# State Supported Living Centers Obstacles to Community Referral and Transition in Fiscal Year 2017

**As Required by**

**the Department of Justice**

**Settlement Agreement**

**Section II.T.1.g**

**May 2018**

TEXAS
Health and Human Services

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# 1. Introduction

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 the 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 the movement of individuals to more integrated settings that are 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 appropriate agencies. Based on each SSLC's assessment of obstacles to the movement of individuals to more integrated settings, the Health and Human Services Commission (HHSC) has produced the following consolidated report to satisfy this requirement.

# 2. Background

## Identification of Obstacles

Obstacles are defined as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his or 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 (ISPA).

When identifying obstacles, IDTs will:

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

Any needed supports and 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 the development of specific action plans to address identified trends and/or patterns of issues.

## Conducting the Comprehensive Assessment

The SSLCs are charged with the collection of data based on several categories:

### 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) reluctance for community placement, at least one subcategory is identified to better delineate the obstacle. For each obstacle identified, the IDT must develop a plan to overcome or minimize the obstacle to referral.

Category:

- Individual's reluctance for community placement;
- LAR's reluctance for community placement;
- 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); and
- 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 are preventing the individual from a successful transition. Staff must develop a plan to overcome the obstacle, 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:

- Lack of supports for people with significant challenging behaviors;
- Lack of specialized mental health supports;
- Need for services and supports for individuals with forensic needs/backgrounds;

- Need for environmental modifications to support the individual;
- Need for transportation modifications to support the individual;
- Lack of availability of specialized medical supports;
- Lack of availability of specialized therapy supports;
- Lack of specialized educational supports;
- Need for meaningful employment and supported employment;
- Individual/LAR indecision;
- Limited residential opportunities;
- Medicaid/Supplemental Security Income (SSI) funding; and
- Other.

# 3. Process

For the past year, obstacles were identified by the IDTs during the living options discussion, as well as during the community transition process. Each center's assistant director of programs, quality assurance director, admission/placement coordinator (APC), qualified intellectual disabilities professional (QIDP) coordinator, and data analyst are charged with working collaboratively to produce the center's annual obstacles report. These individual reports are gathered and combined in to this report. Strategies that target multiple obstacles to referral and transition will be found in each of the sections to which they apply.

## Statewide Obstacles to Referral

### Fiscal Year 2017 Statewide Data

**Table 3-1. Statewide Obstacles to Referral, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 1,693 | 47.24% |
| Individual's reluctance for community referral** | 685 | 19.11% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 612 | 17.08% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 502 | 14.01% |
| Lack of funding | 70 | 1.95% |
| Court will not allow transition (Ch. 55/46B only) | 11 | 0.31% |
| Evaluation period (Ch. 55/46B only) | 11 | 0.31% |

*Data Source: IRIS and MyAVATAR systems – Living Options Discussion*
**See Table 3-3*
***See Table 3-2*

**Table 3-2. Individual Reluctance for Referral Statewide Data, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 292 |
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 186 |
| Individual is not interested in being provided information and exposure to community living options | 99 |
| Unsuccessful prior community transition(s) | 64 |
| Mistrust of providers | 32 |

*Data Source: IRIS and MyAVATAR systems – Living Options Discussion*

**Table 3-3. LAR Reluctance for Referral Statewide Data, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community transition | 1228 |
| LAR is not interested in being provided information and exposure to community living options | 315 |
| Mistrust of providers | 174 |
| Unsuccessful prior community transition(s) | 145 |
| Lack of understanding of community living options | 104 |

*Data Source: IRIS and MyAVATAR systems – Living Options Discussion*

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

- Local intellectual and developmental disability authorities (LIDDA) enhanced community coordination (ECC) service coordinators continue to provide intense monitoring and flexible assistance to individuals to support success in the community. The ECC service coordinator ensures individuals are linked to critical services, and receive person centered services for up to five years following a transition from an SSLC. LIDDAs provide supports to their communities including educational opportunities, technical assistance, and consultation to ensure individuals maintain independence and success in their chosen communities, and professionals are educated on the most up to date information pertaining to support of Texans with disabilities. Intensive coordination by the LIDDA may address some LAR concerns regarding community services.
- Each SSLC continues to employ at least one social worker to increase and improve communication and coordination of services with LARs, family members, actively involved persons (AIP), and other agencies. The social worker positions are available to assist in educating individuals and LARs regarding community services and addressing related concerns regarding transition.
- In 2017, the 85th Texas Legislature enacted Senate Bill 547 authorizing the SSLCs to provide non-residential services. Rules outlining the categories of services and rates are in the process of being drafted and approved. Non-residential services that may be provided include: habilitation therapies, dental services, primary care provider services, psychiatry services, behavioral health services, adaptive aids, and durable medical equipment. In the fall of 2018, HHSC plans to pilot providing dental services at Austin and Richmond SSLCs to individuals who are not SSLC residents. It is believed the provision of these services will increase the level of comprehensive services available to promote living in the most integrated environment possible, including community transitions.
- HHSC received funding from the 84th Legislature to support individuals with intellectual and developmental disabilities with significant psychiatric and behavioral challenges, many of whom transitioned or were diverted from institutional settings. This funding provides crisis intervention specialists to support the mobile crisis outreach teams in LIDDA local service areas and provides crisis respite including short-term, community-based, in-home, or residential therapeutic support. Currently, all 39 LIDDAs statewide are

directed to provide crisis intervention and crisis respite services to support individuals in maintaining independent lives in the community.

- Two SSLCs are the pilot sites for implementation of the Ukeru system, which is a trauma-informed approach to crisis intervention. The approach emphasizes comfort and safety rather than control, using soft shields to de-escalate a crisis event instead of physical, mechanical, or chemical restraint. Data and staff interviews suggest effectiveness in de-escalation and direct support professionals are positive about using the approach to reduce restraints. The trauma-informed approach may help the individual feel less anxious and result in reduced restraints which will increase the individual's residential options.
- Beacon Board Certified Behavioral Analysts have been assigned to SSLCs to provide behavioral assessments and positive behavior supports for individuals with intense challenging behaviors. These advanced clinicians are developing innovative ways to reduce challenging behaviors, to teach skills to cope with emotional dysregulation that could lead to a crisis, and to develop behaviors that promote positive relationships and an improved quality of life.
- State office created a psychiatric services coordinator position to function as the discipline coordinator for psychiatric services at the SSLCs. This position consults with SSLC staff regarding individuals with complex psychiatric needs and is working to assess the organization and service delivery of psychiatry departments across the system.
- State office implemented a root cause analysis process to prevent undesirable health and behavioral events in individuals served by providing a systematic method for identifying etiology, providing guidelines for establishing effective plans and interventions, and promoting interdisciplinary services for clinical issues. Identified staff were trained in 2017 at state office and on site and continue to receive additional instruction and oversight as needed. A state-wide procedure, monthly reporting system, audit tools, and refresher training have been developed and provided to facilities to ensure ongoing implementation of the process.
- HHSC created an add-on rate for three small (i.e., four to six beds) community-based intermediate care facilities for individuals with an intellectual disability or related condition (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 three ICF homes will be located in the Austin area. The first of the three homes opened in April of 2018. Eleven residents have been screened and determined eligible for the homes and are waiting to move.

- HHSC Legal Services continues to share immigration resources as identified to assist individuals, LARs, and families with citizenship issues. SSLC staff continue to work with local immigration offices to better understand the individual's immigration status and submit an application, when appropriate. One local office completed a presentation regarding immigration issues to SSLC social workers, human rights officers, and reimbursement staff during calendar year 2017.
- HHSC Legal Services continues to work with SSLCs to address the court's opposition and concerns with an individual's proposed move to a community setting to include education regarding community services, including monitoring by the SSLC, the LIDDA, and oversight by HHSC Regulatory Services. State office is also working on an informational website for district and family courts to provide information on the purpose of SSLCs as ICFs.
- The overall turnover rate for QIDPs at the SSLCs has decreased since 2015, when the state auditor's office approved a reclassification of the QIDP position series to higher pay groups. This has supported QIDP recruitment and retention efforts. To further support retention efforts, a variety of training materials and resources will be developed in 2018 to assist and support QIDPs in understanding the ISP process, living options, and the role of the QIDP and IDT.
- Each SSLC has identified an ISP project manager to oversee the progress and implementation of the revised ISP process. Subject Matter Experts (SMEs) have also been identified at each center, including at least one SME trainer who focuses on ongoing training of center staff. During 2017, the SME trainers received specialized consultation and were evaluated on their knowledge and abilities. Follow-up visits and trainings will be conducted throughout 2018 to provide additional guidance and oversight.
- A training conference was held in April 2018 for QIDP Coordinators, QIDP Educators, and Education & Training Department staff on topics such as living options, community engagement/integration, and greater independence. This training was meant to assist facility staff in having meaningful and quality living options discussions, accurately identifying obstacles to referral, as well as developing meaningful action plans to overcome identified obstacles.
- A standardized QIDP monthly review monitoring tool is being developed. This tool will incorporate questions to evaluate the implementation of living options goals and action plans, progress toward completion of action plans and living goals, and whether the action plans, as implemented, adequately address the identified obstacles to referral for transition.

- State Office will conduct quarterly meetings with QIDP Coordinators and AP Coordinators to review obstacle data, provide a forum for exchange of ideas and identification of best practices. The first meeting occurred in April 2018.

# Statewide Obstacles to Transition

## Fiscal Year 2017 Statewide Data

**Table 3-4. Obstacles to Transition Statewide Data, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 62 |
| Need for environmental modifications to support the individual | 52 |
| Lack of supports for individuals with significant challenging behaviors | 47 |
| Individual/LAR indecision | 37 |
| Lack of availability of specialized medical supports | 19 |
| Lack of availability of specialized therapy supports | 7 |
| Medicaid/SSI funding | 4 |
| Lack of availability of specialized mental health supports | 3 |
| Need for transportation modifications to support the individual | 3 |
| Need for services and supports for individuals with forensic needs/backgrounds | 2 |
| Need for meaningful employment and supported employment | 1 |
| Other | 53 |

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

- Following a successful pilot, the revised 14-day ISPA template was rolled out statewide on December 1, 2017 to guide a more meaningful and thorough discussion following a new referral. This new approach will result in providing

better education to the IDT on the transition process, increased focus on individual and LAR preferences, identification of necessary supports to address the individual's needs, and increased quality of assessment summaries and recommendations, which in turn will result in a better community living discharge plan (CLDP). Identification of a more comprehensive set of supports, early in the referral process, will allow for a more informed selection of potential providers that can successfully support the individual's transition.

- State office has worked with the transition specialist team and identified expansion of the community provider base as the systemic goal for the remainder of the Money Follows the Person (MFP) grant period. The community provider profiles have been revised to include more specific information about specialty services, including two staff on duty and nursing staff onsite to ensure IDTs are aware of all available community options.
- To ensure awareness of referrals for transition, HHSC continues to share referral information, categorized by SSLC and LIDDA, with the two community provider trade organizations on a quarterly basis.
- HHSC, as the state Medicaid agency, worked with the Centers for Medicare and Medicaid Services (CMS) to amend the Home and Community-based Services (HCS) waiver to allow pre-approval for environmental modifications when a provider is selected for transition. This pre-approval for funding has been available since November 2015, and has been accessed multiple times to allow modifications to be completed prior to the individual's move from an SSLC.
- HHSC continues to support individuals in maintaining paid employment opportunities when transitioning to the community. To accommodate an individual's desire for paid work, the individual may continue employment through the SSLC work center if he or she desires or if opportunities are not readily available in the community at the time of transition.
- The Corpus Christi and San Angelo SSLCs have continued the paid vocational apprenticeship program after completion of the CMS MFP Demonstration grant. Richmond SSLC participated in the pilot and is exploring reinstating the program due to its success. An additional site at the Mexia SSLC is in initial stages of developing its plan to implement vocational apprenticeship.
- In August 2016, SSLC vocational services began coordination with Texas Workforce Solutions-Vocational Rehabilitation Services (TWS-VRS) for implementation of the Workforce Innovation and Opportunity Act (WIOA). The WIOA requires individuals with disabilities who wish to start or continue participating in subminimum wage or piece rate work to receive career

counseling services. Individuals participating in career counseling and interested in competitive, integrated employment in the community may request application for services through TWS-VRS. Individuals who transition to the community and desire competitive employment can continue to receive services through TWS-VRS as eligible.

Community Referrals and Transitions from State SSLCs, Fiscal Years 2010 – 2017

**Table 3-5. Statewide Historical Data**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns - within 6 months of move | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 224 | 76 | 330 | 8 | 4,207 |
| 2011 | 221 | 90 | 204 | 3 | 3,994 |
| 2012 | 267 | 65 | 207 | 5 | 3,787 |
| 2013 | 243 | 110 | 287 | 16 | 3,547 |
| 2014 | 240 | 137 | 261 | 9 | 3,362 |
| 2015 | 129 | 132 | 233 | 9 | 3,186 |
| 2016 | 149 | 98 | 126 | 10 | 3,103 |
| 2017 | 179 | 92 | 109 | 6 | 3,019 |

*Data Source: IRIS and MyAVATAR systems - Demographics*

# 4. Abilene State Supported Living Center Obstacles to Referral and Transition

## Center Profile

Abilene SSLC opened in 1904. The center is on 200 acres and, at the end of fiscal year 2017, was serving 282 residents. Abilene SSLC employs approximately 1,400 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. These counties make up the three LIDDAs, which are Betty Hardwick Center, Center for Life Resources, and Pecan Valley Centers.

Abilene SSLC is located in Taylor County which has the greatest number of HCS and ICF providers available in the 18-county catchment area. Although 130 HCS providers are listed for Taylor County, only eight currently provide services locally. Out of the HCS and ICF providers in Taylor County, only one HCS and one ICF provider have their own vocational services. Of all the counties in the Abilene SSLC catchment area, only Brown County has a work center which provides resources to individuals with intellectual disabilities. The majority of individuals who have transitioned to the community in the past three years have chosen locations outside of the Abilene area, with the greatest number choosing the Dallas/Fort Worth area. Many individuals have family living in the chosen area while others move to locations with a wider selection of medical specialists and/or day programming. Some choose to live with peers who have previously transitioned successfully. The admissions and placements (AP) department staff work closely with individuals, families, and IDTs to locate providers in chosen areas who can provide the identified supports for each transitioning individual.

The center continues to support individuals with transition to the community as they are referred through the IDT process. During fiscal year 2017 three individuals transitioned to the community. This is a significant decrease when compared with previous years, but was not unexpected due to guardian choice and the number of individuals who have complex medical and behavioral health needs. Individuals who were ready to live in the community have already transitioned.

In July 2016, Abilene SSLC went from two transition specialists to one, due to the reduction in MFP grant funds. The transition specialist continues to work with IDTs, families, and individuals to provide information on services available in the community as well as to provide community tours. The IDTs continue to review living options at least annually and include the AP department staff in these meetings when appropriate. The AP department staff work with the IDTs to ensure individuals move to the community with the needed supports in place. This careful consideration and planning has resulted in a very low number of returns from community transitions.

**Table 4-1. Community Referrals and Transitions from Abilene SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 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 |
| 2015 | 19 | 8 | 24 | 0 | 321 |
| 2016 | 10 | 8 | 18 | 2 | 293 |
| 2017 | 4 | 6 | 3 | 0 | 282 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 4-2. Individuals Not Recommended for Referral from Abilene SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 177 | 45.97% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 114 | 29.61% |
| Individual's reluctance for community referral** | 51 | 13.25% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 43 | 11.17% |

*Data Source: IRIS*
**See Table 4-4*
***See Table 4-3*

**Table 4-3. Individual Reluctance for Referral from Abilene SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 26 |
| Individual is not interested in being provided information and exposure to community living options | 11 |
| Lack of understanding of community living options | 8 |
| Unsuccessful prior community transition(s) | 8 |
| Mistrust of providers | 1 |

*Data Source: IRIS*

**Table 4-4. LAR Reluctance for Referral from Abilene SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 131 |
| LAR is not interested in being provided information and exposure to community living options | 41 |
| Unsuccessful prior community transition(s) | 15 |
| Mistrust of providers | 3 |
| Lack of understanding of community living options | 2 |

*Data Source: IRIS*

## Center Actions to Overcome or Reduce Obstacles to Referral

### LAR reluctance for community referral

LAR reluctance continues to be the greatest obstacle to referral for community transition at Abilene SSLC and is also the most difficult to overcome. Education of LARs about living settings in the community is most often addressed through the Community Living Options Information Process (CLOIP) which occurs before each annual ISP and is facilitated by staff from the Betty Hardwick Center. This process provides basic information about community programs to LARs and family members. However, many LARs decline to receive information from the CLOIP workers or attend community tours of providers and day programs. LARs often state they are aware of the options and are not interested in community placement. LARs and other family members are encouraged to attend the educational community tours provided through the LIDDA that occur twice a month, but a review of tour attendees reveals no LARs or family members attended these tours

during fiscal year 2017. Many LARs are parents or siblings and state Abilene SSLC is the only home their loved ones have known, and they do not want to disrupt their lives after so many years of living at Abilene SSLC. Although the majority of LARs state 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 a belief that community providers cannot provide the same level of supports as Abilene SSLC.

In the past, the Abilene SSLC transition specialist provided tours for some LARs and family members, which proved to be a more effective strategy by staff to assist LARs in seeing actual group homes and day programs. The LARs are now turning down these offers more often. The transition specialist attends ISP meetings to offer additional information and education to LARs on community living options. Articles about individuals who have had successful transitions to the community continue to be published in the bi-monthly center publication, *The Maple Street Messenger*, which is sent to families and correspondents. These articles provide an opportunity for LARs to learn about positive outcomes from community transitions. Some individuals who have been featured in the past may be included for further follow-up to show their continued success. It is uncertain at this time if this approach is effective in reaching LARs, but it does show community transition in a positive light and will be continued.

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

Medical needs continued to be the second greatest obstacle to community transition during fiscal year 2017. Abilene SSLC currently has five homes that provide 24-hour nursing services and care for the most medically-involved individuals at the facility. Abilene SSLC also has an on-site infirmary to provide medical care not serious enough for admission to a hospital, but more than the homes can provide. As the population at Abilene SSLC ages, it is likely that medical needs will continue to be a significant obstacle. It is also important to note that some admissions from the community are due to individuals needing more intensive medical care than can be provided in community settings.

At this time the only 24-hour nursing services available in the local community are through nursing homes or other medically-oriented settings. There has been limited progress in opening a small number of ICF facilities in the Austin and San Antonio area that can address the needs of individuals with health concerns requiring intensive nursing care. The AP department staff will continue to provide families

and IDT members with information and updates on the high medical needs ICF programs as they may become available in the future.

## Individual's reluctance for community referral

Individual reluctance accounts for about 13 percent of the obstacles to community referral. The majority of individuals who are not interested in community options state they like their current homes and do not want to move. Some have had failed community placements in the past. Individuals are attending events in the community more regularly than in the past, but many are still uneasy when not in familiar surroundings. Others only have negative memories of past experiences of living in the community and refuse to consider it. The IDTs are sensitive to these feelings and try to provide opportunities for these individuals to have positive experiences in the community through outings that are of interest to each individual. The hope is that as individuals have positive community visits they will be less reluctant to considering the community as a living option.

The twice-monthly educational community tours given by Betty Hardwick Center continue to provide an opportunity for individuals to learn more about community living options. The APC and transition specialist will continue to assist Betty Hardwick Center staff by providing transportation and additional staff to support tours in fiscal year 2018 to ensure individuals, whose only obstacle is their own reluctance, are given the opportunity to see homes and day program centers; if they agree to attend.

As a supplement to CLOIP tours, the transition specialist continues to assist in setting up tours for individuals that the IDTs feel could be served in a less restrictive setting. Some individuals have visited peers who have successfully transitioned to the community in their new homes. IDTs will continue to use visits with peers as positive experiences in the community for the individuals who have friends who transitioned previously.

The APC will contact the QIDPs for the eight individuals who were identified as having a lack of understanding of community living options to help identify ways to increase understanding. Action plans will be developed that outline specific interventions to address lack of understanding. Provider fairs continue to offer opportunities for individuals to meet different community providers and learn more about the options available to them. With the help of the recreation department, resident attendance at provider fairs has been good, and individuals along with their staff who attend with them receive information on the options available in the

Abilene area, as well as other areas that may be represented. AP department staff attend the monthly self-advocates meetings on campus when invited to talk to attendees and give them more information on community living options. The individuals who attend these meetings appear to enjoy the information presented and often ask questions about some of their peers who have moved to the community. The APC has arranged with the Human Rights Officer to be able to attend at least two of these monthly meetings in fiscal year 2018. If possible, an individual who has successfully transitioned to the community will be invited to come talk to the group at one of the meetings.

## 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 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 and psychiatric needs.

The majority of applications for admission to Abilene SSLC are for individuals who have behaviors which may be difficult to address in the community setting. Psychiatric care is not always readily available and many community providers do not have ready access to behavior specialists who can assist with the implementation and oversight of behavior support plans. As more individuals are admitted with significant behavioral health and psychiatric needs this obstacle will most likely continue to increase.

As individuals are determined to be psychiatrically and behaviorally stable, the IDT will consider community transition through living options discussions. The AP department will continue to assist IDTs by providing information on community providers able to support individuals with psychiatric needs as they are identified. Abilene SSLC has piloted a new program called Ukeru to help individuals become more behaviorally stable. It is hoped that this program will reduce the number of individuals with this obstacle to transition.

## Strategies to Reduce Obstacles to Referral in 2018

### In fiscal year 2018, Abilene SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- The AP department staff will continue to assist IDTs with individuals who have been identified as having no other obstacle to referral, other than their own reluctance. These individuals will be the primary focus of attempts to provide more individualized education on community living options available in an effort to reduce their reluctance. Attendance at CLOIP tours, personal tours with the transition specialist, and opportunities to visit peers who have transitioned successfully will be the main focus by the AP department to address this obstacle.
- The AP department will continue to assist IDTs with individuals who have been identified as having no other obstacle to referral, other than LAR reluctance, by offering personalized tours of community providers and other information to help educate them on the options available. While the number of LARs who have become more open to community living options is still small, the facility believes personal contact continues to be the most effective way to establish a positive relationship with LARs, specifically addressing the LAR's concerns about community transition.
- The AP department will continue to attend annual ISP meetings to provide LARs and individuals with information on services in the community. ISP meetings will be attended based on invitation from the IDT. CLOIP and permanency planning documents for upcoming ISP meetings will continue to be reviewed at weekly departmental meetings to see if there might be additional individuals who could benefit from attendance at their ISP meetings. The QIDP will be contacted prior to the meeting to ensure the department's attendance is appropriate.
- A provider fair will be held during fiscal year 2018 to provide an opportunity for individuals and staff to meet community providers in this area. LARs and family members will be notified of provider fairs and invited to attend through the help of the social workers. However, the focus of the provider fair will be on the education of the individuals and their IDT members.
- AP department staff will attend and provide information on community living options at the January and June Abilene SSLC self-advocates meetings. Plans are to continue to have a Power Point presentation to provide visual aids in communicating information, as well as to invite former residents to 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*. Articles will be submitted as consent is given by LARs and individuals.
- Data regarding obstacles to referral will continue to be shared with state office in order to assist in developing plans to address obstacles at the statewide level.

# Obstacles to Community Transition

**Table 4-5. Obstacles to Transition from Abilene SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Need for environmental modifications to support the individual | 4 |
| Individual/LAR indecision | 4 |
| Lack of supports for people with significant challenging behaviors | 3 |
| Other | 4 |

*Data Source: IRIS*

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

### Need for environmental modifications to support the individual

The four individuals with this obstacle utilized wheelchairs or had low vision and needed homes with modified floor plans that could accommodate their needs. Bathroom modifications were also needed to address bathing needs. Finding providers who had homes with these modifications caused a delay in their transitions due to the difficulty involved in finding appropriate homes. One individual asked to have their referral rescinded after changing their mind about moving to the community. Two others had their referrals rescinded after developing significant health issues that required 24-hour nursing care, and another individual passed away after a brief illness before they could do any pre-placement visits.

## Individual/LAR indecision

There were four individuals whose delay in transition was due to indecision. One individual took an extended amount of time to identify a preferred provider after making pre-placement visits. This individual transitioned to the community in fiscal year 2017 after finding a provider they were comfortable with. Three LARs took extra time to decide on the type of placement they preferred. One individual transitioned to the community in fiscal year 2017 after their LAR was satisfied they had chosen a provider who could meet the needs of their family member. At the end of fiscal year 2017, the other two LARs continued to work with the Transition Specialist and IDTs to determine which provider would be best to provide care for their family members.

## Lack of supports for individuals with significant challenging behaviors

Of the three individuals with this obstacle, one continued to make visits to a provider chosen by the LAR at the end of fiscal year 2017. One other individual successfully transitioned to the community after the chosen community provider was able to put extra supports in place to address concerns related to his safety prior to the move. Referral activity was put on hold for the other individual after experiencing significant psychiatric issues at the end of fiscal year 2017. The IDT continues to monitor psychiatric stability. Pre-placement visits will resume once the psychiatrist and IDT agree.

## Other - Illness during transition period

Three individuals experienced illness during the transition process, and one eventually had their referral rescinded when they could not be medically stabilized. One individual transitioned to the community after their medical issues resolved and they were able to resume the transition process. The third individual has since recovered from their illness and should transition during the first half of fiscal year 2018.

## Other - Provider delay in opening home

One individual experienced a delay in moving when the selected provider encountered issues completing home modifications for wheelchair accessibility. This individual passed away before the community provider was able to complete the needed modifications.

## Strategies to continue reducing obstacles to transition at Abilene SSLC in fiscal year 2018

- 14-day meetings will be conducted by the APC and will identify all needed supports which will be used to identify potential community providers who can meet the needs of the referred individual. By beginning the referral process with a more comprehensive set of identified supports, it should be easier to identify potential providers and schedule initial visits sooner.
- The APC and transition specialist will work with IDTs to identify and address obstacles to transition as they are identified. Additionally, the APC will continue to 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.
- The transition specialist will continue to work with the IDTs to identify providers that can meet the needs of individuals who require 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.

# 5. Austin State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The Austin SSLC is a 95-acre facility opened in 1917. As of August 31, 2017, Austin SSLC was serving 180 individuals and employed approximately 979 staff.

The Austin service area includes Travis, Williamson, and Hays counties. The area has a variety of providers that offer services, including: three and four-bed HCS group homes; host home/companion care; supported home living through the HCS program; ICF group homes; respite care; day habilitation; and work centers. The catchment area for Austin SSLC 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. While the number of community referrals has increased slightly from 11 in in 2015, to 12 in 2017, the number of rescinded referrals decreased significantly from 28 in 2015, to one in 2017.

**Table 5-1. Community Referrals and Transitions from Austin SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 15 | 4 | 15 | 0 | 377 |
| 2011 | 16 | 4 | 14 | 0 | 355 |
| 2012 | 33 | 3 | 16 | 0 | 328 |

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2013 | 27 | 16 | 25 | 0 | 288 |
| 2014 | 48 | 15 | 15 | 0 | 266 |
| 2015 | 11 | 28 | 32 | 0 | 192 |
| 2016 | 6 | 6 | 1 | 0 | 184 |
| 2017 | 12 | 1 | 0 | 0 | 180 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 5-2. Individuals Not Recommended for Referral from Austin SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 146 | 64.04% |
| Individual's reluctance for community referral** | 39 | 17.11% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 25 | 10.96% |

| Reason Not Referred | Total | Percentage of Reasons 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 | 14 | 6.14% |
| Lack of funding | 3 | 1.32% |
| Court will not allow placement (Ch 55/46b) | 1 | 0.44% |

*Data Source: IRIS*
** See Table 5-4*
***See Table 5-3*

**Table 5-3. Individual Reluctance for Referral from Austin SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 22 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 10 |
| Individual is not interested in being provided information and exposure to community living options | 3 |
| Unsuccessful prior community transition(s) | 3 |
| Mistrust of providers | 1 |

*Data Source: IRIS*

**Table 5-4. LAR Reluctance for Referral from Austin SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 127 |
| Mistrust of providers | 11 |
| Lack of understanding of community living options | 10 |
| LAR is not interested in being provided information and exposure to community living options | 9 |
| Unsuccessful prior community transition(s) | 7 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

One of the greatest obstacles to referral for community transition at Austin SSLC continues to be LAR reluctance. Prior to an individual's annual ISP meeting, LARs are contacted by an ECC as part of the CLOIP through the LIDDA. LIDDA staff provide information regarding community living options with a packet sent in the mail, as well as initiate phone calls to the LAR to discuss and answer any questions or concerns the LAR might express. This process continues to be a challenge as some LARs decline the CLOIP information, are not interested in attending tours of community options, and decline the attendance of the LIDDA staff at the annual ISP meeting.

The QIDP and AP departments continue to work in conjunction with LIDDA staff to communicate, educate, and discuss living options with LARs. By working together, we ensure information is being communicated consistently as well as strengthening the relationship between Austin SSLC and LIDDA. LARs are encouraged to attend

educational CLOIP tours of community provider homes, day program, and vocational sites scheduled through the AP department and LIDDA staff that occur at least twice per month.

In fiscal year 2017, individuals, AP staff, direct care staff, and ECC/CLOIP staff from the LIDDA participated in 53 CLOIP tours. A CLOIP tour reaction form is completed for each individual which describes the home and type of program toured and the individual's reactions in both locations. Direct care staff observations of the individual's reactions are also documented at the end of the tour. A copy of the CLOIP tour reaction form is sent to the LAR for review as well as shared with the IDT during an individual's annual ISP meeting.

The QIDP department continues to utilize the facilitator model for all annual ISPs, which allows for more consistency in the facilitation and documentation of the living options discussion. ISP facilitator QIDPs receive specialized training with a focus on improving the living options discussion in the ISP. AP staff attend 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. If a LAR does not attend an ISP, the QIDP contacts them to ask if they are open to the individual attending provider fairs or CLOIP tours. The LAR is informed about the use of community options exposure through these opportunities and the fact that the activities can be scheduled without affecting the individual's referral status.

The QIDP coordinator will complete an audit of these ten individuals living options discussions with LARs with a lack of understanding to ensure the action plan is effective and making progress. If issues are identified they will be addressed with the IDT and through an ISPA meeting to revise the action plan as needed to ensure the lack of understanding is being addressed.

## Individual's reluctance for community referral

The AP department staff continue to attend ISP meetings and are able to discuss an individual's experience during a CLOIP tour. During the last fiscal year, AP staff attended 73 percent of ISP meetings and provided follow-up to the remaining 27 percent. AP staff work with the team to individualize the tours as much as possible, so the resident, IDT, and family member can get a better idea of what an appropriate community setting might look like for this person. Tours are organized in small groups with individuals who have similar preferences and needs. CLOIP tours occur at least twice a month on Fridays, or days with additional staff scheduled. AP staff attends the tour with the individuals and their direct support

professional (DSP). Having fewer people has also proven to decrease anxieties for some of the individuals entering into a new environment.

Provider fairs held on campus provide additional opportunities for individuals to meet different community providers and learn more about the options available to them. On campus provider fairs were held in October 2016 and April 2017. The AP department invites community providers through letters and email and sends information fliers to LARs and families. Fliers are also placed around campus and in all of the homes. Both fairs included games with prizes for the individuals to participate in while touring and interacting with the providers in attendance. Approximately 143 residents attended in October with three community providers and one LAR. In April there were 91 residents in attendance, seven community providers, and eight LARs. The provider fairs continue to be scheduled on Saturdays to allow greater opportunities for families and LARs to attend, as well as greater participation from community providers. As the data indicates, there was an increase in LAR and community provider participation and a significant decrease in resident participation. As appropriate, to address this decrease in attendance, IDTs created service objectives for individuals to attend CLOIP tours or provider fairs throughout the year; this assists in tracking and follow-up to ensure individuals attend these activities.

IDTs promote community exposure by scheduling regular outings in the community and developing service objectives that identify specific destinations according to their preferences. At a minimum, IDTs work to ensure individuals go on outings at least monthly, and if refusals or medical complications arise, IDTs make plans to accommodate the individual based on their needs.

The QIDP coordinator will complete an audit of the living options discussion for the 22 individuals who lack an understanding of community living options to ensure the action plan is effective and making progress. If issues are identified they will be addressed with the IDT and through an ISPA meeting to revise the action plan as needed to ensure the lack of understanding is being addressed.

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

The third greatest obstacle to referral at the Austin SSLC is individuals who require 24-hour nursing services. The AP department continues to work with the IDTs to provide information and training on how to identify individuals whose needs actually require this level of nursing support. Information will also continue to be provided

to IDT members during ISPs outlining the High Medical Needs ICF homes and how they can support those medical needs in the community. There are currently five individuals referred for transition to one of the High Medical Needs ICF homes. There has been little progress with the High Medical Needs ICF provider in regards to obtaining and opening a home.

## 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 14 individuals with behavioral and psychiatric needs identified as an obstacle to referral. The facility will begin using the Living Options form to identify whether the individual has a positive behavior support plan (PBSP), history of failed placement related to behavioral concerns, or noted difficulties related to transitional times, to determine if behavioral health staff should attend future CLOIP tours. The purpose of this initiative will be to proactively plan for any behavioral needs. The Austin Travis County Integral Care (ATCIC) offers Community Based Services (CBS), which provide long term support for individuals with behavioral and psychiatric needs in the community. The goal of the CBS team is to minimize crises that may put individuals at risk for incarceration, hospitalizations, and possible loss of community placement. In addition to ATCIC's CBS program, LIDDAs serving Austin SSLC's catchment area offer Intellectual Disability/Developmental Disability (ID/DD) Crisis Intervention services. This program serves individuals who have experienced a crisis episode or are at risk of experiencing such an episode. This service is utilized to support individuals with ID/DD to remain in the community by providing crisis prevention services, such as referrals to appropriate services and skills training. The AP department will provide information to IDTs about these programs, as appropriate, to assist in living options discussions.

## Lack of funding

Efforts to secure funding for three individuals who are not currently citizens of the United States and not eligible for Medicaid funding will continue in fiscal year 2018. One individual's paperwork was submitted to Immigration Naturalization Service (INS) by his mother, but she has since passed away. The rest of his family is not able to take over the process. A second resident has a Family Elder Care guardian who was looking into the naturalization process, but has been unsuccessful. The third resident had her visa expire in 2015, due to lapse in LAR completion of the renewal process. The guardian, IDT, and social worker are continuing efforts to

update her residency status. The SSLC will continue to research immigration attorneys and agencies that might be able to continue the process for these individuals. Since the last report, an individual who became a legal permanent resident in December 2016 will continue on the five-year waiting period to receive Medicaid funding that would qualify them for a community program.

### Court will not allow placement

One individual was not referred to the community due to court decision. The APC will continue to inquire on the status of his case and provide education to the court as needed prior to the annual ISP or as requested by the IDTs.

### In fiscal year 2018, Austin SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- The AP department will continue to work closely with the LIDDA staff to ensure there is an offering of at least two CLOIP tours per month, with an emphasis on providing individualized CLOIP tours for those who have more focused needs such as environmental, medical, and behavioral. AP staff will also continue to encourage LARs, family, and AIPs to attend and participate in community education tours.
- LIDDA staff continue to attend ISPs and will provide information to the LAR, individual, and IDT regarding the various aspects of the CBS program. Adjacent LIDDAs, including Bluebonnet Trails and Hill Country MHDD, also have crisis intervention programs and speak to these services during an individual's ISP.
- Provider interviews have become an integral part of the community transition process for individuals who have been referred, but this has also provided team members a better working knowledge of community providers and options, to which they can speak during annual ISP meetings. IDTs are also presented profiles of homes the provider being interviewed has that may be appropriate for the individual.
- The AP department will continue to work with the Quality Assurance department and the ISP advisory team to develop new ways for teams to have meaningful, quality living options discussions during ISP meetings that accurately identify possible barriers to referral and placement.
- The ISP advisory team also attends ISPs in order to help counsel IDTs on developing preference based living goals, as well as preparing robust action

plans for promoting community exposure and education for both individuals and LARs.

- The AP department will continue to work with the LIDDA staff presenting information regarding community transition, the role of the LIDDA, as well as the role of the AP department during new employee orientation (NEO). Pictures of provider homes in the community have also been implemented as part of the presentation to give new employees a better idea of what is available in the community.
- Austin SSLC staff will tour the High Medical Needs ICF homes located in the San Marcos area once they have opened and are providing services.
- The AP department will continue to host on-campus provider fairs two times per year, reaching out to community providers to increase participation as well as increase information sharing with LARs and families to promote increased attendance. The AP department will also work with home QIDPs to ensure resident participation.

# Obstacles to Community Transition

**Table 5-5. Obstacles to Transition from Austin SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 2 |
| Need for environmental modifications to support the individual | 2 |
| Lack of availability of specialized medical supports | 2 |
| Lack of supports for people with significant challenging behaviors | 1 |
| Lack of availability of specialized therapy supports | 1 |
| Other | 4 |

*Data Source: IRIS*

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

In fiscal year 2017, two individuals had an identified obstacle of limited residential opportunities. One individual's preferred geographic location was Houston and the other individual's preferred area was San Antonio. Both individuals have chosen community providers in their preferred area and will be transitioning into their community homes in fiscal year 2018.

### Need for environmental modifications to support the individual

Need for environmental modification was an identified obstacle for two individuals. Of the two individuals, one continues to have an open referral for community placement in the High Medical Needs ICF. The High Medical Needs ICF home will be wheelchair accessible and have bathrooms that are modified to accommodate adaptive bathing equipment such as bathing chairs and trolleys. The second individual had their community referral closed by the LAR. This individual was also waiting for the High Medical Needs ICF home and the LAR felt the services and supports currently provided by the Austin SSLC were more appropriate. The AP department, along with the LIDDA staff, continue to provide information regarding other ICF homes in the community during ISPs, provider interviews, and on-campus provider fairs. ICF homes continue to be larger in size and already modified to accommodate wheelchairs and adaptive bathing equipment.

### Lack of availability of specialized medical supports

Lack of specialized medical supports was an identified obstacle to transition for two individuals, however neither individual qualified to participate in the High Medical Needs ICF initiative. Previously, one individual required two staff for all transfers, as she was not able to use a mechanical lift. She is now able to be transferred using a mechanical lift safely. This individual moved to the community in April 2018. The other individual, who is currently on the referral list for community transition, with a focus on providers in the San Antonio area, requires supports for a specialized diet. His IDT recently had an interview with an HCS provider.

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

Behavioral supports was an obstacle to transition for one individual. He remains on the referral list for community transition. This individual currently has a daily

transition schedule which offers him opportunities to participate in different activities in the community as well as on-campus. He is currently visiting his potential group home placement three times per week and meeting with staff from the community group home to assist with his future transition. In addition, the LAR and IDT plan to use ATCIC's CBS program as needed for training and support once the individual moves into his new home.

### Lack of specialized therapy supports

The individual with this identified obstacle is visually impaired, utilizes a wheelchair for all mobility, and previously required two person transfers at all times. She is now able to be safely transferred using a mechanical lift and is scheduled to move to the community with an HCS provider in May 2018. This provider is also completing minor home modifications on the bathroom to widen the doorway as well as accommodate a bathing chair.

### Other – Provider delay in opening home

In fiscal year 2017, there were four individuals with the identified obstacle of provider delay in opening a home. Two of the individuals are currently on the referral to community transition list waiting for the High Medical Needs ICF home. One of the individuals has identified a community provider, and is waiting for the home to be ready for individuals to move in. Weekly, the individual is visiting the new home to help familiarize him with the environment at his own pace. The fourth individual was also waiting for the High Medical Needs ICF; however, the LAR chose to close the referral.

## In fiscal year 2018, Austin SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- The AP department will continue to work with the LIDDA to educate individuals, LARs, and IDT members about community living options, including smaller ICF homes. This is especially important for individuals with complex medication needs. Continued education at ISPs and provider fairs may increase interest in smaller community ICF homes that utilize an enhanced reimbursement rate for individuals with complex medical needs.
- The AP department will continue to utilize provider interviews as a way to communicate the individual's preferences and needs with the provider, as well as increase the IDT's knowledge of the provider and community

supports. This continues to be beneficial for all parties and will be an ongoing practice in the upcoming fiscal year.

- Provider shadowing is also a major focus for the next fiscal year, as it continues to be beneficial in developing the relationship between the individual, IDT members, and the provider prior to the move, thus creating a smoother transition.
- In fiscal year 2018, the center will continue to focus on comprehensive, competency based training for selected community providers.
- The AP department, along with the LIDDA, will continue to educate LARs, families, and teams regarding the various crisis intervention programs in the greater Austin area to assist with living options discussions.
- As appropriate, packets will be submitted for utilization review at state office for consideration of an increased level of need to provide additional funding for increased staffing. The AP department will continue to work with teams during 14 day meetings to identify any potential obstacles to transition in order to remedy these obstacles prior to the 180 day benchmark.

# 6. Brenham State Supported Living Center Obstacles to Referral and Transition

## Center Profile

Brenham SSLC was opened in January 1974. At the end of fiscal year 2017, Brenham SSLC was serving 259 individuals and employing approximately 995 staff. The center serves a 10-county area including Brazos, Burleson, Grimes, Leon, Liberty, Madison, Montgomery, Robertson, Walker, and Washington counties.

Brenham SSLC is located in Washington County which has five active providers. The majority of group homes in the 10-county area are HCS homes. In Washington County, there are 45 HCS group homes. Counties outside of Washington County are more limited in residential options available to individuals with intellectual disabilities.

In Washington County, four of the five providers have their own vocational services. Brenham SSLC contracts with two providers to offer vocational services to the individuals they serve. Both providers utilize the Brenham SSLC off-campus work center and help the SSLC fulfill contracts at their own work centers. Although Brenham SSLC is working with TWS-VRS for vocational services, there are still limited opportunities for individuals to work in the community.

The number of transitions decreased from fiscal years 2016 to 2017. The center is taking steps to increase the number of transitions to the community by educating IDTs on identifying specialized services and supports needed in the community and locating providers that can provide such specialized supports and services. Also the AP department will be attending as many ISPs as possible to assist with questions when living options are discussed.

**Table 6-1. Community Referrals and Transitions from Brenham SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 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 |
| 2015 | 7 | 12 | 12 | 0 | 279 |
| 2016 | 5 | 7 | 13 | 0 | 264 |
| 2017 | 4 | 3 | 4 | 0 | 259 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 6-2. Individuals Not Recommended for Referral from Brenham SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 218 | 74.91% |
| Individual's reluctance for community referral** | 31 | 10.65% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 26 | 8.93% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 14 | 4.81% |
| Lack of funding | 2 | 0.69% |

*Data Source: IRIS*
**See Table 6-4*
***See Table 6-3*

**Table 6-3. Individual Reluctance for Community Referral from Brenham SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 11 |
| Lack of understanding of community living options | 9 |

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual is not interested in being provided information and exposure to community living options | 7 |
| Unsuccessful prior community transition(s) | 5 |
| Mistrust of providers | 1 |

*Data Source: IRIS*

**Table 6-4. LAR Reluctance for Community Referral from Brenham SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 164 |
| LAR is not interested in being provided information and exposure to community living options | 23 |
| Mistrust of providers | 16 |
| Unsuccessful prior community transition(s) | 7 |
| Lack of understanding of community living options | 5 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

LAR reluctance continues to be the greatest obstacle to referral for community transition, and the most difficult to overcome at Brenham SSLC. Currently, 92 percent of individuals that reside at the center have a guardian, which is an increase from previous years. Education of LARs is most often addressed through the CLOIP and occurs before each annual ISP. LARs are contacted by staff at the LIDDA and offered information on community living options. LARs and other family members are encouraged to attend scheduled educational community tours provided through the LIDDA. During fiscal year 2017, no LARs or family members chose to participate in a CLOIP tour.

During fiscal year 2017, Brenham SSLC hosted two community provider fairs; one in October 2016 and one in June 2017. Letters were mailed to all LARs and primary correspondents at least 30 days prior to the provider fair informing them of the opportunity to receive information from local community providers. A total of two families/LARs attended the fair in October and none in June. Reminders were also sent to the IDTs regarding the June 2017 provider fair and a significant increase in individual and staff attendance was noted compared to the October fair. Many of the LARs are family members of individuals who have resided at Brenham SSLC for an extended period of time. These LARs frequently state Brenham SSLC is the only home their family member has known, and they do not want to disrupt their lives after so many years of living in the same place. LARs also frequently state they do not believe community providers can care for their family members as well as Brenham SSLC. Although the majority of LARs state 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 belief that community providers cannot provide the same level of care and supervision as Brenham SSLC.

The transition specialist continues to attend ISP meetings in an attempt to make contact with LARs to offer additional education on community living options. 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 LIDDA. Through this effort, the transition specialist has seen some LARs show interest and start to request provider tours in order to learn more about the community options available in their area. Brenham SSLC will continue to offer two

provider fairs per fiscal year which will provide opportunities for individuals, LARs, and families to meet community providers in the area and learn more about the available options in the community.

The AP department has made it a priority to attend the ISP meetings of the school aged individuals in an effort to educate their families of the community living options available for their loved ones. This has shown to be an effective tool in opening up discussion with the IDTs. The AP department, along with the transition specialist, will continue to offer individualized community visits for family members and individuals.

QIDPs will receive an in-depth training regarding the services and options available for individuals with intellectual disabilities in the community. They will also be educated on the processes and options available at the facility that address this obstacle such as referrals to the AP department to contact the guardian and talk about living options, scheduling group home and provider tours for the LAR and individual, etc. The QIDP coordinator will complete an audit of the five individuals' living options discussions with LARs who lack an understanding of community living options, to ensure the action plan is effective and making progress. If issues are identified they will be addressed with the IDT and through an ISPA meeting to revise the action plan as needed to ensure the lack of understanding is being addressed.

## Individual's reluctance for community referral

Individual reluctance continues to be a frequent obstacle to referral at Brenham SSLC. The center continues to provide individuals with information about the LIDDA's weekly educational community tours where they can learn more about the options available to them in the community. The number of individuals who have participated in tours decreased in fiscal year 2017, with 81 individuals participating, down from 133 individuals in 2015. IDTs have asked the transition specialist for help in setting up tours for individuals and family members who the team feels would be served well in a less restrictive setting. These individuals will continue to be provided opportunities to attend provider fairs, participate in educational CLOIP tours and community excursions, and to connect with peers who have already transitioned.

QIDPs will receive an in-depth training regarding the services and options available for individuals with intellectual disabilities in the community. They will also be educated on the processes and options at the facility to address this obstacle, i.e.

referrals to AP department to contact the guardian and talk about living options, schedule group home and provider tours for the LAR and individual, etc. The QIDP coordinator will complete an audit of the living options discussions for the nine individuals who lack an understanding of community living options, to ensure the action plan is effective and making progress. If issues are identified they will be addressed with the IDT and through an ISPA meeting to revise the action plan as needed to ensure the lack of understanding is being addressed.

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

The need for 24-hour nursing services or frequent physician monitoring has increased as an obstacle to referral at Brenham SSLC. The center has also implemented root cause analysis, which may impact this obstacle to referral. Root cause analysis is an in-depth discussion and review of data to determine the cause or root of a specific challenge or issue; whether that be falls, emesis, frequent hospitalizations, etc. To date, Brenham SSLC has conducted one meeting regarding respiratory compromise/pneumonia, two regarding gastrointestinal/emesis, one regarding weight, and five regarding falls. The IDT will continue to work on implementing the recommendations from these root cause analyses.

## 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, interventions such as BSPs, token economy programs, increased levels of supervision, and psychiatric services will continue to address their challenging behaviors. The center has recently filled the licensed professional counselor position as an additional support to address this barrier for some of these individuals identified. Root cause analyses have also been conducted to address challenging behaviors. Brenham SSLC has conducted three root cause analyses for behavioral health reasons. At this time, the teams in are in the process of implementing the recommendations from these root cause analyses and monitoring and collecting data to determine if the recommendations were successful at reducing these specific behaviors.

### Lack of funding

Efforts to secure funding for the two individuals who are currently not citizens of the United States and not eligible for Medicaid funding in the community will continue in fiscal year 2018. One of the individuals has received his permanent residency card and has submitted his naturalization application. He is awaiting an interview. The other individual immigrated to the United States with her parents when she was an infant. The social worker had started the application process for the DACA program. This individual has a sibling that was born in the United States and may become her sponsor upon his 18th birthday; however, that is six years away. The social workers for these two individuals will continue to work towards obtaining citizenship.

## In fiscal year 2018, Brenham SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- Brenham SSLC will continue to host two provider fairs per year to provide opportunities for individuals, LARs, and families to meet community providers in the area and to learn more about available options.
- The AP department, 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 in order to better educate individuals and LARs about their options in the community.
- The AP department will identify new providers in order to expand the choices for individuals who may have specific medical or behavioral needs when transitioning to the community.

## Obstacles to Community Transition

**Table 6-5. Obstacles to Transition from Brenham SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 3 |
| Lack of availability of specialized therapy supports | 1 |
| Other | 1 |

*Data Source: IRIS*

### Individual/LAR indecision

The LAR for one individual chose not to proceed with the selected provider after they visited. Other providers were located that met the needs of this individual; however, the LAR chose to close the referral. The second individual's LAR was provided a list of providers multiple times, but did not pursue provider selection. The LAR later asked the team to work with the individual's grandmother. The grandmother met with the providers and a selection was made and the individual has transitioned. The LAR for the third individual with this obstacle requested a specific geographic location. A lengthy search was completed and suitable providers were identified but he did not pursue visits. He chose another area, but did not pursue visits with providers in this area and ultimately chose to close the referral.

### Lack of availability of specialized therapy supports

One individual with this obstacle required a home with an open floor plan that could accommodate his oversized wheelchair. Several providers indicated they were unable to serve the individual due to the amount of renovations required to their existing homes. Eventually two providers were identified and visited by the

individual and the IDT. A provider was selected that could meet the individual's needs and he moved.

### Other - Search for new provider

Lastly, one individual had selected a provider, but the home filled before a visit could be scheduled. A new search was initiated which resulted in the individual transitioning to a new provider.

## Strategies to continue reducing obstacles to transition in Brenham SSLC in fiscal year 2018:

- Obstacles to transition will continue to be discussed in the admissions and transfers committee to assist with overcoming these obstacles as they arise.
- The IDT will continue to meet monthly for individuals that do not move within 180 days of their referral. The IDT will identify and address obstacles prior to the 180-day timeline as they are identified. The AP department will continue to monitor these individuals to ensure obstacles to transition are addressed.
- The AP department will continue to expand the list of providers available by touring new providers, day habilitation programs, and by communicating with other SSLCs for areas unfamiliar to Brenham SSLC.

# 7. Corpus Christi State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The Corpus Christi SSLC opened in April 1970. The center was serving 208 residents as of August 31, 2017, and employs 771 full time employees. Corpus Christi SSLC 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.

Corpus Christi SSLC is located in Nueces County, which has the greatest number of HCS and ICF providers available in the 21-county catchment area. There are 74 HCS providers serving the catchment area of Corpus Christi SSLC. According to the HHSC database, there are 15 ICF providers serving the 21-county catchment area. Only two of these providers reflect current vacancies. There are limited vocational opportunities for individuals transitioning to the community from Corpus Christi SSLC. HCS providers often work with TWS-VRS due to the limited opportunities for vocational services in the community; however, the application process through TWS-VRS has proven to be lengthy and has not led to much success for our individuals.

The number of referrals increased at our facility since our last report. The actual number of transitions has not increased proportionately to the referral rate. There have been staffing challenges due to vacancies in the AP department. The department is fully staffed at this time and has resumed attendance at weekly Team Integration and IDT meetings.

**Table 7-1. Community Referrals and Transitions from Corpus Christi SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 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 |
| 2015 | 6 | 10 | 6 | 0 | 221 |
| 2016 | 18 | 9 | 3 | 0 | 220 |
| 2017 | 40 | 22 | 4 | 2 | 208 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 7-2. Individuals Not Recommended for Referral from Corpus Christi SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| Individual's reluctance for community referral** | 65 | 30.52% |
| LAR's reluctance for community referral* | 53 | 24.88% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 50 | 23.47% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 35 | 16.43% |
| Lack of funding | 6 | 2.82% |
| Court will not allow placement (Chapter 55/46b) | 4 | 1.88% |

*Data Source: IRIS*
**See Table 7-4*
***See Table 7-3*

**Table 7-3. Individual Reluctance for Referral from Corpus Christi SSLC, Fiscal Year 2017**

| Reason for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 57 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 4 |
| Mistrust of providers | 2 |
| Unsuccessful prior community transition(s) | 1 |

*Data Source: IRIS*

**Table 7-4. LAR Reluctance for Referral from Corpus Christi SSLC, Fiscal Year 2017**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 24 |
| LAR is not interested in being provided information and exposure to community living options | 15 |
| Unsuccessful prior community transition(s) | 12 |
| Mistrust of providers | 8 |
| Lack of understanding of community living options | 1 |

*Data Source: IRIS*

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

### Individual's reluctance for community referral

Individual reluctance for community referral continues to be the greatest obstacle at Corpus Christi SSLC, specifically due to a lack of understanding of different community living options. CLOIP tours are offered to the individuals three times per month, in county, and out of county. Virtual tours are also provided to the individuals at the facility. The individuals are shown videos of group homes and day habilitation centers. The virtual tours allow individuals to view community programs without having to leave the facility.

### LAR reluctance for community referral

The second greatest obstacle to community referral continues to be LAR reluctance. CLOIP staff continue to provide educational information regarding community services to the LAR prior to an individual's annual meeting. QIDPs also invite the LARs and family members to attend group home tours with the individuals. The LARs and family members are invited to the annual provider fair where are able to meet and interact with community providers.

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

Medical needs are the third greatest obstacle to community referral. A lack of understanding of community providers and the supports and services they provide could be part of the obstacle. IDTs will be trained on the different types of community settings for individuals with complex medical needs. This information will be shared with individuals, LARs, and family members of these individuals. IDT members will be encouraged to visit the High Medical Needs ICF/IID Homes in San Marcos, Texas. This will provide the IDT members with a better understanding of what supports and services are available for individuals that have high medical needs.

## 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 these individuals' needs cannot be met in a community setting due to behaviors that pose a risk to themselves or others. IDTs work with these individuals through development of PBSPs, counseling, psychiatric services, and classes including Skill Training of Paraphilia (STOP) and Anger Management. To provide further education in this area, it is recommended that CLOIP staff, in collaboration with the AP department, provide training to behavioral services regarding level of need (LON) and level of supervision (LOS) in the community.

This year, the Behavioral Health Center of Nueces County provided a Community Living Options Lunch & Learn presentation regarding community services with Behavioral Health Services, Nursing, and the QIDP coordinator. The information provided was beneficial to these departments and would benefit others. The Behavioral Health Center will be approached regarding another training and this training to be provided to the IDT members. Attendance would be mandatory for the IDT members.

## Lack of funding

Six individuals lack the funding to move into the community. These individuals do not receive Medicaid due to citizenship issues. The social workers and QIDPs will continue to work with reimbursement staff as new information is obtained regarding benefits.

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

Four individuals were not referred to the community due to court decisions. The APC will continue to inquire on the status of these cases and provide education to the court as needed prior to the annual ISP or as requested by the IDTs.

## In fiscal year 2018, Corpus Christi SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- The transition specialist will continue to meet with individuals, LARs, and other IDT members as needed to provide them with information regarding all

community options which includes the different types of community settings where individuals with high medical needs can live.

- The facility will continue to work with CLOIP staff from the Nueces County Behavioral Health Center to provide training to IDT members in which attendance will be mandatory. This training will include different types of community settings for individuals with complex medical needs. The transitional specialist will arrange for the IDTs to visit these different types of community settings.
- QIDP coordinator will meet with the QIDP facilitators regarding AP department attendance at ISP meetings to provide living options information and to answer any questions.
- Encourage IDT members who assist individuals with complex medical needs to tour the High Medical Needs ICF homes in San Marcos, Texas.
- The IDT will consider utilizing root cause analysis to address obstacles to referral related to complex behavioral health or medical needs.
- The AP Department, in conjunction with CLOIP staff, will provide training to behavioral health staff regarding LON 9 funding for one to one supervision.
- The QIDP coordinator will continue to collect and report obstacles to referral data quarterly during Quality Assurance/Quality Improvement (QA/QI) council and develop corrective action plans as appropriate.
- IDTs will receive training on living options to assist them in have meaningful, quality living options discussions during ISP meetings, so they can accurately identify possible obstacles to referral and placement.

# Obstacles to Community Transition

**Table 7-5. Obstacles to Transition from Corpus Christi SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 14 |
| Need for environmental modifications to support the individual | 14 |
| Lack of availability of specialized medical supports | 9 |
| Lack of supports for people with significant challenging behaviors | 7 |

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 4 |
| Lack of availability of specialized therapy supports | 2 |
| Need for transportation modifications to support the individual | 2 |
| Need for meaningful employment and supported employment | 1 |
| Other | 3 |

*Data Source: IRIS*

## Center Strategies to Overcome or Reduce Obstacles to Transition

### Limited residential opportunities

Limited residential opportunities were identified for 14 individuals. All individuals chose areas that have a small number of providers with limited vacancies in existing homes. Ten referrals closed, nine due to medical, one individual choice, and four remain in the transition process.

### Need for environmental modifications to support the individual

Fourteen individuals referred for community transition required home modifications. Most of these individuals needed home modifications in the bathrooms (bathing trolleys, wheelchair access to the shower and commode). Providers were unable to complete these types of modifications because their homes were leased. The AP Department is working with the Habilitation Department to have individuals who are using a bathing trolley assessed for a tilt in space shower chair. Of the 14 individuals with this obstacle, seven remain in the transition process, six closed due to medical issues, and one closed due to behavioral issues.

### Lack of availability of specialized medical supports

Of the nine individuals with this obstacle, referrals for four closed and five remain in the transition process. Of the four referrals that closed, two were for medical issues and the other two were individual choice.

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

There were seven individuals with this obstacle. Of the seven, four referrals closed, one individual successfully transitioned, and two are in the transition process.

### Individual/LAR indecision

This obstacle was identified for four individuals. Two individuals changed their minds about the type of community setting or preferred geographic area. Both individuals ultimately decided to remain at the facility and the referrals were closed. The other two individuals have LARs who have been indecisive. One LAR changed the preferred geographic location. This individual is now on pre placement visits in that area. The other LAR has explored HCS, ICF, and skilled nursing facilities in the Rio Grande Valley. The IDT continues to work with this LAR.

### Need for services and supports for individuals with specialized therapy supports

These two individuals required increased staffing levels due to frequent positioning and dining assistance. These individuals remain in the transition process.

### Need for services and supports for individuals with transportation modifications

One individual had this obstacle due to need for transportation that could accommodate an oversized wheelchair. The referral was ultimately closed due to increase in medical issues.

### Need for meaningful employment and supported employment

One individual was identified with this obstacle. The challenge is finding a provider in the preferred area of Corpus Christi that will have a meaningful job for this individual. Most of the providers have sheltered work centers and he is not

interested in those types of jobs. We will work with the IDT to identify the type of job he is interested in and pursue employment prior to transition.

### Other - Illness during transition period

There were three individuals with this obstacle. Two of the three individuals ultimately transitioned and the other individual's referral was closed due to medical issues.

### Other - Provider delay in opening home

Three individuals had this obstacle to transition. These individuals continue to wait for the opening of the two High Medical Needs ICFs in the San Marcos area. The first individual moved in March 2018.

## In fiscal year 2018, Corpus Christi SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- The AP department will continue to meet on a regular basis to discuss the needs of individuals referred for transition, including their medical, environmental, and residential needs.
- The AP department will continue to meet with IDTs at their weekly meetings to assist with obstacle identification and action plans to overcome these obstacles.
- The AP and QIDP departments will continue to monitor individuals whose transitions exceed the 180 day time frame. IDTs will continue to meet monthly to address any obstacles to transition and implement action plans to remove the obstacles. IDT will request assistance from the transition specialist to assist with locating providers as needed. The AP department will continue to work with the habilitation therapy staff to assess and determine the feasibility of alternative bathing equipment for individuals referred for transition. Habilitation therapy staff will be encouraged to participate in group home tours to ensure the appropriateness of each setting (home, day habilitation, etc.).
- As obstacles are identified, IDTs will consider if a root cause analysis would be beneficial in addressing the obstacle.
- The APC will continue to meet with LIDDAs to discuss the needs of individuals referred for transition.

- AP staff and the transition specialist will continue to interview providers at the annual provider fair, and through face to face visits and telephone calls locally and across Texas.
- The AP department will encourage all IDT members to take tours offered by CLOIP staff to local ICFs and HCS homes to get a better understanding of how services are provided in a community setting.
- The AP department will use 14-day meetings to identify all needed supports which will then be used to identify potential community providers who are able to meet the needs of the referred individual. By having a more comprehensive set of supports in place at the very beginning of the referral process, it should be easier to identify potential providers and get initial visits scheduled sooner.
- The AP department will work with the IDT and the Vocational Department during the 14-day meeting to set clear goals and expectations regarding the TWS-VRS process for individuals who are interested in working.
- The APC will present obstacles to transition information in the quarterly QA/QI report.

# 8. Denton State Supported Living Center Obstacles to Referral and Transition

## Center Profile

Denton SSLC opened in 1960. The 189-acre campus was serving 446 people as of August 31, 2017, 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.

Denton SSLC is located in Denton County and is within 30 minutes of the Dallas-Fort Worth metropolitan area. There are over 200 HCS and 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. Denton SSLC has collaborated with 47 community providers in assisting individuals to transition to the community. This increase in providers is largely due to Consumer and Family Relations (CFR) staff and the transition specialist who have been reaching out to new providers and expanding their search outside of the Dallas/Fort Worth metropolitan area. They are encouraging new providers to visit the facility for a tour and to discuss individuals who are currently on our referral list. This has been successful in increasing the provider pool and has provided teams with additional choices of providers who are able to provide services.

The number of open referrals at the end of fiscal year 2017 was 23, which is an increase from 20 in fiscal year 2016. However, there were only five new referrals in fiscal year 2017, which is a decrease from the 16 referrals in fiscal year 2016. One of the challenges in fiscal 2017 was finding providers to meet more significant medical needs of individuals. The majority of these individuals require homes that have modified bathrooms, wider doorways and hallways, and no carpeted floors. Denton SSLC is continuing to invite new providers to visit and tour the facility during the months a provider fair does not occur. This is to increase community awareness and lessen the uncertainty some individuals may have about community living.

The data for 2017 reflects many LARs remain reluctant to community transition. As the population ages, and medical needs become more apparent, LARs may become

more reluctant due to their loved ones having more complex medical challenges. The admission and transition team continues to educate LARs and team members through annual ISP attendance on services available in the community.

**Table 8-1. Community Referrals and Transitions from Denton SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 9 | 5 | 16 | 2 | 545 |
| 2011 | 15 | 1 | 8 | 0 | 519 |
| 2012 | 18 | 2 | 12 | 0 | 494 |
| 2013 | 39 | 7 | 20 | 0 | 484 |
| 2014 | 16 | 16 | 26 | 0 | 460 |
| 2015 | 11 | 6 | 13 | 0 | 458 |
| 2016 | 20 | 3 | 9 | 0 | 458 |
| 2017 | 23 | 9 | 5 | 0 | 446 |

*Data Source: IRIS.*

# Obstacles to Community Referral

**Table 8-2. Individuals Not Recommended for Referral from Denton SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 337 | 54.44% |
| Individual's reluctance for community referral** | 176 | 28.43% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 60 | 9.69% |
| Behavioral Health/Psychiatric Needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 41 | 6.62% |
| Lack of Funding | 5 | 0.81% |

*Data Source: IRIS*
**See Table 8-4*
***See Table 8-3*

**Table 8-3. Individual Reluctance for Referral from Denton SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 66 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 53 |
| Individual is not interested in being provided information and exposure to community living options | 47 |

| Reasons for Individual Reluctance | Total |
|---|---|
| Unsuccessful prior community transition(s) | 19 |
| Mistrust of providers | 4 |

*Data Source: IRIS*

**Table 8-4. LAR Reluctance for Referral from Denton SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 250 |
| LAR is not interested in being provided information and exposure to community living options | 66 |
| Unsuccessful prior community transition(s) | 37 |
| Mistrust of providers | 15 |
| Lack of understanding of community living options | 13 |

*Data Source: IRIS*

## Center Strategies to Overcome or Reduce Obstacles to Referral

### LAR reluctance for community referral

LAR reluctance for community living is the greatest obstacle to referral. There were 337 instances (54.44 percent) in which the LAR was reluctant to consider a community referral. The number of LARs who have experienced unsuccessful

community transitions increased from 30 in 2015 to 37 in 2017. This slight increase may be due to the admission of some individuals who have experienced several failed community placements related to challenging behaviors. Also, the mistrust of providers has decreased from 21 in 2015, to 15 in 2017. In 2017, LARs were provided information but a high number continue to have no interest in community transition. The transition team continues to provide an information packet to the QIDP for each ISP. The packet includes photos of prospective community homes and a list of HCS services available in a community setting as a form of education to address the concerns of a LAR. This has been helpful in the discussion of living options and has provided QIDPs a tool to be able to share and encourage LARs to tour homes in the community. This also helps the transition team member who attends the meeting to give different examples of what services are available in the community. Transition staff attend at least 30 percent of all ISPs. This is to assist in educating LARs when living options discussions occur.

Education of LARs and individuals is also offered through the CLOIP that occurs before each annual ISP. CLOIP staff from the LIDDA contact the LARs and offer information about community living options. This process occurs for LARs and families annually, but may not be effective, as the LARs or families may decline receiving this information. The LARs were also invited to both of the provider fairs held; however, LAR attendance at the fairs has not been successful. The APC now discusses the annual provider fair with LARs during the admissions process. This hopefully will help to increase attendance. LARs will continue to receive a formal invitation in an attempt to increase attendance. The increase in the provider fair attendance is a goal of the IDTs, as it is a means of education for individuals and their family members.

## Individual's reluctance for community referral

Individual reluctance is the second greatest obstacle to referral at DSSLC, with 176 individuals (28.43 percent) reluctant for referral. The lack of understanding of community living options has been identified as a major obstacle, and the center has increased actions to help overcome it. Individual reluctance 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 2017 the facility continued to use the off-campus storefront, Impressions, where residents make and sell merchandise, located on the Denton Square, as a training site. This program allows for community exposure which, hopefully in time,

will help the 66 individuals who lack an understanding of community options become more familiar with community programs. Through the vocational services program, several individuals work at Impressions. They also have the opportunity to talk to customers about their artwork. In addition, at this location, many individuals are able to receive social skills training that focus on things like appropriate greetings, appropriate social distance, pedestrian safety skills, and making new friends. There are approximately 200 individuals involved with this program. Denton SSLC also offers Programs without Walls. This program allows individual formal and informal training in a community setting. Training consists of safety skills, social skills, making personal choices in purchasing items, dining skills, and community integration. There are approximately 70 individuals involved with this program and the facility is looking to expand in 2018. Between these two programs, the 66 individuals identified who are a part of one of the programs will be given opportunities for exposure, training, and socialization in a community setting.

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

There are 60 individuals identified with an obstacle of medical needs requiring 24-hour nursing services/frequent physician monitoring. Medical needs range from vent support, suctioning, breathing treatments, and oxygen support. This is the third greatest obstacle to referral. The CFR department continues to work with nursing services, habilitation therapies, and QIDP staff in identifying comparable services in the community. CFR staff have also continued to help HCS providers understand the need for these types of services. Denton SSLC nursing services staff have helped IDT members consider the timeframes for when nursing services may be needed. For example, IDT members have determined that being within 15 minutes of emergency medical services in the community will suffice for some individuals who currently receive 24-hour nursing or medical services.

Denton SSLC is able to provide on-campus clinics for numerous types of specialty medical services such as neurology, podiatry, pulmonology, gynecology, and cardiology. Denton SSLC is the only facility with 24-hour respiratory staff on duty to support individuals. These services are offered regularly due to the number of people who need them. In community settings, some areas have limited access to specialists who are able to meet the needs of the individuals who have challenging medical needs. Some individuals require sedation for medical procedures which is not always available in community settings.

## 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 PBSPs and, as appropriate, counseling services. The Tarrant County LIDDA and the Systemic Therapeutic Assessment Resources Team (START) provided training to all disciplines regarding how these services would benefit individuals in the community. Other LIDDAs were in attendance and the information was well received.

## Lack of funding

There are four individuals who are noted to have lack of funding as the primary obstacle; they do not have current citizenship in the United States. The facility is working with the individuals to acquire citizenship. Two of the individuals' applications for naturalization have been approved and we are waiting on appearance dates to be issued. For the other two, the facility will continue to work with the immigration office to assist them with approval of their applications. Efforts to secure funding will continue in fiscal year 2018.

## Strategies to continue reducing obstacles to referral at Denton SSLC in fiscal year 2018:

- Additional training is being developed for QIDPs on how to identify obstacles to referral and transition and develop plans to overcome the obstacles. The CFR team attended several QIDP training sessions and brought examples of obstacles and potential action plans that could be considered. The transition specialists and CFR staff will continue to attend ISPs to assist with living options discussions. This has led to more comprehensive discussions regarding living options, identification of obstacles, and development of action plans to remove obstacles.
- A program auditor will continue to attend two ISPs per month to provide data on the living options discussions and documentation to identify IDTs that would benefit from CFR staff and transition specialist attendance. Additionally, the auditor's data will be used to develop training for QIDPs.
- A provider fair will be held at least twice during fiscal year 2018 to provide an opportunity for individuals, LARs, and staff to meet community providers and

learn more about the options available to them. These fairs continue to have high provider participation with approximately 25 providers attending each fair. We had a total of two guardians and 250 individuals on average attend each fair. To increase attendance in 2018, invitations will be sent out earlier. We will also share information during one of the quarterly Family Association meetings. Provider fair flyers will also be posted in the units to get more individual participation.

- The transition specialist will continue to work towards increasing the provider pool by meeting, interviewing, and visiting new providers' homes, workshops, and day programs each month.
- The center will continue to search for additional providers who can accommodate individuals who have more complex medical, behavioral, psychiatric, and adaptive equipment needs, as well as continue to educate providers on supports needed for individuals to transition successfully. As these new providers are identified, they will be invited to the facility for a tour and a face to face meeting to discuss services provided both at the center and the provider's facility.
- The director of CFR continues to encourage the QIDPs and teams to request tours for the individuals they serve throughout the year. CFR staff will coordinate these tours to facilitate education of the individual, team members, and family members.

# Obstacles to Community Transition

**Table 8-5. Obstacles to Transition from Denton SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Need for environmental modifications to support the individual | 15 |
| Individual/LAR indecision | 6 |
| Lack of supports for individuals with significant challenging behaviors | 6 |
| Limited residential opportunities | 3 |
| Lack of availability of specialized medical supports | 1 |

| Obstacle | Total |
|---|---|
| Lack of availability of specialized therapy supports | 1 |
| Need for transportation modifications to support the individual | 1 |
| Other | 4 |

*Data Source: IRIS*

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

### Need for environmental modifications to support the individual

The 15 individuals with this obstacle have oversized wheelchairs or bathing systems. Each of these individuals have toured community homes, however an appropriate home has not been located that can accommodate their adaptive equipment. The IDTs are reviewing their adaptive equipment to determine if alternative equipment is feasible. The transition team is also looking outside the local area for homes and providers that can accommodate the needs of these individuals.

### Individual/LAR indecision

For the six individuals with this obstacle, five have successfully transitioned. These individuals took additional time to figure out which provider they liked the best. The other individual continues in the transition process.

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

One of the six individuals identified with this obstacle has successfully moved into the community. Another individual's referral was closed due to non-compliance with counseling and other programs. The transition team continues to attend the psych-med meetings for the four individuals who remain in the transition process.

### Limited Residential Opportunities

Three individuals had this obstacle to transition. The LARs for two of the three individuals requested a move within 30 minutes from the family. The transition team worked with the guardians and providers have been located close to the preferred area and a move is imminent. One individual's referral was closed due to the lack of providers in the preferred East Texas area.

### Lack of availability of specialized medical supports

This individual required dialysis services and a dialysis center that would accept him in the preferred area. A center was located that would accept his insurance and he moved.

### Lack of availability of specialized therapy supports

One individual had this obstacle. The individual needed a home with a minimum of two staff to assist with changing, positioning, and transfers. The referral was closed due to not being able to find an appropriate home to meet the needs of the specific individual.

### Need for transportation modifications to support the individual

One individual requires a wheelchair van with a lift that can accommodate a specialized wheelchair. The transition team explored six different providers, but none of them could accommodate her specialized wheelchair. A clinical evaluation determined a regular wheelchair could not be used for this individual. The transition team is working with an ICF provider that may have the resources needed to accommodate this individual's wheelchair.

### Other – Family chose to pursue guardianship

Family members for two individuals chose to pursue guardianship following referral. The families did not obtain guardianship and one of the individuals moved to the community and the other individual is in the transition process.

### Other – Illness during transition period

One individual had an illness and psychiatric decline during the transition process and the referral was closed.

### Other – Need for dental work prior to transition

The individual with this obstacle has successfully completed all dental work and is in the transition process.

## In fiscal year 2018, Denton SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- Obstacles to transition continue to be reviewed weekly with CFR staff and the transition specialist. 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.
- The IDT continues to meet monthly to address obstacles for individuals whose referral has exceeded 180 days. Tracking of the 180-day ISPAs by the transition specialists assists the team with addressing the need for an ISPA and how the obstacles identified are being addressed.
- Obstacle data will be reported to QA/QI to address systemic issues related to obstacles.
- The director of CFR, the APC, and the placement coordinator will continue to meet with the community provider to review the supports and services and provide any clarification of supports and services.
- CFR will continue to meet with staff at department meetings throughout the year to answer transition related questions and offer tours of community programs.
- The CFR department will continue to support HCS providers to access resources available to complete environmental modifications.

# 9. El Paso State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The El Paso SSLC 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, 2017, El Paso was serving 95 individuals and employed approximately 407 staff.

There are seven HCS and two ICF providers available in the El Paso community. The El Paso community continues to have limited work opportunities, whether it is work centers, supported employment, or competitive employment. The issue has been discussed with the LIDDA and community providers, but little progress has been made.

The level of intellectual disability and adaptive functioning for persons served at this center varies widely from mild to profound range of intellectual disabilities. Medical and physical disabilities also vary from the need for minor levels of service to a considerable level of care.

**Table 9-1. Community Referrals and Transitions from El Paso SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 6 | 4 | 4 | 0 | 136 |
| 2011 | 9 | 2 | 3 | 0 | 131 |
| 2012 | 14 | 4 | 7 | 0 | 124 |
| 2013 | 10 | 7 | 10 | 1 | 116 |

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2014 | 9 | 7 | 8 | 0 | 110 |
| 2015 | 5 | 5 | 7 | 0 | 106 |
| 2016 | 12 | 2 | 4 | 1 | 107 |
| 2017 | 7 | 3 | 8 | 0 | 95 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 9-2. Individuals not Recommended for Referral from El Paso SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 58 | 56.31% |
| Behavioral Health/Psychiatric Needs requiring frequent monitoring by a Psychiatric/Psychology staff and/or enhanced levels of supervision maintained by a direct service staff | 16 | 15.53% |
| Lack of Funding | 15 | 14.56% |

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 8 | 7.77% |
| Individual's reluctance for community referral** | 6 | 5.83% |

*Data Source: IRIS*
**See Table 9-4*
***See Table 9-3*

**Table 9-3. Individual Reluctance for Community Referral from El Paso SSLC, Fiscal Year 2017**

| Reason for Individual Reluctance | Total |
|---|---|
| Individual is not interested in being provided information and exposure to community living options | 2 |
| Lack of understanding of community living options | 1 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 3 |

*Data Source: IRIS*

**Table 9-4. LAR Reluctance for Community Referral from El Paso SSLC, Fiscal Year 2017**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 27 |
| Mistrust of providers | 16 |
| LAR is not interested in being provided information and exposure to community living options | 10 |
| Unsuccessful prior community transition(s) | 9 |
| Lack of understanding of community living options | 5 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

The greatest number of obstacles to referral continues to revolve around LAR reluctance for community living. Reasons for reluctance vary from fear of their loved ones being unprotected in the community to negative experiences that occurred in the past. This includes failed placements prior to admission which has led to mistrust of providers. Many LARs feel their loved ones are being well cared for at the facility and do not want them to transition into the community because they worry their family members may not receive the necessary supports.

LAR education regarding community transition continues to require one-to-one education in various forums include annual ISPs, provider fairs, and individual conversations. The APC, transition specialist, post-move monitor (PMM), and QIDPs have spoken to reluctant LARs about the transition process, and in some cases, have taken them on tours to provider homes. In several instances, once LARs see

the homes and discuss in detail the supports developed and monitored in the community, some of those LARs have opened up to considering a transition for their family member. LARs and family members have become more open to the idea of community referral after visiting provider homes and day habilitation programs, and having discussions with provider administrative staff regarding how supports are provided in the community.

Living options education continues to be one of El Paso SSLC'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. These educational opportunities include the following:

- Provider fairs continue to be held twice a year concurrently with popular celebrations to increase attendance. Many individuals, LARs, families and staff attended the fairs held in May and October.
- During ISPs, LARs are encouraged to attend and engage with providers. Providers also prefer to combine the provider fairs with facility celebrations.
- Community group tours continue on a monthly schedule to provide residents and LARs the opportunity to visit various community day programs and group homes to experience what each provider has to offer. Small groups of residents are scheduled to participate monthly and are accompanied by the AP department staff, including the transition specialist and direct support professionals, where they can ask questions of the providers.
- Group tours have been extended to all IDT members and interested parties, including staff from the behavioral, habilitation, nursing, QIDP, and residential departments.
- IDT members act as an additional source of information for LARs. IDT members have been able to describe how supports are met in the community by sharing firsthand information as a result of these visits. It has been effective in increasing knowledge as they share their findings with peers, team members, individuals, LARs, and family members.
- CLOIP contacts by the LIDDA provide information to individuals, LARs, and families on availability of living options in the community on an annual basis. The LIDDA is also a participant in the annual ISP meetings as a resource on community providers and their services.

- LIDDA staff are also invited to participate in living options discussions outside of the ISP. They have also begun to participate in the provider fairs to disperse information regarding community living options.
- The transition specialist, PMM and APC, serve as a resource to IDTs, including individuals and LARs, on services that are available in the local community. Innovative ideas for living options education have been created including real estate style information leaflets of the provider homes and day programs, a DVD presentation of the provider homes titled "Galleria of Homes" showcasing all HCS homes in the community, and signs or posters indicating who to call for more information regarding transitions. The real estate style leaflets continue to be shared during living options meetings and ISPs when a new home is available. In the past, the DVD presentation was shared during provider fairs before they were integrated with facility celebrations. The DVD is now shared with anyone interested in learning about the community homes. The DVD will also be shown to individuals during their self-advocacy meeting.

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

There are eight individuals who require access to 24-hour nursing care, and whose needs are difficult to meet in the community. The IDT believes that a transition to the community is not appropriate at this time. AP department staff will continue to identify providers that have experience successfully serving individuals with complex medical needs.

## Lack of funding

There are 15 individuals with the obstacle of lack of funding due to citizenship status. The QIDPs continue to work with the families and reimbursement staff as new information is obtained regarding citizenship status.

## 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 16 individuals 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. Behavioral health staff have identified the need to utilize the root cause analysis process for individuals with complex behavioral health needs. AP department staff have collaborated with the LIDDA to provide a presentation by the LIDDA START team regarding community crisis intervention services.

### Individual's reluctance for community referral

There are six individuals with this obstacle. 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. Teams have discussed, planned, and will continue to work around an individual's schedule in order to support their preferences in regards to tours and provider visits, along with the LAR's preferences. One individual has been identified as having a lack of understanding of community living options. She will attend a provider tour with a familiar staff in order to obtain a better understanding of options available to her in the community.

### In fiscal year 2018, the El Paso SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- The center will continue to discuss the transition process with reluctant LARs in a variety of venues. The most productive strategy has been speaking one to one with reluctant LARs. Staff will show them what is available and explain how supports and services are developed and monitored in the community. The center will continue the education efforts by inviting families and LARs to our facility provider fairs and living options activities on campus. The APC, QIDPs, transition specialist and PMM will continue to speak to reluctant LARs and families about the transition process and take them on tours to provider homes.
- The center will continue to offer individuals family group tours to community providers so they can see for themselves what the homes look like along with meeting the provider's administrative teams and staff in order to obtain a clear understanding on how support needs are met in the community. This will in turn help spark some discussion with their families on what they saw and liked.
- In the upcoming year, the department will provide a presentation on living options during the self-advocacy meeting and share the DVD of provider homes with the individuals.

- The AP department staff will ask to provide a presentation of living options during the Parent's Association meeting and will ask if the Association is agreeable to watching the DVD showcasing community homes.

# Obstacles to Community Transition

**Table 9-5. Obstacles to Transition from El Paso SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 7 |
| Need for environmental modifications to support the individual | 7 |
| Lack of availability of specialized medical supports | 4 |
| Individual/LAR indecision | 3 |
| Lack of supports for individuals with significant challenging behaviors | 2 |
| Lack of availability of specialized mental health supports | 1 |
| Lack of availability of specialized therapy supports | 1 |
| Others | 1 |

*Data Source: IRIS*

## Center Strategies and Actions to 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.

## Limited residential opportunities

There are seven individuals with this obstacle to transition. All seven individuals preferred to live in the local El Paso area where there are a limited number of HCS providers and few vacancies in group homes. Three of the seven individuals transitioned to vacancies that became available in current homes and two individuals moved to a newly opened home. The other two individuals remain in the transition process with one currently visiting providers and one who also requires home modifications.

## Need for environmental modifications to support the individual

Seven individuals required modifications in place prior to transition. AP department staff maintains close contact with providers to assist in understanding the needs of the residents and help provide guidance on needed environment modifications. This process allowed five of the seven individuals to transition. Four individuals required roll-in-showers to support their shower chairs, along with ramps leading inside and outside of the home to accommodate their wheelchairs. One individual required hand rails and ramps for stability. There is one individual who requires additional modifications and home specifications aside from the typical roll-in shower, ramps, and even floor plans. A potential home was identified for this individual, but habilitation therapies assessed him in the home and determined that it could not accommodate his two large wheelchairs. The individual remains in the transition process. The seventh individual found a modified home towards the end of the year.

## Lack of availability of specialized medical supports

Lack of specialized medical supports was an obstacle for four individuals. In the winter of 2016, three of the four individuals' transitions were delayed to allow for additional training and observations with the community providers to ensure they were able to adequately support individuals who receive enteral nutrition. El Paso SSLC registered nurse (RN) case managers provided hands-on training, testing, observations, and follow-up to community provider staff. The individuals also required additional visits and overnights to confirm the providers were able to successfully support them. Providers have gained additional valuable experience with this process. Towards the end of fiscal year 2017, the remaining individual had found a home that will accommodate his needs. His transition occurred in February 2018.

## Individual/LAR indecision

For one of the three individuals with this obstacle, the individual's LAR was undecided on whether to proceed with transition, as the LAR had some concerns about how the individual's needs would be met in the community. After meeting with the provider's team, the LAR decided to proceed and the individual moved into their new home. The second individual's LAR was a new professional LAR at a local agency and wanted to take his time getting to know the individual and community providers before fully committing to a transition. After meeting with the local providers, the new LAR stated he was agreeable to continuing the referral process, and the individual continues to visit HCS homes. The third individual has a history of changing his mind between moving and remaining at El Paso SSLC. He stated he no longer wished to move to the community. During his referral process, this individual also had behavioral challenges when visiting providers, which are being addressed by his IDT with behavioral and psychiatric supports. The team will discuss his progress and options during the living options discussion at his ISP. His referral has been closed.

## Lack of supports for individuals with significant challenging behaviors

There were two individuals whom the IDT identified as having challenging behaviors that posed a barrier to transition. One individual displayed unsafe behaviors while driving in a vehicle and required one to one staff to prevent injury during transportation. The referral was closed.

The second individual walked away from the provider home during an overnight visit, became aggressive and attacked staff. He informed his team he no longer wished to transition into the community. His referral was closed with the LAR's agreement.

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

Forensic needs is an obstacle for one individual. While he is able to transition into the community, there are court restrictions on the proximity to schools and parks. He requires a letter of notification to the courts should he transition. The team continues to search for an all-male home to accommodate his needs.

### Lack of availability of specialized therapy supports

Availability of specialized therapy supports was an obstacle for one individual. This individual required a mechanical lift and a two person lift and transfer. Currently, local providers are unable to accommodate a two person lift and transfer at night. This individual's referral was closed due to medical complications and behavioral challenges that are magnified when this individual is not feeling well.

### Other

One individual faced a delay with transition due to a number of factors involving the provider. The individual required a van with a lift, which the home did not have at the time. Then, there was a no enrollment period with the provider because the home did not have an RN. This provider required additional training to meet the individual's medical supports. The home did not become available until the modifications were completed and the named supports were met, after which, this individual completed a successful transition into her new home and is thriving in her new environment.

### In fiscal year 2018, El Paso SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- In our discussions, the center has pointed out to providers the need for accessible ramps on the front and back patio doors, roll-in showers wide enough for shower chairs, and doorways that can accommodate wheelchairs. Some of the providers' existing homes are still not accessible to individuals using wheelchairs, but progress is being made to modify homes and purchase or lease new homes with planned modifications. During the transition process, habilitation therapies assesses providers and day habilitation sites, as needed, to help the IDT identify potential options for individuals who require modifications.
- Most of the local providers are reaching capacity or are at capacity. When there is a vacancy in a home, issues that limit transition are lack of appropriate vacancies according to gender and homes that can accommodate adaptive aids or equipment. AP department staff continue communication with local providers on transition needs for referred individuals and, as such, they are making progress in obtaining homes for transition.
- The center will continue to provide education to the families and LARs on what is available in the community, as well as on how the individual's supports can be met in the community. The AP department staff will provide

a wide variety of information sharing opportunities to families and guardians via mailers, provider fairs, annual ISP living options discussions, and one-on-one conversations. There were some successes in speaking with those undecided LARs that have since resulted in transitions. The transition specialist, PMM, and APC will continue to work with families and LARs to assist in their understanding of transitions to the community. Twice a year, a living options presentation, including a DVD presentation of community homes, will be shown during a self-advocacy meeting for individuals.

- AP department staff have diligently worked to better target resources for those with challenging behaviors, to assist with transition. One such resource is the LIDDA's START team which targets individuals with challenging behaviors living in the community. START provides behavior interventions and guidance to providers in order to minimize psychiatric hospitalizations, law enforcement contact, or a failed transition. The START team assisted in a transition this fiscal year, and the individual still resides in the community.
- As needed, habilitation therapies staff are reviewing individuals' supports and adaptive equipment to identify potential alternatives that are more accessible in a community setting. Recommendations on alternate supports include the use of different mechanical lifts and transfer protocols that can be safely implemented in the community. The habilitation therapies department will continue to be involved in assessing individuals in their potential new environments.
- AP department staff will attend 14-day meetings to assist IDT members with identifying all needed services and supports or any potential barriers for the individual to have a successful transition.
- In fiscal year 2017, local providers received additional training to better support individuals with medical needs. Providers have been invited to observe nursing staff here at the El Paso SSLC facility. El Paso SSLC nurses have also provided hands on training to ensure the safety of individuals preparing for transitions. 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 to encourage teams to review alternate treatments to meet individuals' needs that may, in turn, facilitate transitions.
- AP department staff will continue to involve the START program, as needed, to provide suggestions and insight for individuals who may benefit from this resource.

# 10. Lubbock State Supported Living Center Obstacles to Referral and Transition

## Center Profile

Lubbock SSLC opened on June 26, 1969, on 226 acres, and serves a catchment area of 54 counties in West Texas. As of August 31, 2017, Lubbock SSLC was serving 185 individuals and employing approximately 726 staff members.

Lubbock SSLC is located in Lubbock County, which has more HCS and ICF providers than any other county in the catchment area. A total of 98 HCS providers contract to serve individuals in Lubbock SSLC's catchment area (the majority of which are in Wichita Falls, Amarillo, and Plainview); however, only 13 of the 98 HCS providers listed for Lubbock County actively provide services in the local area. There are nine active HCS providers in the Amarillo area; three active HCS providers in the Plainview area; and 10 active HCS providers in the Wichita Falls area. Lubbock has 12 day habilitation programs and one vocational program.

The number of transitions has remained consistent over the past six years with a consistent number of referrals, but a slight decline in actual transitions. The AP team continues to provide educational training to individuals, LARs, families, and staff regarding community services to ensure informed living options discussions. This is discussed at the ISP for the individual. The AP team also discusses living options at the community exposure tours, provider fairs, and annual LIDDA living options training.

**Table 10-1. Community Referrals and Transitions from Lubbock SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 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 |
| 2015 | 5 | 4 | 9 | 0 | 201 |
| 2016 | 8 | 2 | 8 | 0 | 191 |
| 2017 | 8 | 2 | 7 | 0 | 185 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 10-2. Individuals Not Recommended for Referral from Lubbock SSLC, Fiscal Year 2017**

| Reason not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 131 | 46.79% |
| Individual's reluctance for community referral** | 64 | 22.86% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff. | 50 | 17.86% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 34 | 12.14% |
| Lack of funding | 1 | 0.36% |

*Data Source: IRIS*
** See Table 10-4*
*** See Table 10-3*

**Table 10-3. Individual Reluctance for Referral from Lubbock SSLC, Fiscal Year 2017**

| Reason for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 32 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 23 |
| Unsuccessful prior community placement(s) | 9 |
| Mistrust of Providers | 4 |

*Data Source: IRIS*

**Table 10-4. LAR Reluctance for Referral from Lubbock SSLC, Fiscal Year 2017**

| Reason for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 102 |
| LAR is not interested in being provided information and exposure to community living options | 18 |
| Unsuccessful prior community placement(s) | 17 |
| Lack of understanding of community living options | 7 |
| Mistrust of providers | 4 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

LAR reluctance continues to be the greatest obstacle to transition, accounting for 46.79 percent of the identified obstacles to referral. Many LARs express that they feel their loved ones are safe and cared for at Lubbock SSLC in a way the community cannot match.

LAR education regarding community placements begins with the CLOIP, which is conducted by the LIDDA prior to each annual planning meeting. LARs who have been part of the process for years often choose not to participate and even request that the CLOIP representative not be present at the ISP due to lack of interest in community referral. Many of the LARs who are not interested in community transition are parents of individuals who have resided at the SSLC for most of their lives. Despite all educational efforts, these LARs frequently state Lubbock SSLC 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 reluctant LARs (83 percent) have attended a CLOIP at least once, even if they are not currently attending annually. In the event the CLOIP representative is not allowed to be present for the ISP meeting, the transition specialist or APC will attend to ensure that community living options information is available to the LARs and the IDT.

LARs are also encouraged to attend monthly community exposure tours and the annual provider fair. However, data from these events reveal that few LARs participated in fiscal year 2017. To improve LAR interest and participation, a Parade of Homes tour, exclusively for guardians, families, and Lubbock SSLC staff is planned for 2018. This community exposure tour will feature open houses from a variety of local providers, allowing LARs and professional staff to spend as much or as little time at each home as they choose, thus making efficient use of their time. The event will be publicized by the transition specialist, using colorful flyers and mail-outs to spark interest. If successful, the Parade of Homes will become an annual event.

## Individual's reluctance for community referral

The IDTs identified individual reluctance as the second greatest obstacle to referral, accounting for 22.86 percent of the identified obstacles. Of these, almost half were noted to be lacking understanding of community living options. To address this reluctance, Lubbock SSLC offers educational opportunities to individuals regarding supports and services offered in a community setting through exposure tours, provider fairs, LIDDA living options training, and individual discussions. However, for some individuals who attend these events, it is not clear that they actually understand that this could be a permanent change, rather than just an outing. The lack of understanding is not necessarily due to lack of education, but to level of functioning. To address this, Lubbock SSLC is arranging community exposure tours tailored to specific needs, including the needs of individuals with severe and profound ID. Preferred staff attend with the individual whenever possible. This helps to not only make the individual comfortable in the new environment, but the staff person also helps the individual understand the options that are being offered. When an individual has been provided information and exposure to community living options, but is still not interested in community placement, different strategies must be used. One option being explored by the center is having these individuals visit peers who have made successful community transitions. This broadens their understanding of what is available in the community on a more personal level. Other individuals cite bad experiences in the community and failed placements as the reason they are not interested in a community referral. These bad experiences are difficult to overcome, but the center continues to provide these individuals with education and exposure to different providers, as well as support to overcome the issues that may have caused previous placements to fail.

The QIDPs and the transition specialist continue to work together with the LIDDA to schedule monthly exposure tours for individuals. During the most recent CLOIP meeting between the LIDDA and Lubbock SSLC, a plan was made to combat spotty attendance and improve the effectiveness of exposure tours. Rather than offering general tours to anyone on campus who is interested, as was done previously, tours will be customized to best meet the needs of the residents of a particular house. For example, a community provider who is able to offer care for individuals who are medically fragile will host a tour for all interested individuals from a home that caters to residents with medical needs. A provider who is able to handle behavior challenges will host a tour for a home whose residents have these challenges. Since the tour is planned for a specific home, the QIDP and direct care staff who know the individuals best will also be able to attend, ask questions

pertinent to the individuals and also answer any questions from the provider. It is hoped that these more targeted tours will not only increase participation, but will also be more effective in educating individuals on their options as the staff who attend can conduct follow-up discussions and answer individual questions regarding the tour. It is also hoped that providers may be able to provide services for two or more individuals from a particular home, thus easing their transitions by maintaining life-long relationships.

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

The lack of supports for individuals with behavioral health needs was identified as the third greatest obstacle to referral, accounting for 17.86 percent of the identified obstacles. To help alleviate the behavioral needs of residents, challenging behaviors are addressed through PBSPs and psychiatric services. The PBSPs encourage individuals to replace challenging behaviors with socially-acceptable behaviors, thus facilitating their transition to the community. Additionally, the transition specialist identifies providers who may be capable of supporting individuals with behavioral challenges and shares this information with the IDTs.

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

The lack of availability of health services was identified as a significant, but greatly reduced from previous years, obstacle to referral; accounting for only 12.14 percent of the identified obstacles. This percentage has been cut in half since 2015, when the medical needs category was identified as the second greatest obstacle to referral.

There are still a number of individuals at the Lubbock SSLC who are not referred to the community as they require access to 24-hour nursing support. The level of care provided to these individuals would be difficult to obtain in a community setting and is not funded adequately through the HCS program. Examples of the services provided at Lubbock SSLC that are difficult to obtain in the community include: Argo tubs for bathing, physician on call 24 hours, constant feeding with feeding pump, administration of IV fluids and antibiotics, G-tube cleaned every 8 hours, oral suction tooth-brushing by nursing to prevent aspiration, brittle bone precautions, supports to avoid lying flat due to high risk of aspiration and

respiratory issues, crushed or liquid form medications via g-tube , or oral suctioning at least every 2 hours and PRN due to increased mucus levels. While any one of these services may be available in the community, it is hard to find a provider who can provide all of them. Often the required services are only available in the community through a nursing facility, which typically lacks programming and active engagement activities appropriate for individuals with intellectual disabilities.

AP staff provide 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. The ISP discussion will provide information regarding the supports that an individual will need in the community. Once this is determined, the LAR and individual, along with their IDT, can begin provider interviews to establish provider selection visits. The AP department works with providers to ensure they are aware of the needs of individuals served at the SSLC when they attend provider visits and provider fairs.

### Lack of funding

A lack of funding was identified as an obstacle for only one individual whose Medicaid had lapsed. The obstacle was addressed by reapplying for Medicaid and having it reinstated.

## In fiscal year 2018, Lubbock SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- 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. For example, most providers only have a single RN to provide nursing services for all their individuals, as opposed to Lubbock SSLC which has an RN case manager assigned to each home. Most community medical care is provided in much the way one would provide for their own medical needs, through the primary care physician with referrals to a specialist when needed.
- IDT members have the opportunity to ask specific community healthcare-related questions during provider fairs and community exposure tours. The newly customized exposure tours will be tailored to address the needs of individuals on their home.
- Facility medical and health services providers will be encouraged to attend either the Parade of Homes or the exposure tour for their assigned homes in order to further educate themselves on the health supports and services

available in the community. This will give staff more information to assist in recommending supports for the individual.

- The APC, transition specialist, and LIDDA staff coordinate a professional exposure tour monthly to provide an opportunity for professional staff and LARs to discuss services with the local providers.
- The IDT will continue to develop specific ISP action plan steps to address health obstacles to community referral.
- 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. For example, the provider may contract with (rather than employ) a behavior specialist to write and monitor PBSPs. This contracted behaviorist will not have daily, weekly, or sometimes even monthly contact with the individual like they enjoy at Lubbock SSLC. Information as to how behavior and psychiatric services are provided is covered by the provider at the exposure tour or provider interview.
- 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. Again, the newly customized model for exposure tours should ensure that IDT members are touring providers that are able to meet the specific needs of their residents.

# Obstacles to Community Transition

**Table 10-5. Obstacles to Transition from Lubbock SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 6 |
| Lack of supports for individuals with significant challenging behaviors | 5 |
| Individual/LAR indecision | 3 |
| Medicaid/SSI funding | 1 |
| Other | 5 |

*Data Source: IRIS*

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

### Limited residential opportunities

There were six individuals identified with this obstacle to transition. One individual was referred to the Dallas area and looked for almost a year before the geographic area was changed to the Amarillo area. Two individuals preferred the Big Spring and Wichita Falls areas where provider availability is limited. Another individual changed their preference from country living to city living, and the remaining two individuals changed their preference of home type and location multiple times. Five of the six individuals have since moved to the community while one referral has since been rescinded by the LAR, his parent, after obtaining guardianship.

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

There were five individuals with this obstacle. Three individuals displayed challenging behaviors during provider visits and their referrals were subsequently closed. One individual was smearing feces during provider visits; one individual was physically aggressive during exposure tours and had to have more time to become stable. Another individual injured provider staff while on a pre-selection visit. One of the five individuals has moved to the community and the other individual continues in the transition process.

### Individual/LAR indecision

The LARs for three individuals changed their minds about referral. One LAR decided that the individual would remain at the center following provider visits and the referral was closed. Two LARs were non-responsive during the transition process. One LAR chose to close the referral and the other individual has since moved to the community.

### Medicaid/SSI funding

One individual was found not to have his Medicaid/SSI benefits in place due to overpayment at a previous placement. Reimbursement reapplied for benefits and, once reinstated, the individual moved.

### Other – Provider delay in opening home

There were five individuals who experienced provider delay in opening a home. One provider was unable to open a home prior to being selected by one other individual. This individual's referral was subsequently closed due to behavioral issues and LAR decision. One individual had to wait on a house to be built, and due to an extensive rainy season, the home was delayed. This individual has moved. Another individual waited on a home for sprinkler system installation. This individual's referral was subsequently closed due to behavioral issues and LAR decision. Two individuals waited for a vacancy with a selected provider. One has moved and the other is in the transition process.

### In fiscal year 2017, Lubbock SSLC 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 Lubbock SSLC staff, and education of family members as well as IDT members. The IDT will identify supports and services, including individual and provider preference, at the 14-day meeting, following referral, to guide provider selection. Engagement with providers is critical to ensure they have the resources required to meet the challenging needs of the individuals residing at Lubbock SSLC.
- Once provider choice is made by the individual or LAR, the AP team will establish and maintain contact with the provider throughout the transition process to ensure that the supports required will be available for a successful transition. If possible, our team will have a face-to-face meeting with the provider after selection in order to educate them on the CLDP process.
- Training is needed in several areas to reduce the number of obstacles. The AP team, in collaboration with QIDP staff, will continue to train all new IDT members on the importance of identifying and addressing obstacles as they occur. This training will include the CLDP process and timelines.
- Obstacles are addressed as needed by the IDT upon referral. Additionally, the IDT will meet monthly to identify and overcome obstacles to transition and an ISPA will be completed by the QIDP if an individual does not transition to the community within 180 days of their referral. Obstacles to transition will be entered and updated by the AP team immediately following each ISPA. The APC will also continue to monitor individuals who exceed the 180-day timeframe and proactively intervene when indicated to ensure the

obstacles to transition are addressed, thus allowing the individual to move to their selected community provider as soon as possible.

- The APC will provide trend analyses of obstacle to referral and transition data to the QAQI council for review quarterly. Action plans will be established by the APC to address areas of concern.

# 11. Lufkin State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The Lufkin SSLC opened in March 1962 and serves 28 counties in the heart of East Texas. As of August 31, 2017, Lufkin SSLC was home to 298 individuals.

Lufkin SSLC is the fourth largest employer in Angelina County, with over 1,000 staff. Located in Lufkin, Burke Center serves as the LIDDA for the center and provides services for 12 of the 28 counties in Lufkin SSLC's catchment area. Burke Center lists 190 HCS providers for their area; however, only six HCS providers currently provide services locally. Five of the six HCS providers operate day programs, with three of them offering vocational programming. There are three ICF providers in Burke Center's service area currently providing residential services, day programs, and vocational programming. Several of the day/vocational programs offer services both to the individuals who participate in their residential program and to others not enrolled in that service.

In addition to Burke Center, there are three additional LIDDAs within Lufkin SSLC's service area, including Community Healthcore, ACCESS, and Andrews Center.

- ACCESS provides services for two of the 28 counties in Lufkin SSLC's catchment area. ACCESS has a listing of 127 HCS providers for their service area, but only six HCS providers currently provide services locally. One HCS provider operates a day program. There are two ICF providers in their service area and one vocational program.

- Andrews Center provides services for five of the 28 counties in Lufkin SSLC's catchment area. Andrews Center has a listing of 126 HCS providers for their area, but only 30 HCS providers currently provide services locally. There are five HCS day programs, with one offering vocational opportunities. Andrews Center has four ICF providers.

- Community Healthcore provides services for nine of the 28 counties in Lufkin SSLC's catchment area. They have 119 HCS providers, with 25 currently providing services locally. There are 16 HCS day programs and three vocational programs within Community Healthcore's service area. There are

six additional day programs that are independently run, with which HCS and ICF providers may contract. Six ICF providers provide residential and day programming, with only two of the six providing vocational training.

**Table 11-1. Community Referrals and Transitions from Lufkin SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 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 |
| 2015 | 12 | 11 | 22 | 4 | 308 |
| 2016 | 18 | 19 | 14 | 1 | 295 |
| 2017 | 7 | 14 | 7 | 2 | 298 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 11-2. Individuals Not Recommended for Referral from Lufkin SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 183 | 55.29% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 72 | 21.75% |
| Individual's reluctance for community referral** | 48 | 14.50% |
| Behavioral Health/Psychiatric Needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 28 | 8.46% |

*Data Source: IRIS*
**See Table 11-4*
***See Table 11-3*

**Table 11-3. Individual Reluctance for Referral from Lufkin SSLC, Fiscal Year 2017**

| Reasons for individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 24 |
| Lack of understanding of community living options | 16 |
| Unsuccessful prior community transition(s) | 5 |
| Individual is not interested in being provided information and exposure to community living options | 3 |
| Mistrust of providers | 3 |

*Data Source: IRIS*

**Table 11-4. LAR Reluctance for Referral from Lufkin SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 160 |
| LAR is not interested in being provided information and exposure to community living options | 16 |
| Unsuccessful prior community transition(s) | 7 |
| Lack of understanding of community living options | 3 |
| Mistrust of providers | 2 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

LAR reluctance has been the greatest obstacle to referral for community transition at Lufkin SSLC for the past several years. There has been a marked increase in families obtaining guardianship. In fiscal year 2015, a little over 50 percent of the individuals served had either a court appointed guardian or a natural guardian (for minors). In fiscal year 2017, that number increased to almost 65 percent. This increase in guardianship is believed to be due in part to the very active parents association here at Lufkin SSLC. These parents and family members are pro-active in regards to encouraging the acquisition of guardianship, but are also opposed to any type of community placement or alternate transition and are very firm in their belief that Lufkin SSLC is the best place for their family members.

In an effort to inform and expose LARs to the options available in the community, and assist those LARs who have been identified as having a lack of understanding, Lufkin SSLC continues to offer educational opportunities on the various community options through open and ongoing discussions regarding living options, review of the CLOIP worksheet, provider fairs, and community group home and day programming tours. Many LARs, however, are resistant to the educational

opportunities that are provided to them. The most commonly identified reason for this reluctance is, as the LAR states, they are just not interested in community transition, even after being provided this information and exposure to the various community living options. LARs frequently inform teams that they feel that Lufkin SSLC is "home" to their loved one and do not want to make any changes to their environment. In an attempt to address the concerns of these LARs, Lufkin SSLC continues to invite all LARs and involved family members to participate in our on-campus provider fairs, LIDDA in-services, and to tour community programs in an attempt to ensure their awareness of the various options available. During the ISP process, we ask that the LAR at least consider a community referral. Center social workers continue to share an individual's positive responses to community outings to facilitate a more open discussion regarding community programs. Many LARs have voiced their appreciation of information from the outings, but most are still reluctant to pursue community transition.

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

Medical needs requiring 24-hour nursing services/frequent physician monitoring has been identified as the second greatest obstacle to community referral at Lufkin SSLC. Lufkin SSLC serves many individuals whose medical needs require access to 24-hour nursing services and supports and frequent physician and nursing monitoring and interventions. As the center's population continues to age, the specialized needs and required monitoring activities that stem from these needs require more frequent nursing and physician monitoring than is currently available in a typical community setting.

The individuals at Lufkin SSLC who require 24-hour nursing services and frequent physician monitoring reside in two units, Lone Pine and Woodland Crossing. The individuals, as well as IDT members working in these units, are invited to participate in education opportunities regarding community options to increase their awareness. All disciplines who work with these individuals are invited and encouraged to attend.

## Individual's reluctance for community referral

The individual's reluctance for community placement has also been identified as an obstacle to community referral. A lack of understanding of community living options has been identified as one of the main reasons individuals at Lufkin SSLC are not wishing to seek community transition. The AP department, the transition specialist,

and the Burke Center's CLOIP workers have revised their educational and supportive systems to assist the individuals in gaining further knowledge and information, as well opportunities for actual hands-on experiences regarding various community placement options.

These new informational techniques include the use of video recordings shown to individuals, their LAR, and family if they so choose, which allows them to see and hear from a variety of group homes and community providers for themselves. These videos also include information regarding the various vocational and day habilitation services in the community. Pamphlets and brochures are also provided to those who would like them. With the AP department and the Burke Center providing educational sessions through the use of CDs played either on a lap top or DVD/TV, individuals, as well as their families, have been more receptive in regards to being provided information about the various community options available.

In conjunction with the Burke Center, monthly schedules are provided to individuals who are interested in an opportunity to actually experience a visit to community programs for themselves. This includes trips to vocational and day habilitation programs for a "first-hand" experience where, if they so desire, they can actually participate in the activities that are going on during their visit. This visit concludes at the group homes where the individuals actually meet others who live there, as well as the staff working at the home. This individualized support and "get to know them" approach is felt to be important in trying to assist those who may have a mistrust of providers and might be afraid of unfamiliar experiences.

Participation in monthly tours ranges between five and 10 individuals. These tours are now more specialized so that individuals can visit a home that can accommodate their needs, along with visiting either a day habilitation program or vocational program. IDT and family members are invited to participate with the individual during these tours to observe their reaction to the experience. The AP department shares the individual's reactions with the IDT. Also, individuals on specific homes at Lufkin SSLC have been identified to receive additional educational opportunities from the CLOIP workers, as they may have more medical and physical limitations and are less likely to be able to fully participate in these tours.

The transition specialist continues to work with the human rights officer to participate in self-advocacy meetings and provide information on community options. Lufkin SSLC 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. Plans are already in place for the 2018 Provider Fair to be held at Lufkin SSLC. These fairs, throughout past years, have shown a substantial increase in attendance, as more activities have been added in an attempt to encourage participation. Each fair has a theme which aims to encourage individuals, providers, and staff to interact with each other. The Recreation and Community Relations departments have agreed to assist with activities that will promote participation in each fair. Individuals will be provided assistance from Employment and Day Programming if they have mobility issues. All future fairs will attempt to integrate more disciplines in the fair activities in order to educate staff and individuals on the options available in the community.

Staff from the AP department have attended 14 annual ISP meetings this past year and will continue to do so for those individuals identified as potentially being successful in transitioning to the community. During these meetings, AP 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.

Community living options are discussed with individuals, family members, LARs, and the rest of the IDT through the ISP process. Through the ISP process, including the preferences and strengths inventory and the ISP prep meeting, individuals, LARs, and team members are encouraged to have an open and thorough discussion about an individual's wants and needs in a community setting.

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

Lufkin SSLC has certain individuals with behavioral, psychiatric, or supervision needs which prevent them from being referred for community transition and pose a barrier to transition. The facility continues to provide behavioral health services, psychiatric services, monitoring, and enhanced supervision levels as needed. 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. Some team members are more open to consideration of community referral due to enhanced post-referral activities. These activities include clinician-to-clinician psychiatric discussions and the ability to develop a support to require consultation with the facility psychiatrist for any recommended changed in psychiatric medication change.

## In fiscal year 2018, Lufkin SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- LARs and family members will continue to be encouraged by the social workers and IDT members to participate in individuals' ISPs, provider fairs, LIDDA in-services, and community tours in an effort to encourage consideration of community options.
- During the ISP, LARs and involved family members are being encouraged to share and discuss their fears and concerns regarding their family member's possible transition.
- LARs and family members will continue to be provided the most recent and up-to-date information and data regarding new community programs, group homes, and available community transition options.
- The AP department staff and the transition specialist will continue to offer individualized community visits for individuals, LARs and family members to provide a one-on-one approach to various community options.
- The transition specialist continues to provide educational tour opportunities and to discuss the individual's response to the group home and day programming tour with the LAR, IDT, and family.
- The center will continue providing community education to the IDT members for the units serving medically involved individuals.
- AP department staff will continue to encourage the Burke Center, as well as other LIDDAs, to participate in the ISP process as another resource for community information.
- Provider fairs will continue with increased efforts to include specialty providers to offer individuals, LARs, families, and IDT members a broader spectrum of available options.
- The transition specialist will continue to provide community options information during self-advocacy meetings.
- The transition specialist will continue to use new informational techniques, including videos. This allows the individual to both see and hear about various group homes and community providers.
- Lufkin SSLC has some family members who might consider having their loved ones move closer to them; however, many of them reside in small rural areas where there are few community provider homes. Lufkin SSLC will communicate this information to the LIDDAs and providers for those specific areas.

# Obstacles to Community Transition

**Table 11-5. Obstacles to Transition from Lufkin SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 6 |
| Lack of supports for people with significant challenging behaviors | 3 |
| Need for Environmental Modifications to support the individual | 3 |
| Lack of availability of specialized medical supports | 1 |
| Lack of specialized mental health supports | 1 |
| Other | 8 |

*Data Source: IRIS*

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

### Limited residential opportunities

There were six individuals for whom the IDT members and transition specialist struggled to locate an appropriate provider within the preferred search area. Three of the six individuals with this obstacle transitioned to the community within their specific service area. One individual's team preferred a home in a small, rural area close to his grandmother. There was a lack of homes in the preferred area and the grandmother did not want the individual that close to her home, as she knew he would have unauthorized departures trying to get to her. The team agreed to close the referral. The other two individuals are still in the transition process. One of these individuals has a guardian that prefers him to be placed locally in a host home, which has proven to be difficult to locate. The other individual prefers to live

close to his family; however, due to failed placements with the providers in that area, locating a provider has been difficult.

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

There were three individuals whose obstacle to transition was identified as significant challenging behaviors. One individual with a diagnosis of pica was receiving increased supervision due to documented attempts and successful ingestion of inedible objects. A provider was eventually located that could meet his behavioral and supervision needs, and he moved. The second individual had a significant history of failed community placements due to his psychiatric needs. There were limited psychiatric services in his preferred area. The individual had a pre-placement visit with a provider selected in his preferred area; however, the visit was interrupted due to him exhibiting behaviors that led to his initial SSLC admission. His psychotic behaviors continued to increase and the team was in agreement to close his referral. The third individual also had a long history of failed community placements. Due to his significant behavioral needs, selected providers were reluctant to move forward in the transition process because of their limited behavioral and psychiatric resources. At his request his referral was closed.

### Need for environmental modifications to support the individual

Three individuals required environmental modifications be made to their potential group homes. One individual's referral was rescinded due to the inability to locate a home that could accommodate his adaptive equipment (oversized bathing trolley and wheelchair), as well as an appropriate vehicle for transportation. The other two individuals required home modifications due to their mobility needs. A provider was selected to serve both of these individuals in the same home, as their mobility needs were quite similar. They have moved and are doing well.

### Lack of availability of specialized medical supports

One individual was receiving continual g-tube feedings which took up to 17 hours per day. Providers with nursing staff available for those lengths of time each day, in his preferred area, were not available. He was assessed again and it was determined that he could graduate from continual feeding to bolus feedings four times per day, which dramatically decreased the time spent feeding and initiated more positive responses from prospective providers. After interviewing the providers and completing a successful pre-placement visit, this individual moved into the community and is doing well.

### Lack of specialized mental health supports

One individual had a significant history of failed community placements due to his psychiatric needs. There were limited psychiatric services in his preferred area which prompted his admission into Lufkin SSLC. The individual had a pre-placement visit with a provider selected in his preferred area; however, the visit was interrupted due to him exhibiting behaviors that led to his initial SSLC admission. Lufkin SSLC staff attempted to assist the provider in making the visit successful; however, the individual's behaviors continued to be more than the provider could handle. Upon return to the facility, the individual and the team agreed to rescind the referral.

### Other – Illness during transition period

One individual became ill during the transition process, and the team determined that due to her decline in health status, she could not participate in referral activities until her medical issues were resolved. This resulted in the transition process being placed on hold. Once her health began to stabilize, the team felt it appropriate to commence with the referral process. Once transition activities resumed, she transitioned in a reasonable amount of time.

### Other – Provider delay in opening home

One individual's transition was delayed due to the provider remodeling and opening a new home upon selection. The provider remained in contact with the facility regarding the progression of the home. Once all renovations were complete and the home was fully staffed, she toured the home and participated in a three-day visit and successfully transitioned.

### Other – Family chose to pursue guardianship

Five individuals referred for community transition exceeded their 180-day timeframe due to the family members' decisions to pursue guardianship. During a tour of possible providers, one individual communicated he did not want to leave the facility to live in a group home. His cousin obtained guardianship and the referral was closed. Another individual's family initiated guardianship proceedings. The family failed to proceed with the guardianship process, and he eventually transitioned. Following referral for two other individuals, very involved families opposed the community referrals. Both referrals were closed once guardianship was obtained. The family of the remaining individual pursued guardianship following

referral due to numerous failed community placements. The individual was later arrested and court-ordered to a forensic facility. The referral was closed.

### Other – Criminal court issues

One individual's transition process was placed on hold to determine the status of legal charges in two counties. The charges were ultimately dismissed and he transitioned to the community.

## In fiscal year 2017, Lufkin SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- Issues with locating homes with modified wheelchair accessibility have continued to be an obstacle to transition. The AP department will continue to communicate with community providers regarding the need for modified wheelchair accessibility.
- Lufkin SSLC's Habilitation Therapy department will continue to assist teams and community providers in assessing homes to identify the environmental modifications needed to safely serve individuals.
- Transition plans will continue to be developed for individuals who need additional assistance in adjusting to new environments. These plans have assisted with several successful transitions during the past year. Teams will be encouraged to identify the needs for these plans at the 14-day meeting or early in the referral process.
- Lufkin SSLC will continue to offer educational opportunities to families once an individual is referred. These opportunities will be designed to support them in decision-making regarding the selection of a provider in an attempt to eliminate delays in transition.
- The AP department monitors all referrals and works with teams to assist them in supporting individuals to transition within the 180-day timeframe.
- A member of the AP department staff will attend all meetings for any individual who is referred.
- If an individual does not transition to the community within 180-days of their referral date, AP department staff will continue to have the IDT meet monthly to identify and develop action plans to address any obstacles.

# 12. Mexia State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The Mexia SSLC opened in March 1946. The facility is located on 220 acres in Limestone County and employs approximately 1,375 people. Mexia SSLC was serving 246 individuals as of August 31, 2017, and is the catchment area for Bell, Coryell, Falls, Freestone, Hamilton, Lampasas, Milam, Bosque, Hill, Limestone, McLennan, and Tarrant counties. Mexia SSLC also serves all of Texas as the forensic facility for male individuals.

Limestone County is served by three active community providers. One has both HCS group homes and ICFs, along with host/companion care services. Another provider is the LIDDA, which has HCS group homes. The other provider only offers HCS 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 Mexia SSLC catchment area. McLennan, Bell, and Tarrant counties are served by the largest number of providers, with McLennan being served by 15 active HCS community providers, Bell being served by 20 active HCS community providers, and Tarrant by 84 active HCS community providers. Tarrant, Hill, and Coryell also have ICF providers. Tarrant County also has several day habilitation services providers.

**Table 12-1. Community Referrals and Transitions from Mexia SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 89 | 15 | 100 | 1 | 417 |
| 2011 | 45 | 44 | 51 | 1 | 390 |

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2012 | 47 | 8 | 41 | 2 | 372 |
| 2013 | 55 | 21 | 52 | 2 | 331 |
| 2014 | 45 | 29 | 68 | 1 | 288 |
| 2015 | 26 | 16 | 57 | 2 | 256 |
| 2016 | 15 | 22 | 18 | 3 | 256 |
| 2017 | 35 | 6 | 29 | 0 | 246 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 12-2. Individuals Not Recommended for Referral from Mexia SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons 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 | 126 | 58.60% |

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 35 | 16.28% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 19 | 8.84% |
| Individual's reluctance for community referral** | 15 | 6.98% |
| Evaluation period (Ch. 55/46B only) | 9 | 4.19% |
| Court will not allow placement (Ch. 55/46B only) | 6 | 2.79% |
| Lack of funding | 5 | 2.33% |

*Data Source: IRIS*
**See Table 12-4*
***See Table 12-3*

**Table 2. Individual Reluctance for Community Referral from Mexia SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 6 |
| Individual is not interested in being provided information and exposure to community living options | 5 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 2 |
| Mistrust of providers | 1 |

| Reasons for Individual Reluctance | Total |
|---|---|
| Unsuccessful prior community transition(s) | 1 |

*Data Source: IRIS*

**Table 3. LAR Reluctance for Referral from Mexia SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR is not interested in being provided information and exposure to community living options | 15 |
| LAR 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 | 2 |
| Mistrust of providers | 2 |
| Unsuccessful prior community transition(s) | 2 |

*Data Source: IRIS*

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

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

Behavioral health and psychiatric needs requiring frequent monitoring by psychiatric or behavioral health staff and increased levels of supervision maintained by direct support staff continues to be the most frequent obstacle for community

transition at Mexia SSLC. This is attributed to the center serving a large population of individuals with forensic commitments. Many of these individuals 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 IDTs review the individual's behavioral data, response to counseling, and behavioral programs monthly, or as needed, to assess whether the individual requires additional time for intervention through behavioral health services prior to a referral for community transition.

For the individuals identified as having behavioral needs that prevent them from moving to a less restrictive setting at this time, interventions through root cause analysis, improved PBSP, psychiatric services, and an increased focus on more meaningful activities continue to address the individuals' challenging behaviors.

Mexia SSLC also has a high risk determination process in place to identify individuals who are at a high risk of causing substantial physical harm to themselves or others. This process requires that the individual's IDT review the individual's history and current behavioral data to make such a determination. This process gives the IDT another opportunity to assess the individual's needed supports to determine if the individual may be served in a less restrictive community environment. The strategies listed above appear to be effective at Mexia SSLC and will continue in fiscal year 2018.

## LAR reluctance for community referral

LAR reluctance is the second most frequent obstacle and the most difficult to overcome. The two LARs that lack an understanding of community living options will be encouraged to attend the educational community tours provided, community living provider fairs, and family association meetings.

In fiscal year 2018, QIDPs and AP department staff, with assistance from CLOIP staff, will continue to offer educational opportunities to LARs and AIPs regarding community living options. LARs and AIPs will be encouraged to attend provider fairs, family association meetings, and visit community provider homes, day

habilitation and work centers. If LARs or AIPs are unable to attend the provider fair at Mexia SSLC, the QIDP will coordinate with the LIDDA for the LAR or AIP to attend a provider fair in or near their county.

CLOIP staff and the transition specialist will continue to attend ISP meetings to provide information regarding community options to individuals, LARs, AIPs, and IDTs. QIDPs and AP department staff will continue to follow up with LARs throughout the year to ensure community living information is provided and tours of provider homes and programming areas have been scheduled and completed.

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

Mexia SSLC provides services for individuals whose medical needs are such that they require 24-hour nursing services and monitoring, which is often only available in a nursing facility or other medically-oriented setting in the community. The transition specialist will continue to identify providers that have demonstrated success to individuals with complex medical needs.

## Individual's reluctance for community referral

Individual reluctance for community referral is the fourth most frequent obstacle to referral at Mexia SSLC. For the six individuals that lack understanding of community living options, provider tours will be scheduled to provide an opportunity to learn more about the options available in the community. If possible, the IDT may also arrange for the individuals to visit peers who have successfully transitioned to a community setting.

IDTs will continue to encourage all individuals to attend provider fairs held on campus. This year, 22 HCS providers participated in the Mexia SSLC provider fairs, which were attended by 146 individuals, three LARs/AIPs, and 79 Mexia SSLC employees. These strategies appeared to be effective in reaching out to the individuals and family members of Mexia SSLC. These strategies will continue in fiscal year 2018.

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

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

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

Occasionally courts will not allow an individual to transition from Mexia SSLC into the community. In most cases, the AP department will notify the court of an individual's potential referral for community transition. This process allows the court to ask questions or request current documentation on the individual's progress since admission and updated testing (with court order). This restriction regarding community transition is sometimes included in the court documents received from the committing court.

## Lack of funding

Efforts to secure funding for individuals at Mexia SSLC who are not currently eligible for Medicaid funding will continue in fiscal year 2018. The QIDP will continue to work with reimbursement and state office to secure funding for the identified individuals.

## In fiscal year 2018, Mexia SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- The IDT will identify any obstacles to referral and implement detailed action plans to address the barriers. This plan will be reviewed by the individual, LAR, and AIP for understanding. The IDTs will continue meeting monthly to review goals and action plans for efficacy.
- The transition specialist will continue attending ISP meetings, educating teams, and providing guidance on community living option discussions.
- The QIDP and transition specialist will continue assisting and educating LARs and AIPs on community living options as needed or requested.
- The AP department will continue hosting provider fairs in order to provide educational opportunities for individuals, LARs, family members, and staff.
- IDTs and LIDDAs will continue to offer community provider tours for individuals and LARs.
- Community living option information will be provided during quarterly Family Association meetings.

# Obstacles to Community Transition

**Table 12-5. Obstacles to Transition from Mexia SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 7 |
| Individual/LAR indecision | 6 |
| Lack of supports for individuals with significant challenging behaviors | 5 |
| Medicaid/SSI funding | 3 |
| Need for environmental modifications to support the individual | 2 |
| Need for services and supports for individuals with forensic needs/backgrounds | 1 |
| Lack of availability of specialized therapy supports | 1 |
| Other | 5 |

*Data Source: IRIS*

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

### Limited residential opportunities

Seven individuals were identified as having their move to the community delayed due to limited residential opportunities in the preferred geographical area. Of these seven individuals, five have transitioned to the community, and one referral was closed by the IDT due to an increase in behaviors. One individual is still in the transition process with a move scheduled in fiscal year 2018. In these cases, individuals and LARs were encouraged to explore providers in other locations close to their families.

## Individual/LAR indecision

Of the six individuals whose obstacle was individual/LAR indecision, four have transitioned to the community and one referral was closed at the individual's request, as the individual felt that he was not ready to move due to a recent issue with inappropriate sexual behavior. One individual continues to search for the perfect provider. This individual is having difficulty locating a provider and a day habilitation program that he likes. He has visited several providers and day habilitation programs in various areas and has liked one or the other, but not both. He and his team continue their search. Indecision is frequently caused by the individual's or LAR's stated preferences as to the location of the home, the home's proximity to family, or they expressed displeasure with potential providers. The individual is encouraged to interview several potential providers in order to make a good decision on whether to schedule a visit to their group home. This could result in several pre-selection visits to assist them with making a decision of their preferred provider for services.

## Lack of supports for individuals with significant challenging behaviors

Of the five individuals with this obstacle, four have transitioned to the community. For the other individual, the IDT team is pursuing a LON 9, which will provide one-to-one staff for 16 hours a day. The IDT will continue to request assistance from the transition specialist in locating providers who have had success in serving individuals with complex behavioral needs.

## Medicaid/SSI funding

Of the three individuals whose identified obstacle to transition is lack of Medicaid/SSI funding, two have transitioned to the community. These two individuals had to apply for SSI upon turning 18 years old. The other individual's referral was closed by the IDT due to an increase in behaviors. Reimbursement staff continue to work on this individual's Medicaid eligibility and application has been completed. Moving forward, an individual's funding will be reviewed at the 14-Day meeting to prevent an obstacle to transition.

## Need for environmental modifications

For the two individuals whose identified obstacle to transition is environmental modifications, necessary modifications include a wheelchair-accessible home or

modifications to a bathroom for specialized bathing techniques. One individual's referral was closed and he was subsequently discharged to his family per court order. The other individual has made a final provider selection for an HCS program and the CLDP meeting and subsequent move has been scheduled in fiscal year 2018.

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

For the one individual with this obstacle, the individual and IDT continue to research providers who can offer needed supports and services. This individual will need a home in a rural setting with limited access to children. The team members will request assistance from the transition specialist in locating a provider who has provided services for individuals with this specialized need.

### Lack of availability of specialized therapy supports

One individual has been identified with this obstacle. This individual requires behavioral health and habilitation therapies professionals to collaborate and continue the work of decreasing the undesired hand-mouthing behavior by introducing appropriate replacement items to prevent skin issues. The IDT is pursuing a LON 9.

### Other – Family chose to pursue guardianship

The family for this individual was in the process of renewing their guardianship, and then transferring it to a niece due to the death of the other parent. This individual is currently in the transition process.

### Other – Criminal court issues

The court had concerns about four individuals moving to a community setting. Through close communication with the courts, three have transitioned and the other individual has a CLDP scheduled.

## In fiscal year 2018, Mexia SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- The transition specialist and AP department staff will attend the 14-day meeting to assist IDT members with identifying all needed services and

supports or any potential barriers for the individual to have a successful transition.

- AP department staff will work with IDT members on identifying obstacles to transition prior to 180 days and will assist with developing action plans to address obstacles.
- Individuals whose transitions exceed 180 days will continue to be monitored by the AP and QIDP departments. IDTs will continue to meet monthly to address any obstacles to transition and implement action plans to remove the obstacle. IDTs will request assistance from the transition specialist to assist with locating providers as needed.

# 13. Richmond State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The Richmond SSLC opened in 1968. The center is located on 242 acres and was home to 319 individuals as of August 31, 2017. Richmond SSLC employs approximately 1,261 people and serves 13 surrounding counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Hardin, Harris, Jefferson, Matagorda, Orange, Waller, and Wharton.

Richmond SSLC is located in Fort Bend County. Fort Bend, Harris, and surrounding counties are served by 400-plus HCS and 150 ICF providers, with over 200 HCS providers and all 150 ICF providers actively serving 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 transition 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.

**Table 13-1. Community Referrals and Transitions from Richmond SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 13 | 4 | 52 | 0 | 407 |
| 2011 | 28 | 6 | 24 | 0 | 378 |
| 2012 | 25 | 1 | 30 | 1 | 352 |

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2013 | 13 | 6 | 22 | 0 | 339 |
| 2014 | 17 | 3 | 18 | 1 | 335 |
| 2015 | 5 | 12 | 14 | 1 | 330 |
| 2016 | 15 | 5 | 6 | 0 | 328 |
| 2017 | 19 | 13 | 16 | 0 | 319 |

*Data Source: IRIS*

## Obstacles to Community Referral

**Table 13-2. Individuals Not Recommended for Referral from Richmond SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community placement* | 206 | 60.77% |
| Individual's reluctance for community placement** | 71 | 20.94% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 26 | 7.67% |

| Reason Not Referred | Total | Percentage of Reasons 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 | 24 | 7.08% |
| Lack of funding | 12 | 3.54% |

*Data Source: IRIS*
**See Table 13-4*
***See Table 13-3*

**Table 13-3. Individual Reluctance for Referral from Richmond SSLC, Fiscal Year 2017**

| Reason for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 48 |
| Individual has been provided information and exposure to community living options, but is not interested in community placement | 7 |
| Unsuccessful prior community transition(s) | 6 |
| Mistrust of providers | 5 |
| Individual is not interested in being provided information and exposure to community living options | 4 |

*Data Source: IRIS*

**Table 13-4. LAR Reluctance for Referral from Richmond SSLC, Fiscal Year 2017**

| Reason for LAR Reluctance | Total |
|---|---|
| Mistrust of providers | 85 |
| LAR is not interested in being provided information and exposure to community living options | 84 |
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 66 |
| Lack of understanding of community living options | 45 |
| Unsuccessful prior community placement(s) | 17 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

LAR reluctance continues to be the greatest obstacle to referral and most difficult to overcome. The majority of LARs have received information about community living options and they are not interested in learning more. Many LARs are parents or siblings of individuals who have resided at Richmond SSLC for many years and frequently state that Richmond SSLC is the only home their family members have known, and they do not want to disrupt their lives. Furthermore, they do not believe community providers can care for their family members as well as Richmond SSLC.

Education of LARs is most often addressed through the CLOIP, which occurs before each annual ISP meeting. LARs are contacted by staff from the LIDDA, Texana Center, 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

twice-monthly educational community tours provided through the LIDDA. The AP department staff continue to attend ISPs on a regularly scheduled basis to assist in educating LARs and families about the community living options and the CLOIP tour process. The AP department staff continue to share community provider profiles which include information and pictures. This approach appears to be successful in providing education on community living options to LARs who might otherwise turn down information from the LIDDA. Moreover, social workers are encouraged to offer family members the option of participating via teleconference, as there are a number of guardians who are aging and unable to travel to campus. The social workers send a letter, along with the pre-planning questionnaire, informing LARs about the upcoming ISP. The letter informs the LAR that a living options discussion will occur to capture the thoughts and ideas in regards to the most integrated setting, supports, and services for their loved one. Additionally, the social workers serve as the front line liaison between the families and the IDT, when the LAR is not receptive to a discussion regarding community living options.

A provider fair is held twice a year, in May and November. Provider fairs are held on campus and afford an additional opportunity for LARs to meet different community providers and learn more about the options available to them. For the May 2017 fair, 22 providers attended the event. At the November 2017 fair, Richmond SSLC had 28 providers in attendance. Letters were mailed to all LARs and primary correspondents informing them of the opportunity to receive information from local community providers. The Richmond SSLC family association was also informed of the provider fair dates and times.

The QIDP coordinator will complete an audit of the living options discussions for the 45 LARs that lack an understanding to ensure the action plans are effective and making progress. If issues are identified they will be addressed with the IDT and through an ISPA meeting to revise the action plans as needed to ensure lack of understanding is being addressed. The transition specialist will assist as needed to provide information to these LARs.

## Individual's reluctance for community referral

Individual reluctance continues to be the second greatest obstacle to referral at Richmond SSLC, and the main reason is a lack of understanding of community options available. The LIDDA's monthly educational community tours continue to offer individuals an opportunity to learn more about the options available to them in the community. Individual CLOIP tour participation has increased with 22 individuals participating in the October 2017 tour. Individuals who have attended

the educational community tours have either gotten comfortable while on the short visit (e.g., by sitting on the couch) or have walked through the home and then left.

Individuals who lack an understanding of community options are given the opportunity to participate in virtual tours. The individuals are encouraged to participate in the provider fairs twice a year. All of the individuals are given the opportunity to go out into the community and get exposure to what the community has to offer. The individuals go to restaurants, shop, attend recreational events, and visit former residents in the community.

Monthly self-advocacy meetings continue to be a platform for individuals to discuss community living. In this setting, they are able to talk openly and freely, and ask any questions they may have about transition to community living. We currently have 10 individuals participating in this forum.

The QIDP coordinator will complete an audit of the living options discussions for the 48 individuals with a lack of understanding to ensure the action plans are effective and making progress. If issues are identified, they will be addressed with the IDT through an ISPA meeting to revise the action plans as needed to ensure lack of understanding is being addressed. The transition specialist will assist as needed to provide information to these individuals.

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

Another obstacle is having medical needs that require 24-hour nursing services, which often can only be provided in a nursing facility or other medically-oriented setting. For example, Richmond SSLC has several residents who require G-tube feedings (either bolus or continuous), a strict repositioning schedule to reduce the risk of skin breakdown, and breathing treatments multiple times a day. The AP department will continue to search for providers that can specifically accommodate significant medical needs.

### 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 services will continue to identify clear functions of challenging behaviors, rationale for increase in behaviors, and behavioral interventions. IDTs will continue to work on developing individualized positive behavior supports and

making appropriate environmental changes. Individuals will continue to receive treatment that is coordinated between psychiatry and behavioral health services that will help individuals become more behaviorally stable. It is hoped that this coordination will reduce the number of individuals with this obstacle to transition.

### Lack of funding

There are 12 individuals who cannot be referred to the community due to funding and citizenship status. Three of the 12 individuals are involved in the citizenship process. Reimbursement and social work staff continue to work together as new information is received regarding the remaining individuals and their citizenship and funding status.

### In fiscal year 2018, Richmond SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- Provide educational opportunities to individuals and LARs to ensure they are able to make informed decisions regarding community referral.
- The AP department will continue to attend ISP meetings to offer additional education on community living options to LARs.
- Increase participation in the CLOIP tours in order to further educate and expose individuals to community living options.
- Hold provider fairs and invite all current and prospective providers, individuals, LARs, families, and LIDDAs.
- Social workers and QIDPs will continue to discuss living options with LARs outside of the ISPs.

## Obstacles to Community Transition

**Table 12-5. Obstacles to Transition from Richmond SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Lack of supports for individuals with significant challenging behaviors | 7 |
| Limited residential opportunities | 3 |

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 1 |
| Need for environmental modifications to support the individual | 1 |
| Other | 12 |

*Data Source: IRIS*

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

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

Seven individuals had an obstacle related to a lack of supports for significant challenging behaviors. Four of the individuals exhibit behaviors that can result in critical injuries to others, two individuals invade personal property and space and respond negatively when redirected, and one individual has pica-related issues. These seven referrals have been closed.

### Limited residential opportunities

Three individuals had limited residential opportunities due to very few active providers in the preferred location. Richmond SSLC worked diligently to locate a provider within the individuals' preferred geographic area, and all three individuals were able to move to a home close to their families.

### Individual/LAR indecision

One individual was uncertain about moving to the community. The individual visited with a friend who transitioned, made a final provider choice, and successfully moved.

### Need for environmental modifications to support the individual

One individual required environmental modifications prior to the move. The individual has an oversized wheelchair and the provider had to widen the doorways. The work was completed and the individual moved.

### Other – Family chose to pursue guardianship

There were five individuals for whom the family chose to pursue guardianship following referral. Guardianship was awarded and the referrals were closed.

### Other – LAR reluctance to choose a provider

There were two individuals with the obstacle of LAR reluctance to choose a provider. For one individual, family issues prevented provider selection and the referral was closed. For the other individual, the LAR was not comfortable proceeding with transition and the referral was closed.

### Other – Illness during transition period

There were five individuals who were unable to complete the transition process due to ongoing and new medical issues. The referrals were closed.

### In fiscal year 2018, Richmond SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- The AP department will continue to actively in-service facility QIDPs on the importance of the 180-day transition time frame and the need to identify and address obstacles as they occur. IDTs, in conjunction with the AP department, will continue to meet monthly to identify and address obstacles to transition.
- The director of the AP department, with the support of the state office continuity of services specialist, will continue to provide training to all disciplines and department heads on the community transition process.
- The 14-day ISPA meeting will be used to identify all needed supports and will be used as a reference document throughout the transition process.

# 14. Rio Grande State Center Obstacles to Referral and Transition

## Center Profile

The Rio Grande State Center (RGSC or SC) 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 2017, was serving 60 individuals. RGSC employs approximately 565 people, of whom approximately 240 work for the ICF/IID division. The ICF/IID component of RGSC serves 12 counties: Cameron, Hidalgo, Starr, Duval, Brooks, Jim Wells, Kenedy, Kleberg, Jim Hogg, Webb, Zapata, and Willacy.

Although there are more than 30 community providers listed for this area, we continue to have only 13 provider agencies that have HCS homes and only two have ICF homes. Most of these providers do have their own vocational services, including employment assistance for individuals with community jobs. Two providers have sheltered work center services. However, more employment opportunities for individuals beyond referral to TWS-VRS would be beneficial.

**Table 14-1. Community Referrals and Transitions from Rio Grande SC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 2 | 1 | 2 | 0 | 72 |
| 2011 | 11 | 2 | 2 | 0 | 71 |
| 2012 | 14 | 5 | 7 | 1 | 70 |

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2013 | 6 | 2 | 13 | 1 | 62 |
| 2014 | 5 | 6 | 5 | 1 | 67 |
| 2015 | 7 | 0 | 7 | 0 | 71 |
| 2016 | 8 | 5 | 10 | 0 | 61 |
| 2017 | 4 | 2 | 7 | 2 | 60 |

*Data Source: MyAVATAR system – Demographics*

## Obstacles to Community Referral

**Table 14-2. Individuals not recommended for referral from Rio Grande SC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons 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 | 23 | 37.10% |
| LAR's reluctance for community referral* | 18 | 29.03% |
| Lack of funding | 13 | 20.97% |

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 4 | 6.45% |
| Individual's reluctance for community referral** | 4 | 6.45% |

*Data Source: MyAVATAR system – Living Options Discussion*
**See Table 14-4*
***See Table 14-3*

**Table 14-3. Individual reluctance for referral from Rio Grande SC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 4 |

*Data Source: MyAVATAR system – Living Options Discussion*

**Table 14-4. LAR reluctance for referral from Rio Grande SC, Fiscal Year 2017**

| 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 | 18 |

*Data Source: MyAVATAR system – Living Options Discussion*

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

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

The most frequent obstacle to referral is the individual's behavioral health and psychiatric needs and their supervision requirements. This obstacle has increased by 14 percent since 2015, partly due to admissions of individuals with complex psychiatric and behavioral health needs. Rio Grande SC serves individuals who require enhanced supervision due to significant behavioral needs and psychiatric symptoms.

There are several challenging behaviors and needs that may prevent some individuals from being served in a community setting. Some residents display elopement behaviors that are an area of concern for community referral as a client leaving a home out in the community poses several risks for the individual as well as the provider agency. A few individuals have a target behavior of suicidal ideation that requires increased levels of supervision and restriction of access to certain items. The behavioral and psychiatric departments have begun to implement supports through behavioral support plans, medication, and counseling.

The psychiatry and behavioral services departments continue to work with these individuals closely through behavior support plans and medication management. Behavioral health staff continue to provide additional training of Rio Grande SC staff in implementing these plans. An increase in modeling of behavior support plans has been provided to direct support staff and it has expanded to natural environment training. Behavioral staff continue to provide individualized behavior therapy and counseling for individuals with significant behavior issues.

Rio Grande SC continues to provide clinical supervision to Board Certified Behavior Analyst (BCBA) students from the University of Texas–Rio Grande Valley. It is the goal of Rio Grande SC to be a teaching facility where these students will provide services locally to help families decrease the need for placements outside of the home and to provide supports to the local community providers for individuals living in group homes.

## LAR reluctance for community referral

LAR reluctance is the second most frequent obstacle to referral. LARs continue to receive education through the CLOIP, which includes an opportunity to tour community programs. LARs are also invited to participate in twice annual provider fairs on campus.

Many LARs continue to be reluctant to referral because their family members are aging and they are concerned that the community cannot meet their medical needs. Other LARs feel that this is home to their loved ones and are concerned about their reaction to change. AP department staff are exploring ways to link LARs and family members with families of individuals who have successfully moved to a community settings.

Community providers will continue to be invited to speak at family association meetings to present information regarding their community services. In this next year, the AP department and QIDPs will be coordinating efforts to invite an individual, LAR or family member to speak at the next family association meeting to share information regarding their community transition experience.

## Lack of funding

Rio Grande SC serves 12 individuals who do not have full Medicaid benefits due to non-citizenship/residency status, which makes it difficult for community transition. Reimbursement staff continue to pursue benefits for these individuals. Rio Grande SC continues to refer families to local organizations to assist with immigration issues.

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

Rio Grande SC serves four individuals who require access to 24-hour nursing and medical services. Some individuals have chronic co-morbid illnesses such as obesity, diabetes, percutaneous endoscopic gastrostomy (PEG) tube feedings, aspiration, constipation, choking, gastrointestinal issues, ulcers, skin integrity problems, and individuals with high risk for falls due to osteoporosis.

The AP department identified two local providers who have received training on PEG tube feeding and now serve individuals who have this need. Rio Grande SC will

continue to communicate with local providers regarding medical needs that require services in the community at quarterly LIDDA meetings.

### Individual's reluctance for community referral

Individual reluctance continues to be an obstacle to referral at Rio Grande SC for four individuals. These four individuals will continue to be provided with the opportunity to tour community group homes and to participate in provider fairs, as well as attend monthly self-advocacy meetings. These individuals continue to visit former peers who now live in a community setting.

AP department staff have provided and arranged for extended day and evening visits for these individuals with preferred peers in the community. These were provided throughout the past year.

### In fiscal year 2018, Rio Grande SC will continue its efforts to reduce obstacles to referral with the following strategies:

- The AP department continues to work with IDTs to ensure LARs and families are aware of community options. Rio Grande SC continues to offer individuals the opportunity to tour group homes and attend provider fairs. These tours and fairs are also offered to their LARs and families. The continuity of care workers at the LIDDA, Tropical Texas, continue to educate LARs and families annually on the different living options available for their loved ones. IDTs will continue to meet with individuals as needed to discuss their living options at least annually.
- The IDTs have arranged for individuals to visit their peers living in the community with staff support as needed. Rio Grande SC staff are working with community providers to facilitate community activities to individuals from the center. This will provide an additional opportunity to learn about community providers and life in a community setting.

# Obstacles to Community Transition

**Table 14-5. Obstacles to Transition from Rio Grande SC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 1 |
| Other | 2 |

*Data Source: MyAVATAR system – Obstacles to Transition*

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

### Individual/LAR indecision

One individual had this obstacle to transition. The LAR changed their mind regarding community transition following referral. The referral was closed following issues with provider staff training.

### Other – Provider delay in opening a home

One individual and family chose to wait on a new home to be built. The individual has since successfully moved to the community, eight months after being referred.

A second individual's move was delayed because the selected provider opened a new home. The IDT and his LAR wanted extra visits at the home and day program. He has since moved to the community.

### In fiscal year 2018, Rio Grande SC will continue its efforts to reduce obstacles to transition with the following strategies:

- The AP department will continue to assist individuals that show an interest in moving to the community. Tours of community group homes and day habilitation programs will be scheduled for any individual requesting visits or referred by their IDT.

- The AP department will continue to work with community providers and the LIDDA to expand the community provider pool. Availability of group homes is a current issue as providers have few vacancies and have expressed concerns about opening a home for one individual.
- The AP department will ensure that the community living discharge process begins at the 14-day meeting, and will assist the IDT in identifying supports needed for community living. There will be increased attention regarding the training process and competency exams for group home staff that will be working with our individuals.
- Provider fairs will continue to be offered to individuals and their families at least two times per year.

# 15. San Angelo State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The San Angelo State SSLC was converted from the McKnight State Tuberculosis Hospital in September 1969. The 1,031-acre center was serving 213 individuals as of August 31, 2017, and employs approximately 763 staff. The center primarily serves three LIDDAs and has 37 counties in its catchment area:

- MHMR Services for the Concho Valley serves Coke, Concho, Crockett, Irion, Reagan, Sterling, and Tom Green Counties
- Permian Basin Community Centers for MHMR serves Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, and Presidio Counties
- West Texas Centers for MHMR serves Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum Counties

San Angelo SSLC currently works with eleven different providers. The providers in San Angelo are all HCS providers and not ICF. San Angelo SSLC does not typically refer individuals into an ICF program. The individuals who are currently being monitored through the PMM process have all been transitioned into an HCS home. All the providers either have their own day habilitation program, or contract with another day habilitation.

**Table 15-1. Community Referrals and Transitions from San Angelo SSLC, Fiscal Years 2010 – 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 19 | 10 | 27 | 1 | 251 |

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2011 | 26 | 8 | 19 | 0 | 239 |
| 2012 | 24 | 13 | 25 | 1 | 229 |
| 2013 | 16 | 18 | 28 | 6 | 210 |
| 2014 | 15 | 11 | 22 | 5 | 208 |
| 2015 | 11 | 14 | 18 | 0 | 214 |
| 2016 | 11 | 8 | 14 | 1 | 217 |
| 2017 | 15 | 4 | 16 | 0 | 213 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 15-2. Individuals Not Recommended for Referral from San Angelo SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons 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 | 138 | 61.88% |
| Individual's reluctance for community referral** | 35 | 15.70% |
| LAR's reluctance for community referral* | 32 | 14.35% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 12 | 5.38% |
| Lack of funding | 4 | 1.79% |
| Evaluation period (Ch. 55/46B only) | 2 | 0.90% |

*Data Source: IRIS*
**See Table 15-4*
***See Table 15-3*

**Table 15-3. Individual Reluctance for Community Referral from San Angelo SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual is not interested in being provided information and exposure to community living options | 14 |

| Reasons for Individual Reluctance | Total |
|---|---|
| Individual has been provided information and exposure to community living options, but is not interested in community transition | 9 |
| Lack of understanding of community living options | 5 |
| Unsuccessful prior community transition(s) | 4 |
| Mistrust of providers | 1 |

*Data Source: IRIS*

**Table 15-4. LAR Reluctance for Community Referral from San Angelo SSLC, Fiscal Year 2017**

| 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 | 9 |
| Unsuccessful prior community transition(s) | 8 |
| Mistrust of providers | 1 |
| Lack of understanding of community living options | 1 |

*Data Source: IRIS*

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

### 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 is the greatest obstacle identified for individuals served at San Angelo SSLC. Behavioral issues such as severe physical aggression, self-injurious behavior, sexual behavior, and unauthorized departures are identified as challenging behaviors for many individuals at San Angelo SSLC. These individuals require intensive staff supervision, a secure environment, frequent observation checks, and other restrictive practices for their safety and the safety of others. With the expected admission of individuals who have behavioral and psychiatric needs, this will continue to be the greatest obstacle. The following strategies have been developed to address this obstacle:

- IDT members are required to seek more education on available community supports through the annual provider fair and LIDDA in-service.
- PBSPs will be kept current and their effectiveness monitored. Training is completed with the staff who work with the individuals in all areas. Integrity checks are completed with the staff who work with the individual either monthly or quarterly depending on the severity of the individual's behavioral needs. The checks are to ensure staff have been properly trained on the PBSP and are able to carry it out.
- Root cause analysis training has been conducted with the IDTs to identify the root cause and strategies to address behavioral issues.
- IDTs were trained in creating supports for residents when creating behavioral health summaries so that they are more easily generalized to a community setting. The behaviors displayed, as identified in the PBSP, should be considered in the community setting along with 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.

### Individual's reluctance for community referral

The second greatest obstacle for referral was individual reluctance, which saw a significant increase from 2015. Many of the individuals with this obstacle have resided at the facility the majority of their lives and wished to exercise their right to

choose to remain in the environment in which they feel most comfortable. They are offered the opportunity to attend site tours, but often refuse. They attend trips that match their preferences so they may explore other places in the community. Other individuals with this obstacle felt this was the right place for them until such time as they have the tools needed to be successful in the community. Plans are created within the individual's ISP to address the needs and barriers to overcome in order to have successful community placement. For those who have a lack of understanding, IDTs have created individual specific action plans to include more education for the individual such as writing down their own personal questions to ask of providers at the annual provider fairs. San Angelo SSLC and the LIDDA will continue to offer site tours and opportunities to visit with former residents who now reside in the community so individuals may see where they live and what they do.

## LAR reluctance for community referral

LAR reluctance is the third greatest obstacle to referral for community transition at San Angelo SSLC. Education of LARs is most often addressed through the CLOIP 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 declined to receive information from CLOIP workers. LARs and other family members are also encouraged to attend the educational community tours provided through the LIDDA 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 families live outside the center's service area. Some of the LARs reluctance comes from previous failed placements. The following strategies were developed to address this obstacle:

- The IDT developed resident-specific action plans addressing educational needs of LARs to learn about community living options at the annual ISP, including the one LAR identified as having a lack of understanding.
- The APC and transition specialist worked with the LIDDA regarding improving the quality of the CLOIP with LARs.
- The CLOIP service coordinators continue to invite family and LARs to the CLOIP tours that they schedule for San Angelo SSLC residents which will continue annually. Data for fiscal year 2017 indicates that no LAR or family attended the CLOIP site tours. This was not unexpected since most of the residents at San Angelo SSLC 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 LIDDA.
- The AP department continues to provide references to LARs who are interested in learning about the experiences of other individuals who have transitioned to the community.
- The annual provider fair and LIDDA in-service will continue to provide exposure and education to residents, LARs, families, and staff. In fiscal year 2017, the provider fair was held in September. The facility scheduled the provider fair on the same day as the annual family day picnic in hopes to increase family attendance, but that did not occur.
- The LIDDA in-service was held in October, and there were no LARs or family members in attendance.

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

Medical needs are identified as the fourth greatest obstacle at San Angelo SSLC. 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 in the community. The following strategies were developed to address this obstacle:

- The transition specialist will contact the QIDP for each of the residents with this obstacle to arrange a meeting to ensure that effective action plans are in place.
- The IDTs were provided training on identifying obstacles. They were provided with clarification on services available in the community specific to individuals with medical needs.
- Training with the QIDPs on identifying obstacles will continue yearly.
- Root cause analysis training has been conducted with the IDTs to identify the root cause of, and strategies to address medical issues.

## Lack of funding

Lack of funding is the fifth greatest obstacle to referral at San Angelo SSLC. San Angelo SSLC provides treatment and supports to individuals who are not United States citizens and have not been able to obtain permanent residency within the country. If these individuals were to be referred, they would not be eligible for federally-funded programs due to their citizenship status. Therefore, until they are able to gain permanent residency, these individuals will remain at the SSLC to

receive the supports that they require. Reimbursement staff will continue to work with state office as information becomes available regarding each individual's citizenship status.

## Evaluation period (Chapter 55/46B only)

Evaluation period (Chapter 55/46B only) is the sixth greatest identified obstacle to referral at San Angelo SSLC. San Angelo SSLC is designated to admit female adults and adolescents for forensic evaluations as ordered by Texas courts. Individuals who are 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.

## In fiscal year 2018, San Angelo SLC will continue its efforts to reduce obstacles to referral with the following strategies:

In fiscal year 2017, the accuracy of the obstacle data continued to improve as the ISP QIDP facilitators consistently captured obstacle data. In fiscal year 2018, San Angelo SSLC will continue to identify and collect data on obstacles through the ISP and ISPA process. The following steps will be added to current efforts in an attempt to improve the referral process:

- San Angelo SSLC will continue to improve upon the new root cause analysis process to address obstacles to referral for some of the most challenging individual cases.
- The APC will train the QIDPs more frequently on identified issues with living options discussions and provide feedback on alternative ways to approach long-standing obstacles to referring residents that may simply be reluctant to make the change to living elsewhere.
- The APC and QIDP coordinator will work together to communicate with providers in an attempt to arrange meetings with LARs that have not had the opportunity to tour homes. Efforts will focus on encouraging providers to meet with LARs when educational materials (brochures and videos) have not been successful in educating them on supports that can be provided in the community.

# Obstacles to Community Transition

**Table 15-5. Obstacles to Transition from San Angelo SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Limited residential opportunities | 11 |
| Lack of supports for individuals with significant challenging behaviors | 6 |
| Lack of availability of specialized medical supports | 2 |
| Individual/LAR indecision | 1 |
| Need for services and supports for individuals with forensic needs/backgrounds | 1 |
| Lack of specialized mental health supports | 1 |
| Other | 2 |

*Data Source: IRIS*

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

### Limited residential opportunities

Of the 11 individuals identified as having an obstacle of limited residential opportunities, 10 transitioned to the community in fiscal year 2017. Two individuals who transitioned required a home that was not in the vicinity of children, near schools, or where children congregate. Homes that met the specific criteria were found for both. The other individuals chose areas that did not have any group homes with an opening. Homes eventually became available in the preferred area. One of the individuals remains at San Angelo SSLC, with her referral having been closed due to behavioral issues.

## Lack of supports for individuals with significant challenging behaviors

A lack of supports for individuals with challenging behaviors was identified for six individuals who have a long history of behavioral issues in the community. All six of the individuals had an increase in behavioral issues during the referral period, resulting in four of the referrals being rescinded. The other two individuals have moved to homes that could meet their behavioral health needs. These same two individuals had an additional obstacle of limited residential opportunities.

## Lack of availability of specialized medical supports

Two residents had obstacles related to a lack of available specialized medical supports. One of the residents also had obstacles identified of limited residential opportunities, behavioral supports, and indecision regarding provider selection. Her referral was later closed due to behavioral issues. The other individual required surgery and rehabilitation. Due to the length of time required for the surgery and rehab, the IDT and her guardian made the decision to close the referral until rehabilitation is completed.

## Individual/LAR indecision

The one individual identified as having the obstacle of individual/LAR indecision took an extended period of time to select a provider. She later had incidences of elopement and other behavioral issues which eventually lead to her referral being rescinded.

Most of the individuals at San Angelo SSLC are more than capable of providing input and making decisions on where they want to live. Over half of community transitions from San Angelo SSLC are in distant locations. Working with unfamiliar providers, scheduling complications, and travel combine to complicate the decision-making process.

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

One individual was identified as having needs for services and supports for individuals with forensic backgrounds. She also had an obstacle of limited residential opportunities. After an extended search, a home was located that could provide the services she needs, which also included the stipulation of a home that

was not in the vicinity of children, near schools, or where children congregate. She has transitioned into the community.

### Lack of availability of specialized mental health support

One individual was identified as having this obstacle. She was determined by the psychiatrist to be psychiatrically unstable, and was undergoing psychiatric medication changes in an effort to find a medication that would stabilize her. She had a long history of psychiatric instability while living in the community. She had an obstacle of limited residential opportunities identified as well. Stabilization was achieved and a home in her preferred area was located that could provide her with the needed supports. She has transitioned into the community.

### Other

There were two individuals identified as having obstacles in the other category. One individual had an illness during the transition period. He developed some medical issues that required lengthy treatment and was eventually stabilized. The transition process resumed and he has since moved to a home that can meet his needs. He had obstacles of behavioral supports and limited residential opportunities identified as well.

The second individual had selected a home in Houston. His CLDP was completed and he was scheduled for a transition date. Before that date arrived, Houston was hit by a hurricane and the transition was delayed. He was not able to transition to his new home within the 180 day time period and the obstacle was determined to be provider delay in opening home. He has since transitioned to his new home in Houston.

### In fiscal year 2018, San Angelo SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- All referrals continue to be 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 needed meetings and are provided a timeline of expected transition activity. Unit directors will review the transition timelines at their daily home meetings and remind IDTs of scheduled meetings.
- Community transitions will continue to be a standing agenda item at the QIDPs' bi-monthly meetings.

- Transition-related IDT meetings will be combined when possible to limit the number of meetings throughout the process.
- The APC and QIDP educator will train new QIDPs on the transition process.
- A new 14-day meeting template was created by the state office continuity of services staff and piloted by San Angelo. The new format has now been implemented at all SSLCs. The new format addresses supports that are identified during ISPs, annual evaluations, and assessments. This assists IDTs in identifying supports and services that need to be provided in the community. The state office transition specialist is heavily involved in locating community providers that can provide the identified supports and services. This has proven to be an effective procedure and has provided valuable assistance to IDTs and individuals in locating homes that are appropriate and beneficial to their placement in the community.

# 16. San Antonio State Supported Living Center Obstacles to Referral and Transition

## Center Profile

The San Antonio SSLC opened in 1978. The center is on 40 acres of land in southeast San Antonio, Bexar County, adjacent to the San Antonio State Hospital and the Texas Center for Infectious Disease. San Antonio SSLC serves a catchment area including ten counties: Atascosa, Bexar, Dimmit, Frio, Karnes, La Salle, Maverick, McMullen, Wilson, and Zavala. At the end of fiscal year 2017, San Antonio SSLC served 227 individuals and had approximately 696 full time employees.

According to the Alamo and Camino Real LIDDAs' HCS program provider lists, there are a total of 110 HCS providers contracted to serve individuals in San Antonio SSLC's catchment area. Approximately 59 of the 110 providers currently provide services in Bexar County, with a more limited number serving the surrounding counties. The Alamo LIDDA reports that there are 18 ICF/IID providers who operate a total of 91 ICF/IID group homes. There are 33 day habilitation programs and five vocational programs/work centers serving San Antonio SSLC's catchment area.

The community transitions documented for fiscal year 2017 were primarily referrals that occurred in fiscal year 2016. These referrals took additional time to accomplish due to the specific needs of each individual referred, as well as the availability of community living options that were able to fulfill each individual's required supports. In fiscal year 2017, nine community referrals were rescinded due primarily to the lack of available and necessary supports in the community (primarily psychiatric/behavioral).

There was an increase in referrals in 2017. The transition team continues to research available and appropriate community living options and shares this information with the individuals, their families, LARs, and IDTs.

**Table 16-1. Community Referrals and Transitions from San Antonio SSLC, Fiscal Years 2010 - 2017**

| Fiscal Year | Community Referrals as of August 31 | Rescinded Referrals | Community Transitions | Community Transition Returns | Fiscal Year Census as of August 31 |
|---|---|---|---|---|---|
| 2010 | 6 | 1 | 8 | 0 | 281 |
| 2011 | 6 | 5 | 6 | 0 | 278 |
| 2012 | 16 | 7 | 4 | 0 | 275 |
| 2013 | 22 | 6 | 21 | 0 | 250 |
| 2014 | 20 | 10 | 13 | 1 | 240 |
| 2015 | 4 | 8 | 12 | 1 | 229 |
| 2016 | 7 | 2 | 8 | 0 | 229 |
| 2017 | 13 | 9 | 4 | 1 | 227 |

*Data Source: IRIS*

# Obstacles to Community Referral

**Table 16-2. Individuals Not Recommended for Referral from San Antonio SSLC, Fiscal Year 2017**

| Reason Not Referred | Total | Percentage of Reasons Not Referred |
|---|---|---|
| LAR's reluctance for community referral* | 99 | 33.56% |
| Individual's reluctance for community referral** | 80 | 26.12% |
| Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff | 60 | 20.34% |
| Medical needs requiring 24-hour nursing services/frequent physician monitoring | 52 | 17.63% |
| Lack of funding | 4 | 1.36% |

*Data Source: IRIS*
**See Table 16-4*
***See Table 16-3*

**Table 16-3. Individual Reluctance for Community Referral from San Antonio SSLC, Fiscal Year 2017**

| Reasons for Individual Reluctance | Total |
|---|---|
| Lack of understanding of community living options | 34 |
| Individual has been provided information and exposure to community living options, but is not interested in community | 26 |

| Reasons for Individual Reluctance | Total |
|---|---|
| Unsuccessful prior community placement(s) | 9 |
| Individual is not interested in being provided information and exposure to community living options | 4 |

*Data Source: IRIS*

**Table 16-4. LAR Reluctance for Community Referral from San Antonio SSLC, Fiscal Year 2017**

| Reasons for LAR Reluctance | Total |
|---|---|
| LAR has been provided information and exposure to community living options, but is not interested in community placement | 78 |
| Unsuccessful prior community placement(s) | 17 |
| LAR is not interested in being provided information and exposure to community living options | 14 |
| Mistrust of providers | 9 |
| Lack of understanding of community living options | 3 |

*Data Source: IRIS*

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

### LAR reluctance for community referral

LAR reluctance to community referral continues to be a challenging obstacle, inhibiting referral for approximately 33 percent of the individuals. Many LARs are adamant about their family members residing at San Antonio SSLC. The LIDDA reports that approximately 11 LARs have requested that the LIDDA not be present at the annual ISP meeting. The LIDDA addresses education regarding community living options with the individual, LAR, and primary correspondent(s) through CLOIP, which begins shortly before the ISP. The CLOIP report is thoroughly discussed at the ISP meeting. The LARs will commonly state that they are satisfied with the current services and supports provided by San Antonio SSLC and they have not found an alternative placement that compares favorably to the individual's current situation. LARs are offered opportunities to tour group homes and 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 be scant. In fiscal year 2017, San Antonio SSLC held the annual provider fair, and four families attended.

### Individual's reluctance for community referral

At 26.76 percent, individual reluctance was the second greatest obstacle to community referral. Some were not interested in transition after receiving information from their LIDDA or due to prior negative experiences in the community. Some of these individuals have resided at the center for several years and consider San Antonio SSLC their home. These residents clearly indicated their preference to reside at San Antonio SSLC. Monthly educational tours provided by the Alamo LIDDA and additional tours provided by the transition specialists offered opportunities for individuals who do not normally want to tour to see an example of community living options that are available in the San Antonio area. Referrals have historically occurred when an individual's curiosity and interest is peaked when they see and hear about their roommates and/or workmates successfully moving to a home in the community. The majority of individuals who were documented as reluctant for community referral did not have an opportunity to tour and learn about community options. Education will be a continued priority so that, by their next ISP, the 34 individuals who have a lack of understanding will be able to make an informed choice with the assistance of their knowledgeable IDT members.

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

Approximately 20 percent of individuals at San Antonio SSLC have an obstacle of challenging behavioral and psychiatric supports. This number has increased due to concerns regarding the availability of community psychiatric supports, which is evidenced by an increase in the number of individuals admitted with a co-occurring psychiatric diagnosis. At San Antonio SSLC, the IDTs continue to review behavior support plans and psychoactive medications at least quarterly to work toward reducing targeted behaviors and to replace with a positive skill set in preparation for community integration.

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

Approximately 17 percent of individuals have an obstacle of medical needs requiring 24-hour nursing services and frequent physician monitoring. There continues to be a limited number of providers that support individuals with complex medical needs. The transition specialist will continue to research providers that specialize in medical needs and share updated information 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. State office has approved two ICF providers that can provide 24-hour nursing to individuals with complex medical needs. These two ICFs will be operational in fiscal year 2018. This information has been shared with IDTs via the resource guide.

## Lack of funding

Efforts to secure funding for the four individuals who are ineligible for Medicaid in the community will continue in fiscal year 2018. There are currently three individuals who are non-citizens and do not receive funding. The reimbursement manager will continue to work with state office as information becomes available regarding each individual’s citizenship status. One of the four individuals is a citizen; however, due to the lack of a birth certificate as proof of citizenship, the individual is not receiving funding. The reimbursement manager, in conjunction with the social workers, will continue to work towards obtaining necessary documents to move the process forward.

### In fiscal year 2018, San Antonio SSLC will continue its efforts to reduce obstacles to referral with the following strategies:

- The transition team will continue to work closely with the IDT, specifically the QIDP department, to discuss issues related to living options, obstacles and training opportunities.
- The transition team and active treatment specialist meet once a month to develop a schedule of tours for the following month. This ensures that tours are occurring and integrated into each home's monthly active treatment calendar. The transition specialist continues to scan and file tour notes into the shared file that can be easily accessed by the IDT members.
- With participation from the Alamo LIDDA, educational tours, as they are scheduled, will be available to all individuals and interested family members and LARs.
- The transition team will continue to provide IDTs with information on local providers with ready access to board certified behavior analysts and psychiatrists.
- The transition team will continue to work closely with the QIDPs to create plans that address each obstacle to community referral. QIDPs will continue to include the transition specialist in ISP preparation and ISP meetings (when appropriate) if the team believes that further education will benefit the individual and LAR. The transition specialist will be available to offer information such as brochures, resource guides, and any general information that may assist the individual and LAR to better understand resources available in the community. The transition specialist will also offer to schedule tours if the LAR is interested.
- The transition team will continue to have a representative attend quarterly family association meetings to update family members on transition-related activities and will be available to answer questions.
- With participation from the Alamo and Camino Real LIDDAs, the transition team will continue to host an annual provider fair at San Antonio SSLC and encourage individual attendance by posting flyers, offering incentives, and visiting the homes to personally invite individuals to the event.
- The transition specialist 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. A member from the transition team continues to attend meetings at least monthly. By participating in self-advocacy meetings, a transition specialist is

readily available to answer questions, provide additional education about community living options, and assist in arranging tours or visits.

- The human rights officer and transition specialist will continue to invite, at least annually, a former self-advocate or peer who has moved to the community to speak about his/her transition experience with the San Antonio SSLC self-advocates.
- The transition specialist will provide tours at least monthly focusing on non-referred individuals who have lack of understanding as their only obstacle. Home supervisors will ensure that knowledgeable staff participate to better gauge each individual's reaction to the tour and to provide input as to what the individual may like or dislike about the community home or day program (this will be documented by the knowledgeable staff in tour notes).
- IDTs will continue to focus on PBSPs that will assist individuals in managing challenging behaviors.
- The transition specialist will schedule quarterly tours of the high medical needs ICF homes for IDTs and PCPs. IDT members will continue to participate in more group home tours to ensure the home is appropriate or can be adjusted to fit the needs of the individual.

## Obstacles to Community Transition

**Table 16-5. Obstacles to Transition from San Antonio SSLC, Fiscal Year 2017**

| Obstacle | Total |
|---|---|
| Individual/LAR indecision | 5 |
| Need for environmental modifications to support the individual | 4 |
| Limited residential opportunities | 3 |
| Lack of supports for individuals with significant challenging behaviors | 2 |
| Other | 2 |

*Data Source: IRIS*

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

### Individual/LAR indecision

There were five individuals identified with this obstacle to transition. One individual completed two unsuccessful dinner visits. The LAR changed her mind regarding community transition following the dinner visits. She felt it was not a good fit and the referral was closed. A second individual continues to tour providers, however has not shown interest in a particular home for an extended visit. The transition specialist found two potential providers and the individual and IDT members continue to tour and inquire with those providers. It has been difficult to interpret the third individual's preferences as he would not communicate his response to the home unless he was with a preferred staff. Preferred staff will be available as he continues to visit the home in the hopes of moving forward with a pre-placement visit. Another individual identified with this obstacle exhibited agitation during tours which the team later identified as his way of communicating that he did not like the homes and was uncomfortable with a new environment. The IDT discussed his responses during the tours and agreed to close the referral. For the fifth individual identified with this obstacle, he communicated that he was uncomfortable with exploring a new environment by refusing to enter the home and showed no interest. The IDT discussed his responses and agreed to close the referral.

### Need for environmental modifications to support the individual

There were four individuals that required environmental modifications. One individual required a sidewalk from the driveway to the front door, which was delayed due to staff availability, weather, materials, and inspection. He successfully transitioned in March 2017. Another individual required modifications to the bathroom. The individual successfully transitioned in October 2017. Another individual will be moving home to live with family. The family is in the process of securing another home to allow her to have her own bedroom. The final individual identified with this obstacle requires a home with wide hallways and close access to a bathroom from her bedroom. This individual and her IDT continue to visit community providers.

### Limited residential opportunities

There were three individuals identified as having limited residential opportunities. One individual's LAR preferred a specific smaller ICF home. Subsequently, the individual became medically unstable and the referral was closed. A referral will be reopened when the individual becomes stable. For the remaining two individuals, the IDT experienced difficulty in finding a home that could support their preferences, strengths, or an appropriate peer group. Tours and visits continued until a provider could be located. The individual moved in fiscal year 2017.

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

There were two individuals identified with this obstacle to transition. During the transition process, one individual continued to refuse programming and his referral was closed. For the other individual, she exhibited pica behavior and attempted to run away during a pre-selection visit. Her referral was closed.

### Other – Family pursues guardianship

For one individual, a dinner and pre-placement visit was made with a potential provider; however, the family obtained guardianship as they did not want him to transition to the community. The referral was closed.

### Other – Provider closed home

One individual selected a home, however the available vacancy was taken by another individual before the transition plan could begin. She continues to tour providers.

### In fiscal year 2018, San Antonio SSLC will continue its efforts to reduce obstacles to transition with the following strategies:

- The transition team will attend 14-day meetings to assist the IDT members with identifying all needed services and supports or any potential barriers for the individual to have a successful transition.
- IDTs will continue to focus on PBSPs that will assist individuals in managing challenging behaviors. Early in the transition process, the IDT will consider what crisis supports will be needed in the community.

- The transition team will continue to work with the QIDPs to ensure that monthly meetings are held if the individual has not transitioned to the community within 180 days. The team will participate actively in planning next steps to address obstacles to transition.
- Individuals with prior failed community placements will complete additional dinner and overnight visits to ensure that they are comfortable with the home and staff. This will ensure the placement is a good fit for the individual.

# List of Acronyms

| Acronym | Full Name |
|---|---|
| AIP | Actively involved person |
| AP/APC | Admissions and Placements/Admission Placement Coordinator |
| ATCIC | Austin Travis County Integral Care |
| BCBA | Board Certified Behavior Analyst |
| CBS | Community Based Services |
| CFR | Consumer and Family Relations |
| CLDP | Community Living Discharge Plan |
| CLOIP | Community Living Options Information Process |
| CMS | Center for Medicare and Medicaid Services |
| DAHS | Day Activity and Health Services |
| DD | Developmental disability |
| DSP | Direct support professional |
| ECC | Enhanced Community Coordination |
| HCS | Home and Community-based Services |
| HHSC | Health and Human Services Commission |

| | |
|---|---|
| ICF | Intermediate care facility |
| ICF/IID | Intermediate care facility for individuals with an intellectual disability or related condition |
| ID | Intellectual disability |
| IDT | Interdisciplinary team |
| INS | Immigration and Naturalization Services |
| ISP | Individual support plan |
| ISPA | Individual support plan addendum |
| LAR | Legally authorized representative |
| LIDDA | Local Intellectual and Developmental Disability Authority |
| LON | Level of need |
| LOS | Level of service |
| MFP | Money Follows the Person |
| NEO | New employee orientation |
| PBSP | Positive Behavior Support Plan |
| PCP | Primary care physician |
| PEG | Percutaneous endoscopic gastrostomy |
| PMM | Post-move monitor |

| | |
|---|---|
| QA/QI | Quality Assurance and Quality Improvement Council |
| QIDP | Qualified intellectual disability professional |
| RN | Registered Nurse |
| SC | State center |
| SME | Subject matter expert |
| SSLC | State Supported Living Center |
| START | Systemic Therapeutic Assessment Resources Team |
| STOP | Skill training of paraphilia |
| TWS-VRS | Texas Workforce Solutions-Vocational Rehabilitation Services |
| WIOA | Workforce Innovation and Opportunity Act |