CENTRAL CARE

PROGRAM DESCRIPTION

Developmentally Disabled Community Homes

June 23, 2009

Central Care is a provider of Community Residential Alternative and Community Access services utilizing Medicaid Waiver slots, SSI fund services and/or Regional Board allocation of state funds. Central Care Community Homes provides services through the COMP waiver (Comprehensive Supports Waiver Program), which will provide home and community based services for eligible persons with mental retardation and/or developmental disabilities (MR/DD) that are in Medicaid funded institutional placement and in need of comprehensive and intensive services. This program will grow as the need increases for consumers to live successfully in the community. Some of the goals for Central Care's services are:

- Providing home and community based services for authorized eligible persons with mental retardation or developmental disabilities as an alternative to institutional care;
- Provide Community Access services for persons requiring services designed to acquire, retain, or improve self-help, socialization, and adaptive skills for active community participation and independent functioning outside the home setting. These services are designed for persons that do not desire to attend traditional "day support" facilities and are planned to meet the person's individual needs and preferences for active community participation;
- Enhancing continuity of community habilitation and support services care;
- Improving linkages to health and dental care;
- Improving accountability and efficiencies in service delivery; and
- Enhancing services monitoring and oversight.

The DMA is responsible for final approval of services, enrollment of providers, utilization review and claims payment. The Standards for Community Mental Health, Mental Retardation, and Substance Abuse Services (Standards) apply to all services included in the COMP waiver.

Central Care Community Services organizational structure is under the general supervision of Central State Hospital's Chief Executive Officer (CEO). Day to day operations is delegated to the Director of Central Care with reporting mechanisms to the CEO and the Regional Coordinator. Presently, Central Care is operating fifteen Community Living Arrangement homes and will open one Community Living Arrangement Homes in the near future with a specific focus on behavior support.

Purpose

The purpose of the initial program plan was to identify the required strategies to discharge nine (9) consumers from Developmental Disabilities Services/Central State Hospital by June 30, 2002. This plan was successfully implemented with an additional slot (for a total of ten) in August 2002. Further plans were implemented to increase Central Care's population by ten (10) more consumers. Presently Central Care is operating 15 (fifteen) CLA homes. We are serving 41 MR/DD consumers.

Target Consumer Population

The target consumer population at the Developmental Disabilities Services for this community initiative is divided into categories:

1. Consumers who are primarily from the Central Region who have been identified by their Interdisciplinary Team as candidates to move to the community, although clients from other regions will be considered if the IDT recommends them for community placement.
2. Individuals on the Olmstead List for community placement.
3. Consumers who are under the umbrella of DFCS.
4. Consumers who have no families.
5. Consumers whose families are out of state.

Staffing will be based on the needed supports of the consumers selected by the Developmental Disabilities Services Interdisciplinary Teams for placement in the Developmental Disabilities Community Services.

Selection Process:

The selection process for the transfer of consumers from the Developmental Disabilities Services/Central State Hospital to the community will be based on the following principles:

- All consumer moves will be based on the "person centered" assessment and the services/supports which addresses the consumer's individual needs, preferences, and abilities.
- To the extent possible, consumers who are selected may have a history of living together compatibly somewhere in Developmental Disabilities Services.
- Consumers will be located as close to their families as possible.

- Families will be informed of all options regarding the placement of their family member. Social workers will be responsible for working closely with families to address their concerns.

All identified consumers for community placement will be reviewed by the consumer's Interdisciplinary Team to assess the consumer's acuity, priority needs, and compatibility. The consumer's Interdisciplinary Treatment Team will complete a "person centered" assessment.

As consumers are identified, families will be encouraged to participate in the person-centered planning process and to address any concerns they have about the transfer of their family member to the community. The strategy is to identify those concerns and develop a plan to address the issues that will facilitate the transfer of the consumer to the community.

Description of Community Services

Central Care Community Services will develop residential options that will include but not be limited to three or four bedroom homes/apartments/townhouses. Central Care Community Supports will truly be integrated into the community by utilizing the established Community Access Services, Community Day Services, and Supportive Employment. Life Enrichment Center and Rivers Edge provide those services for Central Care. (See Attached Program Description). In addition to having their needs met in this home or day program, each consumer will access any and all community settings, which promotes the implementation of their "person centered" plan. The majority of these consumers will be transferred from hospital settings and will be utilizing the COMP waiver program. These consumers will live in a home environment and be provided with three meals a day with two snacks. Grocery shopping and domestic chores will be a part of their individualized service plan. Any and all recreational activities will be provided on Saturday and Sunday and will include picnics, swimming, visits to special places and other seasonal community events. There will be opportunity for church and other religious events especially on Sunday.

Program:
Each home will have staff to supervise the consumers twenty-four hours a day and seven days per week. There is a minimum of one to three/four ratio at all times. The day will consist of highly structured activities that include self-help, daily living skills, prevocational, vocational, sheltered work, and/or leisure activities. Nursing services will be available to provide, teach, and supervise self-medication.
Services will include:

1. Intensive, individualized (specialized) day programming,
2. Dietary services
3. Structured recreational/leisure services
4. Behavioral support
5. Family support
6. Sheltered work if needed

7. Integration in the community environment

The program will provide a home with staff to teach skills in communication, social, work-readiness, leisure, self-help, and daily living as determined by the consumer's individual needs. Consumer's individualized service plans will be reviewed at least annually and changes in the plan will be documented.

Staffing Schedule:
Staff will be available for twenty four hours/seven days per week. Because consumers may not be at home during the day habilitation, there will be a creative staffing schedule with the majority of staff working in the evenings and weekends. Hourly staff will provide necessary coverage for sick leave, annual leave and holidays to ensure continuity of care and cost effectiveness.

Compliance with Standards:
The homes will comply with the ***Standards for Community Mental Health, Mental Retardation and Substance Abuse Services, Policies and Procedures for Community Habilitation and Support Services Waiver Program, and JCAHO Standards for Behavior Health.***

Licensure Requirements:
The homes will be licensed as Community Living Arrangements (CLA).

Intake and Evaluation, Support Coordination:
Central Care consumers will be evaluated, ISP written and Support Coordination implemented with the Central Region for those services contracted for this region.

Clinical Record:
Each consumer will have a consumer record, which will be located in the home. Appropriate staff will write progress note, training notes, and monthly summaries that relate to the consumer's ISP.

Transportation:
Each home will have a van assigned to attend special events in the community, day programming, physician visits and to go shopping.

Enrolling in Community Medical Services:
All consumers will be enrolled in needed community medical services as identified in the transition process following guidelines of the JCAHO National Patient Safety Goal.