LAR, while the other transitioned to the community. The IDT developed a plan in which extended the process of the community transition. BSSLC provided familiar facility staff to help this individual become familiar with his new staff in the group home. By extending the transition process, this has led to a successful transition for this individual.

**Lack of availability of specialized medical supports**

The individual in this category had a need for a specialized support in cardiology, which was not available in the preferred geographic location. The IDT expanded the geographic location to include areas that have more specialized medical supports; however, the brother became the LAR and rescinded the referral.

**Medicaid/SSI funding**

The one individual in this category had an Intelligence Quotient (IQ) test result that did not meet the criteria for Intellectual Developmental Disability (IDD). The LAR appealed the decision and is currently upheld through the DADS Appeals Process. At this time, the LAR has not requested follow-up referral for the minor child.

**Other:**

**Illness during transition period (2)**

One individual had an illness coupled with a surgery with a recovery period that lasted longer than anticipated. The individual's team is in the process of selecting a provider at this time.

The second individual had needed specialized equipment. In the beginning, the team had a difficult time securing the equipment needed; however, the individual was tapered off of the equipment successfully and has since transitioned to the community.

**Family chose to pursue guardianship to prevent transition (1)**

As mentioned earlier under the section Lack of availability of specialized medical supports, one individual's sibling chose to pursue guardianship to stop the transition. The sibling has a mistrust of community providers based on promises and conversations with their parents many years ago about different incidents that happened in the past.

**In fiscal year 2015, BSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

- The Center has instituted guidelines that are more stringent for teams regarding follow-up in an effort to reduce the number of individuals who have not transitioned within 180 days. Unit Directors are now part of the Admissions and Transfers Committee where obstacles to transitions are discussed. The Unit Director then meets with the team to help guide the team past the obstacle(s)/reluctance to transition. The Admissions and Placement Coordinator sets routine deadlines with teams to respond to inquiries and/or meeting requests for ISPAs to keep the process timely. The APC reports teams that are not meeting deadlines to the Unit Director for assistance.

- The Center has added all department heads to the Admissions and Transfers Committee which convenes to discuss obstacles to transition on at least a monthly basis.

- Additional training will be conducted during the fiscal year to all IDT members regarding what constitutes a true obstacle to transition.

- If an individual does not move within 180 days of their referral, the IDT will meet monthly to identify and address obstacles to transition. The IDT will identify and address obstacles prior to the 180-day timeline as they are identified. Unit Directors will be attending the Admissions and Transfers Committee meetings where community transition timelines are discussed. The UD will follow up with the IDT to ensure that obstacles are addressed more timely and reported back to the Committee for assistance, if needed.

- The Admission and Placement Department will continue to monitor individuals who exceed the 180-day timeframe to ensure that obstacles to transition are addressed, and they can move to their selected community provider as soon as possible.

- It would be beneficial for State Office to work with discipline coordinators in polling disciplines on reluctance to community transitions. This would allow State Office to see what the various disciplines at the facility are experiencing and to voice their reasons for their reluctance on referring individuals for community placement; thus, developing education across disciplines. Also, working with agencies on ensuring there are enough resources, such as psychiatrists, to serve the number of individuals in a geographic area. In some of the specific and/or rural areas, there is a lack of specialty health care professionals to provide services to individuals with IDD – either due to a lack of understanding of the population, or funding – Medicaid acceptance. Many times this lack of services in these small areas are the reasons for the admission to the SSLC's.

# Corpus Christi State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The Corpus Christi State Supported Living Center (CCSSLC) opened in April 1970. The Center was serving 224 residents as of August 31, 2014 and employs approximately 933 people. The CCSSLC serves a 21-county area: Aransas, Bee, Brooks, Calhoun, De Witt, Duval, Goliad, Jackson, Jim Hogg, Jim Wells, Kennedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Starr, Victoria, Webb, and Zapata.

The CCSSLC is located in Nueces County, which has the greatest number of Home and Community Based Services (HCS) and Intermediate Care Facility (ICF) providers available in the 21-county catchment area. While there are 108 HCS providers listed for Nueces County, only 11 currently provide services. There are two ICF providers serving the 21-county catchment area. There are limited vocational opportunities for individuals transitioning to the community from the CCSSLC. One HCS provider provides sheltered workshop services. HCS providers often work with Department of Assistive and Rehabilitative Services (DARS) due to limited vocational services.

The number of transitions has remained consistent over the last two fiscal years with close collaboration between the IDTs and the Admission and Placement Department to support individual's successful move. The Transition Specialists continues to provide education to individuals and Interdisciplinary Team (IDT) members, increasing their awareness of community services and the transition and Community Living Discharge Process (CLDP).

**Community Referrals and Transitions from CCSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 16 | 7 | 25 | 1 | 355 |
| **2009** | 26 | 5 | 27 | 1 | 325 |
| **2010** | 9 | 5 | 25 | 0 | 292 |
| **2011** | 16 | 2 | 13 | 0 | 274 |
| **2012** | 17 | 2 | 9 | 0 | 258 |
| **2013** | 18 | 5 | 15 | 1 | 242 |
| **2014** | 14 | 2 | 16 | 0 | 224 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from CCSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| Individual's reluctance for community referral | 100 | 47.8% |
| LAR's reluctance for community referral | 60 | 28.7% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 25 | 12% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 19 | 9.1% |
| Lack of funding | 3 | 1.4% |
| Court will not allow placement (Ch. 55/46B only) | 2 | 1% |

Data Source: HHS CARE System

**Table 2. Individual's reluctance for community referral, FY 2014**

| Reason for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 89 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 6 |
| Mistrust of providers | 3 |
| Unsuccessful prior community placement(s) | 1 |

**Table 3. LAR's reluctance for community referral, FY 2014**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 22 |
| LAR is not interested in being provided information and exposure to community living options | 19 |
| Unsuccessful prior community placement(s) | 10 |
| Lack of understanding of community living options | 7 |
| Mistrust of providers | 2 |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### Individual's reluctance for community referral

Individual reluctance is the greatest obstacle for community referral at the CCSSLC, specifically due to a lack of understanding of different community living options. Bi-weekly Community Living Options Information Process (CLOIP) tours are offered to individuals, including tours in surrounding areas outside of Nueces County. This is a positive addition to tours since many individuals want to move to other geographic locations. CCSSLC held one provider fair this year in conjunction with the CLOIP Department from Nueces County Behavioral Health. CCSSLC encouraged HCS providers to invite individuals they serve, who formerly lived at the center, to share their community success story at the provider fair. IDTs are seeking assistance from the Transition Specialists and Placement Coordinator in scheduling tours for individuals who have not been referred to the community but are interested in increasing their knowledge of different living options. The Transition Specialists have developed a resource directory with images of group homes, day habilitation centers, and information about providers. The resource directory is available to all individuals and IDT members, who are interested in exploring community transitions on SharePoint.

### LAR's reluctance for community referral

The second greatest obstacle to community referral for individuals at CCSSLC is Legal Authorized Representative (LAR) reluctance. A common misconception is that the quality of care and services for the individual at CCSSLC cannot be matched in the community. The CLOIP service coordinator provides educational information regarding community services prior to an individual's annual ISP meeting. Some LARs remains uninterested in community services or chooses not to receive the information. Provider fairs are held annually to provide LARs and family members an opportunity to meet and interact with community providers. Despite invitations being mailed to all LARs and primary correspondents, low participation continues. Transitions Specialist also telephoned families/LARs and invited them to provider fairs.

Unwillingness and fear of change make it difficult to overcome this obstacle. LARs are also invited to participate in facility activities in combination with the family association quarterly meeting. The Admission and Placement Department developed a newsletter entitled Seashore Express and it was shared during a family association meeting. The purpose of the newsletter is to help establish rapport with LARs and provide information to LARs regarding community services and educational and social events at the center and in the community. The Seashore Express will share success stories of individuals who have transitioned to the community in an effort to address negative experiences of some LARs.

### Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff

There are a number of individuals whose obstacles to referral are their behavioral and psychiatric needs. The IDTs have determined that these individuals' needs cannot be met in a community setting due to behaviors that pose a risk to themselves or others. The IDTs are working with these individuals through development of Positive Behavior Support Plans (PBSPs), counseling, psychiatric services, and classes, including Skill Training of Paraphilia (STOP) and Anger Management.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

Two units at CCSSLC serve individuals with significant medical needs who require access to 24-hour nursing services. The center also has an infirmary for individuals who require ongoing medical care which often can only be provided in a nursing facility or hospital setting. The IDTs from these units are beginning to make referrals or express interest in referring individuals to the community. Individuals from these units take part in provider fairs and the Transition Specialists meet with the IDTs when they have questions regarding potential community referrals for individuals who have extensive medical needs. The Behavioral Health Center of Nueces County, the LA, has conducted training with IDTs regarding HCS services. During the training, the LA reviewed nursing services, home modifications, Occupational Therapist (OT)/Physical Therapist (PT) services, and answered IDT member questions regarding available community services.

**Lack of funding**

The three individuals who have been identified for lack of funding either do not have citizenship or do not have Medicaid/SSI benefits. The Admission and Placement Department will continue to work with the reimbursement office as new information is obtained regarding potential benefits and work with the IDTs to explore non-Medicaid community services.

**Court will not allow transition (Ch. 55/46B only)**

Two individuals were not referred to the community due to court decision. The Admission and Placement Department did mail inquiries on the status of their cases to the court in Nueces County and Webb County courts, and both county judges said no to the community referral. The other individual is a registered sex offender and the court will not allow community placement. Written notification is sent to the appointment court informing them of IDT decision to refer an individual to the community.

**In fiscal year 2015, CCSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

- Training regarding obstacle identification is scheduled to be conducted for the Qualified Intellectual Disability Professionals (QIDPs) during the month of September 2014 by State Office staff. The identification of obstacles to referral is being completed during the Living Options portion of the ISP and the IDT will develop actions to address each obstacle. The Admissions and Placement Department are scheduled to retrain IDTs on obstacles to referral during the month of October 2014. The Admissions and

Placement Department would like to schedule an annual course for FY 2015 on obstacles to referral.

- The Admission Placement Coordinator (APC) will collect and report obstacle to referral data quarterly during Quality Assurance (QA)/Quality Improvement (QI) council and develop corrective action plans as appropriate.

- The APC Department has begun to have provider agencies participate in a meet and greet with the IDTs on campus. This has provided the IDTs an opportunity to ask questions regarding services and availability homes in the area. Provider agencies will be invited every three months to the facility for a meet and greet with the IDTs. IDTs will be invited by email and APC will notify Discipline Heads of the meet and greet in an effort to encourage higher attendance.

- The APC will conduct training with the IDTs on the localized Most Integrated Setting policy in an effort to increase team member understanding of the community transition process. The APC Department is scheduled to conduct the training during the month of October 2014. The APC Department created a booklet for each IDT member with a copy of the Most Integrated Setting in an effort to provide the IDT with quick access to the policy.

- In an effort to reduce obstacles to referral, the IDTs need to become aware of what services are available in the community. Possible training for IDTs with representatives from Local Authorities on an annual basis to make IDTs aware of services available in the community can help reduce obstacles to referral.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from CCSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 14 |
| Individual/LAR indecision | 11 |
| Need for environmental modifications to support the individual | 8 |
| Lack of availability of specialized medical supports | 7 |
| Lack of supports for individuals with significant challenging behaviors | 6 |
| Need for meaningful employment and supported employment | 2 |
| Need for services and supports for individuals with forensic needs/backgrounds | 1 |
| Lack of specialized mental health supports | 1 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Limited residential opportunities

There are 14 individuals with this obstacle. One individual would like to live in a group home in Austin; however, the providers that the individual toured do not have immediate

openings at this time. Every effort to locate a provider, in the Austin area who could meet the individual's needs, continues.

Ten individuals selected to remain in the Corpus Christi area. Three have moved to the community while the other seven are still pending and seeking community placement.

Of the seven individuals, one individual was in the process of moving; however, this individual had some medical issues prior to the move. The second individual continues to look for a group home in the Corpus Christi area with needed home modifications. As for the other five individuals, IDTs continue to look in the Corpus Christi area, but they have also begun to look at the other areas as well. Two individuals selected a provider in the Houston area; however, due to their pica diagnosis, the IDTs had a difficult time locating a provider who has experience in dealing with this challenging diagnosis. Despite the difficulties, these two individuals eventually moved to Houston with a provider knowledgeable with this diagnosis. One individual selected to move to the Valley in order to be closer to her family. This individual moved to the area when the home became available in the area.

**Individual/LAR indecision**

Eleven individuals and/or their LAR were indecisive or reluctant to choose a provider. The individuals toured provider companies; however, they were indecisive and were unable to make a provider selection. Eight out of the eleven individuals have moved to the community. In an effort to assist the eight individuals to move to the community the IDT would follow up with the individual and would coordinate with the APC Department to facilitate movement. Two other individuals' referrals were rescinded due to their indecision and their preference to remain at the facility. One individual's LAR continues to be indecisive regarding the type of services and selection of a provider company.

**Need for environmental modifications to support the individual**

Eight individuals required home modifications. Three of the individuals have moved and their homes were modified to meet their needs. There was delay in movement because provider companies needed to lease or purchase a home and modify the home. The other five still need home modifications prior to transition. The IDTs for these five individuals want a home in Corpus Christi; however, there are no available group homes in the Corpus Christi area. The Admission and Placement Department has made efforts to find provider companies outside of the area. Provider companies from Brenham and Houston came to the facility to meet with the IDTs to talk about their company and services. The IDTs met with the companies; however provider selections were not made. The Admissions and Placement Department will continue to have provider companies conduct presentations at the facility every three months in an effort to assist IDTs.

**Lack of availability of specialized medical supports**

A total of seven individuals have not moved to the community due to their medical needs. One of the individuals has a diagnosis of diabetes. The provider companies indicated that because of the individual would not comply with his diabetic diet, insulin dependency, and at times refuses medication, the potential provider companies felt it a risk to provide

services. The IDT identified a potential provider; however, the provider did not feel they could meet the individual's nursing and medical needs.

Two of the individuals have transitioned to the community. One of the individuals has identified a provider company; however, the company does not have an immediate opening in the home and are in the process of looking for a home in Corpus Christi. For one of the individuals, the family has selected a provider company and the provider is in process of looking for a home. The IDT and Admissions and Placement Department continue to seek a provider who can meet the medical needs of the remaining two individuals.

**Lack of supports for individuals with significant challenging behaviors**

There are six individuals with significant challenging behaviors. Five of the individuals have moved to the community and one of the individual's community referral was rescinded due to his preference. This individual is aware of the different living options, but prefers to remain at the facility until he retires as he is currently a State employee. The IDT will continue to expose the individual and LAR to different providers in the Corpus Christi area. The individuals who transitioned to the community have a history of displaying physical aggression towards others or self. With the behavioral supports identified by the IDT during their Community Living Discharge Planning (CLDP) meeting, these individuals continue to reside in the community.

**Need for meaningful employment and supported employment**

Employment was identified as necessary support for two individuals. One of the individuals has transitioned to the community. For the other individual, working is important to him to support his preference of smoking. A potential provider company has been identified; however, they do not have a contract for employment services. The provider company is still searching for a contract. The Transitioned Specialist has been following up with the provider company in regards to finding employment.

**Lack of specialized mental health supports**

One individual was identified as needing specialized mental health supports due the use of psychoactive medication and the need for related weekly blood work. This individual has transitioned to the community.

**In fiscal year 2015, CCSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

- The APC will continue to present obstacle to transition data quarterly during the QA/QI council and develop corrective action plans as appropriate.

- The APC will continue to meet with the Local Authority to discuss the lack of medical supports and lack of supports for individuals with significant challenging behaviors. The Local Authority has offered their crisis services and hotline including the use of their psychiatric clinic for individuals needing this service once they transition to the community.

- The APC will continue to attend the community provider quarterly meeting to ensure provider awareness of the needs of the individuals served at CCSSLC. The APC department will continue to conduct training with IDT in an effort to help the IDT identify obstacles to transition.

# Denton State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Profile of Denton State Supported Living Center

The Denton State Supported Living Center (DSSLC) opened in 1960. The 189-acre campus was serving 460 people as of August 31, 2014 and employs approximately 1,670 people. The center primarily serves the 18 counties in its catchment area: Camp, Collin, Cooke, Dallas, Delta, Denton, Ellis, Fannin, Franklin, Grayson, Hopkins, Hunt, Kaufman, Lamar, Morris, Navarro, Rockwall, and Titus.

DSSLC is located in Denton County and is within 30 minutes of the Dallas-Fort Worth metroplex area. There are over 200 Home and Community Based Services (HCS) and Intermediate Care Facility (ICF) providers listed as having contracts in the 18 counties; however, many do not actually provide services in all the counties where they have contracts. DSSLC has collaborated with 13 service providers in assisting individuals to transition to the community.

DSSLC has shown significant progress in increasing the number of referrals and transitions to the community from 2008 through 2014. The number of referrals rose significantly in 2013, mostly due to the addition of the two transition specialists. The people who were referred in 2013 transitioned to the community during 2013 and 2014. There was a decrease in the number of new referrals in 2014 due to the continued effort to transition the people who were referred to the community in 2013 and also because in 2014 the people with the fewest number of barriers to referral had already been referred. Despite the lower number of new referrals, in 2014 the facility was able to transition 26 people to the community, which was an increase from the 20 that transitioned in 2013.

Most HCS providers in the 18 county catchment area have limited ability to provide services to individuals with more complex medical challenges. As DSSLC's population ages, medical needs become more apparent and medical concerns have become a more frequent obstacle to referral. Behavioral supports for people moving to the community appear to be improving with the increased availability of board certified behavioral analysts (BCBA) to the HCS providers, but these are not yet fully utilized.

**Community Referrals and Transitions from DSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| 2008 | 7 | 4 | 10 | 2 | 621 |
| 2009 | 16 | 2 | 16 | 0 | 582 |
| 2010 | 9 | 5 | 16 | 2 | 545 |
| 2011 | 15 | 1 | 8 | 0 | 519 |
| 2012 | 19 | 2 | 12 | 0 | 494 |
| 2013 | 39 | 7 | 20 | 0 | 484 |
| 2014 | 16 | 16 | 26 | 0 | 460 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from DSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral | 274 | 55.4% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 99 | 20% |
| Individual's reluctance for community referral* | 72 | 14.5% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 48 | 9.7% |
| Lack of funding | 2 | .4% |

Data Source: HHS CARE System

**Table 2. Individual's reluctance for referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 43 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 24 |
| Unsuccessful prior community placement(s) | 3 |
| Mistrust of providers | 1 |

**Table 3. LAR's reluctance for referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 156 |
| Lack of understanding of community living options | 55 |
| LAR is not interested in being provided information and exposure to community living options | 37 |
| Unsuccessful prior community placement(s) | 17 |
| Mistrust of providers | 14 |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

Legal Authorized Representative (LAR) reluctance for community living is the greatest obstacle to referral. There were 274 instances (55.4%) where the LAR was reluctant to consider community placement; this is an improvement from last year's 309 instances (69.4%). The decrease in the percentage of LAR reluctance is primarily related to the LARs and the IDTs agreeing that the health of the individual is the primary barrier to referral for community transition. Prior to March 2014, the specific reasons for LAR reluctance was not tracked but this has been remedied. During the last quarter of fiscal year 2014, the majority (60%) of LARs who were reluctant were provided information but were not interested in community transition.

Discussion with LARs has shown a genuine concern for the well-being and safety of the individual as a driving force behind not wanting information as well as their mistrust of providers, and a history of unsuccessful prior community placements. This may be through their experiences or through the experiences of others. By not viewing the LAR as the obstacle but as partners in the process, DSSLC works to understand the reasons for concerns through: Interviews, Integrated Support Plan (ISP) discussions surrounding the living options, and by anecdotal commentary on past experiences. These discussions show, in many instances, reasons for concern; however, these concerns are often based on experiences from many years ago. Transition Specialists and DSSLC Consumer and Family Relations (CFR) staff also frequently attend ISPs to assist in educating LARs when the living options discussions occur.

Education of LARs is also offered through the Community Living Options Information Process (CLOIP) that occurs before each annual ISP. CLOIP staff from the Local Authority (LA) contact the LARs and offer information about community living options. This process has occurred for LARs and families repeatedly on a yearly basis and there are times when this may not be effective as the LARs or families may decline receiving this information. LARs were also invited to both of the Provider Fairs; however, attendance at the fairs was not as successful with the LARs as hoped. The Provider Fair invitation process with the LARs will be revised for 2015.

### Medical needs requiring 24-hour nursing services/frequent physician monitoring

There are 99 individuals identified with an obstacle of having medical needs requiring 24-hour nursing services/frequent physician monitoring. This is an increase from last year's 33 individuals (7.4%) and is the second greatest obstacle to referral at DSSLC. The increase can be attributed to the aging population of DSSLC and the level of medical care required by the individuals moving into DSSLC; this change is an expected increase. The CFR department continues to work with nursing services, habilitation therapies, and Qualified Intellectual Disability Professional (QIDP) staff in identifying comparable services in the community. CFR staff has also continued to help HCS providers understand the need for these types of services. DSSLC Nursing Services staff has helped IDT members

to consider the timeframes for when nursing services may be needed. For example, IDT members have accepted being within 15 minutes of emergency medical services as being comparable for some individuals perceived to require 24-hour nursing services.

DSSLC is able to provide on-campus clinics for numerous types of specialty medical services such as neurology, podiatry, pulmonology, gynecology, and cardiology. These services are offered regularly due to the number of people who need these services. In community settings, some areas have limited access to specialists who are able to meet the needs of the individuals who have challenging behavioral or medical needs. Some individuals require sedation for medical procedures which is not always available in community settings.

**Individual's reluctance for community referral**

Individual reluctance is the third greatest obstacle to referral at DSSLC with 72 individuals (14.5%) being reluctant for referral; this is an improvement from last year's 85 individuals (19.1%). The lack of understanding of community living options has been identified for increased actions to help overcome this obstacle. This category is broad and includes people who lack understanding of community options as well as those who do not want to move to the community for a variety of reasons such as preferring to stay in their current residence.

During 2014 the facility has used the off-campus storefront Impressions, which is located on the Denton Square, as a training site. Through the Vocational Services Program, several individuals work at Impressions and create their merchandise on-site in the community. They have the opportunity to talk to customers about their artwork and have the opportunity for community exposure. In addition, many individuals are able to receive skill training such as learning appropriate greetings, appropriate social distance, pedestrian safety skills, and making new friends. There are approximately 200 individuals involved with this program.

DSSLC has begun a program called "Eat and Greet" in which one new community provider is invited to the facility each month to informally provide information at the facility's café. This program is showing success in increasing the individuals' awareness of community services from different provider perspectives; between 14 and 30 people have attended each month.

The result of these efforts is the IDTs have additional opportunities to work with the individuals to determine their preferences and increase their awareness of options. For FY 2014, the number of active referrals has declined; however, the number of individuals assisted to transition to the community per their or their LAR's preference has continued to increase. In fiscal year 2014, 26 individuals transitioned to the community, which was an increase of six from the previous year.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

The individuals identified as having behavioral needs that prevent them from being referred for community living are provided intervention from the Behavioral Health Services Department through Positive Behavior Support Plans (PBSPs) and, as appropriate, counseling services. Additionally, DSSLC provides psychiatric services for individuals who need psychiatric support. DSSLC has provided behavioral supports training for HCS providers at provider fairs and has included post move support for some individuals for whom DSSLC psychiatry and BCBA staff were available for ongoing supports for 90 days. This support is available to assist HCS providers to provide services to individuals who have more challenging behavioral/psychiatric needs. This process is also a support for the accepting BCBA in which the facility BCBA provides support and assistance as requested.

**Lack of funding**

The number of obstacles related to lack of funding has remained the same from last year to this year. There are two people who are noted to have lack of funding as the primary obstacle as they do not have United States citizenship. Efforts to secure funding will continue in fiscal year 2015 for these individuals through IDT training regarding obtaining legal status.

**In fiscal year 2015, DSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

- A new training curriculum is being developed for Qualified Intellectual Development Professionals (QIDPs) regarding living options. This new curriculum is scheduled to be completed at the end of January 2015. Small group training regarding the new curriculum is scheduled for completion in March 2015.

- Additional training is being developed for QIDPs regarding how to develop obstacles to referral and obstacles to transition.

- New positions for Skill Acquisition Plan (SAP) writers have been created and training will be completed with the SAP writers to ensure SAPs are practical and functional in community settings.

- Transition Specialists and CFR staff continued to attend ISPs to assist with living options discussions. This has led to an improvement in appropriate referrals and more comprehensive discussions about placement needs. This practice is now part of the Transition Specialists routine process.

- Programs Without Walls (PWoW) is a Life Skills program in which individuals are able to receive training in a variety of community settings. A trial program had been implemented to schedule tours of community homes to increase the individuals' awareness of their options and also so that accompanying staff members can document their reactions to the different settings in order to assist the IDT in determining their preferences. This program will be continued in FY 2015.

- A program auditor will continue to attend four ISPs per month and provide data on the living options discussions and documentation to identify IDTs that would benefit from

CFR and transition specialist attendance. Additionally, the data will be used to develop training for QIDPs.

- A provider fair will be held at least twice during fiscal year 2015 to provide opportunities for individuals, LARs, and staff to meet community providers and learn more about the options available to them. These fairs continue to have high participation, especially on weekdays. Approximately 25 providers attend each fair.

- The transition specialists work to increase the provider pool by meeting, interviewing and visiting homes, workshops, and day programs of a new provider each month.

- CFR staff will continue training regarding community living options during new employee orientation. These training sessions are increasing staff knowledge about the options available and lead to increased participation in living options discussions.

- CFR staff will continue to offer training to habilitation therapies and medical services staff regarding community living options. This has led to more individuals being referred for transition who have adaptive equipment/positioning needs.

- Articles regarding successful community transitions have been included in the Grapevine newsletter which has allowed staff members to talk to individuals about peers who have achieved their goals of moving to a more integrated setting.

- To assist more people to overcome their barriers to transition, more community providers need to be able to accommodate individuals who have more complex medical, behavioral/psychiatric, and adaptive equipment needs. As an example, when conducting tours, many homes are not able to be successfully visited because they do not have wheelchair accessible ramps or doorways.

- The CFR department will review obstacles to referral every month, with the aid of the new Social Worker positions, and will assist the IDTs with plans to overcome barriers to referral.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from DSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 28 |
| Need for environmental modifications to support the individual | 12 |
| Lack of supports for individuals with significant challenging behaviors | 6 |
| Lack of availability of specialized medical supports | 4 |
| Lack of availability of specialized therapy supports | 3 |
| Lack of specialized mental health supports | 3 |
| Limited residential opportunities | 2 |
| Need for transportation modifications to support the individual | 2 |
| Need for meaningful employment and supported employment | 1 |
| Other | 6 |

**Center Strategies and Actions to Overcome or Reduce Obstacles to Transition**

Obstacles to transition are addressed on an ongoing basis throughout the transition process by the CFR staff. They work with the providers individually to develop plans to overcome each individual's obstacles. Once referred, DSSLC's goal is consistent with the promoting independence initiative in working to assist the person to transition to the community within 180 days of the referral for community living. After 180 days, if the individual has not transitioned to the community, the IDT meets every 30 days to address any obstacles to the transition and develop plans to overcome the obstacle. These obstacles may change monthly as new needs may arise. Additionally, there may be several obstacles to transition for one individual and thus the number of obstacles noted above is significantly higher than the actual number of individuals who were assisted to transition to the community.

**Individual/LAR indecision**

Indecision is the greatest obstacle to transition at DSSLC. For the 28 individuals, LAR indecision is related to the LAR's or the individual's repulsion toward the homes, the location, or are not motivated to tour the homes and assist in making a provider selection. DSSLC has begun providing a home requirements checklist for the IDT to complete once the referral has been made. This has helped in provider selection due to the very specific nature of what the LAR is looking for. Resources are then geared to seeking providers who meet the needs identified in the home requirements checklist. This has allowed approximately five transitions to proceed. Once the provider has been selected, the CLDPs are completed in a timely manner and the move occurs.

**Need for environmental modifications to support the individual**

The need for environmental modifications has often been for individuals needing homes that can accommodate oversized wheelchairs or bathing systems. The transitions were delayed until these modifications could be made or another home located. In some cases, the modifications needed were beyond what was available and the referrals were closed. It has been noted that providers may be hesitant to make the modifications if they are expensive. HCS providers are more willing to make the modifications when they know the modifications are the sole reason the individual cannot transition. Of twelve individuals who have environmental modification as a barrier, 7 were able to transition to the community in 2014 while 2 of the individuals still have open referrals. The IDTs has not located a home that can meet their needs. However, there were 3 individuals whose referrals were rescinded.

**Lack of supports for individuals with significant challenging behaviors**

The BCBAs continue to provide supports to reduce incidences of inappropriate behavior. DSSLC has continued to invite HCS providers for in-services on an ongoing basis. Some HCS providers have accepted enhanced behavioral support training for individuals prior to trial visits to their homes. This has been successful for three of the six individuals with challenging behaviors. In two cases, the behavioral/psychiatric challenges were beyond

what was available and the referrals were closed. The sixth individual's referral is currently open at this time.

**Lack of availability of specialized medical supports**

The lack of specialized medical supports has been identified for four individuals. Of these, the IDT closed one referral, two have been able to move, and one person will move in in FY2015. In regards to the closed referral, the individual requires a customized wheelchair that needs frequent alterations to the personalized seating system. DSSLC is able to fabricate the seating system as needed to support his body morphology changes and his behavioral needs. The referral was closed due to the team's inability to locate similar resources in a community setting.

**Lack of availability of specialized therapy supports**

Three individuals had a lack of specialized therapy supports as an obstacle to transitioning to the community. One person's referral is still open at this time pending locating a home that can meet his bathing needs and is willing to modify the home and walkways to become wheelchair accessible. The two other referrals have been rescinded due to decline in medical health status and the need for modifications to the home to support their wheelchairs and mobility needs.

**Lack of specialized mental health supports**

The individuals delayed in transitioning to the community for lack of specialized mental health supports are followed by DSSLC psychiatry. The individuals' transition activities are resumed when the psychiatrist informs the IDT that medication changes have been effective and/or the person is now stable. Three individuals have since moved to the community.

**Limited residential opportunities**

Two individuals and their guardians have requested specific residential opportunities near their families. In these cases, the guardianships were provided by a guardianship services that was not able to provide services outside of their county. One individual was able to move to a nearby community which met the approval of the guardian and the family, while the other individual's referral was closed.

**Need for transportation modifications to support the individual**

Two individuals have noted an obstacle related to transportation. One individual's referral has been rescinded due to not being able to find a provider that could meet his needs to support his custom seating system; the other individual's team is working with a potential provider that is willing to make needed modifications and to purchase a van that can accommodate his wheelchair. A pre-placement visit is scheduled for December 2014.

**Need for meaningful employment and supported employment**

One individual had a delay in transition due to difficulty finding suitable employment. A provider was identified and he has since transitioned to a community home. He was not able to keep his previous job; he is now working in a sheltered workshop.

**Other:**

**Family chose to pursue guardianship to prevent transition (3)**

Three individuals' family members chose to pursue guardianship to prevent transition. Of these, two families have successfully obtained guardianship and the referrals have been closed. Both of these families were not supportive of the community transition. The third family is still in the process of obtaining guardianship and is not supportive of a community transition.

**Provider delay in opening home (1)**

One individual had a delay in moving due to the foster care home not being available while the family was in the process of moving. The issue was resolved and he was able to transition successfully.

**Provider closed home; search for new provider (1)**

One individual had a delay in moving due to the chosen home being closed. A new provider was chosen and was able to transition successfully.

**Dental work needed (1)**

One individual had a delay in moving due to the need of completing dental work prior to moving. The needed procedures were completed and he was able to transition successfully. The dental cap in HSC programs is $1,000 per year, the IDT agreed to delay the transition rather than to use the entire $1,000 budget in the first few weeks after transition.

Each of these obstacles was addressed as it arose. The delay in a provider opening or modifying a home to meet the individual's needs is a frequent obstacle. DSSLC works with the provider to see if alternative adaptations or another home is a possibility. The largest "other" category occurred when families decided to pursue guardianship. While DSSLC does not rescind the referral when this occurs, the process is allowed to go forward up to selection of a provider. Knowing the family is a long-term natural support, it is important to keep the family involved and provide the court sufficient time to process the guardianship request. DSSLC does meet with these families to discuss the referral. Unexpected dental or medical needs may delay an individual's transition. DSSLC prefers to ensure dental and medical care is fully addressed before the individual transitions to the community, as the health of an individual takes priority over meeting deadlines for a transition. DSSLC transition staff who's in close contact with medical and psychiatric

providers, modifies their efforts until the illness is sufficiently resolved to allow continued progress toward community transition.

**In fiscal year 2015, DSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

DSSLC is planning to continue previously successful initiatives and to implement new strategies to reduce obstacles.

- Obstacles to transitions are reviewed weekly with transition specialists, placement coordinators, and post move monitors. The team discusses the progress of overcoming identified obstacles including meeting with community providers, habilitation therapy, members of the individual's IDT, and involving LARs and family members to overcome obstacles.

- Every month the IDT meets to identify transition obstacles and develop an action plan to address the obstacles for individuals whose referral has exceeded 180 days. Obstacles to transition are cataloged and reviewed for trends or systemic issues.

- Obstacle date will be reported to QAQI so that the team can assist with ideas for overcoming obstacles.

- The CFR department will review obstacles to transition every month, with the aid of the new Social Worker positions, and will assist the IDTs with plans to overcome barriers to transition.

- The availably of community job coaching services needs to be increased.

The increase in the number of individuals who have transitioned to the community paired with the low rate of community transition returns is a significant indicator of the effectiveness and efficiency of the process to help individuals transition to the community. DSSLC has not had any returns from community since 2010.

# El Paso State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral & Transition Report

## A. Center Profile

The El Paso State Supported Living Center (EPSSLC) opened in 1974 and is located on 20 acres in El Paso's lower valley. The center serves El Paso County and as of August 31, 2014, was serving 110 individuals and had approximately 431 employees.

There are only a handful of Home and Community Based Services (HCS) and Intermediate Care Facility (ICF) providers available in the El Paso community that residents can access when referred for community living. Unfortunately, the El Paso community offers limited resources related to work experience opportunities whether it is work centers, supported employment, or competitive employment. This issue is discussed with our local authority and providers, but there have not been any actions taken to alleviate this issue.

The level of intellectual disability and adaptive functioning for persons served at this facility varies widely from mild to profound range of intellectual disabilities. The individuals' medical/physical disabilities also vary from the need for minor levels of service to a considerable amount of care. There has been a recent decline in opening referrals for transitions as many individuals in the facility have increased levels of behavioral and/ or physical health supports.

**Community Referrals and Transitions from EPSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 1 | 0 | 4 | 0 | 138 |
| **2009** | 4 | 1 | 3 | 0 | 142 |
| **2010** | 6 | 4 | 4 | 0 | 136 |
| **2011** | 9 | 2 | 3 | 0 | 131 |
| **2012** | 14 | 4 | 7 | 0 | 124 |
| **2013** | 10 | 7 | 10 | 1 | 116 |
| **2014** | 9 | 7 | 8 | 0 | 110 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from EPSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 60 | 63.2% |
| Lack of funding | 12 | 12.6% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 10 | 10.6% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 7 | 7.3% |
| Individual's reluctance for community referral* | 6 | 6.3% |

Data Source: HHS CARE System

**Table 2. Individual's reluctance for community referral, FY 2014**

| Reason for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 4 |

**Table 3. LAR's reluctance for community referral, 4th Quarter, FY 2014**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 25 |
| Lack of understanding of community living options | 19 |
| LAR is not interested in being provided information and exposure to community living options | 9 |
| Unsuccessful prior community placement(s) | 5 |
| Mistrust of providers | 3 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

The majority of obstacles for referral continue to revolve around Legal Authorized Representative (LAR) reluctance to place their family member/ward into the community. Reasons for their reluctance vary from fears of their loved one being unprotected in the community to negative experiences that have occurred in the past. Many LARs question the need to transition their loved ones to the community, especially when they are well cared for at the facility along with the concern that they may not receive these services in the community.

During the Individual Support Plan (ISP) meetings, reluctant LARs receives one-to-one education about the homes in the community. Transition specialist and post move

monitors have also spoke to these LARs about the transition process and have also taken them on tours of different homes which have resulted in referrals. However, there are others who had firmly indicated they do not wish to receive any information regarding transition through e-mail or during ISP discussions. Speaking to LARs has been the most productive strategy for EPSSLC.

**Lack of funding**

There are 12 individuals with citizenship/lack of funding issues. QIDPs have worked with the families and reimbursement staff on addressing these issues, but many families have very few resources to assist their family members or are not active in their lives. Discussions are held with the families to explore the processes of gaining citizenship/residency and find solutions for their family members, but there has been very little success. There are three other individuals that also lack funding. The teams continue to work with individuals and families to address this issue.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

At the center, there are ten individuals that require access to 24-hour nursing care whose needs are difficult to meet in the community. The AP Department continually works with our center IDTs to address those individual needs and attempt to find alternatives to help providers meet those needs in the community.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

EPSSLC currently serves seven individuals that have been identified as having behavioral/psychiatric needs which require frequent monitoring and intervention. These individuals are currently participating in behavior support plans and psychiatric monitoring to assist in addressing psychiatric concerns and to develop plans that can be supported in the community.

**Individual's reluctance for community referral**

Individual reluctance to referral is mostly centered on a lack of understanding of living options in the community and the transition process. The center offers a variety of individual educational opportunities such as provider fairs on campus, group tours to provider homes and day programs, presentations during self-advocacy meetings, and signs and posters. A video presentation titled, "Parade of Homes," was developed to show some of the provider homes in the community and a recent video was made of an interview with an individual who successfully transitioned to the community. There have been increasing educational opportunities with more innovative ideas as time goes on.

Of the 4 individuals that are reluctant, two have clearly voiced that they do not want to move to the community despite the team's encouragement to explore community providers on a regular basis. The third individual did not want to listen to the CLOIP worker and indicated that she wanted to be left alone. The team for the last individual felt that since she becomes aggressive /self-abusive in a new environment, this was indicative of a

personal choice. All 4 individuals can be classified under a lack of understanding of what is available out in the community as they have not fully appreciated the supports they can receive in the community.

**In fiscal year 2015, the El Paso SSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

Living options education continues to be one of EPSSLC's strengths. Opportunities to learn more about living options are provided to residents, LARs, and center staff in an effort to promote awareness of community services. It is believed that these educational opportunities help individuals and LARs understand barriers to referrals during living options discussions and help increase their understanding of the transition process. This education piece helps address the lack of understanding as noted in table #2 and #3 above. These educational opportunities include:

- Provider fairs are scheduled twice a year that bring community providers to the campus in order to provide information to individuals, LARs, and center staff on services they provide in the community. The provider fairs include videos, literature, pictures of community homes and day programs, and staff to answer any questions. Data in the form of a survey is collected, trended, and shared with the providers for any improvements that can be incorporated into the next provider fair. For the past fiscal year, EPSSLC had 62 individuals, 56 facility staff, and 5 family/LAR members in attendance. The Admission/Placement (AP) department continues to explore ways to change the provider fairs in order to improve participation by both IDT members and LARs. During the September 2013 fair, the AP department invited a former resident of the center and discussed her life in the community. This interview was videotaped and shown to other residents at the center. EPSSLC plans to invite another individual and his LAR/sister to discuss their satisfaction regarding community living in the September 2014 provider fair.

- The Local Authority (LA) Community Living Options Information Process (CLOIP) in-service is scheduled twice a year concurrently with the provider fair that provides information on living options to individuals, LARs, and center staff. LARs are mailed an invitation to the provider fair/living options in-service in both English and Spanish to accommodate those Spanish speaking families. Every member of the AP department is also fluent in both English and Spanish. Information shared during the in-service is provided in both languages to assist families with the process. Surveys are collected and trended for any improvements that can be incorporated into the next in-service.

- The center has begun to provide in-service training during town hall meetings that provide information on the transition process and answer any questions they may have regarding staff's role in the process. These meetings touch almost every center staff member as attendance is mandatory. Information shared includes policy and processes related to transition and how staff participation in center initiatives such as the provider fairs enhances living options discussions at the annual meetings.

- Community group tours are scheduled monthly to provide residents and LARs the opportunity to visit various community day programs and group homes to experience

what each provider has to offer. There were a total of 74 individuals and 54 facility staff that have participated in community provider group tours this fiscal year. Groups of residents are scheduled to participate and are accompanied by the AP Department staff and direct support professionals to see what the services look like and ask questions of the providers on what they have to offer. There have been 19 family members and LARs have visited homes and day programs in anticipation of choosing a provider for transition.

- During the Community Living Options Information Process (CLOIP), LA contacts and provides information to individuals, LARs, and families on availability of living options in the community. These contacts are completed by the LA approximately two weeks before the individual's annual planning meeting. The LA is also a participant in the annual Individual Support Plan (ISP) meetings as a resource on community providers and their services.

- Transition specialists serve as a resource to IDTs, including individuals and LARs, on services that are available in our local community. Innovative ideas for living options education have been created such as real estate style information leaflets of the provider homes and day programs, a DVD presentation of the provider homes titled, "Parade of Homes," showcasing all HCS homes in the community, signs or posters indicating who to call for more information regarding transitions, and a quarterly newsletter that is mailed out to the LARs and families that contains information on community providers and facility transition activities. The transition specialists also assist the referred individuals and their teams to help make each transition as smooth as possible.

Our strategy for the coming year is to:

- Continue to discuss the transition process with reluctant LARs, show them what is available, and explain how supports and services are developed and monitored in the community. These discussions will occur during annual ISPs and during one to one conversations. We will continue to respect those LARs that do not wish to receive any information on transition.

- Continue to educate LARs by inviting them to our facility provider fairs / Living Options activities on campus.

- Continue to mail out our quarterly facility newsletter with up to the minute news on community supports and transition activities.

- Continue to offer individuals group tours to the community providers so they can see for themselves what the homes look like. This will, in turn help spark some discussion with their families on what they saw and liked.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from EPSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Need for environmental modifications to support the individual | 10 |
| Limited residential opportunities | 7 |
| Individual/LAR indecision | 4 |
| Lack of supports for individuals with significant challenging behaviors | 4 |
| Lack of availability of specialized therapy supports | 3 |
| Lack of availability of specialized medical supports | 2 |
| Lack of availability of specialized mental health supports | 2 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

The following El Paso SSLC strategies and actions to overcome or reduce obstacles to transition are discussed in detail under each individual heading below:

### Need for environmental modifications to support the individual

Ten individuals required homes with environmental modifications such as front and back door ramps and showers that can accommodate roll in shower chairs. Because of these needed modifications, most of these led to limited residential opportunities in the community. This past year, providers have begun to either purchase or lease homes that have been environmentally modified to meet the needs of our residents. Recently, individuals have begun to transition with needed environmental supports to providers that have met the challenge of providing modified homes. Five individuals under this obstacle have transitioned to the community. Of the other five individuals, two individuals were rescinded due to a lack of therapeutic supports that included a two person transfer at all times (cost prohibitive in the community for providers), one individual was rescinded as her mother changed her mind and did not want the transition, the fourth individual was rescinded due to medical reasons, and the final individual was transferred to another facility to be closer to her family. We continue to work with families/LARs on transition education in an effort to help them understand supports that can be available in the community. We have also asked state office for some assistance in possible solutions to help bridge those barriers to transition such as the need for two person transfers and modified homes in the community.

### Limited residential opportunities

There have been limited residential opportunities in the community due to environments not being appropriate or programs reaching capacity with no vacancies. The Admissions/Placement department maintains in close contact with providers to assist in understanding the needs of the residents and help provide guidance on needed environment modifications, as well as encourage providers to increase capacity. Five individuals under this obstacle have transitioned to the community. Of the two individuals

that have not transitioned, in addition to his need for a modified home, he also requires a two person transfer at all times and as such poses a cost prohibitive support out in the community. The second individual also requires a modified home in the community to meet her needs. Her mother asked that the IDT rescind her referral as she did not feel comfortable with a transition into the community for her daughter. The facility continues to work with families/LARs on educating those regarding supports that can be provided in the community.

**Individual/LAR indecision**

There are four individuals listed under this obstacle. Two LARs were undecided on whether to proceed with the individuals' transitions until they were able to visit providers. Teams were able to move forward with the transition and now both individuals have transitioned to the community. One individual's referral was rescinded at the request of her mother/LAR as she was not comfortable with her daughter living in the community despite the fact that both her mother and family as well as the Admissions department visited a provider in the community and provided her with information and education on the supports her daughter would receive in the community. The last individual's referral was also rescinded, but she had transferred to another SSLC which is closer to her family. It is expected that she will transition to a provider in the area near her family.

**Lack of supports for individuals with significant challenging behaviors**

There were four individuals the IDTs identified as having challenging behaviors that posed a barrier to transition. The IDTs have worked with both Behavioral and Psychiatric Services to develop plans to address these behavioral challenges. Two of those individuals have transitioned to the community and the other two individuals' referrals have been rescinded. One individual developed medical issues during his referral and his ID (Interdisciplinary) Team is currently working on stabilizing him medically and will revisit his referral in the future. The second individual initially wanted to move to the community, but refused to attend an overnight visit with a provider twice. During the first visit, he walked away from the provider and, in the second visit he experienced a brief visit to a psychiatric hospital. He has since changed his mind several times regarding transition. His referral has been rescinded by the LAR and the ID Team will continue to work on stabilizing his behaviors and his understanding of community living prior to another referral.

**Lack of availability of specialized therapy supports**

It was identified that providers are very limited in staff at night. For example, two individuals were identified by the habilitation department that a two person transfer/lift at night is needed in order to complete safe transfers. Providers in the community are usually not able to have two staff in a home throughout the night as this practice is not cost effective. The referrals for these two individuals were rescinded. The third individual required an expensive piece of equipment for bathing. Upon review of his treatment plan regarding this need by the IDT, it was agreed that a regular shower gurney could be safely used in the community. This individual has since transitioned to the community.

**Lack of availability of specialized medical supports**

Two individuals have serious medical concerns and required extensive nursing/medical interventions to meet their needs. One individual experienced uncontrollable seizures and his general demeanor had changed that included medication refusals, meal refusals, lack of interest in daily activities. Additionally, his Psychiatrist indicated that something was wrong with his demeanor that may have included depression. His IDT and LAR discussed several medical issues as well as his referral and agreed to rescind his referral as they were not comfortable at this time in moving forward with the transition. The second individual developed an infection and a need for bio-hazard services that are not available in the community. The IDT decided to rescind her referral.

**Lack of availability of specialized mental health supports**

Two individuals have experienced a lack of specialized mental health supports in the community. One individual listed (also above under challenging behaviors) has experienced issues that would require extensive psychiatric services to meet his needs in the community and has not transitioned. His referral has since been rescinded by the LAR with ID Team agreement and will continue to work on stabilizing his behaviors and his understanding of community living prior to another referral. The second individual previously identified as needing specialized mental health supports has improved in his challenging behaviors to the point that he no longer needs psychiatric medications or a behavior plan. He has since transitioned to the community and is doing well.

**In fiscal year 2015, El Paso SSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

El Paso SSLC continues to work with the teams, families/LARs, and individuals on reducing the number of obstacles identified for transitions. Below are some of the strategies that have been employed individually per each barrier identified and the direction for the coming year to address them:

- **Need for environmental modifications to support the individual:** The facility has made much headway to reduce this barrier. In previous years, it was communicated to community providers the types of homes needed for transitioning individuals from the facility. In one communication, providers were sent pictures of the equipment the residents use and the modifications needed to accommodate the equipment, i.e., wheelchair ramps on front and back doors, roll in showers and wider doorways. As a result, providers have modified and/or purchased modified homes. The facility will continue to work closely with the community providers and share up to date information on the changing needs of the individuals. The facility will continue to act as a resource to providers on community environments and needed modifications.

- **Limited residential opportunities:** Unfortunately, appropriate vacancies are limited. There are only a handful of providers (seven) in the area. Some of the reasons opportunities are limited include providers reaching capacity, lack of appropriate vacancies according to gender, and lack of vacancies in homes that can accommodate adaptive aids or equipment. The facility will continue to maintain close contact with the community providers to express the individuals' needs regarding pending transitions.

- **Individual/LAR indecision:** One of the facility's strengths is providing education to the families/ LARs on what is available in the community as well as how their family member's supports can be met in the community. The Admissions/Placement department provides a wide variety of information sharing opportunities to families/ guardians via mailers, provider fairs, and information shared during annual ISP Living Options discussions, and one to one conversations. There were some successes in speaking with those undecided LARs that have since resulted in transitions. Our transition specialists, post-move monitor, and Admissions Placement Coordinator will continue to work with families / LARs to assist in their understanding of transitions in the community.

- **Lack of supports for individuals with significant challenging behaviors:** For this barrier to transition, the IDTs along with the AP department have diligently worked to better target and assist in minimizing these challenging behaviors. By connecting the providers' services and abilities with the teams to assist in identifying what types of behavior supports are needed in the community has helped shape plans to assist in finalizing those referrals and has led to successful transitions. For example, during an individual's provider visit, the psychology services staffs provided "in situ" guidance and modeling at a provider day program while he was there to assist provider staff to better handle his challenging behaviors. Since being placed, this transition has been a successful placement in the community. The Admissions department will continue to provide this type of support to all concerned in an effort to reduce this obstacle and facilitate transitions.

- **Lack of availability of specialized therapy supports:** Many times, recommending to an IDT that a review of alternative ways to address a need for the community might be in an individual's best interest in order to facilitate a transition that results in success. The success with one individual required a change in a special piece of bathing equipment that did result in a successful transition. The facility will continue to work with IDTs to recommend those types of reviews and changes in plans that can be met in the community.

- **Lack of availability of specialized medical supports:** As noted above in the lack of specialized therapy supports, the AP department continues to work with the teams in connecting individual's needs with the provider's ability to accommodate the medical services identified. The department will continue to serve as liaison with the community to match the individuals with the needed medical supports provided in the community and will continue to encourage teams to review alternate treatments that will meet the individual's needs that may in turn facilitate transitions.

- **Lack of availability of specialized mental health supports:** Many of the providers indicated that they were having a hard time meeting this need as psychiatrists were not able to provide services for them. Reasons for this ranged from psychiatrists retiring to loss of their family nurse practitioner/ physician assistant resulting in an inability to keep up with their caseload. There seemed to be an issue with reimbursement rates for Medicaid patients that were also identified. There are one or two providers that still do not have psychiatric services but are working to obtain them. One provider has secured a provider from the Austin area and has made progress with the provider flying

in periodically and using Telemed/ Skype technology to monitor individuals that require psychiatric services. The department has shared the contact information of this psychiatrist with other community providers in the hopes that they may be able to secure those services as well. The department will continue to work with providers and assist however possible by continuing to focus on alternate plans and encourage treatment plan improvements prior to transition.

# Lubbock State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

Lubbock State Supported Living Center (LBSSLC) opened on June 26, 1969, on 226 acres, and serves a catchment area of 54 counties in West Texas. As of August 31, 2014, LBSSLC was serving 203 individuals and employs approximately 810 staff members.

LBSSLC is located in Lubbock County which has the largest number of Home Community Based Services (HCS) and Intermediate Care Facility (ICF) providers in the 54-county catchment area. Of the 85 HCS providers listed for Lubbock County, 12 actively provide services in the area. In addition to the one independent sheltered workshop and three independent day habilitation programs in Lubbock County, nine of the 11 active providers have their own day habilitation or vocational program. In the outlying areas, the extreme northern counties are served by nine active providers, the counties just north of the Lubbock County area are served by the same 12 active providers as Lubbock County and the eastern counties are served by four active providers.

Since June 2005, 119 individuals have transitioned into the community. As evidenced below, 87 of those individuals have transitioned into the community since September 2007. The number of transitions has remained consistent over the past three years with a slight decrease noted in referrals. Of the ten individuals who transitioned to the community in Fiscal Year (FY) 2014, all ten remained within the catchment area of LBSSLC. The Transition Specialist continues to provide educational training to individuals, LARs, families, and staff regarding community services to ensure informed living options discussions.

**Community Referrals and Transitions from LBSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 12 | 8 | 19 | 1 | 266 |
| **2009** | 7 | 0 | 22 | 3 | 242 |
| **2010** | 3 | 2 | 11 | 1 | 230 |
| **2011** | 6 | 0 | 5 | 0 | 225 |
| **2012** | 8 | 4 | 10 | 0 | 214 |
| **2013** | 5 | 6 | 10 | 2 | 209 |
| **2014** | 4 | 5 | 10 | 1 | 203 |

Data Source: HHS CARE System

## Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from LBSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral | 126 | 58% |
| Health needs requiring 24-hour nursing services/frequent physician monitoring | 47 | 22% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/behavioral staff and/or enhanced levels of supervision maintained by direct service staff | 29 | 13% |
| Individual's reluctance for community referral | 14 | 7% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 5 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 4 |
| Unsuccessful prior community placement(s) | 3 |
| Mistrust of providers | 2 |

**Table 3. LAR reluctance for referral, FY 2014**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 83 |
| LAR is not interested in being provided information and exposure to community living options | 22 |
| Unsuccessful prior community placement(s) | 12 |
| Mistrust of providers | 6 |
| Lack of understanding of community living options | 4 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral (126)

Legal Authorized Representative (LAR) reluctance continues to be the greatest obstacle to transition, accounting for 58 percent of the identified obstacles to referral. The education of LARs generally begins with the Community Living Options Information Process (CLOIP) that occurs prior to each annual planning meeting. The contracted Local Authority (LA) representatives from StarCare Specialty Health System contact the LAR and offer information on community living options. LARs are encouraged to attend community exposure tours twice monthly, as well as the twice yearly provider fairs. Tour and provider fair data reveal few LARs participated in either of these events in fiscal year 2014. Many

of the LARs that are not interested in community placement are parents of individuals who have resided at the State Supported Living Center (SSLC) for many years. Despite all the educational efforts, these LARs frequently state LBSSLC is the only home their family members have known, their family members' needs are met here, and a change in residence would be too disruptive. The majority of these LARs have received education regarding community living options.

To address LAR reluctance, the center continues to offer individualized educational opportunities for LARs regarding supports and services offered in a community setting. The following steps have been taken:

- Interdisciplinary Teams (IDTs) have developed individual specific action plans addressing individualized educational needs at the Integrated Support Plan (ISP).

- The Admission Placement Coordinator (APC) and Qualified Intellectual Disability Professional (QIDP) coordinator work with LA representatives regarding improving the quality of the Community Living Information Process (CLOIP) with LARs.

- The APC provides educational materials through quarterly mail outs to LARs providing additional information on services available in the community.

- The Transition Specialist encourages LARs to participate in community exposure tours through information provided at the individual's ISP meetings, family association meetings, provider fairs, and individual requests.

- The Transition Specialist tracks the participation of LARs in community exposure tours, family association meetings, provider fairs, and individual requests for educational opportunities.

**Health needs requiring 24-hour nursing services/frequent physician monitoring (47)**

IDTs identified the lack of availability of health services as being the second greatest obstacle to referral, accounting for 22% of the identified obstacles to referral. The reasons cited are the fact that these individuals require access to 24-hour nursing support that is difficult to obtain in a community setting. These nursing supports are often only available in a nursing facility setting in the community, and those settings typically do not have programming and active engagement activities appropriate for individuals with intellectual disabilities. Staff from the Admission and Placement Office provides educational training to IDT members, LARs, and family members regarding the identification of nursing needs to determine whether the needs can or cannot be met in a community setting. Staff from the Admission and Placement Office work with providers to ensure they are aware of the needs of individuals served at the SSLC.

To address the limitation of availability of health services, the following steps have been taken:

- The APC and Transition Specialist provide training to IDT members regarding the identification of obstacles and the manner in which health supports are provided in the community.

- IDT members attend one provider fair and one community exposure tour annually to further educate themselves on the health supports and services available in the community.

- The Transition Specialist tracks the attendance of IDT members at community exposure tours, Family Association meetings, provider fairs and individual requests for educational opportunities.

- Medical practitioners participate in IDT educational opportunities related to most integrated settings.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/behavioral staff and/or enhanced levels of supervision maintained by direct service staff (29)**

IDTs identified lack of supports for individuals with behavioral health needs as being the third greatest obstacle to referral, accounting for 13% of the identified obstacles to referral. To address this obstacle, these individuals have their challenging behaviors addressed through positive behavior support plans and psychiatric services. Staffs from the Admission and Placement Office identify providers who may be capable of supporting individuals with behavioral challenges and share this information with the IDTs. IDTs work with these providers to educate them in developing the necessary supports for individuals to successfully transition to the community. Staff from the Admission and Placement Office work with community providers to ensure they are aware of the needs of individuals served at LBSSLC.

To address the lack of supports for individuals with behavioral health needs, the following steps have been taken:

- The APC and Transition Specialist provide training to IDT members regarding the identification of obstacles and the manner in which behavioral supports are provided in the community.

- IDT members attend one provider fair and one community exposure tour annually to further educate themselves on the behavioral supports and services available in the community.

- The Transition Specialist tracks the attendance of IDT members at community exposure tours, Family Association meetings, provider fairs and individual requests for educational opportunities.

**Individual's reluctance for community referral (14)**

Individual reluctance continues to be a significant identified obstacle to referral, accounting for 7% of the identified obstacles to referral. The center offers individualized educational opportunities regarding supports and services offered in a community setting.

To address individual reluctance, the following steps have been taken:

- The IDT has developed individual specific action plans addressing individualized educational needs at the ISP.
- Individuals visit with peers, whom they know, that have transitioned to the community by going to their group homes and/or, for example, meeting at public parks.
- The APC and QIDP coordinator work with LA representatives regarding improving the quality of the CLOIP with individuals.
- The Transition Specialist continues to encourage individuals to participate in community exposure tours through information provided at the individual's ISP meetings, provider fairs, diner discussions, and individual requests.
- The Transition Specialist continues to encourage and track the attendance of individuals in community exposure tours, family association meetings, provider fairs, and individual requests for educational opportunities.

**In fiscal year 2015, LBSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

Strategies for improvement in FY 2015 include the following:

- The center will continue efforts in developing individual specific action plans addressing individualized educational needs at the ISP. The Section F Monitoring Tool will be utilized to track the quality of the individualized action plans.
- The APC and QIDP Coordinator will work with LA representatives regarding improving the quality of the CLOIP with individuals and LARs.
- The APC and Transition Specialist will continue providing training to IDT members regarding the identification of obstacles and the manner in which health and behavioral supports are provided in the community. The IDT will review Positive Behavior Support Plans, as appropriate, to ensure the program has been adjusted to meet the changing needs of the individual who will be living in the community setting.
- IDT members will continue attending one provider fair and one community exposure tour annually to further educate themselves on the health and behavioral supports and services available in the community. The Transition Specialist will continue tracking the attendance of IDT members at community exposure tours, Family Association

meetings, provider fairs and individual requests for educational opportunities. Compared to last year, there has been a significant qualitative improvement. For example, medical and psychiatry attended this year. Although there is an increasing trend, IDT attendance remains below what is wanted. Additional emphasis on attendance by the Assistant Director of Programs (ADOP) is addressing this problem.

- The APC and Transition Specialist will continue working with community providers to ensure they are aware of the medical and behavioral needs of individuals served at LBSSLC, assisting them in the development of supports to meet those identified needs.

- Individuals will continue to visit with peers, whom they know, that have transitioned to the community by going to their group homes and/or public venues, for example, parks, as well as increasing their opportunities to participate in community activities to learn more about the community at large.

- At a statewide level, it would be helpful to have a listing of active providers who specialize in addressing the needs of individuals with challenging medical and behavioral issues. This information could then be shared with the IDT and LARs to address their reluctance in community transitions.

## B. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from the LBSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 1 |
| Other | 5 |

**Center Strategies and Actions to Overcome or Reduce Obstacles to Transition**

**Limited residential opportunities (1)**

This young lady was referred for transition to the Lubbock community, which had a shortage of vacancies in homes that serve females. Once a vacancy was created, she transitioned.

**Other:**

**Provider delay in opening home (2)**

One of these individuals and their LAR selected a local community provider. At the time of the selection, the provider did not have a vacancy. The LAR chose to wait for a vacancy rather than select an alternate provider. The second individual and his IDT selected a local community provider. Just prior to his transition, several key staff resigned from the provider. The home was available; however, the provider delayed the transition until replacement staff were hired and trained. Both of these individuals have successfully transitioned to the community.

**Guardianship proceedings (1)**

This individual's transition continues to be delayed due to guardianship proceedings.

**Family chose to pursue guardianship to prevent transition (1)**

The individual's family chose to pursue guardianship to prevent the community transition. The guardianship was received and the individual's referral for transition to the community was retracted.

**Dental work needed prior to transition (1)**

The individual required IV sedation for dental procedures. As the dental benefit under the community HCS program is $1000, the IDT and community provider agreed to delay community transition to allow the completion of the annual dental examination. The individual successfully transitioned to the community.

**In fiscal year 2015, LBSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

Success in addressing obstacles to transition is contingent upon communication between the community providers and SSLC and education with family members. It is apparent more work is needed to ensure family members understand the services available in the community. Communication with providers is critical to ensure they have the resources required to meet the challenging needs of the individuals residing at LBSSLC.

To address these issues, the data analyst will compile the obstacle to transition data quarterly to submit to the Assistant Director of Programs, QIDP Coordinator, Transition Specialist and APC for trending and analysis. The IDT will identify and address obstacles to transition as they occur during the transition process.

If an individual does not transition to the community within 180 days of their referral, the IDT will meet monthly to identify and address the obstacles to transition. The APC will also continue to monitor individuals who exceed the 180-day timeframe to ensure the obstacles to transition are addressed, thus allowing the individual to move to their selected community provider as soon as possible.

The QA/QI Council will provide oversight through review of trend analyses of referral, transition, and obstacle data, with corrective action plans assigned as applicable. Quality Assurance will monitor, per procedure, any corrective action plans implemented.

On a statewide level, it would be beneficial if efforts were made to increase the allotment for dental benefits for individuals who reside in the community. The one thousand dollar cap is inadequate when an individual requires sedation for dentistry.

# Lufkin State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The Lufkin State Supported Living Center (LfSSLC) opened in March 1962, and serves 28 counties in the heart of East Texas. As of August 31, 2014, LfSSLC was home to 322 individuals.

LfSSLC is the third-largest employer in Angelina County, with over 1,100 staff. Located in Lufkin, Burke Center serves as the local authority for the center and provides services for 12 of the 28 counties in LfSSLC's catchment area. Burke Center lists 189 Home and Community Based Services (HCS) providers for their area; however, only 12 HCS providers currently provide services locally. There are five Intermediate Care Facility (ICF) providers in Burke Center's service area which are providing services. There are ten HCS and two ICF vocational programs located in the Burke Center service area. Most providers in this service area operate a day habilitation program for the individuals they serve.

In addition to Burke Center, there are three additional Local Authorities within LfSSLC's service area including Community Healthcore, Anderson-Cherokee Community Enrichment Services (ACCESS), and Andrews Center. ACCESS provides services for two of the 28 counties in LfSSLC's catchment area. They have seven HCS providers who currently provide services locally. There are two ICF providers in their service area, and they also have vocational programs. Although none of the HCS providers in the area provide vocational services, they can contract with other vocational programs in the area(s). Andrews Center provides services for five of the 28 counties in LfSSLC's catchment area. Andrews Center has 25 HCS providers that currently provide services locally. They have three ICF providers who provide residential and vocational services. There are four HCS providers which provide day programming and two which provide vocational programming as well. Community Healthcore provides services for nine of the 28 counties in LfSSLC's catchment area. They have 25 HCS providers currently providing services locally. There are seven ICF providers providing day programming. One ICF provider also provides vocational training. There are 9 HCS day programs and one vocational program in Community Healthcore's service area.

LfSSLC increased the number of community referrals in fiscal year 2014. The active participation of the Admission and Placement Department in team meetings and the continued support of the transition specialists contributed to the increased community referrals and the stable number of transitions.

**Community Referrals and Transitions from LfSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 5 | 2 | 5 | 0 | 423 |
| **2009** | 15 | 4 | 8 | 0 | 415 |
| **2010** | 22 | 10 | 11 | 1 | 405 |
| **2011** | 14 | 8 | 20 | 2 | 377 |
| **2012** | 15 | 6 | 16 | 0 | 361 |
| **2013** | 9 | 11 | 22 | 0 | 342 |
| **2014** | 17 | 16 | 21 | 0 | 322 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from LfSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 138 | 47.8% |
| Individual's reluctance for community referral* | 76 | 26.3% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 45 | 15.6% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 28 | 9.7% |
| Court will not allow placement (Ch. 55/46B only) | 1 | 0.3% |
| Lack of funding | 1 | 0.3% |

Data Source: HHS CARE System

**Table 2. Individual's reluctance for referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 53 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 18 |
| Unsuccessful prior community placement(s) | 3 |
| Mistrust of providers | 2 |

**Table 3. LAR's reluctance for community referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 114 |
| LAR is not interested in being provided information and exposure to community living options | 10 |
| Unsuccessful prior community placement(s) | 9 |
| Mistrust of providers | 4 |
| Lack of understanding of community living options | 4 |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

Legal Authorized Representative (LAR) reluctance is the greatest obstacle to referral for community transition at LfSSLC. Over 50 percent of the individuals served have either a court appointed guardian or a natural guardian (for minors). LARs are offered educational opportunities regarding community options through the Community Living Options Information Process (CLOIP), provider fairs, and community tours; however, many LARs are resistant to the educational opportunities provided to them. The most commonly identified reason for this reluctance is that the LAR is not interested in community transition after being provided information and exposure to community living options. LARs frequently informs teams that they feel as if LfSSLC is the home for their loved one and do not want to make any changes to their environment. In an attempt to address the concerns of the LARs, LfSSLC will continue to invite all LARs and involved family members to participate in Provider Fairs, Local Authority In-Services and community tours in an attempt to encourage and educate them to consider community referral.

### Individual's reluctance for community referral

Individual reluctance is the second greatest obstacle to community referral. Lack of understanding of community living options has been identified as the main reason individuals at LfSSLC are not seeking community transition. The Admission and Placement Department and Burke Center's CLOIP workers increased the monthly educational tour opportunities to three times per month in an effort to provide these individuals more opportunities to learn about the options available to them in the community. Participation for monthly tours ranges about 5 to 10 individuals per month. The tours are now individualized so that individuals can visit a group home that could accommodate their needs, along with visiting either a day habilitation program or vocational program. Individuals at specific homes at LfSSLC have also been identified to receive additional educational opportunities from the CLOIP workers. These individuals have more medical and physical limitations and are less likely to be able to participate in tours.

The transition specialists also work with the human rights officer to participate in self-advocacy meetings and provide information on community options. There has been an average of 18 individuals attending the self-advocacy meetings in the last year.

LfSSLC continues to provide other educational opportunities on campus as well. The provider fair provides an opportunity for those reluctant to participate in tours to meet with community providers in a location that is familiar to them. LfSSLC plans to increase the number of provider fairs to two per year. Our last provider fair was on 11/6/14 and we had 35% of our facility in attendance. Staff from the Admission and Placement Department will continue to attend annual Individual Support Plan (ISP) meetings and ISP prep meetings for those individuals identified as potentially being successful in transitioning to the community. During these meetings, Admission and Placement staff will be providing the individuals and their teams with information regarding community options and transition in an effort to address their reluctance for referral. They will also assist individuals and teams with the transition process if a referral is made.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

LfSSLC serves many individuals whose medical needs include access to 24-hour nursing or frequent physician monitoring. The majority of these individuals reside in the same unit. This unit has been identified as an area to provide additional educational programming at the home to develop a better understanding of the services available in the community. Team members are invited to participate along with the individuals in these sessions.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

LfSSLC has a small percentage of individuals with behavioral, psychiatric, or supervision needs which prevent them from being referred for community transition. They will continue to be provided with the behavioral health services, psychiatric services, and enhanced supervision levels they require. As these individuals stabilize, their teams will continue to evaluate their progress and determine if they are ready to move to a less restrictive setting. The Admission and Placement (AP) Department is currently scheduling the annual local authority in-service, at which time we will also provide efforts to education teams about behavioral health and psychiatric services available in the community.

**Court will not allow transition (Ch. 55/46B only)**

LfSSLC had two individuals with 46B commitments; however, one individual was placed in the community after being determined as a low risk alleged offender. The other individual continues to reside at LfSSLC but has met all the requirements for time served and the County Judge dismissed the 46B commitment. This action occurred after his annual individual support plan meeting where the obstacle to referral was identified. Since the 46B commitment was dismissed, the team met with this individual regarding his living options. He stated he did not want to move to the community; therefore, his Local Authority began the process of obtaining Persons with Mental Retardation Act (PMRA) commitment in order for him to remain at Lufkin SSLC. Action plans were developed to encourage this individual to consider his placement options including continuing to participate in the Community Living Options Information Process and by scheduling visits with his friends that have transitioned to the community.

**Lack of funding**

As noted in the data, there is one individual who is currently not eligible for Medicaid funding due to her citizenship status. Efforts were made with the individual's family to try and gain citizenship prior to the individual turning 18 years of age. As the family was unable to resolve the citizenship issue prior to her 18th birthday, the team developed a living goal for citizenship to be obtained in order for her qualify for funding in the community. The interdisciplinary team developed an action plan to locate and complete the necessary paperwork to file for or obtain citizenship. Although citizenship has not been obtained, efforts were made to assist her in obtaining a work visa and she is currently employed in a part-time job off campus. The center will continue efforts to seek funding for this individual by monitoring the status of her citizenship application.

**In fiscal year 2015, LFSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

- Continue to provide the increased number of educational tours opportunities and to discuss the person's response to the tour in order to determine if they are interested in community referral.

- Continue to provide community education at the home to those identified as unable or less likely to be able to participate in community tours due to their medical or physical limitations. Team members will be invited to participate to ensure they are aware of the medical services available in the community.

- Admission and Placement Department staff will continue to attend ISP and ISP prep meetings for individuals identified as possible candidates for transition.

- Provider fairs will be increased to twice annually.

- Transition specialists will continue to provide community options information during self-advocacy meetings.

- LARs and Family Members will be invited to participate in Individuals' ISP's, Provider Fairs, Local Authority In-Services and Community Tours in an effort to encourage consideration of community referral.

## Obstacles to Community Transition

**Table 4. Obstacles to transition identified from LfSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Lack of supports for individuals with significant challenging behaviors | 3 |
| Need for environmental modifications to support the individual | 3 |
| Limited residential opportunities | 2 |
| Medicaid/SSI funding | 1 |
| Other | 6 |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Lack of supports for individuals with significant challenging behaviors

Three individuals referred for placement had an identified obstacle to transition related to their challenging behaviors. Two of the three individuals participated in pre-placement visits that were not successful due to behavioral issues during their visits. Their referrals for transition were rescinded, as their teams determined that it would be in the individual's best interest to continue addressing their behavioral needs at LfSSLC. The teams will continue to consider the possibility of community referral in the future. The remaining person with this identified obstacle did transition to the community. LfSSLC will continue to seek providers with experience in working with individuals with challenging behaviors. Transition plans will be developed for those individuals who need additional assistance in adjusting to new environments.

### Need for environmental modifications to support the individual

Three individuals were delayed in moving to the community due to the difficulty of locating an HCS provider with the needed home modifications, such as, wheelchair accessibility throughout the entire home to accommodate modified wheelchairs and adaptive bathing equipment in a community close to their family. Search areas were expanded and efforts to locate providers willing to provide the modifications necessary for each person were increased by the transition specialists. All three teams visited numerous providers prior to locating one with the appropriate floor plans to the home and bathroom modifications necessary to support the individual's needs. At this time, these three individuals are still looking at providers to meet their specific requirements.

### Limited residential opportunities

There were two individuals the team and the transition specialist struggled to locate an appropriate provider within the preferred search area. Both individuals with this obstacle had either an LAR or family member who wanted placement in an area with very limited residential opportunities. At this time, each individual is waiting for a provider to either develop a new home or have a vacancy before transitioning to the community. The teams did not want to expand the search area in order to maintain family contact. Both individuals exceeded their 180-day timeframe before a home was located for them in the location sought. Currently, one individual has transitioned while the other is still in process of visiting providers.

### Medicaid/SSI funding

The individual identified as having issues with funding was related to exceeding the medical benefits allowed for her lifetime supply of portable oxygen. These issues were resolved by working with the provider and a local durable medical supply company. However, this individual's referral was rescinded due to her major medical issues and frequent hospitalizations. The individual did not feel safe moving at this time due to her increase in health issues, which was supported by her team members and family members.

**Other:**

**Family chose to pursue guardianship to prevent transition (2)**

Two individuals referred for community placement exceeded their 180 day timeframe as family members decided to pursue guardianship. The guardianships were obtained and the LARs have requested for the team to meet again in both cases to discuss placement. In both meetings, the newly appointed LARs requested the referrals for placement be rescinded as they were opposed to community placement.

**Illness during transition period (4)**

Illnesses during transition occurred for four individuals as their teams determined they could not participate in referral activities until their medical issues were resolved. Of the four individuals who were ill during the transition process: two were rescinded upon their request (individual, team members & family input), one has transitioned, and the last is still seeking a provider.

**In fiscal year 2015, LFSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

- In the past year, it was recognized that there is an increased need for providers to have homes with modified wheelchair accessibility. This is above the "standard" of wheelchair accessibility. Local Authorities and providers have been provided this information for the increased need by our transition specialists. Also the Administration has also made local Legislators aware of the need along with the need for increased need for homes that serve individuals with complicated medical needs. IDT's will be apprised of providers that can meet this expectation for individuals. There has been minor success in these efforts, but the Transition Specialists, along with the other members of the Admissions/Placement Department, will continue to inform community providers of the need for modified wheelchair accessibility in their homes and program areas.

- Past actions to overcome this obstacle have been heard, more providers have opened homes that can serve individuals with behavioral challenges. LfSSLC will continue to seek providers with experience in working with individuals with challenging behaviors. Transition plans will be developed for those individuals who need additional assistance in adjusting to new environments.

- LFSSLC has many family members that would like for their loved one to be closer to their home; however, many of them reside in small, rural areas where there is limited access to provider homes. LFSSLC will continue to state this obstacle to the Local Authorities and providers in an effort to meet our families' desire and reduce the IDT's reluctance to refer.

- LFSSLC will educate the IDT's relating to the individuals' medical needs. This is not to say they do not need to be referred, but rather, ensure that their acute medical needs are addressed prior to referral.

- LFSSLC will continue to work with local providers, local authorities, day habilitation and vocation programs to assist in reducing or eliminating obstacles to transition.

**Summary**

The Admission and Placement Department monitors all referrals and works with teams to assist them in supporting individuals to transition within the 180-day timeframe. We will become more proactive in this process: By reviewing each individual at 90 days to determine the status of their referral, make any modifications necessary to their plan for transition and to provide additional support or information to the individual/team in an effort to deter or eliminate obstacles before reaching the 180 day time frame. If an individual does not transition to the community within 180 days of their referral date, we will continue to have the IDT meet monthly to identify the obstacles to transition and develop action plans to address any obstacles. LFSSLC had fewer individuals that experienced obstacles in FY 2014 than FY 2013. LFSSLC plans to maintain this progress with our continued efforts to support our individuals in transition, our families on decisions, providers with knowledge of current needs and the IDT's with their continued experience and knowledge.

# Mexia State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The Mexia State Supported Living Center (MSSLC) was opened March 1946. The facility is located on 220 acres in Limestone County and employs approximately 1,610 people. MSSLC is serving 288 individuals as of August 31, 2014, and is in the catchment area of Bell, Coryell, Falls, Freestone, Hamilton, Lampasas, Milam, Bosque, Hill, Limestone, McLennan, and Tarrant counties. MSSLC also serves all of Texas as the forensic facility for male individuals.

Limestone County is served by two active community providers. One has both Home and Community Based Services (HCS) and Intermediate Care Facility (ICF) group homes along with host/companion care services (previously called foster care). Another provider is the Local Authority which also provides HCS group home services in the county. One of the two active providers in Limestone County offers only host/companion care services. There is one provider which provides both day-habilitation services and sheltered employment for the area. There are multiple HCS providers in each of the other counties in the MSSLC catchment area. McLennan, Bell and Tarrant Counties are served by the largest number of providers. McLennan is being served by 17 active HCS community providers, while Bell is being served by 13 active HCS community providers and Tarrant by 92 active HCS community providers. Tarrant, Hill, and Coryell also have ICF/IID providers. Tarrant County also has several providers that provide day habilitation services.

The number of referrals and transitions has remained fairly consistent over the last three years. Of the 68 persons who transitioned from the center in fiscal year 2014, 15 stayed within the catchment area.

**Community Referrals and Transitions from MSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2014** | 45 | 29 | 68 | 1 | 288 |
| **2008** | 38 | 5 | 32 | 3 | 517 |
| **2009** | 105 | 8 | 67 | 4 | 477 |
| **2010** | 89 | 15 | 100 | 1 | 417 |
| **2011** | 45 | 44 | 51 | 1 | 390 |
| **2012** | 47 | 8 | 41 | 2 | 372 |
| **2013** | 55 | 21 | 52 | 2 | 331 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from MSSLC, FY 2014**

| Reason not Referred | Total‡ | Percentage of Individuals Not Referred |
|---|---|---|
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 114 | 49.1% |
| LAR's reluctance for community referral* | 35 | 15.1% |
| Evaluation period (Ch. 55/46B only) | 33 | 14.2% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 27 | 11.7% |
| Court will not allow placement (Ch. 55/46B only) | 10 | 4.3% |
| Individual's reluctance for community referral* | 9 | 3.9% |
| Lack of funding | 4 | 1.7% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for community referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 7 |
| Lack of understanding of community living options | 1 |
| Unsuccessful prior community placement(s) | 1 |

**Table 3. LAR reluctance for community referral, 4th Quarter, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 18 |
| LAR is not interested in being provided information and exposure to community living options | 16 |
| Unsuccessful prior community placement(s) | 1 |

**Center Strategies and Actions to Overcome or Reduce Obstacles to Referral**

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatrist/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

Behavioral health and psychiatric needs continue to be the greatest obstacle for community transition at MSSLC. This is attributed to the center serving a large population of individuals with forensic commitments. Persons are admitted with a diagnosis of intellectual disability and have had encounters with law enforcement for issues such as assault, sexual assault, drug possession, weapons possession, arson, burglary or murder.

These individuals often require services to address psychiatric stability as well as specialized psychological counseling as part of their support plans. The center currently provides both individualized counseling and specialized group therapies including groups for substance abuse, post-traumatic stress disorder, specialized treatment of paraphilia, and anger/personal management. The teams review the individual's behavioral data and response to counseling and behavioral programs to assess if the individual requires more time for intervention through behavioral health services before being referred for transition.

Also, the center has a high risk determination process in place to identify individuals that are at a high risk for harming themselves or others. This process requires that the individual's team review the individual's history and current behavioral data to make such a determination. This process gives the team another opportunity to assess the individual's needed supports and determine if the individual can be served in a community setting. All of these strategies appear to be effective at MSSLC and will continue in FY 2015.

**LAR's reluctance for community referral**

Legal Authorized Representative (LAR) reluctance continues to be the second greatest obstacle to referral for community transition at MSSLC and the most difficult one to overcome. Many LARs are parents or siblings of individuals who have resided at MSSLC for extended periods of time. These LARs frequently state that MSSLC is the only home their loved ones have known, and they do not want to disrupt their lives after so many years of residing at MSSLC. LARs also frequently state that they do not believe community providers can care for their loved ones as well as MSSLC. Education of LARs is most often addressed through the CLOIP process that occurs before each annual ISP. LARs are contacted by CLOIP staff and offered information on community living options. This process is not always effective as some LARs decline to receive information from the CLOIP workers. LARs and other family members are encouraged to attend the educational community tours provided through the Local Authority that occur once a month, but a review of tour attendees reveals that no LARs or family members have attended these tours during FY 2014. Admission and Placement staff will continue to send letters to all LARs and primary correspondents informing them of the opportunity to receive information from local community providers. CLOIP and QIDP's will assist the IDT, individual, LAR regarding scheduling of tours upon request. The QIDP will make a follow contact with the LARs and primary correspondents regarding any scheduled tours. Although the majority of LARs state that they have received information about community living options and are not interested in learning more, the real reason for LAR reluctance appears to be a mistrust of community providers due to the belief that they cannot provide the same level of supports as MSSLC. In the FY 2015, to reduce mistrust in community providers, the QIDP's with assistance from CLOIP will continue educating LARs and primary correspondents on the success rate of community referrals. The QIDP and CLOIP will continue to offer and provide information regarding community providers to the LAR/family during Annual meetings. The IDT/CLOIP will also continue scheduling tours of provider homes for the LAR/family. The LAR/family will be encouraged to participate in provider fairs. If the LAR/family cannot attend the provider fair at the facility; the QIDP will coordinate with the Local Authority for the LAR/family to participate in a provider fair in their county.

The center is utilizing three transition specialists to address the need for community transition education. The Transition Specialist have been attending ISP meetings providing much needed education to LARs, teams, families, and individuals regarding the types of services available in the community. This includes planning provider fairs and attending living options meetings, self-advocacy meetings, and parent meetings.

This approach appears to be more successful in providing education on community living options to LARs that might otherwise turn down offers from the Local Authority for information on community living options.

Overall, it appears that LARs have become more knowledgeable about the community referral and transition process. These strategies appear to be a positive step in providing information to LARs and other family members and will continue in FY 2015.

**Evaluation period (Ch. 55/46B only)**

Individuals admitted under a court-ordered 90-day or 120-day restoration commitment are not eligible for referral for transition during the evaluation period.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

The center provides services for individuals whose medical needs are such that they require 24-hour nursing services which often only are available in a nursing facility or other medically-oriented setting in the community at this time. We will continue to monitor to ensure those individuals identified as needing 24-hour nursing services actually have nursing needs that require this level of nursing care in a community setting.

**Court will not allow placement (Ch. 55/46B only)**

On occasion, the court does not allow an individual from the center to transition the community. The Admission & Placement Department has recently begun to notify the courts of an individual's potential referral for community transition. It is hopeful that this would allow the courts to ask questions or request updated testing (with court order). This restriction would be listed in the court documents received from the committing court. The IDT is trained on the review of court-ordered restrictions.

**Individual's reluctance for community referral**

Individual reluctance for community referral has slightly decreased and continues to be one of the least obstacles to referral at MSSLC. This obstacle is due to the lack of understanding of available community options. Although the Local Authority's monthly educational community tours has decreased over the past year due to staffing issues, they continue to offer these individuals an opportunity to learn more about the options available to them in the community. The Transition Specialists are in the process of setting up individual tours for some individuals who the team feels would be served well in a less restrictive setting. Also, the IDTs are in the process of making arrangements for individuals to visit peers who have successfully transitioned to the community in their new homes. As more individuals continue to transition to the community, this will allow more of the residents at MSSLC to make visits to homes of people they know in the community.

Provider Fairs held on campus provide an additional opportunity for MSSLC residents to meet different community providers and learn more about the options available to them. The Transition Specialists continue to attend the monthly Self-Advocates meetings on campus to be available to talk to attendees and give them more information on community living options. All of these strategies appear to be effective in reaching out to the residents of MSSLC and will continue in FY 2015.

**Lack of funding**

There are four individuals who are identified under this obstacle. Efforts to secure funding for one individual, who is not a citizen of the United States and not eligible for Medicaid funding in the community, will continue in FY 2015. The individual's family has not been cooperative with the facility's efforts to gain funding. There are also two other individuals with citizenship/funding issues, QIDPs continue to contact the Local Authority for assistance in the efforts of seeking funding and addressing citizenship issues with local resources for the individuals and their families. The fourth individual with this obstacle has been on unauthorized departure since 2003.

**In fiscal year 2015, MSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

Individuals who are not referred during the Annual ISP meeting will continue to be monitored by IDT. The IDT will identify the obstacle to referral and implement an action plan to address the barrier. The QIDP or IDT will review the action plan monthly for efficacy and progress and address identified issues with addendums as needed until the individual has successfully overcome the barrier and a referral for placement can be made.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from MSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 34 |
| Need for services and supports for individuals with forensic needs/backgrounds | 9 |
| Limited residential opportunities | 7 |
| Need for environmental modifications to support the individual | 4 |
| Lack of availability of specialized medical supports | 4 |
| Medicaid/SSI funding | 3 |
| Lack of supports for individuals with significant challenging behaviors | 3 |
| Lack of availability of specialized therapy supports | 1 |
| Lack of availability of specialized mental health supports | 1 |
| Other | 18 |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Individual/LAR indecision

Of the 34 individuals whose obstacle was individual/LAR indecision, 22 have transitioned to the community and five individuals are still in the transition process. Of these five 1 still researching possible providers, 2 are waiting for CLDP to be scheduled, I waiting for court approval and 1 waiting for the PSV to be scheduled. The referral for the other seven individuals was closed by the individual, LAR, or IDT. Indecision is frequently caused by the individual's or LAR's stated preferences as to the location of the homes, the homes' proximity to family, or they expressed displeasure with potential providers. Often, multiple pre-selection visits are held in order for the individual or LAR to find the provider they are most comfortable with. The IDT continues to encourage individuals and LARs to state their preferences early in the process to achieve successful transitions.

### Need for services and supports for individuals with forensic needs/backgrounds

Of the nine individuals whose obstacle was due to lack of supports for forensic needs/backgrounds, five have transitioned to the community and two are still in the transition process. The referral for the other two individuals was closed by the individual, LAR, or IDT. It appears more training is needed to better assist the QIDPs in identifying forensic needs, issues, and necessary supports to transition to the community.

### Limited residential opportunities

Seven individuals move to the community were delayed due to limited residential opportunities in the areas they wanted to live. Of these seven individuals, three have transitioned to the community and three are still in the transition process. The referral for the other individual was closed by the IDT. In such cases, the teams are encouraged by transition staff to assist the individuals in exploring providers in other geographic locations.

### Need for environmental modifications to support the individual

Of the four individuals whose obstacle was the need for environmental modifications, two have transitioned to the community, and one is still in the transition process. The one still in process, needed environmental modifications were needed in the bathroom to make it ADA accessible and the removal of carpet to allow for independent mobility about the home. The referral for the other individual was closed by the IDT. The IDTs continue to identify and confer with providers on the availability of homes with the necessary environmental modifications.

### Lack of availability of specialized medical supports

Of the four individuals whose obstacle to transition was the need for specialized medical supports (G-Tube feedings, nursing services in homes, tracheotomy care, etc.), one has transitioned to the community. Of the remaining three, one individual is 81 years old and at high risk for aspiration and osteoporosis. The IDT closed the referral as they did not feel

her quality of life would improve significantly in a community setting and had concerns about her medical needs being met. The other two individuals are still in the transition process; one is waiting for the PSV to be scheduled and one continues for provider to make modifications to home that will assist with discussion regarding medical supports.

The teams will continue to seek providers with experience in providing care for persons with more intensive medical needs. The QIDP's and other team members are utilizing the Transition Specialist more to help with seeking possible providers who may be able to meet the individual's needs.

**Medicaid/SSI funding**

Of the three individual whose identified obstacles to transition is lack of funding, Medicaid/SSI, one individual has transitioned to the community while two are still in the transition process. Training will be given to assist QIDP's, the individual, and the individual's family on the process of obtaining appropriate funding and citizenship for the individual.

**Lack of supports for individuals with significant challenging behaviors**

Of the three individuals with this obstacle, two have transitioned to the community. These two individuals exhibited high need for one to one staff due to PICA behavior. The team members requested assistance from the Transition Specialist with locating provider who had provided services to person with PICA behaviors. The IDT teams also researched the possibility of obtaining a LON 9 (one to one staff and was awarded this level of need on one individual that assisted the provider with providing services). The other individual passed away as work was being done to assist his transition to the community.

**Lack of availability of specialized therapy supports**

The one individual with this identified obstacle, transition was closed as the team and his mother were not able to identify a potential provider of services in the area chosen. The individual has severe PICA issues and providers in selected area did not have the experience in this area of need. The individual was recently accepted for transfer to another State Supported Living Center and is waiting for date for transfer.

**Lack of availability of specialized mental health supports**

The one individual with this identified obstacle, his transition was closed by the IDT as he had an unsuccessful pre-selection visit with the provider. The teams will continue to seek providers with experience in providing care for persons with more specialized mental health supports. The QIDP's and other team members are utilizing the Transition Specialist more to help with seeking possible providers who may be able to meet the individual's needs**.**

**Other:**

**Provider closed home; search for new provider (6)**

Of the six individuals whose identified obstacle was closing of homes and searching for new providers, five have transitioned to the community. The sixth individual transition was closed by the IDT due to increase in exhibited inappropriate behavior during the transition process.

**Provider delay in opening home (5)**

There were five individuals identified in which the providers delayed the opening of the home. This was due to the need for obtaining approval for a four bed home. Four have transitioned to the community while one continues to be in the transition process. This individual has been on a pre-selection visit and is waiting to complete the CLDP process.

**LAR reluctance to choose a provider (2)**

Of the two individuals whose obstacles is the LAR reluctance to choose providers, one has transitioned to the community and one continues to be in the transition process. The teams continue to work with the LAR with the process of choosing a provider by sharing of information they have obtained and encouraging them to visit with potential providers.

**Illness during transition period (2)**

For the two individuals whose identified obstacle was illness during the transition period, their referrals were closed by the IDT as it was determined that they were not medically stable to transition to the community.

**Incarceration (1)**

For the one individual with this identified obstacle, his transition was closed by the IDT as he is currently incarcerated in another state. While visiting his family, this individual left with his friends and ended up in another state with burglary charges.

**Criminal Court issues (1)**

The one individual with this identified obstacle continues to be in the transition process. This individual is waiting for the courts to review updated competency evaluation before transitioning to the community. There continues to be a need for training regarding court issues.

**In fiscal year 2015, MSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

Individuals whose transitions exceed the 180 day time frame will continue to be monitored by Admission Placement and QIDP departments. IDT's will continue to meet monthly to identify any obstacles to transition and implement an action plan to remove the obstacle. IDT will request assistance from the Transition Specialist when needed to assist with locating providers as needed.

The Placement Coordinators will work with the IDT members in identifying obstacles to transition prior to their 180 days and develop an action plan to address the obstacles.

The Admission Placement department will work closely with the IDT members to determine obstacles to transition and assist with developing action plans to overcome the obstacle.

# Richmond State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The Richmond State Supported Living Center (RSSLC) opened in 1968. The center sits on 241 acres and was home to 335 individuals as of August 31, 2014. RSSLC employs approximately 1,375 people and serves 13 surrounding counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Hardin, Harris, Jefferson, Matagorda, Orange, Waller, and Wharton.

RSSLC is located in Fort Bend County. Fort Bend, Harris, and surrounding counties are served by 350-plus HCS and 150 ICF providers. The 200 HCS providers and all 150 ICF providers actively serve individuals in their programs. In addition to HCS and ICF services, some providers have their own day programs and vocational services.

The center has had success in helping individuals move into the community as evidenced by the data below. Over time, increased awareness of those seeking services and improved knowledge and ability of the providers to serve individuals has resulted in the continuation of transitions to the community. The Transition Specialists, placement coordinator, and the Transition Qualified Intellectual Disability Professional (QIDP) continue to participate in the community living options discussions and the community living discharge plan (CLDP) process for individuals, LARs, family members, and staff.

**Community Referrals and Transitions from RSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 11 | 2 | 38 | 0 | 491 |
| **2009** | 36 | 2 | 29 | 0 | 462 |
| **2010** | 13 | 4 | 52 | 0 | 407 |
| **2011** | 28 | 6 | 24 | 0 | 378 |
| **2012** | 25 | 1 | 30 | 1 | 352 |
| **2013** | 13 | 6 | 22 | 0 | 339 |
| **2014** | 17 | 3 | 18 | 1 | 335 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from RSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community placement* | 182 | 61.5% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 53 | 17.9% |
| Individual's reluctance for community placement* | 45 | 15.2% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 12 | 4.0% |
| Lack of funding | 4 | 1.4% |

Data Source: HHS CARE System

**Table 2. Individual's reluctance for referral, RSSLC, FY 2014**

| Reason for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 40 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 5 |

**Table 3. LAR's reluctance for referral, RSSLC, FY 2014**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 64 |
| LAR is not interested in being provided information and exposure to community living options | 52 |
| Lack of understanding of community living options | 40 |
| Mistrust of providers | 20 |
| Unsuccessful prior community placement(s) | 14 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

Legal Authorized Representative (LAR) reluctance continues to be the greatest obstacle to referral for community transition at RSSLC and the most difficult to overcome. Education of LARs about various community living options begins with the Community Living Options Information Process (CLOIP), which occurs before each individual's annual ISP meeting. LARs are contacted by staff at the Texana Center, the Legal Authority (LA) and offered information on community living options. These attempts at educating LARs on community living options do not appear to be unequivocally effective at reducing this obstacle to community referral. Some LARs vehemently decline to receive information from CLOIP

workers and LA staff. LARs and other family members are encouraged to attend the educational community tours provided through the LA that occur twice a month. A review of tour attendees reveals that only two family members have attended these tours during fiscal year 2014. Provider fairs were conducted in November 2013 and May 2014, which were opportunities to give LARs further education on community living options. Prior to the provider fairs taking place, letters were mailed to all LARs and primary correspondents informing them of the opportunity to receive information from local community providers. For the November 2013 provider fair, only three family members attended, and for the May 2014 provider fair, only two family members were in attendance.

Many LARs are parents or siblings of individuals who have resided at RSSLC for many years and frequently state that RSSLC is the only home their family members have known and they do not want to disrupt their lives. In one case, an individual's IDT has made numerous attempts to provide the individual with education on community living options by allowing the individual to attend provider tours and provider fairs. The individual required consent from the LAR in order to receive this education. Each time a member of the IDT contacted the LAR for consent to educate the individual, the LAR denied consent. Because the LAR denied consent, the individual has not had any exposure to community living options. LARs and family members frequently state they do not believe community providers can supply the same amount of care for their loved ones that is provided at RSSLC. LARs and family members also have a belief that additional responsibility for the personal and monetary care of their loved ones will be placed upon them if they are transitioned to the community.

The majority of LARs state that they have received information about community living options and are not interested in learning more; therefore, the underlying reason for LAR reluctance seems to be a lack of trust in community providers. The Admissions Department in conjunction with the IDT and the LA will continue to educate and address the concerns of the individual LAR's, primary correspondents and family members by offering and providing opportunities to tour and interview community providers in regards to the services they offer.

The transition specialists continue to attend the individuals' ISP meetings in an attempt to make contact with LARs and offer additional education on community living options. Moreover, the transition specialists present and discuss the provider home site booklet, which has visuals and written information about providers, with LARs. This approach has had noteworthy success in providing education on community living options to LARs who has turned down information from the LA.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

RSSLC serves individuals with medical needs that require 24-hour nursing services which are often only available in a nursing facility or other medically oriented setting, such as specialized group homes. RSSLC has successfully transitioned one individual with high medical needs who also required a wheelchair accessible home, lift for transfers, and frequent repositioning into the community. The transition specialists consistently search for providers that can explicitly accommodate individuals with substantial medical needs. We will continue to monitor to ensure those individuals identified as needing 24-hour

nursing services actually have nursing needs that unquestionably cannot be met in a community setting.

**Individual's reluctance for community referral**

Individual reluctance continues to be the third greatest obstacle to referral at RSSLC, due to the individuals' lack of understanding of community options available. The LA's bi-monthly educational community tours are offered to individuals whose annual ISP is coming up and individuals who have been identified as not having had any exposure to community options. The IDT will continue to offer these individuals an opportunity to learn more about the options available to them in the community. On average, there are five individuals who attend the bi-monthly CLOIP tours set up by the LA. Some individuals visit with peers who have successfully transitioned to the community in their new homes by means of attending birthday parties and brunches. As more individuals continue to transition to the community, more of the individuals residing at RSSLC will have more opportunities to visit the homes of their peers in the community.

The IDT has been taking "baby steps" with one individual in order to give the individual, who has been reluctant to agree to a community referral, exposure to community living. The IDT began with taking the individual on day trips as opposed to trial visits to various community providers. The individual has also visited the homes of his friends who once resided at RSSLC and now reside in the community.

Provider fairs held on campus afford an additional opportunity for individuals to meet different community providers and learn more about the options available to them. The transition specialists continue to attend the monthly self-advocacy meetings on campus in order to speak with attendees and provide information on community living options. All of these strategies continue to be effective at RSSLC.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

The individuals residing at RSSLC often times require services which address psychiatric stability as well as specialized psychological counseling as a part of their support plans. RSSLC currently provides individualized counseling, including therapy sessions for treatment of post-traumatic stress disorder, anger/personal management, and other psychological conditions. The individuals identified are recent admissions to RSSLC from psychiatric hospitals. The IDT reviews the individual's behavioral data and response to counseling, therapy, and behavioral programs in order to assess if the individual requires further intervention by behavioral health services before being referred for community transition.

**Lack of funding**

Efforts to secure funding for the four individuals who are not currently citizens of the United States and not eligible for Medicaid funding will continue in fiscal year 2015. The RSSLC Social Workers are diligently working with the individuals families to obtain legalization status.

**In fiscal year 2015, RSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

- QIDP Coordinator will ensure that the ISP guide is followed at all ISP meetings in order to identify all needed supports and services for the individuals prior to community referral by conducting quality assurance tools on ISPs.

- The IDT will develop and implement a plan to address any identified issues that may be an obstacle to referral. QIDP Educator will provide additional competency based training to the IDTs.

- The IDT will request a provider list specific to LAR/individual preference and needs sixty days prior to the ISP from the Transition Specialist. The Transition Specialist will identify providers that can best serve the individual's needs, in addition to the CLOIP tours. An individualize tour(s) will be set up with a provider that can address the needs such as wheelchair accessible, roll-in showers, wide doors, trolley tubs, and lifts. Once the IDT and individual have completed the tour, an IDT meeting is held to discuss the tour. This will help the LAR and the individual to gain a clearer picture of what community providers and community living can offer the individual. This process has been added to the local policy (G.04) and QIDPs have been trained on this.

- Training will be provided on facilitation and documentation of Living Options discussions with LARs and individuals. The QIDP Coordinator will create a monitoring tool for Living Options Discussion Documentation in order to examine LAR and individual's response to education and exposure to community living options and develop action plans as needed. First, the QIDP Leadership team will create a list of probing questions prior to creating a monitoring tool. Once those questions are created, the monitoring tool will follow.

In fiscal year 2015, RSSLC will continue its efforts to reduce obstacles to referral with the above strategies, as well as provide training to IDTs on appropriately identifying obstacles and creating meaningful plans to eliminate or reduce those obstacles.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from RSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | **3** |
| Lack of supports for individuals with significant challenging behaviors | **2** |
| Limited residential opportunities | **1** |
| Medicaid/SSI funding | **1** |
| Need for environmental modifications to support the individual | **1** |
| Other | **5** |

## Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Individual/LAR indecision

Individual and LAR indecision on a community provider choice is one of the obstacles to community transition. RSSLC had 15 individuals and LARs who took an extended amount of time identifying a preferred provider after making trial visits to various community providers. The transition specialists worked with the LARs and accompanied them on tours to the different providers in order to assist them in identifying an appropriate provider. To overcome this barrier, the transition specialist and IDTs will continue to readily assist with informing the individuals and LARs on community living to diminish the concerns about residing in the community, and provide education on the similar services available in the community such as host home/companion care, residential support, and supervised living to meet the needs of the individuals once they transition. Currently one individual is under extensive wound care therapy and has not transitioned. The remaining two individuals' LARs has visited more than ten homes and has not chosen a provider. One LAR decided that community living was not the least restrictive environment at the present time, but agreed to continue to allow the individual to attend CLOIP and community provider tours.

### Lack of supports for individuals with significant challenging behaviors

Of the two individuals experiencing significant challenging behaviors, one individual had a medical condition which increased the behavioral incidents. For the other individual, providers were being sought who could address the behavioral concerns. Due to many of the providers not being able to provide the same psychiatric/psychological services that RSSLC provides to these individuals, it is difficult to obtain providers and transition these individuals.

The IDT and the Transition Specialist identified HCS Providers who placed emphasis on working with individuals with behavioral concerns, and once identified, the IDT along with one individual's LAR toured each provider home and at length discussed their behavioral specialty. Trial visits were completed, after the completion of each of the trial visit, the IDT met with individual, provider, LA and LAR. A final choice was made, and one individual transitioned to the community.

The IDTs will continue to work with the LA, Transition Specialists, and LARs in order to identify providers who can provide the supports needed for the individual's successful transition into the community. The IDTs will continue to monitor individual behavioral triggers and medical illnesses that could result in the increase in challenging behaviors. The IDTs will also create and implement supports with the intention of decreasing challenging behaviors.

### Limited residential opportunities

A limited number of providers within a certain geographical area are another barrier to transition for individuals at RSSLC. One individual, with this obstacle, wished to only

consider providers near their family, but the providers in the area were limited and not equipped to meet the specific supports needed for the individual. The transition specialists worked with the IDTs to locate providers as close to the family as possible. The transition specialist has currently toured ten provider homes with the individual and LAR in attempt to secure a community living provider that best suits the needs of the individual in the area requested. As a result of these actions, the transition specialist located a community provider whose home were within thirty minutes to an hour from the individual's family and successfully transitioned the individual.

**Medicaid/SSI funding**

Individuals cannot transition into the community if they lack Medicaid/SSI funding, as it is very costly to provide services in the community. The one individual with this obstacle became eligible for Medicaid as her family worked to decrease the inheritance that the individual received. As this is an obstacle that can be foreseen or prevented by RSSLC and the center will continue to work with families in a timely manner in hopes of preventing this obstacle to transition of occurring with future community referrals.

**Other:**

**Provider closed home; search for new provider (2)**

On some occasions, a provider may close a home after the LAR/individual/IDT has identified a chosen provider, further complicating the process of the individual transitioning to the community. For the one individual with this obstacle, the RSSLC IDT team and Transition Specialist will continue to pursue providers equipped to meet the specific needs of the individuals. The IDT worked diligently in order for the individual to have a smooth transition, and the individual has transitioned.

The other individual with this obstacle will search for new provider. The individual's LAR has chosen to conduct their own provider search in close proximity to the LAR's home. The LAR continues to search for a provider. The Transition Specialist has assisted the LAR by providing names and addresses of providers in close proximity as well as within a thirty mile radius of the LAR's home to tour and visit. At this time, the LAR has not identified an HCS provider.

The RSSLC IDT and Transition Specialist will continue to assist any and all guardians in their concerns and pursuit of successful transition.

**Provider delay in opening home (1)**

There has been a delay in the transition process for one individual due to the provider delaying the opening of the home due to renovations. The individual transitioned smoothly once the provider completed the renovations to the home. RSSLC IDT will continue to identify and attempt to assist in resolving any home modifications prior to the date of transition.

**Family chose to pursue guardianship to prevent transition (1)**

RSSLC had one individual whose family chose to pursue guardianship in order to prevent the individual from transitioning to the community. RSSLC IDTs will diligently work to educate families regarding community living options and to effectively address any concerns or fears of transitioning the individual to the community. The IDTs will provide education to the families on their role as a LAR once an individual has been referred and transitioned to the community.

**LAR reluctance to choose a provider (1)**

LAR reluctance to choose a provider has been a hurdle to one individual transitioning to the community. RSSLC IDTs will diligently work to educate families regarding community living options such as foster care, residential support, and community living to address any concerns or fears of the individual transitioning to the community that may cause the LAR to be reluctant in choosing a provider.

**In fiscal year 2015, RSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

- The Admissions Department's Transition QIDP is taking an active approach to in-servicing Facility QIDP's on the importance of the 180 Day transition timeframe. The transition process is explained in detail with the creation of a PowerPoint presentation and the development of a transition calendar which offers the QIDPs a realistic timeframe for transition to occur.

- The Admission Department has developed and implemented training to all disciplines and Department Heads on the Community Transition Process (Path to Community Power-point). Initial training has been completed with the PCPs, QIDPs, and Habilitation Therapies staff and all disciplines and staff training will be completed by March 2015.

If an individual does not move within 180 days of the date of their referral, the IDT in conjunction with the Admissions Department continues to meet monthly to identify and address any obstacles to the individual's transition to the community. The IDT aims at identifying and addressing obstacles prior to the 180-day timeline. The QIPD's have been in-serviced on, and new QIDP's will be in-serviced on 180 day timeframe, the family and teams are continuously educated by the Transition Specialist about providers, supports and services they provide. None of the individuals identified as having an obstacle to transition in fiscal year 2014 were delayed due to a lack of IDT action on the referral.

The Admission and Placement Department will continue to monitor individuals who exceed the 180-day timeframe to ensure that obstacles to community transition are addressed so that the individuals can expeditiously move to their chosen home within the community.

# Rio Grande State Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The Rio Grande State Center (RGSC) opened in 1962 and began providing services for individuals with intellectual disabilities in 1972. The center is built on approximately 78 acres and at the end of fiscal year 2014, was serving 67 individuals. RGSC employs approximately 565 people, of which approximately 240 work for the ICF/IID division. The ICF/IID component of RGSC serves twelve counties: Cameron, Hidalgo, Starr, Duval, Brooks, Jim Wells, Kennedy, Kleberg, Jim Hogg, Webb, Zapata and Willacy.

Although there are over 30 providers listed for this area, only 13 have HCS homes and only two have ICF homes. Most of these providers have their own vocational services; however, more employment opportunities for individuals in the community would be beneficial.

In past years, RGSC has placed the individuals who could be successfully transitioned to the community. In fiscal years 2012 and 2013, 20 individuals transitioned to the community. That number has decreased in fiscal year 2014 to 5 due to numerous reasons which include: Approximately 20% of the individuals residing at RGSC don't have appropriate financial resources to move to the community, many individuals have been living at RGSC for many years and are satisfied and comfortable in their homes, and RGSC has numerous families who are pleased with the services and supports provided at RGSC. The IDT continues to work with these individuals and families to prepare them for possible future placement.

**Community Referrals and Transitions from RGSC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 2 | 2 | 2 | 0 | 75 |
| **2009** | 1 | 4 | 4 | 0 | 71 |
| **2010** | 2 | 1 | 2 | 0 | 72 |
| **2011** | 11 | 2 | 2 | 0 | 71 |
| **2012** | 14 | 5 | 7 | 1 | 70 |
| **2013** | 6 | 2 | 13 | 1 | 62 |
| **2014** | 5 | 6 | 5 | 1 | 67 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from RGSC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 25 | 44.6% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 10 | 17.9% |
| Lack of funding | 14 | 20.8% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 7 | 12.5% |
| Individual's reluctance for community referral* | 6 | 10.7% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 3 |
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 3 |

**Table 3. LAR reluctance for referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| Legal Guardian/LAR has been provided information and exposure to community living options, but is not interested in community transition | 15 |
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 5 |
| Mistrust of providers | 3 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Referral

### LAR's reluctance for community referral

The most frequent obstacle to referral is the Legal Authorized Representatives (LARs) reluctance for community referral. Some LARs/parents have mentioned that they have had negative past experiences with group home providers. During the last provider fair

held at RGSC, only one family attended. LARs/families have voiced that they prefer for their loved ones to live in an environment where there is twenty-four hour nursing care.

For some individuals at RGSC who have been living here for many years, their LARs/parents/families feel that this is home to their loved ones and don't want to change their living arrangements. LARs and families continue to be invited to tour community homes and programs. They are also invited to the semi-annual provider fairs. The Community Living Options Information Process (CLOIP) is provided to LAR's annually, as well. RGSC will continue to work with LARs to provide education regarding the community transition process and information about community services.

Community providers have also presented information about their programs at the Parents Association meetings. Angel Community Services and Lifetime Living have both provided information to the LARs/parents at the Parents Association meetings in this past year. About 30% of LARs/parents participated in these meetings; however, as mentioned previously, many LARs/parents are not receptive to having their loved ones move to the community.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

The second most frequent obstacle to referral is the individuals' behavioral health/psychiatric needs and their supervision requirements. RGSC currently serves individuals who require enhanced supervision due to their significant behavioral needs and psychiatric symptoms. The Psychiatry and Behavioral Services Departments continue to work with these individuals closely through behavior support plans. Some of the individuals living at RGSC have had medication changes due to health reasons and therefore have required more behavioral interventions and revisions to their behavior support plans. The Board Certified Behavioral Analysts (BCBA) is assisting with additional training of RGSC staff.

Community providers are reluctant to serve individuals with challenging behavioral issues. We will continue with current supports to address specific challenging behavior and will continue to recommend for community providers to obtain training in working with individuals that have increased behavioral needs. RGSC currently provides training to community providers on an individual basis. At times, RGSC will also provide refresher trainings for staff serving individuals that have already moved to the community.

In addition, the RGSC BCBA's are providing clinical supervision to BCBA students from both the University of Texas Pan-Am and University of Texas Brownsville. It is the goal of RGSC to be a teaching facility whereby these students will provide services locally in support of the local schools to help families decrease the need for placements outside of the home and to provide supports to the local community providers to support those individuals who live in group homes.

**Lack of funding**

RGSC serves 14 individuals who do not have full Medicaid benefits which makes it difficult for community transition. We will continue to work with our Reimbursement office to exhaust all efforts to secure benefits. RGSC is referring some families to Legal Aid to be provided with additional information on how to obtain residency and therefore be able to help our individuals obtain benefits. Unfortunately, some families don't have the financial means and at times are not legal citizens and are not able to obtain any help for their loved ones. The IDTs are working with local agencies to find "sponsors" for residency. RGSC has been successful with one such endeavor and that individual was placed in the community successfully. The process is long and requires that the individual have a family member who resides in the United States, is a legal resident, and is willing to work with RGSC on sponsoring the individual.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

RGSC currently serves 7 individuals who require access to 24-hour nursing and medical services. Some of our individuals have chronic illnesses that require twenty-four hour nursing care as well as the constant need for medical interventions. Local providers in this area do not have the required nursing/medical staff available to serve these individuals.

When an individual is referred for community placement, nurses, habilitation staff, Behavioral Services Staff, and nutritionists at RGSC provide specific training to group home staff before placement. This competency based training is required prior to over-night visits. The group home providers feel more comfortable caring for our individuals and can better serve their medical needs once training is provided to them. Admission and Placement staff will explore community providers' ability to address significant medical needs in a community setting.

**Individual's reluctance for community referral**

Individual reluctance continues to be an obstacle for referral at RGSC for many individuals. Individuals will continue to be provided the opportunity to tour community group homes and to participate in semi-annual provider fairs, as well as monthly self-advocates meetings. In this past year, individuals have visited with peers who now live in the community. Most individuals have also seen a video that was made by the Admission and Placements Department about a peer who used to live at RGSC and who has successfully been living in the community for the past five years. Pictures of different group homes are also available for our individuals to assist them in understanding their living options.

Individuals who are reluctant for community placement have been offered tours and visits with their preferred staff and even with preferred peers. In the future, RGSC will try to be creative and provide "fun" events for the individuals that are reluctant to go on tours/visits to make it more enjoyable and enticing for them to attend. A "Fun Day" event will be organized in which previous peers from RGSC will be invited to join us for a day of games, music and snacks with our consumers in order to provide an opportunity of interaction and educate our individuals with their peers' experience of moving into the community.

**In Fiscal Year 2015, RGSC will continue its efforts to reduce obstacles to referral with the following strategies:**

The Admissions and Placement Department continues to work with the IDT to refer as many individuals to the community as possible. We continue to offer individuals the opportunity to tour group homes and attend provider fairs. These tours and fairs are also offered to their LARs/families. Also, the continuity of care workers at our local authority, Tropical Texas, continues to educate LARs/parents/families on the different living options available for their loved ones.

Our IDT continues to meet with individuals as needed, or at least annually, to discuss their living options. In the near future, RGSC will attempt to work with trusted providers to schedule more visits with peers who have successfully moved to their homes. RGSC will also attempt to schedule fun activities with peers that have moved out to the community to build friendships in hopes of encouraging the individuals to want to move out into the community with their friends.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from RGSC, FY 2014**

| Obstacle | Total |
|---|---|
| Need for environmental modifications to support the individual | 6 |
| Lack of supports for individuals with significant challenging behaviors | 5 |
| Lack of availability of specialized medical supports | 5 |
| Lack of availability of specialized therapy supports | 4 |
| Individual/LAR indecision | 3 |
| Need for services and supports for individuals with forensic needs/backgrounds | 1 |
| Limited residential opportunities | 1 |
| Other | 1 |

**Center Strategies and Actions to Overcome or Reduce Obstacles to Transition**

**Need for environmental modifications to support the individual**

Most homes available in the community do not meet ADA requirements which have caused a delay for individuals who require specific modifications based on their adaptive equipment and their needs. RGSC recently had three individuals move to the community that required environmental modifications. The modifications needed for these individuals were walk-in showers recommended by our Physical Therapist. The modifications have been made and the individuals have moved and continue to reside in the community.

Two other individuals also required modifications for bathing where they needed walk-in showers; however, the referrals for these individuals were closed at the preference of the LAR while another individual changed her mind about moving to the community. The IDT proposed to continue providing tours for this individual as often as possible to allow her to become more familiar with the options available to her and be more comfortable with the transition to the community. No action plans were needed at this time as this individual

had no issues with being presented and exposed to her living options. She merely began to voice her preference to remain at RGSC. The IDT plans to inform the Admissions and Placement department when the individual has voiced any desires to move to the community again.

Most of the environmental modifications needed for the individuals residing at RGSC are walk-in showers and wheelchair ramps. Some providers would like reassurance that an individual will be residing at that home before making modifications.

**Lack of supports for individuals with significant challenging behaviors**

Many of the individuals, who reside at RGSC, are dually diagnosed and have challenging behaviors. Approximately 65% of our individuals are dually diagnosed which requires the collaboration of the Psychiatry and Behavioral Services Departments with the need of psychoactive medications and Positive Behavior Support Plans (PBSP). Many of the individuals who are dually diagnosed have an Axis I diagnosis which may include at least one of the following: Autistic Disorder, Schizophrenia, Bipolar Disorder, Manic with or without Psychotic features, Anxiety Disorder Not Otherwise Specified (NOS), Antisocial Personality Disorder, Intermittent Explosive Disorder, Adjustment Disorder with Mixed Anxiety, Depressed mood, Impulse Control Disorder NOS, Autism, Obsessive Compulsive Disorder, Psychotic Disorder NOS, Asperger's, Schizoaffective Disorder, ADHD, Mood Disorder, Hypomania, and Major Depressive Disorder. With these diagnoses comes with challenging behaviors in which they exhibit and are also targeted in their PBSP. These target behaviors include at one of the following: aggression, self-injurious behaviors, sexually inappropriate behavior, disrobing, false allegations, program refusals, attention seeking behaviors, disruptive behavior, and elopement. Unfortunately, most private providers in this area refuse to serve individuals with challenging behaviors. The IDT and our BCBA's continue working closely with these individuals to try and reduce their behaviors and to get them to where they need to be to successfully move to a group home in the community. Four individuals with challenging behaviors successfully moved to the community this past year. The Behavioral Services Department trained the group home staff with their plans.

One referral was rescinded due to the increase of aggression along with a medication adjustment. Once his aggressive behaviors decreased and he has adjusted well to his medication changes, the IDT has made plans to refer again.

**Lack of availability of specialized medical supports**

The five individuals were identified as needing specialized medical supports are extremely medically involved. They require such individualized needs as Peg tube feedings, specialized wheelchairs, Hoyer lifts, hospital beds, standing tables, and specialized habilitation therapy supports. Each of these individuals currently have private bedrooms that are considerably larger, due to their specialized equipment than the average bedrooms in a community home which are considerably smaller. In addition, it requires, at a minimum, 2 staff to provide proper lifting and transferring techniques.

Two of our individuals requiring medical supports have successfully moved to the community this past year. Two referrals were rescinded due to a cancer diagnosis which required surgery and the other required medical follow ups and observation.

Future plans are to hopefully refer at least one of these individuals to the community once their medical conditions have improved. One individual continues on the referral list following surgery and now wears a leg extension device. He has been on the referral list since March 2014. Medical complications, which also include the needed supports for therapy, have prevented him from moving to the community. He is scheduled to transition to the community before the end of 2014. His family is currently making renovations to their home in order to meet his needs, which will also include, psychiatric, behavioral, and physical therapy supports upon transition.

**Lack of availability of specialized therapy supports**

Although specialized therapy supports are not readily available in our area, our local group home providers are working with RGSC to help meet the needs of our individuals in the community. An individual requiring specialized therapy supports moved to the community in September 2014 and another individual moved in April 2014. Speech therapy supports were needed for one individual and the provider was able to secure a contract with a Speech Therapist from the community. The other individual required a VNS and was able to get it prior to his move.

As noted previously, the individual who requires the use of a leg extension device will move to the community before the end of the year. This individual will also require Psychiatric, Behavioral Supports, and Physical therapy supports upon transition.

The last individual noted had his referral rescinded due to an increase in aggressive behaviors. Plans are for him to once again be referred for community placement in the near future. This individual will require Psychiatric and Behavioral Supports upon transition.

**Individual/LAR indecision**

One individual changed her mind about moving to the community. She visited several providers and chose the one she preferred. This individual then changed her mind and said they did not want to move to the community. The individual was offered to tour other providers and has refused. The referral was rescinded. RGSC continues to offer this individual tours and visits but she continues to refuse.

Another individual's LAR changed her mind about having her son move to the community because they prefer their loved one live at RGSC. This individual is legally blind and deaf and has been living at RGSC for almost ten years. His LAR has voiced that she fears her son would get hurt and not be able to adapt to his new environment. The family of one individual was not in agreement with their loved one being referred; the family is also seeking guardianship for him and they prefer that he continue to reside at RGSC.

**Need for services and supports for individuals with forensic needs/backgrounds**

One individual with a forensic background moved to the community in August, 2014. The IDT obtained permission from the court to move to the community. This individual was able to move with a private provider without any further issues.

**Other:**

RGSC had one individual who was going to move closer to his family in the San Antonio area. He completed a pre-placement visit; however, the provider refused to provide their services to him. His family did not pursue his transition to the San Antonio area. After the IDT reviewed this individual's referral, the IDT referred and moved him in this area. His transition continues to be a success.

**In Fiscal Year 2015, RGSC will continue its efforts to reduce obstacles to transition with the following strategies:**

The Admissions and Placement Department will continue to work closely with IDTs to ensure that individuals are referred for community transition within the time allowed. Tours, trainings, and visits with the providers will be scheduled as soon as an individual is referred for community placement. Also, the Placement Specialist or the Transition Specialist will attend annual ISPs and make note of the recommendations made for the living options of the individuals served at RGSC. The Placement Specialist or Transition Specialist will send reminder emails to disciplines to obtain whatever is needed for the individuals who tour or visit group homes in the community. The IDTs will continue to make referrals for community transition.

Community providers will be encouraged to have homes available for individuals wanting to move. These homes should include large bedrooms with walk-in showers and wheelchair accessibility. RGSC and the individuals referred for placement could also benefit from private providers having a current contract with behavioral specialist to assist them in dealing with difficult behaviors. Contracts for employment would also be very beneficial and would help when an individual is referred.

# San Angelo State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The San Angelo State Supported Living Center (SGSSLC) was converted from the McKnight State Tuberculosis Hospital in September 1969. The 1,031-acre center was serving 208 individuals as of August 31, 2014, and employs approximately 930 staff. The center primarily serves three Local Authorities (LA) and 37 counties in its catchment area:

Mental Health and Mental Retardation (MHMR) Services for the Concho Valley
Counties Served: Coke, Concho, Crockett, Irion, Reagan, Sterling, and Tom Green

Permian Basin Community Centers for MHMR
Counties Served: Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, and Presidio

West Texas Centers for MHMR
Counties Served: Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum

SGSSLC has eight providers in the community who are actively providing services. Of these, three only have Home and Community Based Services (HCS) homes; two only have Intermediate Care Facilities (ICF) homes while three have HCS and ICF homes. There are only two providers who offer vocational settings with limited work availability. All the providers operate a day habilitation program or contract with other providers.

**Community Referrals and Transitions from SGSSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2008** | 15 | 3 | 30 | 1 | 290 |
| **2009** | 22 | 6 | 24 | 0 | 274 |
| **2010** | 19 | 10 | 27 | 1 | 251 |
| **2011** | 26 | 8 | 19 | 0 | 239 |
| **2012** | 24 | 13 | 25 | 1 | 229 |
| **2013** | 16 | 18 | 28 | 6 | 210 |
| **2014** | 15 | 11 | 22 | 5 | 208 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from SGSSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 127 | 65.8% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 30 | 15.6% |
| Individual's reluctance for community referral | 24 | 12.4% |
| LAR's reluctance for community referral | 7 | 3.6% |
| Evaluation period (Ch. 55/46B only) | 5 | 2.6% |

Data Source: HHS CARE System

**Table 2. Individual's reluctance for community referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 13 |
| Lack of understanding of community living options | 7 |
| Unsuccessful prior community placement(s) | 4 |

**Table 3. LAR's reluctance for community referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 5 |
| LAR is not interested in being provided information and exposure to community living options | 1 |
| Unsuccessful prior community placement(s) | 1 |

**In fiscal year 2015, SGSSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

Behavioral health/psychiatric needs are the greatest obstacle identified for individuals served at SGSSLC. Behavioral issues such as severe physical aggression, self-injurious behavior, inappropriate sexual behavior, and unauthorized departures are identified issues for many individuals at SGSSLC. These individuals require intensive staff supervision, a secured environment, frequent observation checks, and other restrictive practices for their safety and the safety of others. The following strategies have been developed to address this obstacle:

- Interdisciplinary Team (IDT) members will be required to seek more education on available community supports through the annual provider fair and Local Authority (LA) in-service.

  The provider fair was held on 9/27/13 and staff attendance had similar numbers as last year which had 66 staff members at the fair. The provider fair for FY 2015 is scheduled for 9/27/14. The LA in-service was held on 11/22/13 and staff attendance fell from 83 in FY 2013 to 52 in FY 2014. The next LA in-service is scheduled for 12/12/14. IDT member's attendance will be mandatory. IDT members will continue to be encouraged to learn about supports available in the community at both the provider fair and LA in-service in FY 2015.

- All staff who submits recommendations for community transitions will be required to learn more about the services offered in the community through provider in-services. HCS providers will be invited to give in-services to all staff and residents monthly.

  In FY 2014, 4 private HCS providers visited SGSSLC and presented information about their program and services provided in their respective communities. Both the residents and staff were invited to attend. Unfortunately, staff attendance fell below expectations with only a total of 18 staff attending. In FY 2015, SGSSLC will continue to invite HCS providers to meet with staff and residents. IDT members will be required to attend at least one meeting with an HCS provider.

- Positive Behavior Support Plans (PBSP) will be kept current and effective.

  In FY 2014, all PBSPs were current but not yet modified as needed to provide continuous and consistent implementation throughout the transition process. Many of the PBSPs contain positive reinforcement that is unrealistic in the community such as tokens from our token store. Crisis intervention plans in a facility setting do not translate to the community. The facility has 24 hour access to psychiatrist whereas the community will need to utilize services such as emergency rooms, local mental health clinics, and law enforcement agencies. SGSSLC's transition home will open in FY 2015 and the Behavioral Health Specialist (BHS) for the transition home's IDT will strive to develop PBSPs collaborating with community BHS and psychologist who work with the community providers prior to the individual's transition.

  The behavioral health specialist will be trained by the behavior analyst on developing good community support needs for the Integrated Support Plan (ISP). In the past, supports for residents listed in the behavioral health summaries reflected services in a facility setting such as continuing behavioral management code IV and continue PBSP.

The behaviors displayed identified in the PBSP should be considered in the community setting and how the community provider staff would provide support. Consideration should be made for all settings such as group homes, day programs, employment, and public outings. This training was completed on 11/6/13 and added to the BHS Job Specific Training in FY 2015.

**Medical needs requiring 24-hour nursing services and frequent physician monitoring**

Medical needs are identified as the second greatest obstacle at SGSSLC. There are individuals who are not medically stable and others who require 24-hour nursing services which are often only available in a nursing facility or other medically oriented setting. The following strategies were developed to address this obstacle:

- The transition specialist will contact the Qualified Intellectual Disability Professional (QIDP) for each of these residents with this obstacle to arrange a meeting to ensure that effective action plans are in place.

  In FY 2014, the transition specialist was not provided the data that identified the residents as having this obstacle, and therefore this action step was not implemented. In FY 2015, the transition specialist will coordinate in-services for the IDTs, who identify medical needs as obstacles, with community providers who have individuals with comparable needs in a community setting. The transition specialist now has access to the obstacle database and reports.

  For FY 2015, medical obstacles identified at the ISP prep meeting will be reviewed by the QIDP Coordinator, QIDP Educator, the Admission Placement (APC), and the Director to determine if the team should explore further, or provide more clarification of the individual's medical needs in a community setting prior to the ISP. Some of the individuals with medical obstacles appeared to us as questionable based on our knowledge of the individual. Identifying the questionable medical obstacles prior to the ISP will allow for additional assistance from the transition specialist and APC prior to the ISP meeting.

**Individual's reluctance for community referral**

Individual reluctance continues to be the third greatest identified obstacle for referral at SGSSLC. Some individuals refuse the education about community living options offered to them by the staff at MHMR Services for the Concho Valley. Others receive the education and attend provider tours but continue to prefer to live at SGSSLC. The following strategies were developed to address this obstacle:

- The transition specialist will contact the QIDP for each of these individuals to arrange a meeting with the team to ensure that effective action plans are in place.

  In FY 2014, the transition specialist was not provided the data that identified the residents as having this obstacle, and therefore this action step was not implemented. In FY 2015, the obstacle database will be accessible to the transition specialist for the

necessary data each quarter. The transition specialist will meet with the team and review strategies to address this obstacle.

- The transition specialist, the QIDP coordinator, and QIDP educator will work jointly with IDTs to develop action plans for obstacles, particularly for residents who need a better understanding of community living options.

  In review of this item, the objective of this action plan did not specifically address the obstacle for individual reluctance. This was seen as an overall objective to implement in FY 2015 for all individuals at SGSSLC.

- The community living options information process (CLOIP) service coordinators with the LA will continue to offer education and tours of community programs.

  In FY 2014, 197 individuals were scheduled for community program tours in San Angelo. There were 21 tours conducted for 108 residents. The 89 individuals who did not attend either chose not to go, had a medical appointment, missed due to illness, were visiting with family, or did not attend at their LAR's request. In FY15, community living information process tours will continue for those individuals who want to attend. The QIDP will reschedule tours for those who missed.

- The annual provider fair and LA in-service continue to provide exposure and education to residents, LARs, families, and staff.

  In FY 2014, the provider fair was held on 9/27/13. Individual attendance was 101, an increase from 74 in 2012. The FY 2015 provider fair is scheduled for 9/26/14.

**LAR's reluctance for community referral**

LAR reluctance is the fourth greatest obstacle to refer for community transition at SGSSLC. Education of LARs is most often addressed through the CLOIP process that occurs before each annual ISP. LARs are contacted by staff at MHMR Services for the Concho Valley and offered information on community living options. However, some LARs decline to receive information from CLOIP workers. LARs and other family members are also encouraged to attend the educational community tours provided through the LA that occur at least twice a month, but a review of tour attendees reveals that no LARs or family members have attended these tours. The lack of attendance is not surprising since most LARs and family live outside the center's service area. The following strategies were developed to address this obstacle:

- The IDT will develop resident-specific action plans addressing educational needs of LARs to learn about community living options at the annual ISP.

  In FY 2014, ISP monitoring indicated that action plans addressing educational needs were developed. This will continue in FY 2015 with more emphasis on the LARs' specific needs to address their concerns.

- The Admission Placement Coordinator (APC) and transition specialist will work with the local community center regarding improving the quality of CLOIP with LARs. More effort will go toward involving guardians and family members with CLOIP site tours.

  In FY 2014, an annual meeting was held with the local LA to review CLOIP activities at the State Supported Living Center (SSLC). The CLOIP service coordinators agreed to invite family and LARs to the CLOIP tours that they schedule for SGSSLC residents. This will continue in FY 2015. Data for FY 2014 indicates that no LAR or family attended the CLOIP site-tours. This was not unexpected since most of the residents at SGSSLC are not from the local area and family would have to travel long distances to attend these tours. The CLOIP service coordinators will assist family and LARs with visiting providers in their area through their local LA.

- The Admission Placement (AP) department will provide references to LARs who are interested in learning about the experiences of other individuals who have transitioned to the community.

  In FY 2014, the APC developed a participation consent form for LARs to sign if they agree to be referral source regarding community transitions to other LAR and family members. Their name was entered into a spreadsheet for distribution to QIDPs. This process will continue in FY 2015.

- The annual provider fair and LA in-service will continue to provide exposure and education to residents, LARs, families, and staff.

In FY 2014, the provider fair was held on 9/27/13. Individual attendance was 101, an increase from 74 in 2012. FY 2015's provider fair is scheduled for 9/26/14. All provider fairs are scheduled in conjunction with the facility's annual family day picnic. Family/LAR attendance at SGSSLC's annual provider fairs is not well attended. No family members attended the provider fair in FY 2014. The LA in-service was held on 11/22/13 and there was no attendance by LARs, families, or residents. The FY 2015 LA in-service will be scheduled for December 2014. In FY 2015, the provider fair will be held with the family day picnic; at the same time and location. Provider booths will be set up at the picnic and announcements will be made to encourage family to visit their booths. A second provider fair will be held on campus for the individuals and staff who do not attend the family day picnic.

**Evaluation period (Ch. 55/46B only)**

SGSSLC is designated to admit female adults and adolescents for forensic evaluations as ordered by Texas courts. Individuals who have court-ordered for forensic evaluations are not eligible for community transition referrals. If the individual is re-committed to the center as a result of a determination of incompetency or lack of fitness to proceed, they will then become eligible for the same opportunities as other residents for community transition.

**Obstacle Data**

In FY 2014, the accuracy of the obstacle data improved as the Integrated Support Plan (ISP) facilitating QIDPs began consistently capturing obstacle data. In FY 2015, SGSSLC

will continue to identify and collect obstacles through the ISP process. The following steps previously undertaken to ensure future reliable data collection will continue:

- The APC will provide training to all IDTs regarding obstacle identification. The training will focus on obstacle identification, development and implementation of action plans to overcome the obstacles.

- Three ISP facilitating QIDPs will ensure consistency with the most integrated setting policy, including obstacle identification and action plan development.

- Data collection forms will be completed by the QIDP and saved electronically in the resident's electronic folder. The QIDP coordinator's office assures that documentation of obstacles for all living option discussions are submitted by the QIDP and reviewed for errors.

- The data will be reviewed by the QIDP coordinator, QIDP educator, and the APC on a quarterly basis.

- The APC and QIDP Coordinator will present the obstacle trend analysis to the administrative IDT (Quality Assurance/ Quality Improvement (QAQI) committee) on a quarterly basis to develop corrective action plans as appropriate.

- The Quality Assurance Department will monitor the identification of obstacles in living options discussions on a quarterly basis and will monitor any corrective action plans implemented.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from SGSSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 3 |
| Need for environmental modifications to support the individual | 1 |
| Individual/LAR indecision | 2 |
| Lack of supports for individuals with significant challenging behaviors | 1 |
| Medicaid/SSI funding | 1 |
| Lack of availability of specialized medical supports | 1 |
| Other | 1 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Limited Residential Opportunities

Of the three individual's identified as having an obstacle for limited residential opportunities, one transitioned to the community on 1/9/14. He required a home that needed modifications to meet his mobility and safety needs. The first home selected could

meet his needs, but was unavailable after delays in his transition due to funding issues. He and his team selected another home that was owned by a different provider who was able to make the necessary modifications. To address this obstacle, the transition specialist assisted the team with the search for multiple providers who can meet the individual's needs within the selected geographic area.

One of the other two individuals with limited residential opportunities remains at SGSSLC. This individual requires specific restrictions to housing location and proximity to children. The transition specialist continues to search for providers with the experience and home availability that meet the criteria necessary for this individual's needs. This individual returned from a previous failed placement in Ft. Worth due to other behavioral issues that are currently addressed through her positive behavior support plan. The individual's search for a group home setting in a specific location was expanded from one city near Dallas to include the DFW metro-plex through the efforts of the transition specialist.

The third individual has been referred for community transition to Kerrville. The individual's LAR recently retired to Kerrville and selected a provider. The provider did not have a home that the LAR felt was suitable for the individuals. The provider was in the process of building a new home with plans that met with the LAR's approval. The home is still under construction at this time.

The IDTs continue to meet every month to review the remaining two individuals' obstacles and action plan(s).

**Need for environmental modifications to support the individual**

One of the 3 individuals, who were identified as having limited residential opportunities, also needed environmental modification. He required the following equipment and modifications to accommodate his needs: a wheelchair, specialized lift, and a bathroom which addresses his bathing needs. Finding a provider who has a home with these modifications caused a delay in the transition. A provider, who had a home that could meet the modification needs, was selected, and the individual transitioned to the community. Occupational Therapy (OT)/ Physical Therapy (PT) staff and his team worked with a selected provider to choose a home that already met the individual's needs.

**Individual/LAR indecision**

There are two individuals identified as having the obstacle of Individual/LAR indecision. Most of the individuals at SGSSLC are more than capable of providing input and making decisions on where they want to live. Over half of community transitions from SGSSLC are in distant locations. Working with unfamiliar providers, scheduling complications, and travel combine to complicate the decision-making process.

One resident is taking an extended amount of time to select a provider. Since her referral on 4/2/13, she has visited five providers that include 3 group homes and 6 foster care home settings in northeast Texas. She returns to SGSSLC from each visit with a reason not to return. The transition specialist and the individual's mother continue to seek out new providers to visit in the Sherman, TX area.

The other individual's referral was rescinded after she changed her mind about the geographical area of where she wanted to live, escalating aggressive behaviors, and the development of severe medical issues.

**Lack of supports for individuals with significant challenging behaviors**

Lack of supports for individuals with challenging behaviors is identified for the same person who also has the obstacle for limited residential opportunities. A recent increase of aggressive behavior caused the team to question the provider's ability to meet his behavioral and psychiatric needs. The individual's aggression has since stabilized, but the home is still under construction.

**Medical/SSI funding**

The individual who was also identified as having limited residential opportunities found his transition delayed due to Medicaid/ Supplemental Security Income (SSI) funding issues. The LA was unable to determine this individual's eligibility as a person with ID due to missing data. Psychological records were collected from all his residential facility placements for review by state office and the LA. His eligibility determination was confirmed and he transitioned to his new home on 1/9/14**.**

**Lack of availability of specialized medical supports**

The one resident identified with this obstacle also had the obstacle of LAR/Individual indecision and her referral was rescinded due to increased physical aggression and the development of severe medical issues. The obstacle was identified prior to the decision to rescind her referral. The team was concerned that her cancer of the thyroid diagnosis could not effectively be managed, along with her behaviors, in the community.

**Other:**

**Guardianship proceedings**

One individual's move was delayed by the court until after guardianship proceedings were held and a new guardian was appointed. The individual's mother was her LAR until the court replaced her with a DADS guardian. The court did not feel her mother was able to provide for the individual's best interest. Once the guardianship was no longer an issue, she moved to her new home on 4/17/14.

**In fiscal year 2015, SGSSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

In FY 2014, the center took a number of steps to prevent or reduce obstacles to transition and decrease the time it takes for someone to move to the community. The center implemented and will continue the following actions:

- All referrals are reviewed by the transition committee after 90 days to assist teams with overcoming any barriers in the transition process.

- Unit directors are notified of all referrals and provided a timeline of expected transition activity.
- Unit directors will review the transition timelines at their daily home meetings.
- Community transition will be a standing agenda item at the QIDP's bi-monthly meetings.
- Transition related IDT meetings are combined when possible to limit the number of meetings throughout the process.
- The APC and QIDP Educator train new QIDPs on the transition process.
- A status report on each individual's placement activity is presented to administrative IDT's quarterly or as requested.

**New Strategies for FY 2015:**

SGSSLC began the process of developing a transition home in FY 2014 that is planned to open in FY 2015. Most all of the individuals referred for community transition will have the opportunity to live on the transition home after they are referred until they move. The transition home team will focus on the individual's needs in the community setting and implement a transition plan that will follow the individual throughout their transition adjustment. The transition home team will become experts on identifying and implementing community supports. The transition home team will also be able to recognize obstacles to transition early on and develop a plan to resolve the obstacles to transition before they reach the 180-day goal.

A new Transition QIDP will be hired to assist with the facilitation of transitions and provide consistent documentation of the individual's process. The Transition QIDP will also improve the integrity of the obstacle data collected.

# San Antonio State Supported Living Center
# Fiscal Year 2014 Obstacles to Referral &Transition Report

## A. Center Profile

The San Antonio State Supported Living Center (SASSLC) opened in 1978. The center is on 40 acres of land in Bexar County located in southeast San Antonio. SASSLC shares its location with San Antonio State Hospital and The Center for Infectious Diseases. SASSLC serves a ten county area including: Atascosa, Bexar, Dimmit, Frio, Karnes, La Salle, Maverick, McMullen, Wilson, and Zavala counties. At the end of fiscal year 2014, SASSLC was serving 240 individuals and employed approximately 723 people.

According to the Alamo Local Authority Home Community Based Services (HCS) and the Camino Real Local Authority HCS Program Provider Information reports, there are 167 HCS providers contracted to provide services in Bexar County; approximately 56 of these 162 providers are providing services to Bexar and surrounding residents. Alamo Local Authority reports that there are 18 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers who operate a total of 95 ICF/IID Group Homes. There are about 33 day habilitation programs and approximately five vocational programs/ workshops serving San Antonio SSLC's catchment area Bexar and surrounding county area.

SASSLC continues to transition residents to the community as evidenced by the data below. The slowdown in community transitions for fiscal year 2014 can be attributed to the increasing supports needed by the current community referrals. The transition specialists have continued to provide integral supports to the residents, their families, Legal Authorized Representative (LARs) and staff by providing information and support throughout the transition process. Also, the Interdisciplinary Teams (IDTs) are becoming more involved and proficient with the community living discharge plan (CLDP) development process.

**Community Referrals and Transitions from SASSLC, FY 2008 – FY 2014**

| FY | Community Referrals | Rescinded Referrals | Community Transitions | Community Transition Returns | FY Census as of Aug 31 |
|---|---|---|---|---|---|
| **2013** | 22 | 6 | 21 | 0 | 250 |
| **2014** | 20 | 10 | 13 | 1 | 240 |
| **2008** | 1 | 1 | 10 | 1 | 289 |
| **2009** | 5 | 0 | 6 | 2 | 286 |
| **2010** | 6 | 1 | 8 | 0 | 281 |
| **2011** | 6 | 5 | 6 | 0 | 278 |
| **2012** | 16 | 7 | 4 | 0 | 275 |

Data Source: HHS CARE System

## B. Obstacles to Community Referral

**Table 1. Individuals not recommended for referral from SASSLC, FY 2014**

| Reason not Referred | Total | Percentage of Individuals Not Referred |
|---|---|---|
| LAR's reluctance for community referral | 91 | 38.1% |
| Individual's reluctance for community referral | 61 | 25.5% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 48 | 20.1% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 30 | 12.6% |
| Lack of funding | 7 | 2.9% |
| Court will not allow placement (Ch. 55/46B only) | 2 | 0.8% |

Data Source: HHS CARE System

**Table 2. Individual reluctance for community referral, FY 2014**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 40 |
| Individual has been provided information and exposure to community living options, but is not interested in community | 17 |
| Unsuccessful prior community placement(s) | 3 |
| Mistrust of providers | 1 |

**Table 3. LAR reluctance for community referral, FY 2014**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 27 |
| LAR is not interested in being provided information and exposure to community living options | 27 |
| Lack of understanding of community living options | 25 |
| Unsuccessful prior community placement(s) | 11 |
| Mistrust of providers | 5 |

**Center Strategies and Actions to Overcome or Reduce Obstacles to Referral**

**LAR's reluctance for community referral**

This continues to be a challenging obstacle with approximately 38% of the residents not referred due to the reluctance of their LARs. Many LARs were adamant about their family

members staying at SASSLC. The Integrated Support Plan (ISP) process highlights discussion of community living options throughout the meeting. The Local Authority addresses education regarding community living options with the resident, LAR, and primary correspondent(s) through the CLOIP process which occurs shortly before the ISP; it is then discussed at the ISP meeting. Approximately five LARs have requested that the Local Authority is not present at the ISP meeting. The LARs will commonly state that they are satisfied with the current services and supports provided by SASSLC and they have not found an alternative placement that compares favorably to the resident's current situation. LARs were offered opportunities to tour group homes, day programs and to participate in the provider fair; however, the LAR and family participation in community living options tours and the provider fair continues to be poor. In FY 2014, SASSLC held a provider fair on a Saturday hoping to accommodate family/LAR schedules and increase participation. This change in date was not effective in improving LAR attendance. Plans to overcome this obstacle include:

- Even though LARs continue to be uninterested in touring community living options, Qualified Intellectual Disability Professionals (QIDPs) will continue to offer LARs the opportunity to tour group homes in the community as the regular yearly discussion of living options may peak interest.

- QIDPs will continue to invite a transition specialist to ISP meetings when the team believes that education will benefit the individual and LAR. The transition specialist will bring resource guides and any pertinent information and offer to schedule educational tours with the LAR. This needs to continue with the implementation of the plan for transition specialists to attend more ISP meetings (particularly for the individuals who have LAR only as the obstacle to referral). Also, by December 2015, at their weekly update meetings, the transition team will begin assigning ISPs to attend. This will ensure increased attendance at ISP meetings.

- The transition team will include an article on transitions in the quarterly SASSLC Bridge Newsletter. Articles have been written, and will be viewed in each Bridge Newsletter as they are published. The Bridge Newsletter is distributed to LARs, family members and actively involved persons.

- The transition team will develop a biography sheet on individuals, with their consent, who have successfully transitioned to the community post on their former home so they are readily visible to visiting LARs.

- The transition team will continue to have a representative attend quarterly Family Association meetings to update family members on transition-related activities and be available to answer questions.

- The transition team will continue to hold provider fairs at least annually and invite all LARs and family members to the event.

**Individual's reluctance for community referral**

Individual reluctance continues to be a significant obstacle to community referral. Approximately 26% of residents were not interested in transition after receiving information from their Local Authority. There are residents who consider SASSLC their home and have resided at the facility for several years. The residents will clearly indicate their objection to moving and express their wish to stay at SASSLC. Monthly educational tours provided by the Local Authority and supported by the transition specialists provide an opportunity for residents that don't normally tour to get out and see an example of community living options that are available in the San Antonio area. Referrals are commonly due to residents seeing and hearing about their roommates and workmates successfully moving to the community.

Plans to overcome this obstacle include:

- The transition specialists will continue to attend self-advocacy meetings to answer questions and assist self-advocates in sharing information with others about community group home and day habilitation tours they attended. The transition team continues to attend meetings at least monthly. By participating in self-advocacy meetings, a transition specialist is readily available to the group of individuals in self-advocates to answer questions, provide additional education about community living options, and assist in arranging tours or visits.

- The transition specialist will continue to invite a former self-advocate, at least annually, to speak about his/her transition experience.

- The transition specialists will provide tours at least monthly for non-referred residents. Home Supervisors will ensure that knowledgeable staff participate to better gauge the resident's reaction to the environment and to provide input as to what the resident might like or dislike about the community home or day program (this will be documented by the knowledgeable staff in tour notes). There needs to be improvement in this area; in FY 2014, teams focused on already referred residents for touring and choosing homes which left little resources for educational tours by residents who have not been referred.

- Transition specialists will arrange visits and dinners with friends at their new community homes. This will still be an available opportunity when appropriate to reduce the resident's reluctance to be referred.

- The transition specialists will continue to offer residents the opportunity to participate in monthly educational tours. To increase the number of touring opportunities, the transition specialists will schedule one day a month per home for an educational tour with the expectation of a significant improvement in FY 2015. This will be implemented in January 2015.

- The transition team will continue to host provider fairs at SASSLC at least once annually and encourage individual attendance by posting flyers and offering incentives, as well as visiting the homes to personally invite residents to the event.

- The transition specialists will reach out to the QIDPs and work with Group Home Supervisors and Active Treatment Specialists to schedule educational tours for residents who exhibit a lack of understanding of community living options. Notes will be made available in a shared file for IDTs to review and discuss at ISP-As.

- Transition team is in the process of requesting to take on responsibility of AVATAR data entry for living options so that they will have immediate access to review individual obstacles and address with touring/educational opportunities as appropriate. This will also provide the transition team with an opportunity to educate the QIDP should questions arise regarding the data.

**Medical needs requiring 24-hour nursing services/frequent physician monitoring**

There are a limited number of providers that support persons with a high level of medical needs, and those providers have infrequent vacancies in their homes. The transition specialists will continue to research providers that specialize in medical needs and share with the IDTs and medical staff. Educational tours of HCS and ICF homes with strong medical supports and Day Activity and Health Services (DAHS) Programs (nursing on site) will be arranged for residents and their IDT members as appropriate.

**Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff**

Approximately 13% of residents at SASSLC require both behavioral and psychiatric supports. The teams review behavior support plans and psychoactive medications at a minimum quarterly to work toward reducing targeted behaviors, level of supervision, and adjustments to their supports to decrease maladaptive behaviors and replace with positive skills through services such as anger management or communication skills training.

- The transition team will search for providers with ready access to psychologists, board certified behavior analysts, and psychiatrists. This continues to be an ongoing challenge for community transition as there are a limited number of psychiatrists that accept Medicaid (or will quickly drop after the first visit if too complicated).

- IDTs will continue to focus on positive behavior support plans that will assist individuals in managing challenging behaviors. IDTs will consider community options for crisis intervention *prior* to referral. Crisis intervention services in the community continue to be an area in need of improvement. It is important to make sure that the resident is stable prior to move due to lack of adequate crisis support in the Bexar County area.

**Lack of funding**

The SASSLC reimbursement officer continues to work on securing funding for the individuals who are not eligible for Medicaid due to citizenship status. One individual continues to receive services from Disability Rights Texas; his advocate is working on helping him become a citizen. This continues to be a daunting challenge.

**Court will not allow placement (Ch. 55/46B only)**

This is dependent on court decisions. There are two individuals at SASSLC that are committed under 46B. These individuals appear before court annually to review status of their charges.

**In fiscal year 2015, SASSLC will continue its efforts to reduce obstacles to referral with the following strategies:**

- The transition team also worked closely with the IDT to discuss considerations for referral. Many referrals were made due to the former "repurposing" plans (one of the homes was going to be downsized for other purposes) and the residents were not quite ready to transition to the community. The transition team worked with the QIDP department to discuss obstacles in relation to referral.

- Transition specialists continue to attend self-advocacy meetings to answer questions and assist self-advocates in sharing information with others about their participation in recent tours. Former self-advocates will be invited to speak about their transition experience at a self-advocacy meeting at least annually. This is a positive experience for the residents and increases their comfort in communicating with transition team members on what they really want in the community and will continue in FY 2015.

- The QIDP and transition specialist continue to schedule tours ensuring knowledgeable staff accompany the resident so that the knowledgeable staff can document the individual's reaction to the environment and provide input as to what the resident might like or dislike about the home or day program (this was documented by the staff on tour notes and made available to IDT for discussion at team meetings). There needs to be more tours available for non-referred residents on a regular basis. In FY 2015, the transition specialists will work with the unit directors and home supervisors to arrange monthly tours and/or educational opportunities on "lap" days (designated day of the week for each home where all staff for all shifts are scheduled to work which means there is optimal staff availability for touring) at least one day monthly for each home with a focus on providing education to all residents with priority on the residents who are documented with lack of understanding of community options.

- Arranging visits and dinners with friends at their new community homes will continue to be an option if requested or appropriate in FY 2015. One resident has recently made a request to visit a former SASSLC resident and this will be scheduled if both parties are interested.

- Local Authority tours were made available to all residents as they were scheduled. Local Authority arranged tours are temporarily unavailable because the service coordinator in charge of the tours resigned. The transition specialists will arrange monthly tours for individual and IDT participation with each home as noted above.

- The transition team will continue to hold a provider fair at SASSLC annually and promote individual, staff, LAR, and family attendance through phone calls, flyers, letters, and incentives.

- The transition team is in the process of requesting to take on responsibility of Avatar data entry with living options for immediate access to review individual obstacles and address with touring/educational opportunities as appropriate.

- The transition team will provide IDTs with information on local providers with ready access to board certified behavior analysts and psychiatrists. This information will be provided to QIDPs. This is an on-going process and FY 2015 activities will include emailing resource guide information to QIDPs on providers/homes that excel in behavioral health supports.

- The transition team will continue to work closely with the QIDPs to better create plans that address each obstacle to community placement. This will include training on considerations for referral, CLOIP training, provider presentations, provider fair, and other educational opportunities.

- In FY 2015, the transition team will develop a biography sheet on individuals (with their consent) who have successfully transitioned to the community to be posted in their former home so they are readily visible to visiting LARs, residents and staff.

## C. Obstacles to Community Transition

**Table 4. Obstacles to transition identified from SASSLC, FY 2014**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 18 |
| Individual/LAR indecision | 13 |
| Lack of supports for individuals with significant challenging behaviors | 9 |
| Lack of availability of specialized medical supports | 2 |
| Need for environmental modifications to support the individual | 2 |
| Need for meaningful employment and supported employment | 2 |
| Need for transportation modifications to support the individual | 1 |
| Other | 5 |

### Center Strategies and Actions to Overcome or Reduce Obstacles to Transition

### Limited residential opportunities

The reason that limited residential opportunities obstacles existed were due to very specific preferred area requests, coupled with very specific needs for supports and services. An example of which are residents and families interested in group homes in Corpus Christi with strong behavioral and psychiatric supports, or in Weslaco which has limited appropriate provider choices with strong behavioral and psychiatric supports. The transition specialists made monthly contact with providers and suggested close alternative homes when available for the resident and IDT to tour during the transition process. Due to the increased challenges (behavioral/psychiatric and medical) that face the FY 2014, the IDT is very discerning and are only looking at established/experienced providers.

**Individual/LAR indecision**

The touring process was slowed down based on the inability of the LARs to make decisions and follow up on providers suggested for touring. Several residents were indecisive and changed their minds throughout the process (wanting different cities, backing out of decisions to have overnights) which caused significant delays in transition. One LAR preferred moving his brother to a Georgia state facility which was not an option as the State of Georgia is no longer accepting admissions as they are planning to close state facilities and institutions per Georgia's Department of Justice (DOJ) settlement agreement and the referral was rescinded. Another resident was referred with strong family support; however, the IDT learned after referral that the resident was clearly uncomfortable with touring or any community interaction. The referral was rescinded and the IDT put a desensitization plan in place. Another LAR referred four persons on her caseload with a specific provider in mind, who made promises that were not kept. The LAR could not decide on an appropriate alternative placement and rescinded two referrals. One referral was rescinded due behavior and psychiatric concerns; however, the LAR found an alternative placement for one resident that met her criteria and the transition occurred in FY 2015.

**Lack of supports for individuals with significant challenging behaviors**

The referrals for placement included four individuals who received 1:1 level of supervision. Three of the four referrals were rescinded by the IDT (two by guardians and one by the IDT due to pica related concerns and increased medical needs), two others had become psychiatrically and behaviorally unstable during the transition process. The remaining individuals required providers with strong behavioral supports, which was more time intensive as the individual required significant psychiatric and behavioral supports. This person moved in February 2014. Two individuals are actively looking for an appropriate provider. One is dependent on a LAR decision and the other has limited provider availability due to significant unauthorized departures and need for the Level of Need (LON) to increase; his team is currently working on a packet to increase his LON prior to transition.).

**Lack of availability of specialized medical supports**

One resident requires catheterization and another resident had a peg tube inserted one month prior to his referral and required 1:1. A provider has been chosen for the first resident; however, his medical needs have increased and the IDT and LAR are waiting on a Hematology consult (the resident already visited his potential community PCP).

**Need for environmental modifications to support the individual**

One individual's guardian has previously selected the provider and environmental modifications have been completed. The individual requires a mechanical lift for all transfers. Although the provider went as far as to order a lift to accommodate this individual's needs, upon review by OT/PT the lift in the home would not have been appropriate for the individual. Since the modifications have been made, the resident has experienced exacerbations of health issues that have delayed transition. The IDT is

concerned that the community cannot meet his medical needs. He is still referred, but his LAR has requested a community hematology consult prior to moving forward with transition.

**Need for meaningful employment and supported employment**

The IDT for one resident had concerns about lack of employment supports. The chosen provider agreed to work with DARS and send the individual to employment services; however, the LAR did not agree with this approach. The resident moved without issue, but without employment. The other resident has medical issues that can only be met in a Day Activity Health Services (DAHS) program which does not offer employment opportunities. This resident's transition is pending a community hematology consult.

**Need for transportation modifications to support the individual**

The transition specialist has been working with a referred resident who utilizes a customized wheelchair. The wheelchair does not have the ability to be folded down which requires any potential provider to have a wheelchair accessible van. The transition specialist contacts different providers monthly to explore the availability of wheelchair accessible homes with wheelchair accessible vans with monthly follow up. The individual and his team continue to tour and contact providers for appropriate placement. There is one home that has promise and may be considered for pre-placement visit by January 2015.

**Other:**

**Illness during transition period**

One resident had a significant increase in seizures with increased lethargy, which slowed down touring. This individual moved to a 4 bed HCS group home in October 2014 and appears to be very happy in his new home. The other resident had an injury which required significant rehabilitation and repeated hospitalizations which was then rescinded by his team.

**Provider Delay in Opening Home**

Three residents chose a particular provider and home, but their transition was slowed due to pending San Antonio Fire Department (SAFD) Fire Marshall's approval. Two of the individuals are scheduled to move to the community in October 2014, while one individual's referral was rescinded due to medical issues.

**In fiscal year 2015, SASSLC will continue its efforts to reduce obstacles to transition with the following strategies:**

In FY 2014, the transition team worked on assisting the QIDP in finding or scheduling updated Determinations of Intellectual Disability (DIDs), finding or obtaining certified birth certificates and Identification cards and working closely with the QIDP coordinator and educator to better understand the importance and purpose of team participation throughout the transition process for the referred residents. By the end of FY 2014 there was significant improvement in the occurrence of over 180 day ISP-As as well as correlating progress in most of the referrals.

- In FY 2015, the transition team will continue to follow up and prompt the QIDPs of over 180 day ISP-As through monthly emails and attendance at QIDP monthly meetings.

- In FY 2015, the transition team will work with Unified Records and QIDP Coordinators to enter the obstacle to transition data in AVATAR so that it can be accurately and efficiently documented as well as to provide the transition team with immediate information on obstacles to transition that can be addressed through education and assistance.

- The transition team and QIDP will address potential obstacles at 7-14 day meeting so that they can be addressed early in the process and prevent transition delay.

The transition specialists' most important role to reduce obstacles appears to be education. The goal is to increase educational opportunities for all residents, families and professionals associated San Antonio State Supported Living Center. San Antonio has a small transition team, so this has contributed to the slower transition process for many of the individuals. The transition process requires time from all team members and the local authority. Getting the group together can be challenging. The APC and QIDP Coordinator will continue to work on strategies for getting the team together more consistently throughout the individual's referral process.