Chuck's Story

Transitioning from a Nursing Facility

Case Study: Child with developmental disability transitioning from a Nursing Facility

The Office for Citizens with Developmental Disabilities (OCDD) first met Chuck when he was 15 and entering a nursing facility located in rural Jackson Parish. Chuck had been injured in a motor vehicle accident while riding in the back of a pick-up truck. During the accident he was ejected from the truck. The injuries Chuck sustained from the accident left him comatose and not expected to survive. Chuck was diagnosed as having traumatic brain injury (TBI). Even though his primary disability was TBI, he also had multiple physical disabilities stemming from the brain injury to further qualify him as an individual with developmental disability (DD). Because Chuck was younger than age 22 and because of his diagnoses, Chuck was considered by Louisiana law to have a developmental disability.

Anyone with a DD entering a nursing facility must be certified for entry by the OCDD Regional Office. This process is called the Pre-Admission and Screening and Annual Resident Review (PASARR). The OCDD Regional Office staff was contacted by the nursing facility to complete the PASARR review. OCDD Regional Office staff visited Chuck in the nursing facility and talked to the facility staff and Chuck's family. OCDD Regional Office staff identified Chuck's dad as the primary contact. Chuck lived with his Dad prior to the accident. OCDD Regional Office staff explained to Chuck's dad that by Louisiana law, Chuck was now considered to have a developmental disability and that the OCDD Regional Office would work with Dad to discuss information about services and options available.

The OCDD Regional Office made the initial determination that Chuck was categorically eligible for nursing facility care due to his comatose state. Chuck's comatose state made him ineligible for admission to an intermediate care facility for persons with developmental disabilities because he would not be able to receive active treatment, a federal requirement for a person in an intermediate care facility for persons with developmental disabilities. He had even recently been readmitted to the hospital due to further brain hemorrhaging. The family was naturally very concerned for Chuck's life. Dad felt that Chuck was best served in the nursing facility due to his fragile medical state. Dad saw no way that he could support Chuck at home. Also, because they thought he was going to die, the family felt that a nursing facility met a temporary need. Their decision was supported by the attending physician.

OCDD was supportive of the family in their grief following the accident and their grief in anticipating Chuck's not surviving. OCDD Regional Office staff stayed involved, talking to Chuck's dad at least every three months and visiting the nursing facility to see how Chuck was doing. Every three months, the OCDD Regional Office would renew Chuck's certification to stay in the nursing facility.

While Chuck resided at the nursing facility, his parents remained active in his life. Though his parents were divorced and not living together, they both lived in proximity to the nursing facility and each visited at least twice a week.

Chuck surprised everyone and woke from his coma about nine months later. He was now 16. He was still having a large amount of medical and disability challenges, but his family was overjoyed that he woke up. They had been prepared for his death. The OCDD Regional Office staff remained in touch with Dad and now began visiting more frequently to establish a deeper relationship with Chuck and Dad. OCDD Regional Office staff regularly discussed with Chuck and Dad the service options available for people with developmental disabilities, such as ICF/DD services, waiver services, Medicaid state plan, and state funded services. OCDD Regional Office staff hoped that after Chuck's medical condition was evaluated thoroughly, Dad would consider an alternative placement.

As a part of the PASARR process, OCDD Regional Office staff is always considering more appropriate living options for people with developmental disabilities living in nursing facilities. It had not always been possible for OCDD to provide immediate opportunities to access the full range of service options to meet the family and consumer's preference. Private ICFs/DD in a certain area may not have an open bed. The wait for a waiver service may be years. State funding may not be available in the amount needed. With the My Place Louisiana program, the OCDD Regional Office believed that Chuck might qualify to get a waiver opportunity with no wait using money follows the person methodology. The Medicaid funding available to pay for Chuck's nursing facility care would be used to fund home and community-based services instead. The My Place program was operating from 2008 through 2011 and was working through the PASARR process to offer children like Chuck access to a waiver option and allow transition from a nursing facility to home and community-based living options. It would be a great opportunity for Chuck to move home with the assurance of having all of the supports he needed.

After Chuck awoke from his coma, the nursing facility staff and attending physician worked hard to complete a thorough assessment of Chuck's medical, nutritional, and physical support needs. The physical disabilities that accompanied the TBI did not allow Chuck to walk or support himself outside a wheelchair. Chuck was also left with bowel and bladder incontinence. Other noted disabilities included a decrease in his motor skill involvements, which resulted in minimal range of motion in his arms and hands. He was left with total blindness and slow speech.

Chuck required physical therapy, occupational therapy, and speech therapy to see if he could recover some of his abilities. He depended on a wheelchair to be able to get around but had difficulty maneuvering the chair due to decreased motor skills in his arms and hands. The nursing facility attempted to begin therapies; but Chuck did not want to participate in any therapies, and no one (not even Dad) could persuade him to do so. This could have been due to his head injury and the changes this caused in his personality or due to the fact that staff were more familiar with elderly persons than young persons. One nursing facility staff member told OCDD staff that she felt Chuck was embarrassed to be at the nursing facility and so was shutting everyone out.

As Chuck’s medical condition improved and he began to speak, he communicated to dad that he wanted to go home. Dad began telling OCDD he wanted to take Chuck home. Mom was supportive of this decision but did not wish to play an active role in the planning process. Since his parents’ divorce, Chuck’s relationship with his mom was not very good because Chuck chose to live with his dad. Although Chuck had speech challenges, he could make his wishes known. Chuck clearly expressed a preference to go home to live with his dad. Dad was happy to take on the responsibility of planning for Chuck’s supports at home, even though he knew this would change his life. Dad would have to monitor and support Chuck’s medical status, assist Chuck with personal care and moving around, and would need to prepare himself to do all of these things for many years, as Chuck might remain dependent on his dad. Dad felt that the challenges of meeting Chuck’s needs were well worth the return in the joy of sharing everyday life with Chuck.

OCDD Regional Office staff told Dad and Chuck about the opportunity to move home using a waiver service provided through the My Place Louisiana program. The OCDD Regional Office staff felt that using a waiver was the best option for long-term success of Chuck’s in-home placement. The waiver services would be flexible enough to meet Chuck’s changing support needs and offered a well-rounded service package when coupled with Medicaid State Plan benefits. Because Chuck had resided in the nursing facility for more than 180 days, he was a good candidate for the My Place program. The My Place program offered the Children’s Choice Waiver in Phase I of the program. The OCDD Regional Office staff would assist Chuck and Dad to evaluate whether the Children’s Choice waiver would meet Chucks’ needs if they were interested. Dad understood that My Place would provide a way for Chuck to receive home and community-based services that would be important to help him live at home. Dad and Chuck were very excited about participating in My Place and receiving a waiver opportunity through the program. Dad signed the informed consent form that the OCDD Regional Office staff presented to him for Chuck to be a part of the My Place program.

The nursing facility social worker was not positive about Chuck going home and insisted to OCDD staff that it was a bad idea. The social worker believed that taking Chuck out of the facility would not benefit him. OCDD Regional Office staff had to firmly repeat to the social worker that the Regional Office was there to support the family and Chuck in the goal of having Chuck at home if at all possible.

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Unfortunately, there was a general lack of support for Chuck’s move home from nursing facility staff on Chuck’s facility treatment team. The only support came from Chuck’s physician. He agreed to participate in planning sessions for Chuck’s move. Other facility treatment team members did not participate in planning for Chuck’s discharge. OCDD Regional Office staff did request that Chuck’s entire facility treatment team participate in Chuck’s initial person-centered planning to transition to home but could not require them to do so. Facility treatment team members repeated that they felt that taking Chuck from the nursing facility would be harmful to his care.

Chuck’s facility treatment team members were not familiar with home and community-based services provided by OCDD and did not understand that Chuck would be able to get many of the same services delivered by the facility in his home through the waiver program and Medicaid state plan. The OCDD Regional Office recognized the lack of understanding on the facility staff’s part and vowed to try to overcome this barrier for Chuck and others who wish to move home using community-based services. This would be done by encouraging education of nursing facility staff. Only in educating facility staff would these staff begin to support Chuck and others in their goal of transitioning home. It would also enhance the information provided by the nursing facility staff for transition planners/support coordinators. If facility treatment team staff understands the community-based model the person is moving to, they may make better recommendations regarding supports needed to be successful in the community.

Although the facility treatment team staff chose not to participate in planning meetings, their opinions regarding the transition process were noted. Their expertise in Chuck’s medical, nutritional, and physical support needs were important in planning for Chuck’s move. Their thoughts on the challenges of Chuck’s care were documented to be used extensively in the person-centered-planning process. In addition, the OCDD Regional Office staff accessed Chuck’s nursing facility records. These records also provided in-depth information about Chuck’s current support needs and projected need for specialized therapies.

Even as nursing facility staff voiced concerns about Chuck’s move, Chuck and Dad stood firm in their decision to work toward a move home. They were reassured by the OCDD Regional Office staff that the person-centered planning process would identify potential needs or barriers and discussed solutions to Chuck’s support needs. If at any time it looked as though the move home would not work well for Chuck, other options would be discussed. The OCDD Regional Office worked diligently to move forward with the transition planning in a timely manner, hoping to complete the initial person-centered planning session and link Chuck to a chosen waiver service within 30 days.

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The OCDD Regional Office worked with My Place staff in the OCDD Central Office to link Dad with the local Families Helping Families chapter. Families Helping Families is a parent based advocacy agency that has chapters in different Regional s of the state. This would give Dad an opportunity to talk to another parent of a child with a developmental disability. Sharing common feelings, even anxieties, would help Dad through both the planning process and the life transition he would have to make to support Chuck at home. The Families Helping Families parent would also help Dad to think about questions he wanted answered by the OCDD Regional Office staff and to identify the kinds of things that Chuck and Dad wanted in Chuck's life. Thinking about goals and Dad's and Chuck's vision for their life would help the OCDD Regional Office staff in the initial person-centered planning session.

It helped Dad to talk to another parent who has a child with a disability. He felt like he could trust what they said and that he was getting a reality-based picture of what he and Chuck were about to do together. Dad felt like he was doing the right thing by following his heart in working to move his son home, even if some of the professionals at the nursing facility didn't agree.

Phase I of the My Place program only offers the Children's Choice waiver. Thus, Chuck and Dad had to decide whether or not the Children's Choice waiver would meet Chuck's needs. Because Children's Choice does not offer 24 hour supports in the waiver alone and must be combined with Medicaid state plan/ EPSDT services, Chuck and Dad needed to be sure that the waiver and state plan service package was right for them and would work with the lifestyle and routine that Chuck and Dad envisioned. OCDD Regional Office staff did person-centered planning with Chuck, his parents and the nursing facility physician. This planning session also used the documentation from the other facility treatment team members and Chuck's records. They worked to identify a vision for Chuck's life that would accomplish his goals, identify Chuck's support needs, and match those needs with services available in the two waiver options. They also looked at what providers might be available near Dad's home. After considering all of this and looking at services available through My Place, Chuck's family believed the Children's Choice waiver would work great for Chuck. They chose this waiver because it was very flexible and had all of the core services that Chuck needed (Environmental Accessibilities Adaptations, Family Support, Family Training, and Center-based Respite). Children's Choice offered the best opportunity to combine with the State Plan services for Children that would meet Chuck's more extensive nursing and therapeutic needs- Extended Home Health– Early & Periodic Screening & Diagnostic Treatment (EPSDT) benefit, Early & Periodic Screening & Diagnostic Treatment—Personal Care Attendant (EPSDT-PCS), and Durable Medical Equipment (DME). Also included in the State Plan package for children that Chuck would be able to use were audiological services, speech therapy, physical therapy, and speech & language therapy. Chuck also would need dental services and might seek mental health services over time, per his TBI diagnosis and the possibility of manifestation of a co-occurring psychiatric concern. The Medicaid package of services for people age 21 and younger was extensive enough to provide for Chuck's support needs. By choosing Children's Choice, Chuck and Dad understood that when Chuck reaches age 19, he would be referred to an appropriate DD waiver. The choice as to which waiver Chuck is offered would be made based upon Chuck's support needs at that time.

OCDD Regional Office staff completed the paperwork to link Chuck to the Children's Choice waiver services and forwarded this paperwork to My Place staff. The paperwork was processed by the Medicaid Data Contractor (SRI, Inc.), who sent a letter to Dad notifying him of the offer of a Children's Choice opportunity through the My Place program. Dad signed the informed consent form to accept the Children's Choice waiver and chose a support coordination agency. Chuck was officially linked to the Children's Choice waiver as a My Place participant, and the 60 day transition planning clock started.

Within a couple of days, the Support Coordinator made contact with Dad and Chuck and began putting together Chuck's Individual Support Plan (ISP). The Support Coordinator had 60 days to work with the facility treatment team, Chuck and Dad, and any new community-based providers that would be serving Chuck after the move to get the ISP drafted and approved by the OCDD Regional Office-Waiver Supports & Services division.

The Support Coordinator used a lot of the information from the person centered planning meetings held the month before by the OCDD Regional Office staff. This information provided a good foundation for discussing the services within the waiver that Chuck might like to use and the State Plan services that would need to be set up. The Support Coordinator visited Dad's home to look at where Chuck would be moving. She talked to Dad about what life might be like once Chuck moved home. She talked to Chuck to learn what he liked to do. She talked to Chuck's physician about Chuck's health needs. She reviewed records and talked to nursing facility staff to gather information and complete the plan. The Support Coordinator maintained at least weekly contact with Chuck and Dad throughout the 60 day transition window. She talked to them more frequently at certain points, like when they were making appointments to meet potential providers, making choices related to community-based medical care, and firming up some of the details of the modifications that would be needed for Dad's home.

Because Chuck was using the My Place program to transition, the Support Coordinator received assistance from the My Place Transition/Quality Management Regional

Coordinator. This staff person was part of the administrative support structure of the My Place program and offered help in the form technical assistance to the support coordinator. The My Place Transition/ Quality Management Regional Coordinator helped the Support Coordinator to stay on track with the 60 day transition timeline.

In addition, the My Place Transition/Quality Management Regional Coordinator met Chuck and Dad to make sure that they did not have any unanswered questions about the My Place program and how the program affects Chuck’s services and eligibility. The My Place Transition/ Quality Management Regional Coordinator explained to Chuck and Dad that My Place collects and tracks a lot of information about Chuck, such as what services are planned for him versus those he receives, how Chuck is doing in terms of critical incidents (like going to the emergency room), and how Chuck feels about his life. The way that My Place finds out the last item is through a Quality of Life survey. The survey would be administered by a person from an agency that My Place staff are employing to administer the surveys. The first survey is administered before the person moves out of an institution or nursing facility, the second survey about a year after the move has occurred and the third survey about two years after the person moves. Chuck and his Dad agreed to participate in the three Quality of Life surveys that are requested for all My Place participants.

In finalizing the ISP, Chuck and Dad had to make decisions about which services they would use in the waiver, which State Plan services they might use, and how school services would fit into their plan. In making these decisions, Dad felt like he did not need 24 hour care and did not want the intrusion of persons in their home every minute of the day. Chuck’s plan included his receiving in-home personal care attendant services through both the State Plan EPSDT-PCS and the Family Support component of the Children’s Choice waiver. Chuck would have a personal care attendant during Dad’s scheduled work hours. Dad also arranged for some breaks for himself with respite hours in Children’s Choice’s Center-Based Respite service. However, Chuck did not receive paid staffing 24 hours a day. Dad felt that he was able to provide support for Chuck during the time periods when he was at home. Dad did not work a typical 8 hour day/ 40 hour week. He was a plumber and worked during hours he scheduled as calls came in. Dad could schedule his time to coincide with Chuck’s personal care service (PCS) worker hours. The PCS agency providing Chuck’s services was available 24 hours a day in the event Dad needed emergency coverage, like if Dad had to work unexpectedly or if Dad was sick. The Support Coordinator also spoke with Chuck’s mom about playing a role in providing natural supports in the event of a change in schedule. She agreed to assist as needed. All of this was documented in Chuck’s ISP.

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OCDD Regional Office staff helped by locating a hospital bed, which was available under Medicaid's durable medical equipment service. Home Health was arranged to assist in continuing medical assessment. The Support Coordinator arranged for assessment for State Plan services offered to children through the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) so that Chuck could start these services as soon as possible after his transition. Some of these services could not be applied for or approved until Chuck moved out of the nursing facility. Thus, the goal of the Support Coordinator was to have all waiver services and all possible State Plan package items (like home health) in place for the day of the move and then to get the other needed services offered through EPSDT in place as soon as possible after the move.

The Support Coordinator contacted the local school board office and talked with a number of individuals about services that could be offered to Chuck. The school board offered to send someone to Chuck's home to test his reading and learning abilities. Chuck and Dad would need to participate in the process of developing an Individualized Education Plan (IEP). The school personnel said it would take a number of weeks to set up the scheduling of assessment, carrying out the assessment, developing the IEP, and putting the plan elements into place. The area school board had limited special education services that Chuck could use. To use the education services would require Chuck leaving home and traveling the 45 miles to the Special Education facility to receive the services. The My Place participant booklet provided information about Louisiana Parent Training and Information Center (LaPTIC), which provides workshops for parents of students with special needs to learn how to understand the process of getting educational supports for children with disabilities and the process of developing Individualized Education and Individualized Transition Plans. Dad also talked to the Support Parent about seeking help with schooling resources and talked to the Parent about her experience with the educational system. Chuck and Dad talked about using school services. Chuck declined going back to school, because he felt it was not important to him. Dad supported Chuck's decision. OCDD Regional Office staff and Chuck's Support Coordinator encouraged Chuck to attend school, but he did not change his mind. Chuck was of the age where he could legally drop out of school with no repercussions. The OCDD Regional Office staff shared with Chuck and Dad about habilitation and vocational training options that may be available once Chuck reaches age 18. They left information with Chuck and Dad and also prompted Chuck's support coordinator to discuss these programs with Chuck and Dad again closer to Chuck's birthday.

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The Support Coordinator visited Dad's home and was concerned about the feasibility of Chuck's living in the home. Chuck's Dad lived in a mobile home that was small and not very accessible to someone with needs like Chuck's. There were steps leading into the trailer, and the inside of the trailer would allow for a hospital bed only in the living room. A lift inside the trailer was not feasible due to the small area in the living room and the space the bed took up.

The Support Coordinator worked with the My Place Transition/ Quality Management Regional Coordinator to present alternatives to Chuck's dad. The Support Coordinator assisted them in learning about subsidized housing in the area and in completing an application to receive a voucher to use for a house or apartment. During the application process, the My Place Transition/ Quality Management Regional Coordinator found out from the My Place Housing Coordinator that the area had a 6 month wait for vouchers, but that new accessible, affordable scattered site housing was just coming online in the area. The developers utilized HOME funds and Low-Income Housing Tax Credits for the project, so it was listed on the DHH housing directory at www.lahousingsearch.org. The My Place Transition/ Quality Management Regional Coordinator got the contact information for the new housing available and also gave the www.lahousingsearch.org web site link to the Support Coordinator. There was a two bedroom house with a bathroom large enough for a lift available for rent within 14 days.

The My Place Transition/ Quality Management Regional Coordinator also worked with the Support Coordinator on an application for some financial assistance through the My Place program to help Dad and Chuck move into the new housing. The Children's Choice waiver does not offer One-Time Transition expenses reimbursement. The My Place program received $33,000 from the Louisiana Developmental Disabilities Council to assist with transition and housing expenses not covered by Medicaid funding. Dad and Chuck asked for $1,500 in moving and set up expenses that they would need when they moved into the house. They made a detailed list of their needs and they talked it over with their Support Coordinator. The Support Coordinator completed an application to receive the funds after researching the lowest costs for the items on the list. The application was approved and Chuck's Support Coordination agency received the funds so the Support Coordinator to help Chuck and Dad purchase the items they needed. The Support Coordination agency then invoiced OCDD.

It was fortunate that housing was available within the timeframe needed. Housing availability varies dependant on location, particularly in urban versus rural areas. In addition, certain urban areas in Louisiana are rebuilding (New Orleans and Lake

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Charles) while others are expanding (Alexandria, Baton Rouge, and Shreveport), and accessible, affordable units may be more readily available in these areas. If it had not been available, a temporary rental may have been sought using the My Place DD Council funding.

Before Chuck moved, his certification for Medicaid and state developmental disability services were verified, including Chuck’s qualification for ICF/DD level of care. Chuck and Dad also talked to OCDD staff about Chuck’s quality of life. Chuck’s Dad was contacted by a contractor who was administering the “Quality of Life” surveys for the My Place program. Chuck’s Dad and the interviewer agreed to meet at 7:30 a.m. one morning at the nursing home to complete the interview. Chuck made sure that the interviewer knew he was glad to be going home.

It took a little over one year from the time Chuck woke from his coma to the time he came home. Much of this time was spent seeing what physical progress he would make after waking from his coma.

When he moved home, Chuck had many family and friends there to welcome him. His young friends that he had known a long time had not deserted him. These friends were happy for Chuck to leave the nursing facility and to be back home. They liked to meet in the late afternoons at the Burger Barn to visit with each other and talk about the local high school football team. Now they could also go to Chuck’s and visit.

Chuck’s extended family was also able to easily visit him as well. Chuck’s Aunt Emma quickly got very involved in his life and comes a few hours a week to visit with Chuck and Dad or stay with Chuck while Dad ran errands or went to work.

Everyone was very happy for Chuck and considered his coming home a great accomplishment. They had all believed that Chuck may not make it after his accident.

After Chuck moved, his Support Coordinator called once or more every week for the first month, just making sure that everything was fine. She also called frequently the first month because she was working with Chuck and Dad to get the EPSDT services assessments and approvals through. Medicaid staff came to their home to complete assessments. Chuck was approved for therapies and other services that he needed to continue to develop skills for independence. After the initial move period, Chuck’s Support Coordinator touched based every month and visited in person at least once every quarter.

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Chuck's Support Coordination agency was available 24 hours a day to answer questions and respond to emergencies. Chuck and Dad understood that the OCDD Regional Office was also available to them. They understood that they could complain about not receiving a service or the way a service was delivered. Among on other things, the Support Coordinator had prepared a three ring binder for Chuck and his Dad that contained copies of DHH and OCDD contact information. She also put a copy of the Children's Choice Waivers Fact Sheet and information she had put together about OCDD Customer Complaint Policy, the DHH Critical Incident Policy, a *My Place Louisiana* Handbook, and the DHH Abuse and Neglect Policy. She also provided them with emergency numbers for the local DHH Regional Office, Chuck's Support Coordination agency, her own cell and home phone numbers, Chuck's doctor's numbers and numbers for the local police, fire department, and emergency medical response units. They understood that if Chuck was ever abused or neglected, had an emergency, or any complaint that they were to contact the numbers in the book immediately.

Chuck's Support Coordinator worked to make sure that Chuck was getting the services and supports he needed. Chuck and Dad liked the personal care attendants and the Home Health nurse who came to serve him. Once he was at home, Chuck's overall attitude changed. At the nursing facility, Chuck felt everything was geared to elderly people and that he felt out of place and lonely, which manifested as anger and refusal to participate in activities. At home, he felt more comfortable with his surroundings and began to be hopeful about his future. Chuck participated excitedly in therapy and was cooperative with nursing staff. He was increasingly engaged in his rehabilitation process as his treatment corresponded with things he wanted to do. Learning to use a wheelchair to get around on his own became important. Chuck wanted to talk to friends on the phone and maybe one day have a job.

At the end of the first year and one year later, Chuck's Dad was again contacted by someone who was conducting the "Quality of Life" surveys for the My Place program. Chuck and Dad had a good experience with the pre-move survey and agreed to participate in the 1 year after move questioning. They scheduled an appointment with the survey administrator. It took a little more than an hour to answer the questions about how Chuck was enjoying life at home.

Throughout the first year of Chuck's move (the first 365 days after he transitions from the nursing facility), the My Place program staff tracked a number of individual-level and systemic data elements. This level of individual attention is above and beyond the usual waiver program. My Place staff looked at individual-level data elements, such as what services were planned for Chuck versus those he actually receives, critical incidents (like hospitalization, emergency room visits, abuse and neglect, serious injuries), and satisfaction. These show how Chuck is doing and whether any corrective action needs to be taken to help Chuck to stay healthy and happy living in the community. My Place staff noticed that Chuck did not receive dental services as prescribed in his plan of care. The My Place Transition/ Quality Management Regional Coordinator contacted Chuck’s Support Coordinator to ask if assistance was needed. The Support Coordinator said that she could not locate a dentist to perform the procedure required. The My Place Transition/ Quality Management Regional Coordinator assisted Chuck’s Support Coordinator to set up an appointment with the nearest OCDD Center offering dental services. Chuck got his service within 30 days from a dentist affiliated with the LSU Dental School that travels to OCDD contract sites.

The My Place program looked at various elements of Chuck’s service usage and planning throughout the first year after his move. These trends come together to create a big-picture approach to proactive problem-solving that will help better support Chuck and others who have moved from facilities into the community.

After the first year, Dad received a letter that Chuck’s annual re-evaluation for OCDD services was scheduled. Chuck’s Support Coordinator and the OCDD Regional Office worked together to update Chuck’s ISP and validate his level of care. The My Place program paid for the first 365 days of Chuck’s services, but Chuck was enrolled as a Children’s Choice waiver participant from the day that he moved. On day 366, Chuck’s waiver services would be paid for through the regular Medicaid funding mechanism. Chuck would never notice the change in funding source. When the 365 days of the My Place program ended, Chuck became a regular waiver participant, using the traditional Medicaid funding stream and becoming a part of the Children’s Choice waiver’s quality management system. Chuck’s Children’s Choice services would continue uninterrupted after his annual re-evaluation and planning session took place.

Dad knew he could call the OCDD Regional Office if he had any questions about Chuck’s services or the letters he received about Chuck during this time.

The local Families Helping Families chapter invited Dad to their regular meetings and to some special training events. Dad has made some friends there. Chuck and Dad also began talking about Chuck’s future and whether Chuck might like to use a habilitation or vocational training service during the day. Chuck was interested in computers and the Internet. He especially likes the sports Websites and wants to

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learn how to “blog.” Dad and Chuck talked to his Support Coordinator. The Support Coordinator was glad to hear Chuck was interested in seeking training or further schooling. She talked to Chuck about his options at age 18 and got in touch with the OCDD Region about Chuck’s request. While still using the Children’s Choice waiver, Chuck might utilize state funding for habilitation or vocational supports for one year before moving to an adult waiver that includes the service. The Support Coordinator encouraged Chuck’s interest in computers. She was excited that Chuck was working hard to find out what he likes to do and was establishing goals for his future.

Chuck and Dad are doing great! Chuck still has many of his old friends visiting him every day. He and his Dad take rides around town a lot. Chuck enjoys riding in his dad’s pick-up truck. Dad and Chuck were not interested in a wheelchair accessible vehicle because Chuck wants to be “normal”. His friends pick him up in their cars by placing him in the seat and putting the wheelchair in the trunk of their car or dad’s truck. Chuck has enjoyed sports his entire life; his support staff assist him in attending local high school sporting events. Even though Chuck still has vision-impairment, it hasn’t stopped him from hanging out with friends or going where he wants to go. Recently, Chuck started walking with a walker and is hopeful, with more therapy, that one day he will not even need the walker.