PLAN FOR COMMUNITY DEVELOPMENT

Relating to:
Conner vs. Branstad Consent Decree

Developed by the Department of Human Services
Division of Mental Health and Developmental Disabilities

March 12, 1996

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BACKGROUND

In December, 1986, a law suit was filed by a number of people residing at Glenwood and Woodward State Hospital Schools in cooperation with Iowa Protection and Advocacy Service, Inc. The suit challenged the continuation of Iowa's institutionally based model of services for persons with developmental disabilities. On November 14, 1994, a settlement was reached.

The Consent Decree requires the Department of Human Services to develop a plan. The purpose of this plan is to identify and provide for the development of appropriate community supports and services needed for community placement of people who reside at either Glenwood or Woodward State Hospital-Schools. This plan is designed to assist those residents of the state hospital schools who wish to leave the institutions, to do so. In order for this to occur, community resources must be available. Discharges will not be forced on those who wish to continue to reside at either of the two schools, nor will discharges be made solely for the purpose of "downsizing". Each individual's needs and desires will drive the discharge process.

It is recognized that the role of the State Hospital-Schools (SHSs) is changing from one of permanent long term care and toward shorter term and support services. Both schools are experiencing more short term admissions, assessments and evaluations, consultations, and other forms of community supports. As part of the oversight responsibility associated with this plan, statistics from the SHSs will be reviewed to assure the continuation of this trend, with the assumption that the activities within this plan will assist in this change.

It is also recognized that county governments, through the development of their county management plans, have the responsibility for planning for the development of services for people with mental retardation. This plan will build on this responsibility and focus on how the Department of Human Services can assist, ease, and otherwise support the counties in this planning.

An Advisory Committee assisted the Division of Mental Health and Developmental Disabilities in drafting this plan by recommending specific goals and strategies and by also identifying training and other issues of concern. The committee consisted of:

Rik Shannon, Arc Iowa
Lyle and Ruth Sturtz, Parents
Connie Fanselow and Merv Roth, Iowa Protection and Advocacy
Gayla Harkin, Story County Community Life
Linda Hinton, Iowa Association of Rehabilitation and Residential Facilities
Murlean Hull, DD Council
Deb Westvold, Iowa State Association of Counties

Bob Bacon, Iowa University Affiliated Program
Mary Hodapp, Woodward State Hospital School
Diana Hoogistraat, Glenwood State Hospital School
Loren Bawn, State/County Assistance Team, Department of Human Services
Jim Chesnik, Housing Specialist, Division of Mental Health and Developmental Disabilities, Department of Human Services
Janet Shoeman, DD Specialist, Division of Mental Health and Developmental Disabilities, Department of Human Services

Essential Lifestyle Planning
This past year, a new type of planning process was begun at the SHSs. Each person residing at the two schools is developing an Essential Lifestyle Plan. This plan is different from, and in addition to, the traditional goal/objective development planning process. Essential Lifestyle planning is a structured way of learning how people want to live in order to plan for the person's future. Essential Lifestyle planning is:

- a snapshot of how someone wants to live today, serving as a blueprint for how to support someone tomorrow,
- a way of organizing and communicating what is important to an individual in "user friendly", plain English.
- a flexible process that can be used in combination with other person centered planning techniques,
- a way of making sure that the person is heard, regardless of the severity of their disability.

This Essential Lifestyle Plan is the cornerstone to both the development of specific out placement plans for an individual as well as the over all service/housing development by the community. This information on an individual level, is used to determine where and how the person wants to live and work. This information on a systems level, can be used to help communities develop services that will meet the needs and desires of their citizens.

GOALS/ACTION STEPS

This plan has five major goals. Two of these goals focus specifically on the relationship between the SHSs and the counties, two goals focus on the development of community supports and one focuses on the need to build community capabilities through training. These goals will be reviewed at least annually and changes and additions will be made at that time.

State Hospital-School/County Relationship

Goal 1: Develop and implement a clear and consistent process to share information between the state hospital schools, central point of coordination, DHS workers and Case Managers (both county and DHS) for the purposes of individual planning and services development.

Goal 2: Provide for a smooth transition for individuals who move from the State Hospital Schools to full community life.

Community Development of Services and Supports

Goal 3: Service, supports and resources shall be developed, as needed, to assist consumers who wish to leave the SHSs to live, learn, work, and socialize in the community of their choice.

Goal 4: Consumers have safe, affordable housing available in the community of their choice.

Training

Goal 5: Community will have the capacity to provide the services and supports needed to assure that people can reside within their own communities and avoid the need for admission into a SHS.

State Hospital-School/County Relationship

GOAL 1: Information Sharing

It is recognized that a close relationship between the SHSs and the counties is essential for the success of an individual's movement from the SHS to the community. Information must flow freely between these entities to assist the individual and the overall service development in the communities. The counties and the SHSs need to have a clear and consistent process for sharing this information.

Goal Statement: Develop and implement a clear and consistent process to share information between the state hospital schools, central point of coordination, DHS workers and Case Managers (both county and DHS) for the purposes of individual planning and services development.

A. Have information releases signed by all current residents by July 1996.
   1. By March 1996, include information release forms in all admissions packets. These forms will allow the exchange of information between the SHSs and the person or entity designated by the county to implement their management plan.
   2. By July 1996, have releases signed by current residents.

B. Identify information and information format needed by counties for planning purposes by Sept. 1996.
   1. By May 1, 1996, convene a workgroup of SHS staff, county Central Point of Coordination (CPC) Administrator or designated staff, Case Managers and DHS service coordinators. This workgroup will identify what data, both individual and aggregate, will be useful to the CPCs, in what format the data needs to be shared and how often. This workgroup should continue to monitor and adjust the process when necessary.

2. The SHS data system will be modified to provide the information identified as needed according to the timeline set by the workgroup.
3. By July 1996, the SHS staff will be involved in county planning processes. The workgroup consisting of CPC Administrators (or designee) and SHS staff will work together to identify how best to include the input from the SHSs. When the SHSs are aware of a county planning meeting, parents/guardian are notified of the meeting.

C. By Sept. 1996, identify information and information format needed by the SHS to coordinate discharge planning.
   1. By March 1996, the SHSs will have a current list of all CPC Administrators and will be kept updated from then on.
   2. By May 1996, convene a workgroup of SHS staff and county CPC Administrators (or designee), Case Managers and DHS service coordinators (see above). This workgroup will identify how the SHSs will be included in the county planning processes and division of duties related to discharge planning.
   3. The county CPC Administrator or their designee is considered part of the SHSs' Interdisciplinary Team for each person the county is responsible and will be included in the team process as releases are obtained.

Identified Barriers

1. A consumer/guardian may choose not to sign a release to share information with the CPC. Some information can be shared without a release (information related to being a third party payer), but this information may not assist the county in planning for needed services. The county would also not be able to be involved in the individuals planning process without a signed release. Since the CPC must pre-approve funding for services, this would be a problem if the CPC could not be part of the planning process.
2. Since the SHSs are Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), Targeted Case Management activities cannot be charged for people residing there until 30 days prior to discharge. Counties may choose to involve their Case Managers prior to that, but they would not be able to draw on Medicaid dollars. There must be a smooth process for payment for Case Management services when it is not covered by Medicaid.

GOAL 2: Transition Process

Once a placement has been identified a specific transition plan is developed to assist a person in their movement from the SHS to the community. It is recognized that movement from the SHS to the community is a major life change. A smooth, planful transition process is crucial for success. The person needs to have time to build trust within the new situation. Transition plans should be fluid, adjusting to the person's changing needs. Transition plans not only include the residential component but all aspect of the person's life: living, working, learning, socializing.

Goal Statement: Provide for a smooth transition for individuals who move from the State Hospital Schools to full community life.

A. By January 1997, the SHSs will implement a plan for consumers to be able to visit different living options so a more informed choice can be made when discharge becomes eminent. This would not be the same as visiting specific programs that are possible placements, but would be more generic visits, such as visiting friends who live in an apartment to get an idea of what apartment living is like. This could be part of a life experience type of programming available.
   1. By September 1996, a workgroup at each SHS will be formed to develop guidelines and procedures for this type of experience.
   2. By January 1997, funding and resource issues will be identified in the plan and submitted to the current SHS groups looking at funding options related to their futures planning

B. Transition Plan development will be strengthened.
   1. Once a placement has been determined, a specific transition plan is developed based on the person's individual needs. Components of this transition plan may include (this is not meant to be an all inclusive list, but a list of examples):
      - visits to that site, either day visit or overnights.
      - visits to the day program, school, etc.
      - visits by the staff from that program to the SHS to spend time with the person and the direct care staff.
      - video tapes of the program, area, staff, roommates, etc. to help the person build familiarity.
      - SHS could go with the resident and stay for a determined amount of time to assist in the transition.
      - SHS will be available to the community placement for consultation whenever needed.
      - the person may begin a job first (be transported) then move.

      By March 1996, the Social Workers and Treatment Program Managers at the SHSs will review transition plan development to be sure all are clear on what could be included in the transition plans.
   2. As funding and resource issues are identified they will be submitted to the current SHS groups looking at funding options related to their futures planning
   3. By July 1996, transition plans will include how the parents/guardians will be "transitioned". This may include information dissemination, site visits, and active involvement by the parents/guardians in the process.

C. By July 1997, procedures will be recommended which cover resource and funding issues involved in the transition process. The Division of MH/DD will work with the current SHS groups looking at funding options related to their futures planning on the following issues:

- When a person visits a proposed outplacement site and when transitioning to a specific outplacement, who submits the per diem claim? This is a problem when the visit requires significant involvement by staff from both the SHS and the community program. How can the funding be "shared"?
- Funding for continued consultation once the person is discharged from the SHS.

D. The information and training which are provided to the outplacement site will be strengthened. Currently training is given to the outplacement staff concerning any of the person's program information including OT, PT, any adaptive devices, communication systems, self-help program, behavior programs, etc. At times staff from the SHS travel to the outplacement site, at times the outplacement site staff travel to the SHS.
   1. The question of funding for training, especially when it is extensive, will be submitted to the current SHS groups looking at funding options related to their futures planning.
   2. By April 1996, when a placement is made, the team will put together a list of SHS contact people and contacts for support within the community and give to the provider.

Identified Barriers

1. Funding overlaps in service, when both SHS and a community provider is involved, can be problematic.
2. Continued involvement by the SHSs once the person is discharged needs a funding stream.

Community Development of Services and Supports

GOAL 3: Community Services

It is recognized that, though the counties may wish to have an organized overall plan for movement of many of their people residing at the SHSs, that true success is achieved by attention to each individual and their needs and wants. The basis for individual support plans is the Essential Lifestyle Plan developed at the SHS in conjunction with the person, their family and their county. It is also recognized that, in service development, the full needs of the person need to be addressed. As people move to smaller, more individualized situations, isolation may occur if leisure skills and community involvement needs are not addressed.

Goal Statement: Service, supports and resources shall be developed, as needed, to assist consumers who wish to leave the SHSs to live, learn, work, and socialize in the community of their choice.

A.. By April 1, 1996, the state will provide counties with information on the Conner Decree. The counties will be encouraged to work cooperatively with each other in the development of needed services. Information may be presented at the ISAC Spring School in March 1996.

B. Counties will be involved in the Essential Lifestyle Plan for their people at the SHSs. This will occur as Release of Information forms are signed to allow this information exchange.
   1. By April 1996, county CPC Administrators (or designee) will be considered part of the SHSs' Interdisciplinary Team and will receive notices of planning sessions as releases are signed.
   2. As Information Release Forms are completed, CPC Administrators will receive the information packets on all of their residents who have already gone through the Essential Lifestyle planning.
   3. By April 1996, SHS will begin notifying CPC Administrators of the training times available at the SHSs in the Essential Lifestyle Planning. Basic information on the process and what is included in an Essential Lifestyle Plan will also be given to the CPC.

C. By September 1996, the state will develop and distribute aggregate information on people residing in the SHSs. This information will be particularly useful for the development of services for low incidence populations with specialized needs. In order to plan effectively, counties need to know with whom they need to coordinate.
   1. By May 1996, develop a workgroup of SHS staff and county CPC Administrators (or their designees) (see Goal 1). This workgroup will identify what data in what format the data needs to be shared and how often. This workgroup should continue after Sept. 1996 to monitor and adjust the process when necessary

D. A Crisis Intervention Plan or Network will be designed and implemented. This network could be either a private agency network, a network supported by the SHSs or a combination of the two. This plan should include how to fund the service and how to make it geographically accessible. This plan should include exploring the addition of crisis intervention as a HCB service under the MR waiver.
   1. By June 1996, a steering committee will be put together. This committee will design the first steps of the development of the planning process. They will look at who should be involved, how to organize the Network, and whether planning should be on a regional basis.
   2. By September 1996, an initial timeline for implementation will be developed. Components of the system/network will be implemented as appropriate, not waiting until full program is designed.

E. Training costs will be made an allowable cost within the service rate under the MR waiver distinct from Administration costs.
   1. By September 1996, the Division will put together a workgroup in cooperation with the Division of Medical Services, SHS staff and county representation to develop this process.

Identified Barriers

1. The Home and Community Based waiver for people with mental retardation needs to be revised. HCB waivers are a very flexible program at the Federal level and can be designed to meet most needs. A close look needs to be given to the services offered under the waiver in relationship to what is needed to support individuals in their communities. Reimbursement processes currently used also need to be reviewed.
2. Regulation for community providers needs to be consistent with the philosophies presented in this plan. This includes Purchase of Service and Department of Inspections and Appeals regulations as well as standards under the purview of the MH/DD Division.
3. Outcome based standards and funding by services instead of service packages needs to be instituted. Accrediting by outcomes and by services will promote the type of development needed for community supports. The proposed Outcome-based Standards Pilot Project should assist in this process.

Goal 4: Community Housing

Traditionally housing and services have been packaged together as "residential programs". This usually means that a person must move when their service needs change. For example, if a person's support needs decrease, they may move from a supervised group home to an apartment. Also the opposite occurs, if a person's needs increase, they usually must move to a more restrictive setting. By separating the services from the housing, a person's supports may be increased or decreased as needed without having to change residences. It is recognized that all people need safe, affordable housing. This is not only a "disability issue" but a larger, community issue. Essential Lifestyle Planning includes looking at the desires and abilities of persons to live in the communities and homes of their choice.

Goal Statement: Consumers have safe, affordable homes available in the community of their choice. Housing should not be determined by a service package.

A Information on methods to develop affordable housing will be available to CPC Administrators.

1. Beginning in July 1996 and ongoing, counties will be offered information related to steps of developing affordable housing. This information will focus on organization, planning, development, and management. Counties will be encouraged to facilitate the development of broad based local coalitions that have the common interest of developing affordable housing opportunities.
2. Counties wanting technical assistance will be provided with methods to develop Strategic Housing Development Plans.

B. An important part of Housing Development Plans comprises ways that communities can facilitate access to a variety of housing options. In order to accomplish this:
   1. By September 1996, the Division will put together a workgroup in cooperation with the Division of Medical Services, SHS staff and county representation. This workgroup will consider the following options and present a plan for implementation by July 1997:
      a The use of family homes, including Family Life Homes, in conjunction with HCBS funding. Explore and recommend how to recruit, train, and provide supports to families.
      b. Other housing funding streams will be explored in order to maximize the number of possibilities to meet housing needs. This may include state appropriations, county appropriations, or other funding to be used as rent subsidies, grants, low or no cost loans, etc.
      c. Increase the funding cap on funding for Home and Vehicle Modification through HCBS/MR which could make it easier for persons to use a variety of housing types.
      d. Add a *Live In Care Giver* option (for people who rent or own their own homes) to the HCBS/MR. This option allows for the rent/house payment and utilities to be split between the live in care giver and the consumer.
      e. Facilitating consumer home ownership.

Identified Barriers
1. Lack of affordable housing.
2. Lack of coordination among community entities in its development.
3. HCBS does not cover housing expenses, so other funds need to be used.

Training

GOAL 5: Community Capacity Building

It is recognized that, in order to increase the rate of outplacement from the SHSs and to reduce the need for admissions into the SHSs, communities will have the capacity to provide supports for people who have differing needs than they have traditionally served. Affordable training must be available to assure that the community providers have this capacity.

Goal Statement: Community providers will have the capacity to provide the services and supports needed to assure that people can reside within their own communities and avoid the need for admission into a SHS.

A. A training plan will be developed which will include types of training needed and how the training can be organized, marketed, and funded.
   1. By July 1996, the Division of MH/DD will establish a Training Consortium. This Consortium will include representatives of community

providers, consumers/families, counties, SHS staff and agencies who conduct statewide training such as the University Affiliated Program. The Consortium will develop a plan including types of training needed and the service delivery system.

Some examples of the training that has been identified needed are:

Consumers and guardians: Self Advocacy and Legal Advocacy. What to expect in the Community (explore use of parent to parent mentoring).

Providers: How to View Behavior as Communication. "Specialized" services (e.g., autism, severe behaviors, sexual problems). Creative Funding. Ownership vs. Use of Regular Housing Issues, Essential Lifestyle Planning.

Counties: Service Options, State of the Arts Information, Information and success stories from other counties in meeting individual needs, Essential Lifestyles Planning, Involving Consumers Effectively in County Planning, How to Build Housing Coalitions.

2. By September 1996, an initial timeline for implementation will be developed. Components of the training network will be implemented as appropriate, not waiting until the full program is designed.

Identified Barriers
The Consortium will identify barriers as they develop the training plan.

CONNER PLAN IMPLEMENTATION
Workgroup/Committees

	Make up	Dates	Responsibility
County/SHS Communications Workgroup	SHS staff, CPC staff, DHS workers, Case Managers	Convene: 4/96 Product due: 9/96	SHS

Duties:

- Identify what data, both individual and aggregate, will be useful to the CPCs, in what format the data needs to be shared and how often (Goal 1, B)
- Identify how best to include the input from the SHSs in county planning (Goal 1, B)
- Identify how the SHSs will be included in the county planning processes and division of duties related to discharge planning (Goal 3, C)
- Continue to monitor and adjust the process when necessary

	Make up	Dates	Responsibility
SHS Life Experience Committee	SHS staff	Convene: 9/96 Product due: 1/97	SHS

Duties:

- Implement a plan for consumers to be able to visit different living options so a more informed choice can be made when discharge becomes eminent. This would not be the same as visiting specific programs that are possible placements, but would be more generic visits, such as visiting friends who live in an apartment to get an idea of what apartment living is like. (Goal 2, A)
- Funding and resource issues will be identified in the plan and submitted to the current SHS groups looking at funding options related to their futures planning (Goal 2, A)

	Make up	Dates	Responsibility
Crisis Intervention Network Steering Committee	MH/DD, IUAP, SHS, CPC	Convene: 6/96 Product due: 9/96	MH/DD

Duties:

- They will look at who should be involved, how to organize the Network, and whether planning should be on a regional basis. (Goal 3, D)
- Develop an initial timeline for implementation. Components of the system/network will be implemented as appropriate, not waiting until full program is designed. (Goal 3, D)

	Make up	Dates	Responsibility
Funding Committee	MH/DD, Medical Services, SHS and county representation	Convene: 9/96 Product due: 7/97	MH/DD

Duties:

- Explore including training as an allowable cost under the MR waiver distinct from Administration costs. (Goal 3, E).
- Consider the following options and present a plan for implementation. (Goal 4, B)
  - a The use of family homes, including Family Life Homes, in conjunction with HCBS funding. Explore and recommend how to recruit, train, and provide supports to families.
  - b. Other housing funding streams will be explored in order to maximize the number of possibilities to meet housing needs. This may include State Supplemental Assistance, county appropriations, or other appropriations to be used as rent subsidies, grants, low or no cost loans, etc.
  - c. Increase the funding cap on funding for Home and Vehicle Modification through HCBS/MR which could make it easier for persons to use a variety of housing types.
  - d. Add a *Live In Care Giver* option (for people who rent or own their own homes) to the HCBS/MR. This option allows for the rent/house payment and utilities to be split between the live in care giver and the consumer.
  - e. Facilitating consumer home ownership.

	Make up	Dates	Responsibility
Training Consortium	MH/DD, IUAP, SHS, CPC, Community Providers, Consumers	Convene: 9/96 Product due: 7/97	MH/DD

Duties:

- Develop a training plan which will include types of training needed and how the training can be organized, marketed, and funded. (Goal 5, A)
- Develop an initial timeline for implementation. Components of the training network will be implemented as appropriate, not waiting until the full program is designed. (Goal 5, A)