LIDDA Local Plan

FY 22-23

Texoma Purpose, Vision and Values

PURPOSE:

Strengthening Resiliency and Supporting Recovery

VISION:

Promote and enhance access to intellectual, developmental, and behavioral health services that improve the lives of those in our community

To achieve this vision, the center is committed to:

- Engaging Individual Recovery Planning, Service Coordination, & Service Monitoring Activities That Demonstrate Regard for Choice While Improving Levels of Functioning
- Promoting a Network of Providers That Demonstrates Good Cost Management While
- Providing Effective Service Outcomes
- Providing Community Education That Focuses on Eliminating Stigma & Promoting the Capabilities of Persons with Mental & Developmental Disorders
- Promoting Satisfying Lifestyles for Persons Served
- Promoting Wellness
- Promoting Awareness of the Disabling Effects of Mental & Developmental Disorders
- Assuring That Services Are Delivered in Environments That are Trauma Informed and Appreciate Ethnic & Personal Diversity

VALUES:

We pledge to deliver quality services through partnerships with individuals, families, and community stakeholders.

Texoma Community Center strives to develop and equip all staff with Trauma-Informed Care knowledge and competency-based skills. Trauma-Informed Care means treating the person, considering past trauma and the resulting coping mechanisms when attempting to understand behaviors. Our goal is to provide effective treatment as well as improving the quality and impact of care.

The Purpose, Vision and Value Statements are written with input from all levels of the organization. Training on the Purpose, Vision and Values begins with new employee orientation and permeates throughout the organization on a continuous basis. Upon the direction of the BOT, the Purpose, Vision, and Values are reviewed with input from employees, individuals served, families and other stakeholders.

Demographic Profile and Organizational Overview

❖ Service Area

Texoma Community Center serves Cooke, Fannin, and Grayson counties. Our service area covers 2,698 miles, and the population in the tri-county area is 218,149 (2021).

Texoma Community Center is a Certified Community Behavioral Health Clinic.

❖ Governed by a Board of Trustees

NAME	POSITION	REPRESENTING
Sheriff Mark Johnson	Chair	City of Bonham
Sheriff Ray Sappington	Vice Chair	Cooke County
Billy Hamilton	Treasurer	City of Sherman
Lander Bethel	Secretary	City of Sherman
Open Seat	Trustee	City of Denison
Margie Morris	Trustee	City of Sherman
Chief Deputy Tony Bennie	Trustee	Grayson County
Paul Chandler	Trustee	City of Bonham
Captain Tom Reynolds	Trustee	City of Gainesville

❖ Employees

Texoma Community Center (TCC) employs 205 full-time employees.

❖ Local Intellectual and Developmental Disability Authority

TCC is the Local Intellectual and Developmental Disabilities Authority (LIDDA) for Cooke, Grayson, and Fannin Counties. TCC serves as the point of entry for publicly funded

intellectual and developmental disability (IDD) programs, whether the program is provided by a public or private entity. The LIDDA will provide or contract to provide an array of services and supports for persons with intellectual and developmental disabilities.

Populations Served

Intellectual and Developmental Disabilities, eligibility definition:

The priority population for intellectual and developmental disabilities (IDD) services includes those persons who request and need services and possess one or more of the following conditions:

- Intellectual Disability, as defined by §591.003, Title 7, Health and Safety Code;
- the IQ requirement has been lowered from 70 or below to 69 or below as of April 1, 2016. Individuals found eligible with an IQ of 70 prior to April 1, 2016, remain eligible despite the change.

- Autism Spectrum Disorder as defined in the Diagnostic and Statistical Manual (DSM-V), which encompasses all previous sub-types (autistic disorder, Asperger's Disorder) of the DSM IV-TR category "pervasive developmental disorder (PDD).

- Children eligible for Early Childhood Intervention Services (ECI) regardless of IQ.

- Nursing facility residents who are eligible for specialized services for Intellectual and Developmental Disabilities or a related condition pursuant to Section 1919(e)(7) of the Social Security act

- individuals with intellectual disabilities or a related condition as listed at:https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/icd10-codes.pdf

The Determination of Intellectual and Developmental Disabilities, pervasive developmental disorders, and related conditions must be made through the use of assessments and evaluations performed by qualified professionals. A member of the priority population for Intellectual and Developmental Disabilities services may not be eligible to receive all Intellectual and Developmental Disabilities services funded by the department. (For example, a person with related conditions may not be programmatically eligible for certain services or a person with Intellectual and Developmental Disabilities may not be eligible for a service because it is not appropriate for the individual's level of need.) Admission to Intellectual and Developmental Disabilities service is based on an individual's need and eligibility for a particular service, in accordance with rules and policy of the department.

Persons who are members of the priority population are eligible to receive services from the HHS system. Since resources are insufficient to meet all the service needs of all the members of the priority population, services should be provided to meet the

most intense needs first. Intense needs are conceptualized to have the following consequences:

- Danger or risk of losing support systems, especially living setting or supports needed to maintain self
- At risk of abuse or neglect
- Basic health and safety needs not being met through current supports
- At risk for functional loss without intervention or preventive /maintenance services; or
- Demonstration of repeated criminal behavior

IDD Services and Supports

Texoma Community Center (TCC) serves individuals with IDD beginning with Eligibility Determination at Intake, Service Coordination for the development of Individual Person Directed Plans, and a variety of community services intended to promote independence. TCC also has responsibilities in Continuity of Services, including implementing the Community Living Options Information Process (CLOIP) for certain individuals, Permanency Planning for children in residential facilities, Home and Community Based Services (HCS) and Texas Home Living (TxHmL) interest list maintenance, enrollment into Intermediate Care Facilities (ICF), and the TxHmL and HCS programs. The Center provider functions include TxHmL, HCS, ICF, and PASRR programs. All provider programs include the full array of high-quality services typical to the programs as noted below.

Throughout the tri-county region, the HCS program contracts with numerous individuals to provide host homes (foster care) for individuals interested in that service. The day habilitation program serves individuals across all programs.

Following is a summary of IDD services we currently provide:

1. **Screening and referral:** the process of gathering information through structured interview, and by reviewing medical and school records to determine potential eligibility for IDD services. Most individuals for whom information is gathered move toward eligibility determination. For those who clearly will not be eligible for services, referrals to the most appropriate service resource are made. During the screening process, the individual's initial service preferences are documented and placement on the interest lists for HCS and TxHmL is discussed.

2. **Eligibility Determination:** the required interview and assessment or an endorsement conducted in accordance with Texas Health and Safety Code, §593.005, and 40 TAC Chapter 5, Subchapter D, and in conjunction with HHSC Eligibility Determination Best Practices Guidelines to determine if an individual has an intellectual disability or is a member of the IDD priority population.

3. **Service Coordination:** the assistance in accessing medical, social, educational, and other appropriate services and supports that will help an individual achieve a quality of life and community participation acceptable to the individual as described in the Plan of Services and Supports*. Service

Coordination is provided to people in the General Revenue, HCS, TxHmL, and Community First Choice (CFC) programs. Service coordination functions are:

- **Assessment -** to identify an individual's needs and the services and supports that address those needs as they relate to the nature of the individual's presenting problem and disability.
- **Service planning and coordination-** activities to identify, arrange, advocate, collaborate with other agencies, and link for the delivery of outcome-focused services and supports that address the individual's needs and desires.
- **Monitoring-** activities to ensure that the individual receives needed services, evaluates the effectiveness and adequacy of services, and determines if identified outcomes are meeting the person's needs and desires; and
- **Crisis prevention and management-** activities that link and assist the individual to secure services and supports that will prevent or manage a crisis

*The plan of services and supports is based on a person-directed discovery process that is consistent with HHSC's *Person and Family Directed Services Planning Guidelines* and describes the individual's:

- Desired outcomes
- Services and supports including service coordination services to be provided to the individual to meet the desired outcomes.

4. **Habilitation Coordination:** performed for individuals with IDD who reside in Nursing Facilities and includes the basic requirements in Title 26. HHS, Part 1. HHSC, Chapter 303. Additional responsibilities for Habilitation Coordination are included in the PASRR IDD Handbook. Habilitation Coordination is meant to:

- Occur as a service at least monthly.
- Assure that all needs within the nursing facility are met.
- Assure that barriers to community placement are addressed in a way that will eventually allow the individual to be transitioned from Nursing Facility (NF) placement to community living.

5. **Continuity of Services:** activities performed in accordance with:

- 40 TAC Chapter 2, Subchapter F, for an individual residing in a SSLC whose movement to the community is being planned or for an individual who formerly resided in a state facility and is on community-placement status, or;
- Article II. B. 6 of the current HHSC Contract for an individual enrolled in the ICF/ID program to maintain the individual's placement or to develop another placement for the individual.
- HHSC-LIDDA Performance Contract, which requires the completion of PASRR Level II evaluations and the implementation of Habilitation Coordination to residents of Nursing Facilities.

6. **IDD Community Services in the General Revenue Program are defined in the IDD Performance Contract** and are services provided to assist an individual to participate in age-appropriate, community-integrated activities and services. The type, frequency, and duration of support services are specified in the individual's Person-Directed Plan and the Implementation Plans specific to the services provided. The Local IDD Authority (LIDDA) ensures that an array of support services is available in the local service area. Some IDD Community Services are mandated by the contract with HHSC; others are optional based on the ability to provide the service. The services that ***may be available*** include:

   a. **PAS/HAB (previously labelled as Community Support)** – optional and provided**.** This category includes individualized activities that are consistent with the individual's person-directed plan and provided in the individual's home and at community locations, (e.g., libraries and stores). Supports include:
      - Habilitation and support activities that foster improvement of or facilitate an individual's ability to perform functional living skills and other daily living activities. For example, teaching someone to cook meals, to wash clothes, to do basic housework, or to do comparison shopping at a grocery store because someone needs these skills as they work on a goal to move into an apartment.
      - Activities for the individual's family that help preserve the family unit and prevent or limit out-of-home placement of the individual. For example, providing transportation to an individual so that he/she can get to medical and psychiatric appointments, or providing supervision for an individual in the home so that the family can attend a sibling's school functions.

      - Transportation for an individual between home and the individual's community employment site or day habilitation site. Without this transportation, the person would not have a way to get to work or to Day Habilitation; and
        - Transportation to facilitate the individual's search for employment opportunities or to participate in community activities. For example, providing transportation to pick up applications at an employment site or to attend a concert in the community.

b. **Respite –** required and provided. Respite is the planned or emergency short-term relief to an unpaid caregiver when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances. Respite can be in-home -- provided at the home of the individual, or out of home – provided at a Center owned facility. To better accommodate a family's needs, we encourage them to find family or friends willing to provide in-home respite for them.

c. **Employment Assistance –** optional and provided. This is assisting an individual in locating paid, competitive employment in the community. Employment Assistance includes helping the individual identify what they want to do, what their job skills are in relation to what they want to do, what special work requirements and conditions might need to be in place so they can work and finding the right employer to meet the individual's preferences, skills and work requirements and conditions.

d. **Supported Employment –** optional and provided. This is a service provided to an individual who currently has paid individualized, competitive employment in the community and helps the individual maintain that employment. Direct support can be provided to the individual to improve job skills; support can also be given to the individual's supervisor or manager to help the manager best train the individual for their job.

e. **Behavioral Supports** – optional and provided. Behavior Supports are specialized interventions by a Psychologist or Board Certified Behavior Analyst (BCBA) to assist an individual to increase adaptive behaviors and to replace or change disruptive behaviors that prevent or interfere with the individual's inclusion in home, family, school or community life. The Psychologist or BCBA analyzes the causes of the unwanted behavior and develops a behavior support plan specific to the individual. Interventions are primarily pro-active, and include family, teacher and/or care-taker training in the principles of behavior support and the techniques to be applied in the specific plan for the individual.

f. **Nursing** – optional and provided on a limited basis. This service includes assessment, treatment, and monitoring of health conditions or care procedures prescribed by a physician or medical practitioner or required by standards of professional practice or state law to be performed by licensed nursing personnel.

g. **Specialized Therapies** – optional. These include assessments and treatments by licensed or certified professionals for social work services, counseling services, occupational therapy, physical therapy, speech and language therapies, audiology services, dietary services, and behavioral health services other than those provided by a local mental health authority pursuant to its contract with HHSC; and training and consulting with family members or other providers.

h. **Day Habilitation** – optional and provided. This service includes activities that have the outcome of helping individuals to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully in the community, and to participate in home and community life more actively. Individualized activities are consistent with achieving the outcomes identified in the individual's person-directed plan and activities are designed to reinforce therapeutic outcomes targeted by other service components, school, or other support providers. Day habilitation is normally furnished in a group setting other than the individual's residence for up to six (6) hours a day, five days per week on a regularly scheduled basis.

7. Crisis Intervention Services

Crisis Intervention Services (CIS), including IDD Crisis Respite, are mandated and funded through the HHSC Performance Contract. These services are intended to be used in a way that allows people with challenging behaviors the support they need to avoid

interactions with law enforcement and subsequent admission to emergency rooms or inpatient mental health treatment facilities.

a. Crisis Behavior Support: A Crisis Intervention Specialist (CIS) works with Service Coordinators and Waiver service providers in the community to identify people with IDD who are most likely prone to require crisis services. Many of these individuals have a difficult time finding someone in the community to fulfill the need for behavior support, and the CIS will step in to offer services. The CIS will assess behaviors, write behavior support plans, do individual skills training related to the plans, and train provider staff and families, methods to avoid or address significant behavioral issues. The CIS is supported by a Licensed Professional Counselor and a full-time crisis team.

b. Crisis Respite: Part of CIS services is IDD Crisis Respite (CR). TCC has a crisis respite facility where space for two individuals receiving IDD Services is reserved. In crisis respite, the intent being that the individuals may need a short period of time to deescalate before returning to their home; this is a valuable diversion from lengthy ER stays or even psychiatric inpatient admission. Individuals can be in CR for up to 14 days, during which time they will be expected to participate in skills training sessions that have as a goal, learning strategies to deal with stress or frustrations. The CIS will create a transition plan for the individual/family/staff to use as a planning tool for when the individual returns home. Typically, the CIS will provide ongoing Behavior Support and skills training for the individual to avoid future need for CR.

8. Medicaid Waiver Programs

Medicaid Waiver programs are home and community-based programs providing services and supports to persons with IDD who live in their own or their family home or in other home-like settings in the community. They are called "waivers" because certain ICF/IDD requirements are "waived." In most situations an individual who is eligible for the ICF/IDD Program is also eligible to participate in one of the waiver programs. An important and distinguishing feature of funding provided in the waiver program is the ability to move that funding source with the individual to any part of the state. For example, if an individual enrolled in a waiver program in Sherman, then moves to El Paso, they can continue to participate in the waiver program in El Paso. An individual also can change providers within the same city or county. Public or private entities may provide waiver program services and supports. All waiver providers are certified by HHSC initially who then reviews each provider at least annually to ensure the provider continues to meet the program certification principles. The two waiver programs are*:*

a. **Home and Community-based Services (HCS) Program:** The HCS Program provides services to individuals with IDD who live with their family, in their own home, in a foster or companion care setting, or in a residence with no more than four individuals who also receive services. The HCS Program provides services to meet an individual's needs so that they can maintain themselves in the community and have opportunities to participate as a citizen to the maximum extent possible. Services consist of adaptive aids, minor home modifications, counseling and therapies, dental

treatment, nursing, residential assistance, respite, day habilitation, employment assistance and supported employment. In the HCS Program, individuals who are in a residential program contribute to their room and board. Service coordination is provided to the individual by the Local Authority. There is a cost-cap to the yearly cost of services provided through the HCS Program.

b. **Texas Home Living (TxHmL) Program:** The TxHmL Program provides essential services and supports so that individuals with IDD can continue to live with their families or in their own homes in the community. TxHmL services are intended to supplement instead of replacing the services and supports an individual may receive from other programs, such as the Texas Health Steps Program, or from natural supports such as his or her family, neighbors, or community organizations. Services consist of community support, nursing, adaptive aids, minor home modifications, specialized therapies, behavioral support, dental treatment, respite, day habilitation, employment assistance, and supported employment. Service coordination is provided to the individual by the Local Authority. Like HCS, TxHmL Program services are limited to an annual cost cap. The cap is lower in TxHmL because there is no residential option.

- An individual is typically on both the TxHmL Waiver Interest List (IL) and the HCS IL. If the individual accepts an offer to enroll in the TxHmL program, their name will remain on the Interest List for the HCS program.

- If an individual is offered an opportunity to enroll in either the HCS or TxHmL Program, the Center will provide information about the applicable timelines for enrollment.

- If an individual receiving services in the General Revenue program is offered either TxHmL or HCS and declines participation, the Local Authority will terminate General Revenue services in accordance with the rules governing the HCS and TxHmL programs.

- A review of the Medicaid Estate Recovery Program is provided by the Center's enrollment staff in accordance with Texas Administrative Code, Title 1, Part 15, Chapter 373 Medicaid Estate Recovery Program (MERP), to all individuals and their legally authorized representatives, who seek enrollment in a SSLC, a community ICF/ID, HCS or TxHmL

9. Other Programs

a. **PASRR Evaluations** – TCC is mandated by Title 26. HHS, Part 1. HHSC, Chapter 303, the PASRR IDD Handbook and the FY2020- 2021 HHSC Performance Contract to complete Level 2 PASRR Evaluations for individuals residing in Nursing Facilities who are identified as possibly eligible for IDD Specialized Services. The intent of this requirement is to identify those individuals with IDD in Nursing Facilities that need additional advocacy and support to assure they receive the services they need and to

possibly transition from the nursing facility to a community setting.

b. **Benefits Eligibility** – TCC provides individuals with assistance in completing applications for Medicaid, Medicare, Medicare Part D, and other third-party assistance. The initial and annual fee assessment identifies individuals who may be eligible for benefits, but who are not currently receiving benefits. Identified individuals are referred to Benefits Eligibility staff and those staff work through the entire process of application, approval, and when necessary, appeal.

c. **Permanency Planning Requirements –** The Center conducts and documents that permanency planning for persons under the age of 22 years who are enrolling in or currently residing in an ICF/IDD or HCS residential setting is completed in accordance with HHSC rule 40 TAC, Chapter 9, Subchapter D (HCS) and 40 TAC, Chapter 9, Subchapter E – ICF/IDD – Contracting.

d. **HCS and TxHmL Interest List Maintenance –** The Local Authority is responsible for managing and updating the local TxHmL and HCS Interest Lists, which connect to the state-wide HCS and TxHmL Interest Lists. The Local Authority adds people to the list and makes biennial contacts with individuals on the list to confirm their continued interest in the HCS and TxHmL Waiver programs.

e. **Community Living Options Information Process (CLOIP) –** In FY 2009, DADS added CLOIP requirements to those Centers with a State Supported Living Center (SSLC) within its local service area. The CLOIP unit has the specific responsibility for annually providing specific community living program and resource information to residents of the SSLC or their LAR, and to help facilitate provider tours and transition activities.

In addition to IDD services provided, TCC also provides the following:

10. **Integrated Healthcare Services -** Over the last 11 years the Texas Healthcare Transformation and Quality Improvement Program: Medicaid 1115 Waiver, approved by the Centers for Medicare and Medicaid Services (CMS) has funded a number of special projects within the Center, including the Integrated Healthcare Program. Through this waiver, Regional Healthcare Partnerships (RHPs) comprised of different types of healthcare providers have been formed to assess barriers and devise methods to improve access to healthcare. These partnerships utilize 1115 funds to implements these plans. The Center is in the Region 18 Healthcare Partnership with Collin County serving as the anchor. This program has allowed greater access and coordination of care for individuals served through the LIDDA. It has also improved patient care by focusing on patient needs in integrated care, scheduling appointments, and establishing follow-up protocols for maintaining stability and patient satisfaction. Overall, the integration of primary, behavioral and IDD services helps to improve and protect the health and well-being of individuals receiving IDD Services.

❖ **Values That Guide the IDD Service System**

Individuals with intellectual and developmental disabilities choose among flexible, dependable services that meet everyone's needs and support everyone's goals and dreams for a lifestyle of full inclusion, interdependence, and respect.

Families of individuals with intellectual and developmental disabilities are supported in their efforts to help family members meet their goals and dreams.

The service system supports individuals in their choices by offering support services that are:

- Valued by the individuals served.
- Responsive to their needs.
- Available and easily accessed.
- Consistent with everyone's dreams and goals.
- Used by other members of the community; and
- Respectful of cultural values and dignity.

The opinions of the people we serve are considered most important when we evaluate the quality of the services.

Individuals with intellectual and developmental disabilities make choices about how their needs are met and how their goals/dreams are supported. This means that they:

- · Are trained in skills to make choices and to understand and accept the possible results of their decisions.
- · Are given chances to use their power of choice and to experience the results of their choices; and
- · Are supported in making those choices that will govern their lives and futures.

Individuals with intellectual and developmental disabilities have the same legal and human rights as all citizens and are not deprived of their rights without due process of the law.

❖ Local Planning Process

The goal of the planning process is to aggregate the requirements of all stakeholders into a set of initiatives which guide the center's resource allocation and priorities, considering fiduciary responsibility as well as excellence of care. The resulting plan is also developed to ensure that community needs are communicated to governing bodies and area and state agencies.

The planning process solicits input from a variety of sources and is also held to standards and requirements of funding and accreditation bodies. The approach chosen by TCC involves not only consumers and their families but also referral sources, community representatives and services, advocacy groups, advisory committees, and employees. This reflects TCC's commitment to understanding the needs of all its constituents.

The initiatives of TCC are based on elements of governance, which support the Center in its obligation as a public steward. These initiatives are developed as part of the planning process and are further defined as they flow into the development of objectives and strategies. Monitoring and evaluation activities support the need for ongoing assessment of responsiveness, effectiveness, and efficacy.

Planning and Network Advisory Committee (PNAC): TCC has a planning and network advisory committee that meets quarterly and is composed of representatives of the community, consumers and their families and center's liaisons. The PNAC serves as a resource to TCC, objectively evaluating services for quality of care and best value and assuring an appropriately developed provider network and sound procurement practices. The PNAC also provides oversight and consumer empowerment, while assuring public input in these processes.

TCC Standing Committees: Several oversight committees within TCC assess the center's performance and make recommendations to the Executive Management Team on results of audits, surveillance, reporting, investigations, and surveys. The Safety, Risk Management, and Infection Control Committee, made up of staff from all service areas, center Safety Officer and Director of Quality Management, meet quarterly to monitor safety practices and incidents which have the potential to put individuals at risk. The Compliance Committee meets quarterly to review compliance, privacy, rights, and abuse prevention functions. These committees all have the potential to identify needs for improvement, reporting to Executive Management Team and identifying issues, which include input from employees, consumers, and consumer's families.