Center for Developmental Services

Local Provider Network Development Plan
FY2022

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I. VISION, MISSION AND GUIDING PRINCIPLES

A. Vision Statement: The purpose of the IDD Division of the Heart of Texas Region Mental Health Mental Retardation Center (HOTRMHMR or the "Center") is to provide individuals who have a diagnosis of an intellectual or developmental disability the opportunity to live meaningful and productive lives and to develop their abilities to interact with the community to the fullest extent desired. HOTRMHMR provides services to eligible individuals who live in the local service area: Bosque County, Falls County, Freestone County, Hill County, Limestone County and McLennan County.

B. Mission Statement: (The Center) strives to deliver accessible, caring and responsive support services to individuals and families coping with mental illness, intellectual disabilities, developmental delays and emotional conflict**.**

C. Guiding Principles:

- HOTRMHMR is committed to providing quality services in partnership with the individual, the family, and the community;
- HOTRMHMR strives to empower the individual and family by respecting their right to make choices about their lives;
- HOTRMHMR is actively involved with community initiatives that will improve the quality of life;
- HOTRMHMR believes that it is through commitment to the individual's personal and professional development that you build an organization that strives for excellence.

II. AGENCY OVERVIEW

A. History and Organizational Overview

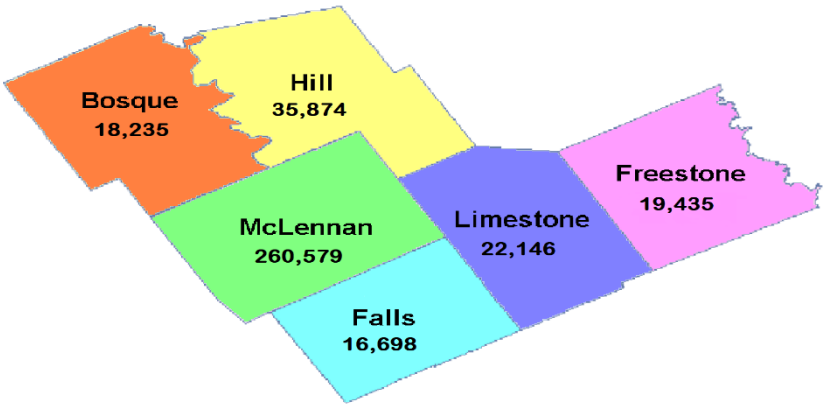
In 1965, the State of Texas passed legislation establishing the Texas Department of Mental Health and Mental Retardation (TDMHMR) and authorized the creation of a local Board of Trustees. In 1967, the original Board of Trustees for HOTRMHMR was sworn in under the sponsorship of McLennan County, the City of Waco, and the Waco Independent School District. The Board initially contracted with a team of mental health professionals at Baylor University to develop a comprehensive plan for mental health services in McLennan County. Additional funds were secured that enabled Providence Hospital to develop an Inpatient and Outpatient mental health facility. Later, the Board itself applied for staffing grants to provide the human resources necessary to implement services in McLennan County.

In 1973, under the direction of TDMHMR, the Board of Trustees initiated efforts to develop services for five remaining counties in the Heart of Texas Council of Government region. Bosque County, Hill County and Limestone County became Center sponsors as well. (Currently, the City of Waco and Waco ISD are not Center sponsors.) The Center provided services for persons with intellectual and developmental disabilities (IDD) in McLennan, Bosque and Hill Counties in accordance with the state performance contract. The state provided IDD services through the Mexia State Supported Living Center (SSLC) in Falls, Freestone and Limestone Counties until 1998 when the state transferred all of the SSLC community operations to local MHMR Centers. HOTRMHMR is currently both the mental health authority and the IDD Local Authority for all six counties in the HOT Council of

Governments region. State legislation in 2002 realigned state departments and dissolved TDMHMR. The Department of Aging and Disabilities Services was the specific agency contracting with HOTRMHMR to provide IDD services. In 2016, state legislation began the process of combining essential functions between state agencies and has folded IDD, ECI and Mental Health services under the broad Health and Human Services (HHS) umbrella. HOTRMHMR now contracts with HHSC to provide Mental Health, ECI and IDD services, although through branches that specifically serve those three programs.

The Heart of Texas Region MHMR Center has a nine-member Board of Trustees. The Trustees are appointed by Center sponsors, are representative of the community and are diverse in composition. The Board has many planning functions including policy development, oversight of fiscal planning and fiscal performance, and oversight of agency performance and compliance with the state contracts. The Board meets monthly to review and act on reports regarding finances, programming, state initiatives, state funding, contract compliance, new books of business and center-wide planning.

Six Counties
5,527 Square Miles
Population
372,967*
* 2020 Census



B. Heart of Texas Region Demographics

Most recent information from the U.S. Census Bureau

County	Bosque	Falls	Freestone	Hill	McLennan	Limestone
Population- 2020	18,235	16,698	19,435	35,874	260,579	22,146
Median Income 2015-2019	52,148	39,497	49,471	53,357	49,778	44,418
Average Persons per Household 2020	2.49	2.99	2.67	2.67	2.68	2.68
Ethnicity- 2020						
White	14,040	8,432	12,866766	25,112	144,360	12,867
Hispanic	3,446	4,008	3,129	7605	70,356	5,005
African American	401	4,041	3,071	2,404	38,566	3,876
Other	348	217	369	753	7,297	398
Poverty Levels 2019 Source: US Census SAIPE State & County Estimates for 2019						
Number of Individuals in Poverty	2513	3314	2801	4700	44574	4190
Percentage in County	13.7	21.6	15.5	13.1	18	19.2
Educational Levels 2020 (persons 25 years and older)						
High School Graduate	16163	13301	16286	30602	217873	19007
Percentage in County	86.5	76.9	82.6	83.5	84.9	81.1
College Degree, Bachelor or above	3700	2145	3017	6377	62103	3469
Percentage in County	19.8	12.4	15.3	17.4	24.2	14.8
Civilian Veterans 2020	1198	1188	1145	2662	14555	1517

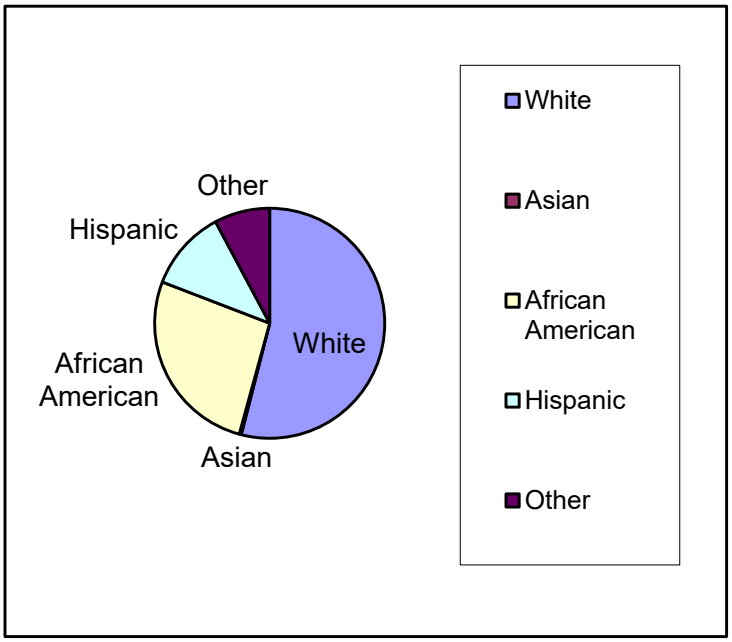
Overall, socioeconomic data for McLennan County indicates that it is a risk area. Median household income reported from the U. S. Census Bureau was $49,788, compared to the state median of $61,874. Per capita money income (for 2015-2019 in 2020 dollars) for the entire county was $25,703 compared to $31,277 statewide. Waco, the largest of 21 incorporated cities in the county, with a population of 139,236 had a per capita income of $22,461, and a median household income of $40,190, rates substantially lower than the county itself.

According to the U.S. Census Bureau 2019 ACS Survey, Waco has a poverty rate of 26.2% which is higher than that of Abilene, Beaumont, Denton, Killeen, McAllen, and Pasadena. The child poverty rate is 32.1% slightly higher than McAllen at 31.4%.

C. HOTRMHMR Center for Developmental Services Demographics

Total People Served in FY2021

	Internal # Served	External # Served (Providers)	Total Served
HCS	104	358	462
TxHmL	58	83	141
ICF	14	NA	14
General Revenue	156	NA	156
Nursing Facilities	124	NA	124
Crisis Intervention	191	NA	191
Children's Autism Program	28	NA	28



Registered Consumers Annual Income

156	$0 –$6,620	14%
624	$6,621- $11,140	56%
112	$11,141 - $15,660	10%
73	$15,661 - $20,180	6.5%
151	$20,181+	13.5%

D. 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 was 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 eligible for PASRR mandated services for individuals with intellectual disabilities or a related condition per federal guidelines.

For persons with IDD and autism, the priority population includes only those individuals whose needs for services can be most appropriately met through programs currently or potentially offered by the IDD services division of HHSC.

E. IDD Services and Supports

Intellectual and Developmental Disability Services (IDD)/Center for Developmental Services (CDS):

The CDS offices in Waco and Mexia serve individuals with IDD beginning with Eligibility Determination at Intake, Service Coordination for the development of Individual Person Directed Plans, respite as required by the performance contract and LIDDA handbook, Day Habilitation and Supported Employment. Although other services are possible under the General Revenue program – such as community support, nursing, and vocational training – the cost of employees to provide the services and the difficulty in finding staff to provide the services makes it unlikely the services will be provided, except to those individuals who have been in GR services for many years. CDS also has responsibilities in Continuity of Services, including implementing the Community Living Options Information Process (CLOIP) for residents of the Mexia State Supported Living Center (SSLC) and residents of Nursing Facilities who have an IDD, 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, and Diversion from SSLC or NF placement. The Center provider programs include TxHmL, HCS, ICF, and PASRR. All provider programs include the array of quality services typical to the programs as noted below.

Throughout the six-county region, the HCS program contracts with numerous individuals to provide host homes for individuals interested in that service and operates five group homes for

20 individuals wanting a higher level of care and supervision. In the ICF/ID program, the Center operates two homes in Waco serving fourteen individuals. The day habilitation program serves individuals across all programs with locations in Waco and Marlin (Falls County), and contracts with Private Providers to provide Day Habilitation to individuals in their programs. Day Habilitation offers a wide variety of activities including volunteer opportunities, such as Meals and Wheels, a large container garden project created in conjunction with Alcoa and the Waco Master Gardeners, a library and computer room, and numerous individualized and group activities designed to further educational, social, community and/or adaptive skills, and to accommodate individual needs for community integration.

Following is a summary of IDD services we currently provide:

1. **Screening and referral** is the process of gathering information through structured interview, and by reviewing medical and school records to determine potential eligibility for IDD services. The majority of 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** is 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** is 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-** are 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 the 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** is performed for individuals with IDD who reside in Nursing Facilities and includes the basic requirements in the Code of Federal Regulations, Title 42, Part 483, Subpart C, 26 Texas Administrative Code (TAC), Chapter 303, for LIDDAs, LMHAs and LBHAs; and 40 TAC, Chapter 19, Subchapter BB, for NFs . Additional responsibilities for Habilitation Coordination are included in the PASRR Habilitation Coordination Handbook. Habilitation Coordination is meant to:

  - Occur as a face-to-face 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 NF placement to community living.

5. Continuity of Services are activities intended to reduce the interruption of services as an individual transitions from one program to another. These processes are evident when consumers are enrolled into waiver or ICF programs from their home environment, when people are diverted from nursing facility or SSLC placement to remain in a community placement with additional supports, and when people are transitioned from a State Hospital to IDD crisis respite and ultimately back home. Continuity of Services can take on many different forms but is always intended to get a consumer into the level of care they require, and to get them the services they need in the least restrictive setting.

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. This services that ***may be available*** include:

a. **PAS/HAB (previously labelled as Community Support)** – optional and provided only on a limited basis**.** 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 or home;
- 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 activity;
- 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 on a limited basis. 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 on a limited basis. 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 under IDD crisis services. 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 only 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**

Psychiatric services including medication administration and monitoring is provided for GR consumers by accessing telehealth services contracted with the Behavioral Health Division.

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 actively participate in home and community life. 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. Children's Autism Program

The Children's Autism Program (CAP) is operated under a grant from HHSC to serve children from age 3 to 15 with a diagnosis of Autism. The program is currently small, and has a Program Supervisor, a BCBA, Registered Behavior Technicians, and access to a Speech Therapist and a Licensed Professional Counselor. The program offers focused autism services in both clinic and family home settings. There is a wait list to access autism services, but the plan in growing the program is to increase clinic space, add capacity by adding staff, pursuing billing through private insurance, and taking advantage of upcoming approval to bill Medicaid for Behavior Support services to children and adolescents with Autism.

8. Crisis Intervention and Behavior Support Services

Crisis Intervention Services, 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 Board Certified Behavior Analyst is the Crisis Intervention Specialist and 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 in methods to avoid or address significant behavioral issues. The CIS is supported by two Registered Behavior Technicians.

b. Crisis Respite: Part of CIS services is IDD Crisis Respite. Heart of Texas has a small home that can serve two individuals at a time 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 admissions. 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 a goal of teaching 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 and RBT will provide ongoing Behavior Support and skills training for the individual to avoid future need for CR. The primary entity receiving services from the CIS and RBT are individuals who live in residential settings with private providers of HCS in the region.

9. 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 Waco, 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 because there is no residential option in TxHmL.

- An individual is typically on both the TxHmL Waiver 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

10. Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD)

The ICF/IDD program is a residential program providing habilitation, medical, skills training, and adjunctive therapies such as dietary, speech, occupational or physical therapy, audiology, and behavioral health services. Group homes provide a home environment for individuals who are in need of a more structured environment to live in the community. Individuals receive training and assistance as needed in performing basic self-help and home management skills. Residents are also involved in activities outside of the home such as day habilitation, vocational services, supported employment, and community activities. Each home provides twenty-four hour awake supervision.

To qualify an individual must:

- Have a determination of an intellectual or developments disability or documentation from a physician of a related condition;
- Meet specified level of care criteria;
- Be in need of and able to benefit from the active treatment provided in a 24-hour, supervised ICF/ID setting.

11. Other Programs

a. **PASRR Evaluations** – The Center for Developmental Services is mandated by Title 26. HHS, Part 1. HHSC, Chapter 303, the PASRR IDD Handbook and the FY2022-2023 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** – HOTRMHMR 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 the Benefits Eligibility unit and 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 is 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 (now HHSC) 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.

f. Gifts in Kindness is an independent program in which individuals and families in need can receive everyday paper goods and supplies for free, based on availability. The local Caritas program receives returned items or repackaged damaged items from a major retailer's reclamation center. They offer the opportunity for Social Service agencies to participate in a program where most household items they receive can be purchased at a per-pound rate. CDS is privileged to participate in this program. Our well-stocked GIK store allows CDS staff to complete "purchase requests" on a regular basis for people in services who cannot afford basic needs, such as toilet paper, paper towels, tooth brushes, laundry supplies, hygiene products, cleaning items, etc. In the past year, the Gifts in Kindness program distributed over $212,000 of items to individuals and families receiving services through CDS and to group homes operated by CDS.

III. LOCAL PLANNING PROCESS

A. Local Planning

The Heart of Texas Region MHMR Center has consistently and successfully implemented planning processes since its inception in 1968. Both informal and formal planning takes place on a continuing basis at all levels of the organization through staff meetings, management meetings, case reviews, staff supervision, workgroups, the Planning Network and Advisory Committee (PNAC), and the Board of Trustees.

Formal planning is active year-around. The Center's performance, community needs, anticipated changes in state contracts, data analysis, budget analysis, and input from stakeholders are considered in the ongoing planning process that develops the current strategic plan and the Center's specific work groups derived from the strategic plan.

Most ongoing planning takes place through workgroups and committees which address specific issues in the Center's strategic plan, or needs that have been identified through data, surveys, interviews, advisory committees, community involvement, client rights, departmental directives and budgetary issues.

HOTRMHMR values the meaningful participation of individuals, family members, community stakeholders, and current and past employees into the development and improvement of Center programs. Input is gathered in a variety of ways including meeting with stakeholders in regular group meetings with individuals in service and their families, distribution of satisfaction surveys, informal individual interviews, community collaborative committees, provider network meetings, etc., and feedback received from other community organizations, such as the HHSC Regional Services, the Heart of Texas Council of Governments/Area Agency on Aging, and the Region 12 Education Service Center in conjunction with individual school districts.

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 Children's Autism 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 16 Healthcare Partnership with Coryell Community Hospital serving as the anchor.

The Poverty Solutions Steering Committee, now called Prosper Waco, is a group of citizens and social service agencies and non-profits that banded together to study and devise solutions to the high level of poverty in Waco. Membership includes city leaders, religious leaders, educators, and business leaders. The Baylor University School of Social Work, Masters of Social Work Advanced Community Practice Concentration class compiled extensive information regarding best practices from other cities, current research, and the work currently being done locally to combat poverty. The committee initially used this information to identify community needs and goals, identifying three broad needs: building economic strength, aligning support to promote self-sufficiency, and fortifying health and

education for children. The committee has continued to move forward in its work and now has full time staff, including a staff position shared with HOTRMHMR.

Several times during the year, the Planning and Network Advisory Committee (PNAC) receives updates on the planning process and status, and their guidance is solicited. The Executive Director of the Arc of McLennan County, and several family members who have a son or daughter in IDD services currently represent IDD services on the PNAC.

The Executive Director presented a revised strategic plan to the PNAC and Board over the last three months of FY2021. The plan includes current strategic initiatives around preserving contractual services required of Center programs, reducing the reliance upon state funding by actively pursuing grant funding and developing new books of business, and actively building IT, regulatory and communication functions to promote and strengthen Center programs. The PNAC and the Board have reviewed and approved the strategic plan. The program divisions within the Center are working to develop policies and procedures to meet the intention of the strategic plan and are creating new programs to address the goal of reducing dependence upon state funding. The strategic plan and the initiatives across the Center will be reviewed on an on-going basis. . Integral parts of the strategic plan, represented by actual services provided, will be reviewed quarterly by the Planning and Network Advisory Committee. The plan is monitored by the Executive Director, quality management staff and the division directors. Additional monitoring is accomplished by committee reports to the Board of Trustees. If necessary, the strategic plan will be changed as a result of monitoring and feedback throughout the year.

B. Community Needs and Service Gaps

The Center has a history of meeting with stakeholders and community partners to identify needs and to collaborate on services. Stakeholders and partners include the Center's PNAC, the City of Waco, the Heart of Texas Council of Governments, The Area Agency on Aging, CRCGs, Caritas, Friends for Life, Region 12 Education Service Center, Arc of McLennan County, Baylor University School of Educational Psychology, Heart of Texas Autism Network, and Heart of Texas Down's Syndrome Network.

The following have been identified as specific community needs or service gaps:

- No- or low-cost qualified individuals to provide assessment and analysis of challenging behaviors and to develop individualized behavior support plans, to serve individuals at or below poverty level; includes qualified individuals to provide behavior support training to families, caretakers, and group home staff;
- Willing and qualified Psychiatrists and/or Psychiatric Nurse Practitioners to serve individuals with dual diagnosis; No specific program for individuals with MI and IDD diagnoses;
- A short-term residential treatment program for adolescents with significant challenging behaviors resulting in ER and/or jail stays and inpatient psychiatric admissions;
- Increased capacity of the IDD Crisis Respite program;

- Increased capacity in the Children's Autism Program;
- Better transition for children from the Early Childhood Intervention Program to similar community services such as Physical, Occupational, and Speech Therapies.
- Respite and PAS/HAB Provider pool for individuals who want to choose their own service providers;
- Lack of qualified individuals to provide direct support services in Day Habilitation and Residential programs, exacerbated by low wages offered for those positions.

C. Community Partnerships

The Center values its relationship with stakeholders, collaborators, and partners in the community. The following is a summary of the Center's interaction with them.

1. **The Planning and Network Advisory Committee (PNAC)** is composed of ten members who are family members of persons served, individuals who receive or have received services, representatives from sister agencies, and other professionals with experience and a continued interest in mental health and/or IDD service provision. The PNAC reviews and advises the Center on plans for and implementation of the various programs. The Committee meets at least once each FY quarter.

   October 20, 2020- Updates from the Executive Director, Chief Financial Officer, adult mental health, children's mental health, Early Childhood Intervention, and IDD services were given along with updates on the Crisis Counseling Program and the electronic health record.

   January 19, 2021- Discussed were donated storage space for veterans, Chromebook usage in nursing facilities for residents with IDD, COVID-19 overview, and announcement of a new Chairperson.

   April 20, 2021- Discussed were an update on the rebrand of the center, overview of Certified Community Behavioral Health Clinics (CCBHC), and update on CCBHC certification and implementation across all programs.

   July 20, 2021- Presentation on Disability and Rehabilitation Services Division, initial and ongoing PNAC training covering roles and responsibilities of PNAC, center plans, confidentiality, and update of PNAC by-laws draft.

2. **Waco Family Medicine** is a Federally Qualified Health Center (FQHC) and county funded. HOTRMHMR individuals are often WFM patients. There is an established WFM clinic on site that provides wellness opportunities for individuals in both the MH and IDD programs with the Center.

3. **Waco Housing Authority** and HOTRMHMR have worked cooperatively for over 20 years to maintain safe and affordable housing for persons served by both entities.

4. **The Aging and Disability Resource Center, including the Heart of Texas Council of Governments and the Area Agency on Aging** and HOTRMHMR have a positive working relationship to maintaining protocol for a regional no-wrong-door approach to service provision, resource sharing, case collaboration, and improving rural transportation.

5. **Central Texas Senior Ministries** The Heart of Texas Day Habilitation program works directly with CTSM in assisting with the Meals and Wheels program.

6. **Friends for Life** is a non-profit program that serves the elderly and people with disabilities. FFL serves as the guardian agent for a large number of the individuals who receive services through HOTRMHMR, is an alternative provider for Day Habilitation services, and contracts with HOTRMHMR to provide Independent Living Skills training and Day Habilitation through the PASRR program to people with IDD living in Nursing Facilities.

7. **The Arc of McLennan County** is an affiliate of the Arc of Texas and has long-term positive relationship with HOTRMHMR. Currently, we provide training to staff in the Arc summer camp, and contract for the Arc to provide skills training in a day program setting to individuals with Autism. As stated previously, the Executive Director of the Arc of McLennan County serves on the Center PNAC.

8. **Heart of Texas Autism Network/Down Syndrome Support Group** We actively support these groups in their missions to provide resource information and care-giver support to families with children with Autism, Down Syndrome, and other developmentally related disabilities.

9. **Baylor University,** School of Special Education, Applied Behavior Analysis Program has provided behavior support assistance the past 11 years to 25-30 children (annually) in the Children's Autism Program and the Crisis Intervention program. Graduate Assistants provide direct services to families while being supervised by a Board Certified Behavior Analyst.

10. **County CRCG – Adult and Child** We actively participate in multiple CRCGs, for children and adults (and combined) across the six counties. HOTRMHMR staff often take the lead in helping individuals staffed in the CRCG to coordinate the various service providers and agencies willing to provide specific support.

11. **Collaboration with Regional 12 Educational Service Center, transition program.** IDD services participates in regular transition coordinator meetings facilitated by Region 12 and individually interacts with school district transition staff to actively assist in transition of students from school to community.

12. **Other Partnerships:** The Waco Mayor's Committee for People with Disabilities. Area Colleges and Universities such as Baylor University, McLennan Community College, Tarleton State University and others, team up to place students into internships supervised by licensed staff in various programs in the Center.

D. Ongoing and Revised Strategic Initiatives

1. IDD services will provide goal-oriented, person-directed care coordination services that are efficient, effective, and that maximize the potential and quality of community life for persons with intellectual or developmental disabilities or related conditions.
2. The Center will facilitate access to, monitor participation in, and follow-up to assess the value of services and supports to everyone.

    a. To assess the effectiveness and thoroughness of current resources and service provision, regular opportunities for public feedback will be offered throughout the year to individuals receiving services, local HHSC agencies, private waiver service providers, the programs within the Heart of Texas Council of Governments, area school districts, area nursing facilities, behavior support providers, peer and family support organizations, and other individuals and entities that serve the IDD population.
    b. IDD Crisis response procedures and services will be assessed through systematic outreach to and analysis of data from Mental Health crisis response teams, law enforcement, hospital emergency departments, and private waiver providers. Feedback from these entities will drive the strengthening of IDD crisis response services.
    c. Recent capacity issues have rendered HOTRMHMR unable to provide medication services to consumers with private providers, but there is an intent to review and expand capacity in order to serve these individuals.
    d. The loss of Medicaid for individuals in Waiver programs has been reduced in the past two years as a result of coordinated efforts between Service Coordination and provider staff. Efforts to maintain momentum in eliminating unnecessary loss of Medicaid will continue. The Center will continue benefits services to assist individuals to receive/maintain Social Security, Medicaid, Medicare, and Medicare Part D.

3. Individuals with IDD who need relocation or transition from one living situation to another will be placed in the least restrictive environment appropriate to their care.

    a. Through the Community Living Option Information Process (CLOIP), SSLC and NF Diversion, Enhanced Community Coordination, Habilitation Coordination, and other means, the Center will continue to provide education regarding community living options to individuals and families considering more restrictive residential settings than may be required.

    b. Through the PASRR process, the Center will ensure that individuals in a nursing facility receive necessary services and supports, will receive education regarding community living options, and will be diverted or transitioned from Nursing Facility placement when possible.

4. The Center will identify opportunities for innovation in services and service delivery, with a critical focus on the effects of services and service delivery in Managed Care for people with IDD.

a. The Center routinely engages with other local social service providers to understand resources and better coordinate the multiple service needs of our individuals including CRCG, Friends for Life, Caritas, Region 12 Education Service Center, McLennan County Arc, Baylor University, HOT Autism Network, and HOT Down Syndrome Network.

5. The Center will continue to improve the variety of services and supports to individuals in their home or in the community to better fill the service gaps identified earlier in this plan, and to continue the focus on individual independence.

    a. Expansion of IDD Crisis services – and Behavior Support Services in general – to support more individuals now served by private providers of HCS and TxHmL programs, and to support those people and families not in formal services;
    b. Expansion of the provision of behavior support training to families, caretakers and group home staff;
    c. Continuing education and awareness information regarding individuals with Intellectual Disabilities and Autism Spectrum Disorders to Center MCOT team, emergency room personnel and police officers;
    d. Expand IDD crisis respite services for individuals with challenging behavioral issues, with the intent on serving internal and external service providers.
    e. Establishment of a Dual-Diagnosis Clinic as a natural addition to the Challenging Behaviors and IDD Crisis Respite program.

6. The Center will continue to analyze the financial stability of the internal TxHmL and HCS Waiver programs to determine the specific needs for personnel and service delivery changes, and ultimately the prognosis for continuing these programs considering increasing costs without subsequent rate increases.

    a. Part of this analysis will include the impact of developing a presentation to TxHmL participants and their families to offer Consumer Directed Services as an option.

    b. Analysis of the impact of restructuring HCS residential services to include the support of a growth in the Host Home (Foster Care) program.

    c. Providing a thorough review and budget analysis for each program for discovery of revenue deficiencies and subsequent recommendations to increase revenues, and to identify cost outliers and recommendations for addressing these issues. The ultimate intent will be to develop recommendations for maintaining some or all of the current services or preparing to close some or all of the provider services not otherwise related to the performance contract.