State of Louisiana

Plan for Transformation of Public Developmental Centers to Supports and Services Centers

Prepared at the request of
the Department of Health and Hospitals
Office for Citizens with Developmental Disabilities
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Preface

The Office for Citizens with Developmental Disabilities (OCDD) developed this plan as a continuation of its *Financial and Programmatic Implications of Downsizing Large Public Residential Services: A Plan for Louisiana,* issued in December 2003.

The 2003 plan will be completed in June 2007. This plan builds on the success of the 2003 plan to continue to transform public sector service delivery into a system that delivers supports and services in a variety of settings and is a resource to families and private providers in enhancing the quality of the services they deliver.

Participation in the development of this plan included a cross section of stakeholders, staff, advocates and administrators from across the state, as well as a review of plans and documents generated by the administrators of the developmental centers.

Support for this plan development came in part from the Real Choice Systems Change Rebalancing Initiative grant.

LOUISIANA'S PLAN BACKGROUND

The Louisiana Office for Citizens with Developmental Disabilities (OCDD) evaluated progress on the 2003 Plan and held a series of meetings with stakeholders and staff to gather information and ideas for the next plan. These activities resulted in three reports which are summarized in this background section.[1]

Review of Progress on the 2003 Plan

The 2003 plan focused on downsizing the residential capacity of Louisiana's nine state-operated developmental centers (DCs) and replacing the shifting capacity with community-based residential alternatives. The plan set target reduction goals for each developmental center and projected the population levels for June 2007.

The plan acknowledged that the established targets were not to be considered absolute, recognizing that the targets depended on a host of variables and that any discharges needed to be voluntary and offer services and supports appropriate for long term success.

The following chart shows the residential population of the developmental centers in December 2003 and the populations as of Feb 28, 2007 in relation to the goals that were set in the 2003 plan.

Chart 1: Population Goals from the December 2003 Plan

DCs	Actual population at DCs Dec 2003	Plan population goals at the DCs June 2007	Actual Population at the DCs Feb 28, 2007[2]	Difference: Dec 2003 Plan Projected and Feb 2007 actual
Metropolitan	252	222	17	-205**
Peltier-Lawless	42	40	43	+3*
Hammond	317	217	299	+82**
Ruston	89	79	71	-8
Northwest	171	152	161	+9*
Southwest	89	79	81	+2*
Pinecrest	614	439	515	+76**
Leesville	19	19	0	-19
Columbia	22	0	0	0
TOTALS	1615	1247	1187	-60

** These centers met their population goals but offered services to people moving from MDC, thus increasing the actual population as of Feb. 2007.*

***Sixty percent of the individuals moving from MDC chose community residential options. For the remaining 40%, the individuals' service needs and personal choices resulted in 21 being admitted to Pinecrest and 36 being admitted to Hammond. Post-Katrina crises also impacted admission numbers to these two agencies.*

Fully four months before the end of the plan projections for June 2007, the developmental centers have exceeded by 60 the established goal for all of the centers. This objective has been

[1] These reports are available in their entirety from the OCDD. Report titles can be found in Appendix A.
[2] From Census Report dated Feb 28, 2007

achieved due to the many focused initiatives discussed in this report, as well as the decision to restructure Metropolitan Developmental Center as a provider of community-based living options and an expanded Resource Center. The Office for Citizens with Developmental Disabilities proposed the conversion of the Metropolitan Developmental Center to an expanded community Resource Center with limited publicly operated community residential options. This was supported by the legislature in 2006.

The <u>first objective</u> of the 2003 plan was to reduce the populations of the developmental centers by diverting admissions, providing opportunities to center residents to transition to waiver options and by establishing an interdepartmental agreement to create a single point of entry for people seeking services.

o The population objective was achieved. As the chart above indicates, populations at the centers have dropped below the anticipated overall level.

o Diversion of admissions is key to maintaining lower center populations. OCDD implemented a policy requiring all referrals to a developmental center be routed first to the local Regional Office to locate an appropriate community residential option in that region. The Regional Office also does a statewide search of other regions, if no options are available within the local region. Only when this process fails to locate an appropriate alternative residential option is the referral then made to the state office for developmental center admission. The state office verifies that there is no appropriate alternative residential option. The state office makes the referral to the most appropriate developmental center, often with guidelines for short term stay discharge planning to begin immediately. Prior approval from the state office is required for admittance to a developmental center. This process assures that community-based alternatives are accessed prior to admittance to a developmental center.

o Availability of New Opportunities Waiver options was important to achievement of this objective. OCDD has made policy decisions (evident in policy and rule) to prioritize DC transitions and has prioritized New Opportunities Waiver (NOW) opportunities for DC transitions. The availability of waiver opportunities has remained consistent with demand.

o Single Point of Entry (SPOE) to the system was achieved by transferring ICF/DD certification to OCDD regions, districts, and authorities. To support SPOE:

> Integration of the Bureau of Community Supports and Services into OCDD as the Waiver Unit allows OCDD to prioritize waiver services with other DD services and integrate DD waiver services with all other DD long-term care services.
>
> OCDD is in the second year of development and testing of the Supports Intensity Scale (SIS) and accompanying assessment Louisiana Plus (LA Plus). The combination of these instruments will be used in the SPOE and is intended to serve as a comprehensive assessment tool to assist in determining support and service needs. The SIS/ LA Plus attempts to determine what supports would be necessary to help the person achieve specific goals and perform specific tasks necessary for daily living. As such, it is very compatible with the current planning literature and is directly linked to specific support

planning for HCBS (Home and Community Based Services). The SIS/ LA Plus will assist individuals to make choices about where to live and available service options through careful assessment of each service domain. To date, OCDD has complete about 3,000 assessments as part of a reliability study. Most assessments were completed in preparation for people to transition to the Supports Waiver; others were completed with representative samples of people using other DD services to give an idea of how the tool works in different service venues.

o The development of a Residential Options Waiver (ROW) is underway. The waiver will be a cost-effective and flexible HCBS option that will impact both admissions and transitions. It is projected to be operational by July 1, 2007, and the Executive Budget has initial funding for 200 opportunities. In addition, some number of people in nursing homes and ICFs/DD are projected to access the ROW via money follows the person methodology.

The <u>second objective</u> sought to achieve reductions to center populations through voluntary transitions, calling for encouraging voluntary transitions from centers to community options through education.

o Considerable work has been done to educate center residents, their families and staff about community options. Efforts in education and at least annual determination of interest in transition have been prioritized by centers and are included in people's Individual Support Plans (ISP). Developmental Center ISPs are considered ~~a~~ discharge plans; that is, the focus of active treatment is those supports and skills needed to live in a community setting. Each ISP contains specific transition planning information, inclusive of a community integration plan. The plan looks at traditional community integration, visiting other living sites with staff and family, and visiting other work/habilitation services in the community. In addition, Transition Services include individual trips each-month taking people, family members, and staff to visit alternate living arrangements. Finally, centers has quarterly provider forums in which 8-12 providers come and present information/answer questions about community services for individuals, family members, and staff.

o This objective called for assembling transition support teams to plan transitions and then follow up to assure that the person and provider had the support needed to assure success. Instead of simply monitoring progress, however, the support team concept has evolved into a partnership with the service provider agency to develop and sustain quality not only for the person who transitioned, but for others served by the provider.

o At MDC, where many transitions were made in a relatively short time, people who transitioned are being followed with the standard immediate transition support activities. Additionally, this six month process has been enhanced and expanded to two years and includes additional data tracking elements, as well as development of quality management partnerships with providers. A new tracking system is being developed to collect specific information about each person's progress. This system looks promising in that it will enable longitudinal analysis of people's experiences and provide information that will help improve future transitions.

A <u>third objective</u> of the 2003 plan called for building community capacity by using resources for the centers to support community options; using Enterprise Funds to support training of staff in community settings; creating nine community support teams (one at each center); establishing crisis stabilization/psychiatric units in five centers and creating resource centers at selected centers to develop and supply information, training and services in specific areas on a statewide basis.

o As of December 2006, nine community support teams were in place. These teams primarily located in the community, funded and administered by the developmental centers, in conjunction with Regional Offices, Human Services Districts and Authorities.

o As of December 2006, five resource centers were in place as shown in the following chart.

Chart 2: Resource Center Development

Location	Resource Type	Notes
Metropolitan	Dental & Medical	
Hammond	Psychiatric/Behavioral	
Pinecrest	Nursing/Physical & Nutritional Support	
Northwest ~~NW~~	**Aging with Developmental Disabilities**	**Transferred from Columbia**
Region V Lake Charles	**Community Inclusion**	New topic

*Resource Centers in **Bold** did not appear on the chart in the 2003 plan*

o Funding was not appropriated for The Crisis Stabilization/Psychiatric Units. However, some of the support capacity envisioned for these teams was built into the Community Support Teams and the Resource Center at Hammond. In addition, Hammond and Pinecrest have provided stabilization services as a diversification effort. Information supplied by stakeholders and staff clearly indicate a continued need for more behavioral support resources and capacity to stabilize a person in psychiatric crisis away from his own home. Hammond and Pinecrest have proposals for crisis stabilization units in their budget requests for fiscal year 2008.

o Resource Centers have provided training and direct services to large numbers of people as shown in the following charts. *Chart 3 A: Resource Center Training Chart* details training provided by resource center staff and focused specifically on the DD population. *Chart 3 B: Resource Center Direct Services Provided* details provision of direct services. These services generally require one-to-one, in-person consultation and entail a significant time investment on the part of the resource centers.

Chart 3 A: Resource Center Training Chart By calendar year; 2006 Data ends October			
Resource Center	**Total Training attendance 2004**	**Total Training attendance 2005**	**Total Training attendance 2006**
Community Inclusion	581	1607	1925
Medical/Dental	1157	1079*	240*
Psychiatric/Behavioral	881	1741	1363
Aging	545	813	281**
Nutritional/Nursing	209	1873	682
TOTAL	3373	7113	4491

Chart 3 B: Resource Center Direct Services Provided By calendar year; 2006 Data ends October			
Resource Center	**Total Number of Participants 2004**	**Total Number of Participants 2005**	**Total Number of Participants 2006**
Community Inclusion	125	0	0
Medical/Dental	728	401*	106*
Psychiatric/Behavioral	11	49	52
Aging	0	0	0
Nutritional/Nursing	467	63	13
TOTAL	1331	513	171

** The Medical/Dental resource center was heavily impacted by Hurricane Katrina in August 2005 and continuing through 2006.*

*** The Aging resource center experienced a time of transition in 2006 as the center moved from Columbia to Northwest.*

- The Enterprise Fund activity had partial funding in place in 2003 and increases were expected to be self-generated. These funds have been developed, but funding sources are not adequate to support the need. Other funding sources, including Home and Community Based Services (HCBS) funding, are being developed to support community-based activity, including micro enterprises. Current enterprise fund projects include community based work opportunities for people. Examples include: a bakery, greenhouses/nurseries, and community-based work crews.

A <u>fourth objective</u> was to enrich the array of community services by creating the alternative of state operated services in the community to serve people unwilling to transition unless the State is the provider and people in need of services, unavailable through private providers.

- The state has developed 14 publicly operated community homes and 90 waiver opportunities in response to this objective as illustrated in the following chart. Seven additional community homes are projected to open before June 30, 2007. The seven additional homes will be at Pinecrest (3), Hammond (2), Peltier-Lawless (1) and Northwest (1). All community homes were developed via the transfer of bed capacity from the large facility to the community home setting; thus, the state is reducing large facility capacity while operating these community homes. In an effort to further enhance HCBS capacity, OCDD intends to convert some of the community homes to waiver services as opportunities allow.

o One action step called for creating state operated Supported Independent Living (SIL) opportunities for people wanting to leave centers. As a Home and Community Based Service (HCBS) provider, the state has encountered challenges in the development of SIL. One clear issue involved the use of shared supports (two or three people sharing a home) as anticipated. It took significant efforts to negotiate what that would entail or whether it was even possible under waiver rules. The result was that the projected increase in state SIL capacity was not fully achieved.

o The Developmental Centers continue to provide Extended Family Living placements which are the foundation of the proposed Host Home Program.

Chart 4: DEVELOPMENT OF STATE-OPERATED COMMUNITY SERVICES

Developmental Centers	community residential supports 2003 #homes/# people	Community Residential Supports Feb 2007	Group Homes Feb 2007	People in SIL 2003	Actual in SIL Feb 2007	Actual in EFL Feb 2007
Metropolitan				0	19	9
Peltier-Lawless	1 home/6	1 home/5	1 home/6[3]	5	4	6
Hammond		3 homes/12		0	3	6
Ruston		3 homes/17		2	2	2
Northwest		1 home/4		0	3	7
Southwest	2 homes/12	4 homes/24		1	1	12
Pinecrest		4 homes/20		10	21	7
Leesville	5 homes/30	5 homes/27	1 home/14	0	0	0
Columbia	4 homes/24	5 homes/29	1 home/15	1	7	0
TOTALS	12 homes/72	26 homes/138	3 homes/35	19	60	49

A <u>fifth objective</u> called for the building of capacity to monitor services to individuals who transitioned.

o A transition team and coordinator follow individuals who transition for six months whether they move to waiver services or to an ICF/DD.

o From 2002 to 2006 OCDD Central Office maintained positions in each region for intensive case coordination that enabled people to transition from developmental centers effectively. These Regional Transition Coordinators also did follow up regarding the results of the person's transition. In late 2006, this function was transferred to intensive private support coordination (State Plan option). Private support coordinators receive an enhanced rate and lower case load ratio requirements in order to offer intensive transition assistance.

[3] Group homes are defined as homes with 7 or more. However, the source data reported this six-bed home as a group home. It was developed as an 8 bed home for people with medically fragile conditions.

o The current transition support structure is still being refined. Everyone who transitions is followed by a Transition Support Team for up to six months. People who choose a waiver option have an independent supports coordinator and are seen at least quarterly and sometimes as often as monthly. Those who move to private community homes have a QMRP. Waiver services and ICF/DD services are distinct service venues, thus protocol regarding data reporting and management, as well as licensure review, is different both at the local agency and state agency level. Multiple state agencies are involved, including OCDD and DHH Health Standards. Further revisions of quality management systems is needed to establish a closed cycle that supports both individual-based quality assurance and systemic quality improvement, the latter of which should be aimed at prevention of recurrent issues impacting health, safety, and welfare of people all in community settings.

o The people who transitioned from MDC are being supported by (1) the traditional six month transition support process, (2) an enhanced data tracking/gathering system that will provide longitudinal data on peoples' experience, and (3) a mentoring/partnering relationship with the MDC resource center working with various private providers for two years. The work being done at MDC to create a data set to follow people who have left the center holds out much promise to serve as a model for a statewide system to assure that people are having their needs met.

The <u>sixth and final objective</u> called for reserving the centers for those who do not choose to leave and whose needs for specialized services cannot yet be met in the community.

The following chart shows the population served by the developmental centers as of Feb 28, 2007 compared to those served in 2003.

Chart 5: PUBLICALY OPERATED RESIDENTIAL SERVICE VENUES			
	Actual:2003	**Actual: Feb 2007**	**Difference**
DC Census	1614	1187	-427
DC operated Group Homes	0	35	35
DC operated Community Homes	72	138	66
DC operated Supported Independent Living	19	60	41
DC operated Extended Family Living Supports	49	49	0
Total	1754	1469	-285

While the number of people served in the developmental center campuses has declined by 427 in the timeframe of December 2003 to February 28, 2007, the overall difference in number of people served by centers is 285. This means that 142 people moved from developmental centers to a publicly operated alternate service venue.

This is a result of the amount of community operated options being established by the developmental centers. In the years 2003 to 2007, a primary option for transformation of large facility campuses was movement of ICF/DD beds to smaller sized group or community home

settings. This is evident in the 101 community-based ICF/DD options created. In addition, the prioritization of NOW opportunities to people living in developmental centers and choosing to transition to HCBS supported the establishment of 41 waiver-based options (SIL).

In response to stakeholder feedback from people supported in developmental centers and their families, the state developed community operated options to address the following concerns: (1) that people will not choose to leave a state operated ICF/DD option and/or (2) that people may require specialized services and have support needs that in their perception cannot yet be met in the community.

The creation and maintenance of the 101 community-based ICF/DD options and 41 waiver options show that:

1. People may choose to transition to a smaller sized state operated ICF/DD option, rather than remain in a larger ICF/DD facility
2. People who choose to or whose needs necessitate retaining the state as a provider are more likely to choose an ICF/DD option (71%) than a New Opportunities waiver option (29%). [See Objective Four second bullet discussion of challenges is SIL development.]
3. People who may require specialized services may be supported in either a waiver or ICF/DD setting when the state acts as provider.
4. People choose the state as provider about 33% of the time.

The state acting as a provider ensures maximum flexibility for people considering transition. These are all important points to consider in evaluating the role of developmental centers and making plans for the continued transformation of the centers.

SUMMARY

OCDD has:

1) Exceeded the 2003 plan goal of reducing the developmental center campus populations to 1247 by 60.
2) Grown the number of opportunities for community living by transitioning developmental center staff to community residences and SILs.
3) Grown the capacity of communities to serve people with developmental disabilities by creating resource centers and community support teams.
4) Offered training and technical assistance to community providers and to families.
5) Focused efforts and resources on the transition process.

OCDD is in the process of:

1) Developing a uniform quality management system for people transitioning from developmental centers.
2) Modifying its New Opportunities Waiver to increase services options and flexibility, including self directed services.
3) Applying for a new waiver with more flexibility (Residential Opportunities Waiver). This waiver is designed to include up to 24 hour supports models, some of which are shared, that are appropriate for people moving from institutions to HCBS.

4) Applying for a Money Follows the Person demonstration program that would allow additional funding to support the transition of people from ICF/DD funded services to waiver funded services.
5) Implementing a major effort to transition people from Pinecrest and Hammond to community alternatives.
6) Adding additional psychological capacity to some community support teams to deliver behavior supports to people in community settings.
7) Bringing quality assurance programs together into a uniform state-wide system of quality management and enhancement with associated data system support.
8) Addressing issues such as the direct support workforce $2 wage pass through has been funded. This is a $40 million DSP funded wage pass through implemented Feb 9, 2007 and rolling through the next fiscal year. This will impact DSP salaries in the non-public venues. In addition, the department is in the process of developing a DSW Registry for public and private providers.

All of these efforts, when successfully completed will improve opportunities for community residential options and help ensure that they provide safe, healthy and satisfying environments for people with developmental disabilities.

Input of stakeholders, staff and administrators to the next plan

As part of the process for developing a new five-year plan, OCDD arranged to bring together focus groups to offer input. Group meetings of stakeholders were held in three locations across the state - Baton Rouge, Alexandria, and Bossier City. The groups may be described as follows:

- One set of three groups included people who had transitioned from a developmental center to the community and their immediate support staff. They were asked to comment on their experiences with the transition process and their lives in the community.
- The second set of three groups included people who are currently supported in main campuses of DCs, family members and staff members at DCs .They were asked to comment on what has changed in the last three years, what still needs to change and to offer their ideas for future diversification of the DCs.
- The third group included members of advocacy organizations like the Louisiana Developmental Disabilities Council and the Louisiana Advocacy Center.
- A fourth source of information included the administrators of the developmental centers and other administrators of OCDD as well as a review of relevant documents.[4]

The input of stakeholders was rich in detail and personal experiences and that detail is available in the complete report. What follows is a summary of input organized around central themes.

Positive Experiences: People who had transitioned to communities had a lot to say about what they liked about their experiences. While comments were sometimes specific to the participant's own interests or to the area of the state where the group was held, there were some common themes that warrant special note.

- One person reported moving closer to family after 47 years at Pinecrest. She has lots of family in the community and runs into them in stores when she is out shopping. She has her own apartment, pays her bills and has constant staff support as well as family around her. Her niece reported that her aunt is more alert and active than ever.

- A father spoke eloquently about his son's move to a community home operated by a developmental center. He noted that he and his wife were involved in every stage of planning for the transition. Folks who knew each other and were compatible moved together. He admitted that he was skeptical about whether his son, who is not verbal and not "high functioning" (his term), could be successful in a community home. But, he said, it has been very successful. His son lives in a nice house in a safe neighborhood. He gets his health care and day services at the center. The center follows his son for 180 days after transition and after that, is still available to help when needed.

- People involved in transitions in the recent past were enthusiastic about their living arrangements and staff unanimously loved their new jobs. Since most of the people contributing comments, referenced state operated community homes and supported independent living, there appears to be a great deal of comfort and satisfaction with that approach.

[4] A list of the reviewed documents appears in Appendix B.

o Staff overwhelmingly reported liking their community assignments, noting they have more time for one to one attention to people, opportunities to get to know families better and they noted improvements in the learning, health and mobility of people they serve. They noted more staff motivation and less use of mandatory overtime.

o Staff noted changes in the developmental centers where there are fewer people per room, vacant buildings have been converted to day activities, and transition is open to people with medical support and behavioral needs.

Challenges Ahead: Stakeholders, staff and administrators identified areas that continue to need work to assure that the emerging community service system will be able to deliver quality experiences to people who chose community living. While the focus groups produced a more extensive list, what appears here are the dominant themes that recurred throughout discussions with the various groups.

#1. One challenge is how to develop **true community connections**. Some people find residences in the community, but continue to rely on developmental center campuses for principal daily activities and relationships. Transition planning and post-move supports should encourage individuals' community connectedness. These connections should be based upon people's choices and personal goals, may take months or years to establish, and may require ongoing supports to foster and maintain. Acknowledging that establishing relationships takes time, the people who shared their transition experiences moved within the past year, thus they may not yet have a well-established community-based network.

#2. Stakeholders said that **generic community supports** are not as strong as they need to be. They noted that people need to rely on center supports, particularly in dental service, psychiatry and behavioral support. Medical services can be hard to organize because some physicians decline to take new Medicaid patients or will not serve people with special needs. Some reported that physicians have declined to sign off on the delegation of administration of medications or treatments for people in Supported Independent Living. Continued training, consultation and sharing of expertise with communities will be needed to overcome this challenge.

#3. **Housing availability** is a problem for both public and private providers in most parts of the state and more acute in the southern areas affected by Hurricane Katrina. Community receptiveness (to ICF/DD community homes) needs to be a constant consideration. While community opposition has not stopped community development so far, it continues to create concerns. In some areas there was an initial furor over community homes, but it settled down as they began to operate. Some administrators have experienced reluctance by owners to sell their property for group home use.

#4. Administrators shared concerns that as individuals are **aging in their community settings** and develop health-related mobility and care issues, that they will be rejected by their private providers and seek return to centers. This suggests the need to build a strong

cadre of nursing professionals who can respond to increased health care needs and educate staff and providers in how to provide enhanced service as people age.

Suggestions for the Next Plan: People were asked for their suggestions about what to address in the next plan. People had many ideas, sometimes related to personal experiences and sometimes to their creative thinking about the future. Below are some of the dominant ideas that emerged.

#1. Families derived comfort from the 2003 Plan's assurance that their loved ones will have **a choice about whether to leave a developmental center**. They wanted to see the same commitment in the next plan.

#2. **Continue to downsize the developmental centers** through voluntary transitions. One suggestion was that all center admissions be considered short-term. Advocacy groups support an aggressive effort to transition people from centers.

#3. Support for **jobs and day services** are available, but geared toward work center services in the developmental centers or in private workshops rather than toward community jobs. People suggested that the developmental centers could lead by example in transitioning a portion of their day supports to integrated community supports.

#4. As the developmental centers continue to refocus on a community oriented role, there is a need for **revising the public image of DCs** to reflect the changes. The suggestion for a public relations effort sparked interest and enthusiasm among the participants of the group that raised it and that reaction may be a signal that a wide variety of stakeholders are ready for a new image of the DCs.

#5. Major **partnering with providers** is needed. There needs to be a collaborative atmosphere between private providers and the developmental centers wherein DC resources can be shared to facilitate private development. The MDC project has offered some experiences in cooperation which warrant examination as examples for the future.

#6. Continue to **expand community supports**, particularly in the area of psychiatric and behavior support services. Efforts are underway to add psychology positions to teams and to use more contracted service. However, this may not completely meet the needs especially in rural communities. A related need is for crisis intervention centers where people in crisis can go immediately for evaluation and stabilization instead of to hospital emergency rooms. For people with seriously challenging behavior, behavioral support will need to be available 24/7 in their community setting. This will require cooperative work with community mental health resources where available, or fielding teams with the necessary expertise from the developmental centers.

#7. As the population of the developmental centers declines, **space will become available** for other uses. People offered ideas about how that space might be used. However, it was clear that further discussion and exploration of options is needed and that such work will need to be individualized to each developmental center.

8. There were multiple suggestions about how DCs could assist with **training private providers and community clinical professionals.** Internally, there remains an on-going need for training about diversity and the growing alternatives available in communities. External efforts for training may include community capacity building goals. One center is exploring LPN training in conjunction with Southern University. Another is involved with LSU medical school to train new psychiatrists. These efforts may produce both good results and information on how to create long-term partnerships with generic community service providers.

#9. People who are legally competent, but have difficulty making decisions do not always have **guardians or advocates** and there is concern by Advocacy stakeholders that people may be taken advantage of by community based providers. One suggestion was that more money be devoted to guardianship and that the service be moved from OCDD to the Governor's office to preserve a sense of independence.

Process Suggestions: Some suggestions related to the processes and administrative matters that underpin operation of supports and services.

#10. A methodology is needed to allow developmental centers to **capture reimbursement for services** provided to communities.

#11. There are some **case management** issues that need to be addressed. The recent change to use of private support coordinators only, while still affording people at least two choices of support coordination service provider, has also produced some uncertainty about case load size and experience of staff in supporting transitions. There appears to be less concentrated time available to transition activities, and this may slow transitions.

#12. **Waiver development is a priority** and should be. It is possible to cover almost any situation with waiver supports with the appropriate waiver approval. Administrators urged that flexibility be built into the waiver programs under development. They cited issues around adaptive equipment as examples of where flexibility is needed. (An example is where adaptive equipment cannot be purchased until a person moves, but it must be in place when the person moves.) People indicated that waivers need to address wheel chair vans and shared supports, allowing people to combine resources and staff to make a community living arrangement affordable. They suggested that the waivers are not always implemented as fully as they could be; citing the reluctance to allow shared living opportunities. The waiver unit sometimes denies or requests revision of plans for unclear reasons, causing delays in transitions.

The description of the new Residential Waiver Option (ROW) indicates that it will:

- Use ICAP scores to determine levels of support.
- Allow for conversion of 8 bed ICFs to HCBS, with a maximum of 6 persons living together in a converted facility.

- Create shared living options of up to four people, and allow existing options (former ICFs) to support up to six people.
- Include individual, host home, companion care, supported employment, transportation, environmental modifications, adaptive equipment, professional services and community support teams.
- Will be participant-directed.
- Target people coming out of ICFs, nursing homes and diversion from DC admissions.

#13. One of the issues throughout discussions with managers involved how to determine a fair **budget for someone in a waiver community setting.** One way would be to use SIS or ICAP to determine a level of support for each person. That level would tie to a maximum allowable cost and the plan would need to be crafted so as not to exceed that figure. - Because the ICAP is currently being used in the ICF/DD rate setting and the new ROW is targeted to allow Money Following the Person for people in these settings, the ICAP will be used for budgeting. When the SIS/LA Plus is ready for implementation, the state plans to move to this tool in place of the ICAP.

#14. **Information Technology needs to be updated** in a variety of ways so that support coordinators and administrators can track incidents by person, by provider and by location. It needs to be able to supply data from standard individual reviews for purposes of trending analysis.

State of Louisiana
Plan for Transformation of Public Developmental Centers to Supports and Services Centers: 2007-2012

The plan continues the theme of diversifying the developmental centers to provide a growing range of supports for community living. Under this plan, some smaller centers will reduce their campus residential capacity to 15 or fewer beds and increase the number and variety of community residential supports they offer. This continuing diversification makes the best use of trained and dedicated staff to bolster community development efforts while making it possible for people with developmental disabilities to live in smaller and more independent settings.

When this plan is completed in 2012, there will be a rich array of residential options and other developmental disabilities supports and services in an efficient and responsive manner promoting choice, independence and quality of life.. The plan aims to transform the Developmental Centers into centers that supply individually determined supports and services to people with developmental disabilities through a growing and diverse range of options and resources operated and/or provided by the Center.The use of waiver supports will be high and the use of ICF/DD funding streams will have diminished. People will find supports for day activities in their communities and those in need of behavioral supports will find them more easily in their communities as well. Only four centers will remain large ICFs/DD, that is 16 beds and above.

This plan is ambitious and responsive; both to the needs of people for the opportunity to chose independent lifestyles, but also to support people who remain in ICF/DD settings to enjoy many of the aspects of it within their smaller centers. It is committed to voluntary moves from centers to communities and to working with the private sector to maximize the quality of their service offerings. The plan acknowledges that the established targets was not to be considered absolute, recognizing that the targets depend on a host of variables and that any discharges need to be voluntary and offer services and supports appropriate for long term success.

This plan is arranged in six objectives with one or more action steps per objective. Each objective includes some explanation of the reason for the objective and its importance to people with developmental disabilities. Action steps include an indication of responsibility, a timeframe, a measure to judge success and an indication of current status.

Objective 1: The main facilities of the developmental centers will **continue to reduce in size through voluntary transitions** to a level of approximately 770 people in four centers with 16 or more residential beds. Five centers will have 15 or fewer residential beds in their main facilities, but will support people in community residential options.

The following chart shows the number of people who lived in the main facilities of the developmental centers in 2003, who are projected to be living on campuses of 16 and over as of the end of June 2007 and the new projections for June of 2012.

Objective 1, Chart 1:
POPULATIONS AT DEVELOPMENTAL CENTERS: 16 AND OVER CAPACITY

Developmental Centers	Pop. at DCs 2003	Pop. at the DC's June 2007 (Projected)	Pop. goal for June 2012	Difference between June 2007 and 2012
Metropolitan	252	0	0	0
Peltier-Lawless	42	40	0	40
Hammond	317	291	191	100
Ruston	89	68	0	68
Northwest	171	167	117	50
Southwest	89	83	62	21
Pinecrest	614	516	400	116
Leesville	19	0	0	0
Columbia	22	0	0	0
TOTALS	1615	1165	770	395

In 2007, three of the centers show population figures at zero. These centers have reduced their campus populations to the size of a large group home (15 people or fewer) and will be tracked as group homes rather than developmental center campuses. Peltier-Lawless and Ruston are represented in 2012 as zero in the above due to scheduled downsizing and conversion to options of 15 people or fewer. The following chart shows the on-campus populations (ICF/DD) of centers scheduled to operate at 15 or fewer by 2012.

Objective 1, Chart 2:
POPULATIONS AT CENTERS: 15 AND FEWER ICF/DD CAPACITY

Centers	Pop. at DCs 2003	Pop. at the DC's June 2007 (Projected)	Pop. goal for June 2012	Difference between June 2007 and 2012
Metropolitan	252	0	0	0
Peltier-Lawless	42	40	15	25
Ruston	89	68	13	55
Leesville	19	15	15	0
Columbia	22	15	15	0
TOTALS	424	138	58	80

Action Step 1: Maintain enrollment at the 15 or fewer level at Metropolitan, Columbia, Leesville.

Responsible: Developmental Center Administrators

Timeline: Annual review for maintenance of under 15 population.

Measure: Actual populations of large group homes operated on campuses of the three centers as evidenced by annual report on plan progress.

Action Step 2: Reduce the enrollment at Ruston and Peltier-Lawless to the 15 or fewer level.

Responsible: Developmental Center Administrators

Timeline: By 2009-2010 according to bed-service reduction targets in center-specific plans.

Measure: Actual populations of main facilities of developmental centers as evidenced by annual update on plan progress.

Action Step 3: Continue to reduce the campus populations at other developmental centers to levels indicated in the above chart.

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Responsible: Developmental Center Administrators.

Timeline: Per the following chart.

Measure: Actual populations of main facilities of developmental centers per annual update to above chart.

Objective 1, Chart 3:
BED SERVICE REDUCTION TARGETS: DC CAMPUSES OF 16 AND OVER CAPACITY

Fiscal Year	Hammond	Pinecrest	Northwest	Southwest
07/08	271	490	157	78
08/09	251	466	147	74
09/10	231	443	137	71
10/11	211	421	127	67
11/12	191	400	117	62

The following chart shows the number of people in developmental center-operated community residential options projected for June 2007, the projections for 2012 and the difference between the two. This information may be used in concert with Objective 1, Chart 1 and Chart 2 in order to create a picture of the shifting nature of residential services provision, as well as capacity shifting. Capacity shifting though downsizing of main campuses supports the use of funding and resources for community-based residential options and non-residential efforts. The second and third columns display continued development of community or group homes. This is achieved by transferring ICF/DD beds from large campuses to smaller community-based ICFs/DD. Columns six and seven detail the number of opportunities to be developed as cooperative endeavor agreements between state and private providers. In this arrangement, the state enters into a written agreement with a private provider for that provider to operate public ICF/DD bed capacity. [NOTE: For Pinecrest this will involve HCBS.] The cooperative agreement includes technical assistance provided by the state, as well as quality management standards.

Objective 1, Chart 4:
PUBLICALY OPERATED COMMUNITY RESIDENTIAL OPTIONS

Developmental Centers	ICF/DD Community or Group Home		Waivers		Cooperative Agreement		Difference 2007 to 2012
	2007	**2012**	**2007**	**2012**	**2007**	**2012**	
Metropolitan	12	0	28	44	28	28	**4**
Peltier-Lawless	12	24	10	14	0	12	**28**
Hammond	24	24	9	50	0	0	**41**
Ruston	18	18	6	47	0	16	**57**
Northwest	6	17	10	33	4	30	**60**
Southwest	24	28	16	34	0	16	**38**
Pinecrest	28	32	28	43	0	9	**28**
Leesville	30	26	0	11	0	0	**7**
Columbia	30	30	7	10	0	0	**3**
TOTALS	184	199	114	286	32	111	**266**

EFL as detailed in Chart 4 on page 8 will be converted to a waiver service.

Action Step 4: Develop state-operated residential options as waiver services and cooperative programs with private providers.

Responsible: Developmental Center Administrators

Timeline: Individual by center as displayed in their individual 5-year plans.

Measure: Actual populations of community residential options programs operated by developmental centers as reported in their annual updates to the five-year plan.

As the residential populations of the center campuses decline, it will be necessary to reduce the personnel working on the campuses. Centers have projected the numbers of staff that will be needed in each of the five years of the plan in the next chart. The difference in staff numbers represents the number of staff that will be available for redeployment to community supports and services.

Objective 1, Chart 5:
STAFF REDUCTION AND REDEPLOYMENT GOALS: CENTERS 16 AND OVER CAPACITY

Developmental Centers	Pop. At the DCs June 2007 (Projected)	Staff at DCs June 2007	Pop. Goal for June 2012	Staff at DC campuses June 2012	Reduction in staff at campuses 2007 to 2012
Metropolitan	0	0	0	0	0
Peltier-Lawless	40	97	0	0	97
Hammond	291	853	191	520	333
Ruston	68	204	0	0	204
Northwest	167	388	117	314	74
Southwest	83	190	62	184	6
Pinecrest	516	1622	400	1223	399
Leesville	0	0	0	0	0
Columbia	0	0	0	0	0
TOTALS	1165	3354	770	2241	1113

As Metropolitan, Leesville, and Columbia maintain enrollment at the 15 or fewer level, and as Ruston and Peltier-Lawless downsize to the 15 or fewer level, staff reduction, redeployment, and maintenance remains a focus.

Objective 1, Chart 6:
STAFF REDUCTION AND REDEPLOYMENT GOALS: CENTERS 15 AND UNDER CAPACITY

Developmental Centers	Pop. At the DCs June 2007 (Projected)	Staff at DCs June 2007	Pop. Goal for June 2012	Staff at DC campuses June 2012	Reduction in staff at campuses 2007 to 2012
Metropolitan	0	0	0	0	0
Peltier-Lawless	40	97	15	51	46
Ruston	68	204	13	40	164
Leesville	15	38	15	38	0
Columbia	15	33	15	33	0
TOTALS	138	372	58	162	210

Action Step 5: Reduce staff related to center residential populations as the numbers of residents decline and redeploy to community supports and services.

Responsible: Developmental Center Administrators

Timeline: Annual reduction in staff per individual plans.

Measure: Number of staff at the centers in relation to residents in each year of the plan as reported in the annual plan update.

Action Step 6: Develop and implement strategies including monitoring activities that produce numbers identified in this plan and assure transition support activities to include but not limited to:

a. Provide training to Developmental Center Interdisciplinary Teams that continue to increase their capacity to meet transition expectations.
b. Educating staff, people served, families, etc.
c. Integration of related activities into day program/activities
d. Further shaping of Transition Support Officer (TSO) in conceptualizing the transformation plan as related to transition and leadership role in developing and executing the same.

Responsible: OCDD Direct Services Program Manager 4

Timeline: July 2007 and on-going

Measure: Number of people that transition into the community.

Objective 2: Move job/day services from main facilities to community settings so that people living at centers or in center-run community-based programs can **work in the community.**

At the present time most jobs and day programs for people at the centers or in residences supported by the centers are still located at the centers. While such location does provide some continuity of services and some familiar locations, it does not take full advantage of the opportunity to connect people to their communities through their jobs and activities.

Some centers have begun to relocate their work activities or job supports into communities. This objective is to broaden this effort so that more people can connect to communities, even if they remain in residence in a center.

An immediate obstacle will be the location of appropriate job and program sites. It will be important to emphasize location of real jobs which do not require site rental, sharing of sites with business and industry at no or low cost.

Action Step 1: All centers will have a diversification goal to relocate at least 20% (over five years) of their work and day activities to community settings.

Responsible: Developmental Center Administrators

Timeline: Approximately 4% of work/day activities per year.

Measure: Percentage of people who reside in a center or in a residence supported by a center enrolled in work or job activities in community settings as evidenced on an annual report.

Objective 3: **Establish developmental centers as "Supports and Services Centers"** which supply resources and supports individually determined to surrounding regions. Examples of resources and supports may include, state-operated community services (day and residential), psychiatric and behavioral supports, medical and dental supports, etc.

OCDD and each Services Center will identify appropriate community supports to be offered in their area. This will be dependant on area need and available resources to meet identified needs.

During the last five years, OCDD has established five Resource Centers as depicted in the following chart.

Objective 3, Chart 1: Resource Centers Established 2003-2007	
Location	**Resource Type**
Metropolitan	Dental & Medical
Hammond	Psychiatric/Behavioral
Pinecrest	Nursing/Physical & Nutritional Support
Northwest	Aging with Developmental Disabilities
Region V Lake Charles	Community Inclusion

Stakeholder feedback indicates that these Resource Centers have proven useful, particularly in the areas of dental/medical and behavioral/psychiatric. This objective builds on the experience of the existing Resource Centers to enhance the ability of centers to provide more service in challenging areas.

Action Step 1: Add adjunct psychologists to Community Support Teams to provide community based supports for people who may not need the entire CST, but do need intensive psychological supports.

Responsible: OCDD Clinical Director

Timeline: September 2009

Measure: Number of psychologists added.

Action Step 2: Ruston will establish a treatment option for youth who are sexual offenders in partnership with a private agency.

Responsible: Administrator of Ruston

Timeline: June 2012

Measure: Data on participants benefiting from the treatment option.

Action Step 3: Complete an initiative at Hammond and Pinecrest to offer Psychiatric and Behavioral supports/ consultations and crisis stabilization units.

Responsible: Administrators of Hammond and Pinecrest

Timeline: January 2008

Measure: Number of people benefiting from the services.

As developmental centers establish their areas of expertise and continue transitioning people to community settings, the developmental centers will be developing their influence and importance to the strength of the community service system. Some developmental centers have already reached the point where their campus populations are at 15 or below in size, while their state-operated community options serve more people and they provide supports to still more people in privately operated community settings.

At some point it will be useful to **change the terminology to reflect the new and increasingly evident role of developmental centers** as centers that also provide expertise and support to people with developmental disabilities in Louisiana's communities.

Proposed name changes are:

Metropolitan DC – Greater New Orleans Supports and Services Center
Hammond DC – North Lake Supports and Services Center
Peltier Lawless DC – Bayou Region Supports and Services Center
Southwest DC – Acadiana Supports and Services Center
Pinecrest DC – Pinecrest Supports and Services Center
Northwest DC – Northwest Supports and Services Center
Ruston DC – Northeast Supports and Services Center
Leesville DC – Leesville Residential and Employment Services
Columbia DC – Columbia Community Residential and Employment Services
Eunice – Acadiana Employment Services at Eunice
Opelousas – Acadiana Employment Services at Opelousas

Action Step 4: Southwest Developmental Center will design and implement a life span project for its aging population.

Responsible: Southwest Developmental Center Administrator

Timeline: January 2008

Measure: Number of people benefiting from the services.

Action Step 5: Southwest Developmental Center will establish a partnership with Family & Friends Club and other entities that will develop an institute (public/private) for fund raising purposes that support Southwest Developmental Center programs.

Responsible: Southwest Developmental Center Administrator

Timeline: July 2008

Measure: The establishment of a revenue generating institute.

Action Step 6: Adopt new names for developmental centers to reflect their emerging roles as centers of expertise and support.

Responsible: Developmental Center Administrators in collaboration with the OCDD Direct Services Program Manager 4.

Timeline: By July 2008

Measure: Official adoption of new names.

Action Step 7: Apply the new name to developmental centers and educate stakeholders about the reasons for doing so.

Responsible: Developmental Center Administrators

Timeline: July 2008 to July 2010

Measure: New terminology is reflected in written materials, website and other places where the roles of the centers are described.

Action Step 8: Central Office will work with center administrators to enhance the new image by creating opportunities to showcase the new diversity of the centers and their value to communities.

Responsible: OCDD Direct Services Program Manager 4

Timeline: July 2008 to July 2012

Measure: Publications, programs and newspaper articles highlighting the changes in the centers.

Objective 4: Explore and develop **alternate use of property** for developmental center campuses.

As campuses downsize, consolidation of operations should occur in order to maximize operating efficiency. This may free up properties for alternate use (preferably revenue-generating or capacity building). Centers should incorporate planning for both consolidation and alternative uses of unused property in their diversification/conversion strategies.

Action Step 1: Establish a consolidation/alternate use plan for Developmental Centers consistent with the campus downsizing schedule in collaboration with stakeholders and communities.

Responsible: OCDD Direct Services Program Manager 4 in conjunction with Center Administrators

Timeline: July 2007 and on-going.

Measure: Written plans in place.

Action Step 2: Determine alternate use of existing available property on the campuses at the Leesville and Columbia sites in collaboration with stakeholders and communities.

Responsible: OCDD Direct Services Program Manager 4 in conjunction with Leesville and Columbia Administrators

Timeline: December 2007

Measure: Available property in use.

Objective 5: Develop a **revenue option** for state-supplied community supports.

Developmental Centers are now supplying an increasing amount of support to people in community-based programs. They are doing this largely with staff that are diverted to community-based activities. As the DCs succeed in transitioning people to community settings, they need to find new ways to capture reimbursement for the services they supply to communities.

Action Step 1: Create a protocol for splitting community-related costs from ICF/DD costs at developmental centers.

Responsible: OCDD Task Force coordinated by OCDD Program Manager 4

Timeline: July 2008

Measure: Adoption of the protocol.

Action Step 2: Implement a program that will use federal dollars to ease the transition away from reliance on ICF/DD services and provider fees. (Use the MFP demonstration program if awarded.)

Responsible: OCDD Assistant Secretary

Timeline: By 2011

Measure: Reduced populations at the developmental center campuses.

Objective 6: Complete or make systems improvements related to **transition and diversion of admissions**

Further reductions in the size of campuses depend in part upon the ability of the OCDD system to manage admissions to those facilities. There are two tools available to help keep admissions in check.

One is the use of the single point-of-entry procedures. It is critical that all admission requests proceed through a single point, using a single approved process for requesting service. This allows for investigation of the need for service and development of a plan to access what is needed

The second tool is community waivers. As the waiver program develops better waiver program categories with broader rules that allow for people with a variety of conditions to access community services, pressure to admit to developmental centers will be reduced.

Action Step 1: Manage the single point of entry procedures to assure that every available alternative to admission to a developmental center is explored.

Responsible: OCDD Direct Services Program Manager 4

Timeline: July 2009

Measure: Reduction in admissions to developmental centers.

Action Step 2: Implement the Residential Options Waiver and the refinements to the New Opportunities Waiver to permit maximum use to avoid developmental center admission.

Responsible: Waiver Director

Timeline: July 2007 and ongoing

Measure:
1. Number of people enrolled in the waiver.
2. Number of people who are admitted to centers.

Action Step 3: Make modifications to systems to support quality management across service settings.

Responsible: OCDD Director of Quality Management and Direct Services Program Manager 4

Timeline: By July 2008

Measure: Data from quality management showing problems identified and addressed.

Action Step 4: Clarify the role of support coordinators and continue to build their capacity to meet increased expectations.

Responsible: Direct Services Program Manager 4

Timeline: July 2007 and ongoing

Measure: Updated policies and procedures for support coordinators.

Action Step 5: Complete amendments to the Transition Manual to make it easier to follow and more effective in tracking transition issues.

Responsible: Direct Services Program Manager 4

Timeline: December 2007

Measure: Adoption of new Transition Manual.

APPENDICES

A List of Reports Developed in Preparation for the Plan

B List of Documents Reviewed in Preparation for the Plan

APPENDIX A

LIST OF REPORTS DEVELOPED IN PREPARATION FOR THIS PLAN

"Stakeholder Input Into Plan for the Developmental Centers," prepared by Toni Richardson, December 22, 2006.

"Input of Administrators and Staff on Plans for the Developmental Centers," prepared by Toni Richardson, December 22, 2006.

"Report on the Progress in Fulfilling the Objectives in *Financial and Programmatic Implications of Downsizing Large Public Residential Services: A Plan for Louisiana*," dated January 16, 2007.

APPENDIX B

LIST OF DOCUMENTS REVIEWED IN PREPARATION FOR THE PLAN

Title of Document	Source
Admission Summary Data thru FY 05-06	OCDD paper
Census Report Oct 31, 2006	OCDD
Cost Control Recommendations for the New Opportunities Waiver	DHH as attachment A to above
Developmental Centers' Five Year Plan for Diversification and Downsizing July 1, 2007 to June 30, 2012 (One for each DC)	OCDD
Discharge Data Summary thru FY 06	OCDD paper
Emergency / Priority Referrals adopted 5/19/03	OCDD
House Concurrent Resolution No. 87 Workgroup Report New Opportunities Waiver	DHH
ICAP Shadow Rate Table	OCDD
Implementing a Needs Based Assessment, Eligibility Determination and Individual Budgeting System for Persons with Developmental Disabilities in Louisiana	DHH as attachment B to above
Louisiana's Application form Money Follows the Person Rebalancing Demonstration: Oct 06 on website	OCDD
Louisiana Long Term Care System: Supports and Services for People with Developmental Disabilities	DHH website
The Louisiana Medicaid Annual Report 2004/05	DHH
Louisiana Money Follows the Person Rebalancing Demonstration Application Proposal Sept 27 06	Website DHH
Louisiana Plan for Downsizing Large Public ICF-MRs dated 10-7-06	OCDD
Louisiana Plan for Downsizing Large Public ICF-MRs (2002-2007) Plan Data 10/07/06	
Moving to the Community: the Economics of Change by Charles Mosely, NASDDDS Sept 2004	DHH website under governor's Health Care Reform
OCDD's Proposal for the Reconfiguration of MDC (Executive Summary) and other data related to the moves from MDC	OCDD
OCDD Developmental Centers' Five Year Plan for Diversification and Downsizing July 1, 2007 to June 30, 2012	OCDD
Office for Citizens with Developmental Disabilities (OCDD) Report to the Developmental Disabilities Council: June 28, 2006	OCDD website

Office for Citizens with Developmental Disabilities (OCDD) Report to the Developmental Disabilities Council: September 27, 2006	OCDD website
Prioritization of Need for Emergency Waiver Supports adopted 10/18/04	OCDD
"The State of the States in Developmental Disabilities 2005," by David Braddock et al; Department of Psychiatry and Coleman Institute for Cognitive Disabilities, The University of Colorado: 2005	AAIDD
System Transformation Grant Application	OCDD
Transfer from Public to Private Support Coordination: Tasks, Responsibilities and Timelines by Transition Committee, Sept. 2006	OCDD
Transition Services Manual: March 14, 2002	OCDD
Visits with Developmental Centers: Quality Enhancement : June to August 2006	OCDD