

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans, at 1:30 p.m. on February 5, 1997 in Room 423-S-of the State Capitol.

All members were present except: Representative Jim Morrison
Representative Becky Hutchins

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Rick Shultz, SRS Director of Community Programs
Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities
Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas
Hugh Sage, SRS Commissioner of Mental Health and Retardation Services

Others attending: See Guest List (Exhibit 1)

Chairperson Mayans announced that consideration of **HB 2137** [expanded first dollar coverage for immunizations] will be postponed until tomorrow's meeting.

Chairperson Mayans then stated that at the suggestion of Representative Henry, the committee will learn more about the Community Developmental Disabilities Services in Kansas. He then introduced Rick Shultz, SRS Director of Community Programs, who reviewed the accomplishments, particularly since August 1995. Paramount to his testimony were the issues now facing the services system of funding and other challenges, which he listed in his testimony (see Exhibit 2).

Jane Rhys, Executive Director, Kansas Council of Developmental Disabilities, described the Council's mission and goals, its role in the developmental disabilities system, and the various issues it confronts.

Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas, presented testimony on the Council's organization and administration to provide a statewide network of independent living services for individuals with disabilities. She explained that Centers for Independent Living (ICL's) are non-residential, community based, private, non-profit organizations designed and operated by individuals with disabilities. ICL's are governed by the Rehabilitation Act of 1973. In 1989, the Kansas In-Home Care Act (HB 2012) made it possible for persons receiving non-medical attendant assistance to direct their care through Home and Community Based Services. She stated the ICL's, in conjunction with SRS, offer tremendous cost savings to Medicaid, Medicare, and/or insurance (see Exhibit 3).

SRS Commissioner Hugh Sage briefed the committee on the status of the closure of Winfield State Hospital (see Exhibit 4); and described the newly-established program at Parsons State Hospital and Training Center for the statewide resource center for persons with dual diagnosis of mental retardation and mental illness (see Exhibit 5).

Chairperson Mayans thanked the conferees for their presentations and encouraged committee members to study their testimonies.

The meeting was adjourned at 3:15 p.m.

The next meeting is scheduled for February 6, 1997.

HOUSE COMMITTEE ON HEALTH AND HUMAN
SERVICES COMMITTEE GUEST LIST
FEBRUARY 5, 1997

NAME	REPRESENTING
Carol Doss	Topeka Independent Living Center
Jessie Briggs	Topeka Ind. Living Res. Ctr.
Jean Kiska	KS Child Prog
Jessie Torrey	Families Together
Jim McDonald	KACIL
Theresa McDonald	SILCK
Theresa McDonald	SRS MHFD
Don Bradley	SRS MHOD
Rick Smith	SRS MH+PD
Yvonne Ada	KS Home Care Assoc.
Kathleen Skibow	
Gay North	KDHE
Richard Schutz	SRS
Jan Koci	SRS
Amy Campbell	R. Rice Law Office
Garbrielle Ann Brown	KHA
Rich Guthrie	Health Midwest
Pat + Rita Hegarty	

HOUSE COMMITTEE ON HEALTH AND HUMAN
SERVICES COMMITTEE GUEST LIST
FEBRUARY 5, 1997

NAME	REPRESENTING
Ron Green	Governor's Office
Joyce Clark	Johnson County
Maurice Chase	So. County Dev. Support
NOBLE MORRELL	Div. of Personnel DoA
michel G Runch	ATTORNEY GENERAL'S OFFICE
Randy Fisher	Ks Common Disability Concern
Deborah Elder	Wellness for KS Educators
Bob Harder	MPS
Susan Baker	Heim + Weir
Michelle Peterson	Peterson Public Affairs
Robert L. Clark	S.D.S.I.

TESTIMONY BEFORE THE HOUSE
HEALTH AND HUMAN SERVICES COMMITTEE
FEBRUARY 5, 1997

INTRODUCTION AND THANK YOU

Mr. Chairman and members of the committee, I am Rick Shults, Director of Community Developmental Disabilities Programs for the Commission of Mental Health and Developmental Disabilities within the Department of Social and Rehabilitation Services. Thank you for this opportunity to share background and information regarding Community Developmental Disabilities Services in Kansas.

REVIEW OF ACCOMPLISHMENTS

When reflecting on where we are it is often helpful and important to take stock of where we have come from. So, with your permission, I would like to review some of the accomplishments of the Developmental Disabilities Services System in the last 18 months. I will not go into detail regarding these accomplishments but will touch on them briefly to give the Committee a flavor of what has been done in the last 1 ½ years.

In August 1995, the Hospital Closure Committee selected WSH&TC for closure by December 1997. In February 1996, SRS published its *Operations Plan for the Placement of Persons from State Mental Retardation Hospitals and the Closure of WSH&TC*. The Operations Plan described steps to be taken to improve the Community Integration Project so successful placements from all three State Mental Retardation Hospitals could be made more quickly allowing the closure of WSH&TC to occur as scheduled. As a result approximately one hundred (100) persons have been placed from State Mental Retardation Hospitals in the last 12 months. This is the largest number of placements to have been made in any previous 12 month period.

New DD Reform regulations were negotiated through out the fall of 1995. At the same time new person centered licensing regulations for Community Service Providers were being proposed. Ultimately, final disagreements regarding both the DD Reform and licensing regulations were resolved through independent mediation and adopted by SRS in July and August of 1996.

Significant efforts have been undertaken to use proven group problem solving process to address issues and challenges in the DD System. For example, independent profession mediation has been used to resolve disputes not only in the development of the DD Reform and licensing regulations but in contract negotiations, licensing disputes and disputes between persons served and providers. In addition to using independent mediation, the other proven group processes have been employed to ensure all stakeholders involved are given a chance to share their concerns and have them addressed.

Along this same line, this past year, a broad cross section of stakeholders in DD services were brought together to formulate a new draft Five Year Strategic Plan. The draft plan was shared with all interested stakeholders across the state and adopted in the fall of 1996. This Strategic Plan will guide the development of community DD services into the 21st century.

HOUSE HEALTH/HUMAN SERVICES
Attachment 2-1
2 - 5 - 87

October 1995 Community DD Service providers worked cooperatively with MH&DD to successfully complete the first Medicaid refinancing effort. Refinancing is a process whereby persons who are HCBS/MR waiver eligible but whose services are funded with all state general funds are added to the HCBS/MR waiver in order to capture more federal Medicaid funds for community programs. Refinancing results in an overall increase in funding for community DD services without the need for additional SGF. The first refinancing effort netted over \$6.7 million in additional total funds which were used to serve approximately 285 persons on community services waiting lists. This effort eliminated the waiting list for adult services at that time.

A second refinancing effort took SGF savings from efficiencies at WSH&TC and allocated them to the community. This second effort increased funding for Community Services by more than \$10 Million. As a result of this increase in funding all Community Developmental Disability Organizations agreed to a contract provision to eliminate the community waiting list for adults and family support services during FY97. This new agreement means that people who need services in order to remain successfully in the community in SFY97 will be provided services with little or no increase in SGF to the DD System. This effort vaults Kansas into an elite group of full service states.

CURRENT FUNDING STATUS

As a result of these efforts the current funding for Community DD Services is at an all time high. The current funding levels are a result of a concerted effort over several years to increase funding for Community DD Services. The sheet which has been passed out shows this effort graphically up through FY96 and, on the reverse side, presents the GBR for FY97 and FY98. The currently proposed budget calls for:

\$98 Million for HCBS/MR waiver funded services;

\$10.8 Million in grants for direct services for those not eligible for the HCBS/MR waiver;

\$ 3.2 Million in SGF for Family Support Services:

\$1.56 Million for Family Support Grants,

\$1.42 Million for Family Subsidy now administered by CDDOs,

\$100 Thousand for a Parent Assistance Network; and

\$8.9 Million in discretionary state aid type funding.

As noted earlier, the significant increase in the last two years are primarily a result of Medicaid refinancing which required little or no additional SGF to the DD System.

ADMINISTRATION OF FUNDS

Community DD Services funds are now being administered at the local level. In previous years HCBS/MR waiver funds were administered and monitored by MH&DD. Community Service Providers were told how many new people they could serve and MH&DD monitored the expenses to ensure they stayed within the appropriation. Now, with the exception of funds set aside to pay for placements from State Mental Retardation Hospitals, all state grant and HCBS/MR waiver funds have been allocated to the CDDOs to be administered at the local level.

This means the CDDO is now actively involved in authorizing adding new people to the HCBS/MR waiver and monitoring the expenditure of funds. This allows the CDDOs to work cooperatively and creatively with persons who are DD, their families and guardians and local Community Service Providers to meet everyone's needs within available funding.

CHALLENGES

The following challenges face the Community DD Service System in the immediate future:

One major challenge is to provide for the choices of guardians representing people living in State Mental Retardation Hospitals. This means developing quality successful person centered community placements for individuals whose guardians are choosing community services. 175 people must be placed in the next 11 months to allow for closure of WSH&TC on time. A total of 235 people living in State Mental Retardation Hospitals have had community placement chosen by their guardians. Therefore, even after WSH&TC closes, more persons will need to be placed in community settings continuing placement efforts of past years but at a faster pace.

In addition, those remaining in the State Mental Retardation Hospitals and private ICFs/MR must be fully informed about the available options in the community so their placement decision can be an informed one. State Mental Retardation Hospitals will do this for the people they serve by continuing their efforts of fully informing guardians regarding their placement options. CDDOs will inform people living in private ICFs/MR of their options through the "Gatekeeping" activities required by DD Reform. As this is done more people may choose community service placements. The choices of these people also, have to be provided for.

A second challenge will be for Community Service Providers to successfully respond to the demand for community services from those whose severe challenging disabilities have not been previously met in community settings. This can be done through:

- * PSH&TC's Dual Diagnosis, Treatment and Training Services;
- * Increasing the number of trained direct care staff; and
- * Hiring more nurses to address the health needs of people with severe disabilities.

A third challenge is to successfully administer DD Services at the local level through the CDDO, as specified by DD Reform. DD Reform requires this include the full involvement of persons with DD, their family and guardians through such groups as:

- * Councils of Community Members;
- * Local Quality Assurance Committees; and
- * Local dispute resolution.

CDDOs are beginning the efforts of establishing these workgroups and committees.

Another challenge is to use the flexibility of local administration of funds and services to meet the needs of all persons who need DD Services and to avoid the re-establishment of a community waiting list. We are actively pursuing the use of the Prepaid Health Plan option under Medicaid to increase local control and flexible use of Medicaid funding. If this effort is successful many of the drawbacks of the Medicaid fee for service system currently required by the HCBS/MR waiver will be overcome.

A final challenge is for CDDOs to welcome and accept new Community Service Providers which are being established to respond to the person centered demands of persons who are DD and their family/guardians.

PROGRAM TRENDS

A new service paradigm is beginning to emerge called "Self-determination". The efforts made in addressing the challenges ahead of us must include implementation of the principles of "Self-determination". "Self-determination" involves more than participation in the development of services within the already existing system of service programs. It involves empowering people who are DD and their family/guardians to shape, establish and commit reimbursement for the provision of services they can choose to design from the ground up to meet their lifestyle choices. These choices should not be limited unless they present unacceptable risks or exceed the costs of services to a person with the same severity of disability.

This new service paradigm comes closest to being achieved through the Community Integration Project and Self-directed Care. The CIP requires Community Service Providers to develop services which are directly responsive to the lifestyle choices of the person who is DD and his/her family/guardian. Self-directed care allows the person or his/her family/guardian to hire and employ the staff who provide them direct services.

Yet, these examples fall short of the "Self-determination" paradigm as currently envisioned and practiced in some isolated areas of the country. MH&DD has applied for and hopes to receive a grant from the Robert Wood Johnson Foundation to establish and expand the concepts of "Self-determination" in the Community DD System in Kansas. Such a grant will help to devise real life solutions to the implementation of "Self-determination" at the local level.

SUMMARY

The Community DD System has undertaken considerable improvement and change in the last 18 months. The amount of funding for Community DD Services has increased significantly by taking full advantage of federal Medicaid funding. As a result, the perennial problem of the community waiting list has been dealt with. In addition, many people living in State Mental Retardation Hospitals have been provided their choice of placement in community service settings. However, this leaves many new challenges ahead including:

- * Providing successful community services for persons still living in State mental Retardation Hospitals who have chosen to move to community service settings;
- * Informing those remaining State Mental Retardation Hospitals and private ICFs/MR what other options might exist so they can make informed placement decisions;

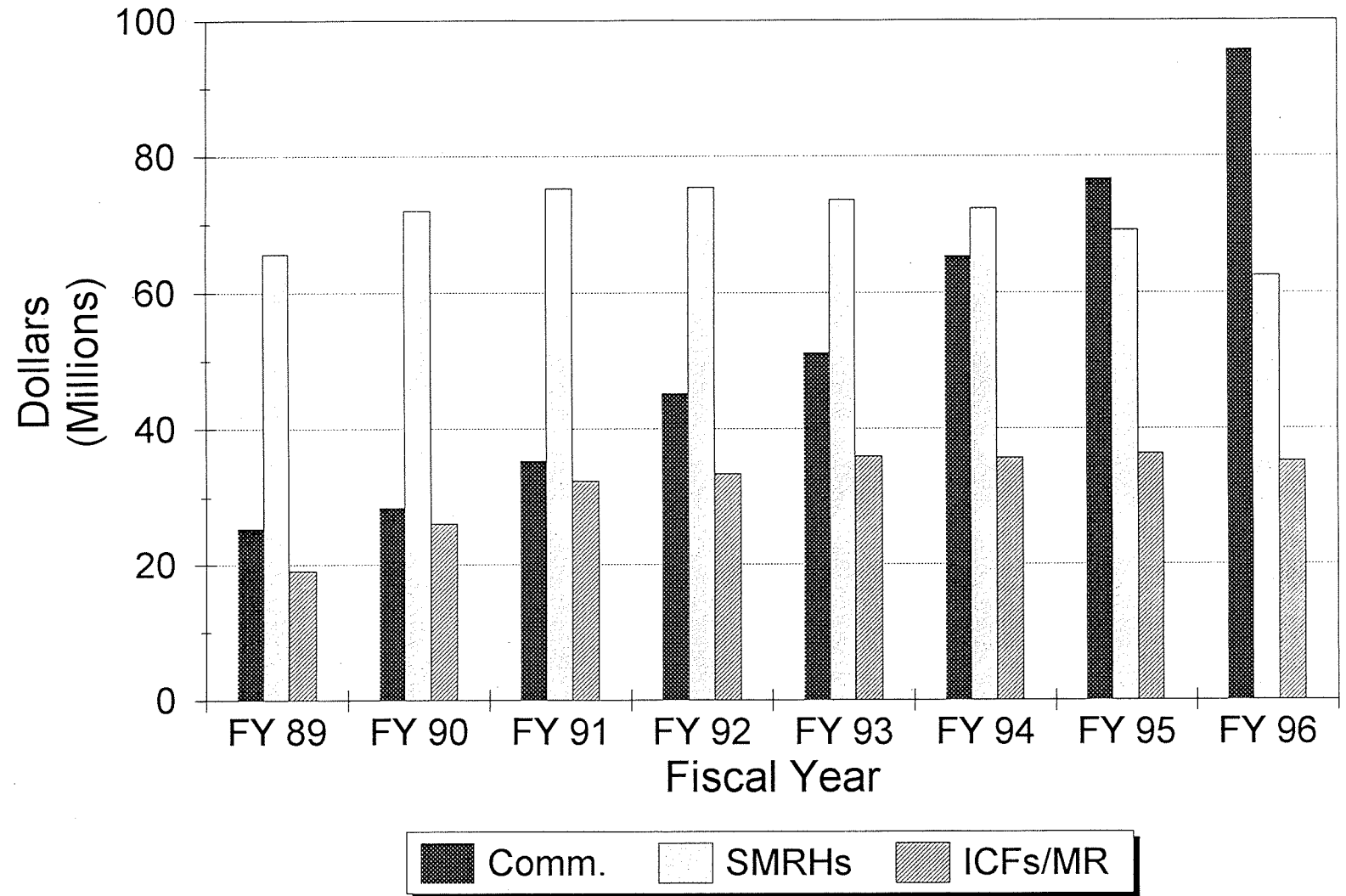
- * Successfully meeting the needs of persons with sever disabilities through:
 - PSH&TC's Dual Diagnosis, Treatment and Training Program
 - Better trained direct contact staff, and
 - Hiring more well trained nursing staff.
- * Establishing a local partnership with persons who are DD and their family/guardians to implement and administer DD Reform through Councils of Community Members, Quality Assurance Committees and local dispute resolution; and
- * Accepting and fostering the development of new Community Service Providers;

All of these challenges will need to be addressed within the context of the new service paradigm of "Self-determination".

The recent passage of DD Reform, the establishment of DD Reform regulations, establishment of person centered licensing regulations, the long history of local community controlled programs and increasing overall funding places Kansas in a unique position to successfully meet all of these challenges.

Thank you again for this opportunity to briefly share issues related to DD services in Kansas. Your vital support for these critical services is greatly appreciated.

COMMUNITY, HOSPITAL, AND ICFs/MR EXPENDITURES



DD PROGRAM SPREADSHEET

	Current Year <u>FY97</u>	Reduced Resource <u>Scenario FY98</u>	<u>GBR FY98</u>
One Time Grant	\$ 107,000	\$ 0	\$ 0
CIP Start-up Grants	\$ 541,458	\$ 0	\$ 0
Closure Pre-placement	<u>\$ 480,254</u>	<u>\$ 0</u>	<u>\$ 0</u>
Subtotal	\$ 1,128,712	\$ 0	\$ 0
Community Support Grants			
State Aid	\$ 5,963,174	\$ 5,963,174	\$ 5,963,174
DD Reform Management	\$ 3,000,000	\$ 3,000,000	\$ 3,000,000
Base Grants	\$ 10,488,849	\$ 7,668,849	\$ 10,488,849
Autism	\$ 97,268	\$ 97,268	\$ 97,268
Alternate Care	\$ 256,609	\$ 256,609	\$ 256,609
Base start-up	\$ 160,000	\$ 160,000	\$ 160,000
School start-up	0	\$ 0	\$ 150,000
Make A Difference	<u>\$ 7,000</u>	<u>\$ 7,000</u>	<u>\$ 7,000</u>
Subtotal	\$ 19,972,900	\$ 17,152,900	\$ 20,122,900
Family Support Grants			
Family Subsidy	\$ 1,425,000	\$ 1,425,000	\$ 1,425,000
Family Support	\$ 1,708,052	\$ 1,708,052	\$ 1,708,052
Parent Assist. Net.	<u>\$ 100,000</u>	<u>\$ 100,000</u>	<u>\$ 100,000</u>
Subtotal	\$ 3,233,052	\$ 3,233,052	\$ 3,233,052
HCBS/MRDD Waiver	\$ 80,406,443	\$ 80,406,443	\$ 80,406,443
Closure Bridge Fund	\$ 16,003,833	\$ 26,843,418	\$ 26,843,418
County Mill Match	<u>\$ 1,661,800</u>	<u>\$ 1,661,800</u>	<u>\$ 1,661,800</u>
Subtotal	\$ 98,072,076	\$ 108,911,661	\$ 108,911,661
Private ICF/MR	<u>\$ 36,371,820</u>	<u>\$ 38,554,129</u>	<u>\$ 38,554,129</u>
Community Services Subtotal	\$ 158,778,560	\$ 167,851,742	\$ 170,821,742
PSH&TC	\$ 18,013,599	\$ 18,455,195	\$ 18,551,534
KNI	\$ 23,495,904	\$ 23,694,419	\$ 23,817,957
WSH&TC	<u>\$ 20,568,100</u>	<u>\$ 7,314,173</u>	<u>\$ 7,253,231</u>
SMRH Subtotal	\$ 62,077,603	\$ 49,463,787	\$ 49,622,722
DD SERVICES TOTAL	\$ 220,856,163	\$ 217,315,529	\$ 220,444,464

Presentation to
Health and Human Services Committee
by
Shannon M. Jones
Statewide Independent Living Council of Kansas, Inc.
February 5, 1997

Thank you for inviting our organization to talk to you today about Independent Living Centers (ILCs) in the state of Kansas. My name is Shannon Jones and I am the executive director for the Statewide Independent Living Council of Kansas (SILCK). The SILCK is a governor-appointed, consumer-controlled leadership organization mandated by a federal law, the Rehabilitation Act as amended in 1992, to conduct planning, evaluation and other activities which increase advocacy, services and community options for people with disabilities who want to live independently in the community of their choice. One of the primary responsibilities of the SILCK is to develop a statewide network of independent living services for individuals with disabilities. We also work to increase the capacity of Centers for Independent Living (CIL's) to develop comprehensive approaches or systems for providing independent living services. The SILCK believes people should live in the community setting of their choice.

BACKGROUND

I'd like to begin, first by giving you all just a brief history of how the independent living movement began. Then I believe you all will have a much better appreciation of how far Kansans with disabilities have really come today. I won't go as far back as Adam and Eve but suffice it say that throughout history people with disabilities have been regarded as second class citizens. This was only reinforced by the negative attitudes and language that depicted us as crippled, deaf-dumb-mutes and the like. These attitudes were further ingrained by our society as a result of the 'medical model' or 'sick role' associated with people with disabilities. Physicians and social workers were thought to be the experts who were to fix people like us and we were to assume the role of the 'sick' patient. Furthermore the 'sick' person was not expected to participate in society, instead we were shut out and sent to asylums and institutions and most recently to nursing homes.

Our movement, the independent living / disability rights movement began in much the same way as the civil rights movement back in the 1960s. Just like other minorities, people with disabilities were being denied access to basic services and opportunities such as employment, education, housing and transportation. Just like Rosa Parks was denied a seat at the front of the bus, people with disabilities couldn't even get on the darn bus!! We began to say things like, 'Hey, it's not me that needs to be 'fixed', it's the environment that needs to change'. If I have a spinal cord injury, that is never going to go away. I may need to use a wheelchair so that I am able to get around but if there is a set of steps or a curb that blocks my entrance, it's not me it's the built environment. If you put in a ramp or a curb cut, I am no longer a problem it was that set of stairs.

Another key principle was that of self help, that persons with disabilities know best how to serve others with disabilities. People who are in similar situations can much better understand your needs than someone who is a professional but yet who has never experienced a disability. So it was during that period of the 60s and 70s, that period of free speech, civil rights, the woman's movement that heavily influenced people with disabilities. As a result, the independent living movement empowered people to say, 'Hey we want to live on our own, make our own decisions and contribute and be part of the community. We may need some assistance but we are the ones in charge. So if I'm person with quadriplegia, I may need assistance getting in and out of bed, but I should be in charge of what needs to be done. After that with an accessible environment I can then go to work, school or whatever.

This was about responsibility. The whole point of I.L. was to be independent, to create a system where people became less dependent on the system. If people with disabilities are given the same array of options as their non-disabled peers, we can then move from the dependency and charity model to an integrated and accessible society.

CENTERS FOR INDEPENDENT LIVING IN KANSAS

These principles of consumer control, self-help, systems change and peer relationships are the cornerstones of Centers for Independent Living. Centers for Independent Living are redefining the problem of disability by looking at the person as a resource and barriers as the handicapping condition.

First and foremost, Centers for Independent Living or CIL's have a strong belief in consumer empowerment reflected in the way they run their organizations. **They are community based, non-residential, consumer directed organizations, meaning that a majority of the boards and staff of a CIL must be people with disabilities that are responsive to the needs of people with disabilities.** CIL's believe that with supports anyone can live independently, and that those supports should be controlled by individuals and/or family and friends. Secondly, there is a very strong commitment to self help in the way they deliver independent living services, called peer counseling. Third there is a commitment to social change and service delivery, therefore a strong advocacy flavor will be found in CIL's. Fourth they are locally defined, locally responsive to the particular issues of that community as seen by that community. Finally, CIL's are cross disability in their commitment, serving all people with disabilities.

Centers are an option for people with all types of disabilities, that will provide employment services, assist in finding housing, assist with locating personal attendants and engage in outreach efforts for community education and advocacy. CIL's do not charge a fee to consumers for any of these services.

Centers believe in the dignity of every person. They provide services designed to empower an individual to participate in community life to the greatest extent possible, and to experience a productive, dignified life. Each Center advocates for the rights and access, and educates individuals and professional organizations about living fully with a disability.

The cost of providing independent living services is as follows:

11 CILs
\$1.7 million Total Funds 1996

<u>Consumers served</u>	<u>Disability type</u>
1,229	Cognitive and Mental Disabilities (including MR)
4,143	Physical Disabilities
804	Sensory Disabilities (including Deaf and Blind)
947	Other or Multiple Disabilities
7,123	TOTAL

\$240 per consumer per year

When compared to the cost of nursing home care at an average of \$24,000/yr, it is easy to see the cost benefits associated with the services that CILs provide. And most often, the only other alternative for people is nursing home care.

Even compared to other programs such as Vocational Rehabilitation that assist people with disabilities find employment, with an annual budget of \$22 million serving 1,410 consumers, that averages out to \$15,602 per consumer!

This measure of efficiency proves the cost effectiveness of independent living services and brings about the realization that people know best how to solve their problems and government is most effective when called upon to respond by the people.

The first federal funding for CILs became available under the federal Rehabilitation Act of 1972. The first Centers in Kansas to start up with these federal dollars were in Hays, Topeka and Lawrence in 1979 and 1980. Subsequently, starting in 1984/85, the state funded an additional 5 Centers, then again in 1991, 3 more Centers were started. These Centers continue to receive the original amount of funding granted with NO cost of living increases. They have survived and continued to grow due to community support and alot of resource development on their own.

Last year funding was received to start two new Centers in southwest Kansas and south central Kansas. The SILCK and KRS initiated a new innovative approach in the request for proposal (RFP) process, called "mentor center" concept. This concept allowed an existing CIL to apply for the new funds to assist in establishing the new Center. Based on past experience where we have seen the start up of new organizations sometimes flounder for years just trying to put together the basics and even then sometimes failing, this seems a much better approach to ensure success while eliminating the chance to duplicate past mistakes that a mentor center may have already experienced. This again is consistent with the independent living philosophy of peer support relationships.

We have been very encouraged by this new innovative approach and feel that the mentor center concept will ensure the stability and survival of the new CILs. In addition, we feel this the most cost effective way of directly getting the dollars into the community for persons to be served.

Currently, Kansas has 13 Centers for Independent Living. The 13 CIL's have a combined budget of state and federal funds totaling \$2.1 million:

State Funding.....	\$	652,558
Federal IL Title VII, Ch. 1, Part B.....		45,000
Federal IL Title VII, Ch. 1, Part C.....		566,935
Federal Title I Voc Rehab.....		450,485
Federal Soc. Security Reimb.....		400,000
	TOTAL \$	2,114,978

A listing of each Center for Independent Living and their funding is attached.

HOME AND COMMUNITY BASED SERVICES (HCBS) FOR PHYSICALLY DISABLED (PD)

For the past fourteen years, SRS has administered long term care services for Kansans who were elderly and/or physically disabled. After the 1995 Kansas Legislature passed House Resolution 5024 directing SRS to develop a new Medicaid Waiver solely directed toward people with physical disabilities, SRS began looking at a new way of providing services to that population through Centers for Independent Living.

Because CILs have long advocated to work towards the development of non medical and community based service system that gives people with disabilities the opportunity to live and participate in their own communities, we have worked in partnership with SRS, Adult Services and others to develop the new Physical Disability (PD) Waiver. This new PD waiver represents over a year of planning, input and discussion. We genuinely appreciate the tremendous support, cooperation and technical expertise everyone has shared to ensure the common goals of quality services to consumers will be achieved. SRS, Adult Services staff, in particular are to be commended for their assistance in assuring the independent living philosophy was always maintained as the waiver was developed.

As mentioned earlier, in the past people with disabilities have been presumed to be forever 'homebound'. However, with the growing advocacy efforts by people with disabilities, the state of Kansas has begun to see how destructive and wrong the institutionalization of people with disabilities could be. Not to mention the huge financial burden associated with the costs of nursing facilities and state institutions. The cost to Kansas in long term dependency care, welfare and lost productivity resulting from disability is in the billions of dollars annually.

The new PD waiver was implemented on January 1st of this year and 1,245 consumers are receiving services through this waiver.

See attached HCBS / PD Program Facts

As you can see this is a very different waiver than what we are used to in the MR/DD, Head Injury (HI) and Frail and Elderly (FE) Waivers. The PD waiver is much more flexible, thereby allowing greater consumer choice while still ensuring quality services and cost effectiveness. The philosophical goals of Choice, Quality and Cost Efficiency have remained our highest priority.

Kansas Centers for Independent Living - 1996-97

<u>CILs</u>	<u>Funding</u>
Independence, Inc. Lawrence (started 9/79)	State \$50,000.00 Title I \$102,353.00 Title VII (C) \$169,843.00 Total Award \$322,196.00
LINK, Inc. Hays (started 3/80)	State \$15,987.00 Title I \$53,522.00 Title VII (C) \$202,938.00 Total Award \$272,447.00
Topeka Independent Living Resource Center (started 12/80)	State \$20,000.00 Title I \$66,957.00 Title VII (C) \$194,454.00 Total Award \$281,111.00
The WHOLE Person, Inc. Kansis City, MO	State \$18,500.00 Total Award \$18,500.00
ILC of Southcentral KS Wichita (started 6/84)	State \$119,500.00 Title I \$33,696.00 Total Award \$152,979.00
Independent Connection/ OCCK, Inc., Salina (started 3/84)	State \$46,071.00 Title I \$66,957.00 Total Award \$113,028.00
Three Rivers, Inc. Wamego (started 5/85)	State \$25,000.00 Title I \$77,000.00 Title VII (B) \$15,000.00 Total Award \$117,000.00
Resource, CIL, Inc. Osage City (started 5/85)	State \$27,500.00 Title I \$50,217.00 Title VII (B) \$15,000.00 Total Award \$92,717.00

ILC of Northeast KS	State	\$30,000.00
Achievement Svcs of NE KS Atchison (started 8/91)	Title VII (B)	\$15,000.00
	Total Award	\$45,000.00
Access to Living Center/ CFI, Inc., KC, KS (started 11/92)	State	\$100,000.00
	Total Award	\$100,000.00
Southeast KS IL., Inc. Parsons (started 11/92)	State	\$100,000.00
	Total Award	\$100,000.00
Garden City Center Garden City (started 10/96)	State	\$100,000.00
	Soc Sec Reimb.	\$200,000.00
	Total Award	\$300,000.00
Hutchison Center Hutchison (started 10/96)	Soc Sec Reimb.	\$200,000.00
	Total Award	\$200,000.00
Funding of CILs		
	State	\$652,558.00
	Title VII (B)	\$45,000.00
	Title VII (C)	\$566,935.00
	Title I	\$450,485.00
	Soc. Sec. Reimb.	\$400,000.00
	Total Award	\$2,114,978.00

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
 Division of Adult and Medical Services
 HOME AND COMMUNITY BASED SERVICES FOR PHYSICALLY DISABLED
 January 1, 1997

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HCBS/PD PROGRAM FACTS

<p><i>The 1995 Kansas Legislature passed House Concurrent Resolution #5024 directing SRS to develop a Medicaid Home and Community Based Service (HCBS) Waiver for persons with physical disabilities (PD). A team of 25 individuals representing consumers, providers and interested state and local governmental agency representatives have been meeting since September, 1995 to draft a waiver. The waiver application has received approval from Health Care Financing Administration (HCFA). Implementation was completed January 1, 1997.</i></p>	<p>Eligibility Group</p> <ul style="list-style-type: none"> • Individuals age 16 - 64 • Physically disabled as defined by Social Security Admin. • Determined need for personal assistance during any part of the "normal rhythms" of the day • If age 21 or younger receive a Kan Be Healthy screening • Not developmentally disabled or severely or persistently mentally ill • Meet Medicaid Financial eligibility criteria • Meet Medicaid LTC threshold criteria 	<p>Medicaid Financial Eligibility Criteria</p> <ul style="list-style-type: none"> • Countable asset test of \$2,000 • Built-in Work Incentives: <ul style="list-style-type: none"> ▸ exemptions for earned income • Consumers will help pay for services if countable income > \$645/mo. <hr/> <p>Caseload</p> <ul style="list-style-type: none"> • As of 1-1-97, 1,245 consumers are receiving services 	<p>Services</p> <ul style="list-style-type: none"> • Independent Living Counseling: <ul style="list-style-type: none"> ▸ Determines need for services ▸ Develops service plan ▸ Arranges needed services ▸ Fiscal Intermediary • Personal Services: <ul style="list-style-type: none"> ▸ Assist a person with a disability to perform tasks which they would typically do for themselves in the absence of a disability ▸ Consumer Self-Directed Attendant Care option will be promoted • Assistive Services <ul style="list-style-type: none"> ▸ When cost-effective, provides adaptive equipment, home modifications and technology assistance.
<p>Service Providers</p> <ul style="list-style-type: none"> • Independent Living Counseling: <ul style="list-style-type: none"> ▸ qualified individuals employed or contracted by Independent Living Centers recognized by SRS or licensed Home Health Agencies • Personal Services and Assistive Services: <ul style="list-style-type: none"> ▸ consumer driven ▸ provided by anyone or any business in the community qualified to provide the needed services • All services will be privatized • Cost cap exceptions for HCBS will be allowed 	<p>Reimbursement</p> <ul style="list-style-type: none"> • Service levels based on individual assessment of need. • Medicaid authorization required. • Independent Living Counselor arranges services for the consumer as an Organized Health Management system. • Reimbursement rates are established on an individual basis and controlled by upper spending limits and state approved range. • Consumer authorizes payments to providers. • Cost-effectiveness will be measured on an "annualized" service plan. 	<p>Funding</p> <ul style="list-style-type: none"> • Only existing resources will be used • Current HCBS/NF and Income Eligible Home Care funds used for this population will be transferred to the HCBS/PD waiver 	<p>Quality Assurance</p> <ul style="list-style-type: none"> • Independent audits • Annual redetermination of eligibility by the fiscal agent • Independent Living Counseling • Consumer satisfaction surveys • Oversight by Area Medicaid Management in SRS • Continuous Quality Improvement • Monthly meetings between AMS and ILC Directors <p><i>c:chart2.pdf</i></p>

HCBS WAIVERS					
PROGRAM	HCBS/FE	HCBS/PD	HCBS MR/DD	HCBS TA	HCBS HI
ELIGIBILITY GROUP	<ul style="list-style-type: none"> • Individuals age 65 and over • Meet LTC Threshold Criteria • Financially Eligible for Medicaid 	<ul style="list-style-type: none"> • Individuals age 18-64 • Physically disabled • Need personal assistance with normal rhythms of the day • KBH screening if < 21 • Not DD or mentally ill • Financially Eligible for Medicaid • Meets LTC Threshold Criteria 	<ul style="list-style-type: none"> • Age 5 or over • Mentally retarded or developmentally disabled • Need IF/MR level of care 	<ul style="list-style-type: none"> • Children under age 18 • Not otherwise eligible for Medicaid • Dependent on mechanical ventilators • Need intravenous administration of nutritional substances or drugs. • Need substantial ongoing care in a hospital setting. 	<ul style="list-style-type: none"> • Age 18 to 55 • Have external traumatically acquired non-degenerative, structural brain injury resulting in residual deficits and disability
SCREENING	Authorized case managers using Uniform Assessment Instrument	Independent Living Counselors using Uniform Assessment Instrument	Community Developmental Disability Organizations (CDDO) using Developmental Disability Profile-2	Medicaid enrolled provider, Advanced Registered Nurse Practitioner Case Manager. Assesses social and health needs of child who without provision of waiver services would be hospitalized	Qualified and trained professionals enrolled as Medicaid providers assess all individuals applying for HIRF placement using Developmental Disability Profile-2.
CASE MANAGEMENT	Area Agencies on Aging or private providers	Independent Living Counseling provided by Centers for Independent Living. Primarily self-directing.	CDDO Staff	Nurse Providers monitored by Adult and Medical Services	Independent Providers

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HCBS WAIVERS					
PROGRAM	HCBS/FE	HCBS/PD	HCBS MR/DD	HCBS TA	HCBS HI
SERVICES	<ul style="list-style-type: none"> • Targeted Case Management • Adult Day Care • Sleep Cycle Support • Personal Emergency Response • Health Care Attendant • Wellness Monitoring • Respite Care • Nursing Facility Services 	<ul style="list-style-type: none"> • Independent Living Counselling • Personal Services • Assisive Services 	<ul style="list-style-type: none"> • Case Management • Supportive Home Care • Wellness Monitoring • Medical Alert • Residential Habilitation • Supportive Family Living • Prevocational Habilitation • Supportive Employment • Respite • Home Modifications • Van Lifts 	<ul style="list-style-type: none"> • Case Management • Night Support • Medical Attendant • Non-Medical Attendant • Medical Alert • Durable Medical Equipment • Drug and Alcohol Therapy • Home Modification • Transitional Living Skills • Physical Therapy • Speech Therapy • Occupational Therapy • Cognitive Therapy • Behavior Therapy 	<ul style="list-style-type: none"> • Respite Care • Medical Equipment and Supplies • Case Management

BRIEF UPDATE ON THE CLOSURE OF WINFIELD STATE HOSPITAL

Since the decision was made to close Winfield State Hospital & Training Center (WSH&TC), a series of activities have been undertaken to assist guardians with decisions concerning the future placement of their wards. On February 20, 1996, MH&DD issued its *Operations Plan for the Placement from State Mental Retardation Hospital and Closure of Winfield State Hospital and Training Center* which set out the guiding principles to be followed in providing for the guardians' placement choices. A summary of these guiding principles is as follows:

1. Persons with DD and their family/guardians will have sufficient information from which to make an informed placement decision;
2. The final choice about where a person with DD will live belongs to that person and his/her family/guardian;
3. A person centered support plan is developed with participation by the person being placed and the family/guardian choosing community placement;
4. An administrative appeals process will be available for persons being placed if they disagree with decisions made on their behalf; and
5. Transfer to one of the remaining State Mental Retardation Hospitals will be one of the placement options.

THE PLACEMENT PROCESS

These principles are being implemented through the activities of the Community Integration Project and implementation of the action plan described in the *Operations Plan*. Some of the more important of these steps are summarized below:

Guardian Choice: In early 1996, the Commissioner of MH&DD sent a letter to guardians of persons at all three State Mental Retardation Hospitals asking them to make a preliminary placement choice for their ward. The guardians were asked to make a preliminary choice of placement in either: a community program, a private ICF/MR, or one of the remaining State Mental Retardation Hospitals. Guardians were subsequently sent information about community agencies in their area or new agencies interested in developing services in their local communities.

Guardians were asked to make their preliminary placement decision by the Spring of 1996 with the assurance the final decision concerning placement would only be made in a formal planning process with their involvement.

Placement Planning: Once a guardian decides to pursue community placement, person centered planning begins focusing on the lifestyle choices of the person being placed and his/her guardians. The resulting Essential Lifestyle Plan directs the development of services in the community.

Referral to the Community: The Community Service Provider (CSP) then completes a Support Plan to address the lifestyles choices of the person and his/her guardian and a Funding Proposal describing funding needed to implement the plan.

Approval of the Support Plan and Funding Proposal: The Support Plan is evaluated by the State Mental Retardation Hospital to make certain appropriate supports will be in place to meet the person's needs in the community. The Funding Request is evaluated by MH&DD staff. Once the Support Plan and Funding Request are approved the person can move to the community.

Monitoring: MH&DD Regional Coordinators review, license, and monitor the community service program insuring the needs of the person placed are met to the guardian's satisfaction.

PROGRESS ON THE OPERATIONS PLAN

The following items reflect progress which has been made in implementing the *Operations Plan* as of January 31, 1997:

1. Guardians representing 568 persons living in State Mental Retardation Hospitals, or 95% of the total, have made a preliminary placement choice;
2. Guardians representing 235 persons living in State Mental Retardation Hospitals, or 39% of the total, have chosen community placement;
3. Start-up funding was increased from \$3,200 to \$6,000 per person and an additional \$3,200 per person is provided to defray pre-placement planning costs incurred by the CSPs;
4. Critical changes were made in the CIP process to: better find suitable roommates, ensure medical care is secured prior to placement and provide individualized reimbursement rates in a variety of service settings;
5. An affiliate handbook was completed explaining to those not currently providing services in Kansas the necessary steps of becoming affiliated with Community Developmental Disability Organizations;
6. The MH&DD Regional Coordinators began closely monitoring all CIP placements; and
7. The Commissioner of MH&DD convened the Commissioner's Closure Monitoring Advisory Committee, consisting of family members, guardians, advocates, educators and CSPs, which meets every other month to monitor MH&DD's implementation of the *Operations Plan* and to identify issues they believe the Commissioner should address in the closure process.

CURRENT STATUS

An average of approximately twelve (12) persons per month, more than twice the average of previous years, are being placed in community settings. As of January 31, 1997, the census of WSH&TC was 159. This is ten (15) more than was projected for this date. The census of the other two State Mental Retardation Hospitals is also slightly more than what was projected. The reason for this is that some CSPs who expected to make placements in the fall of 1996, were unable to due to unexpected problems. These CSPs have successfully addressed their problems and are now ready to expand more rapidly. As a result, community placements are expected to increase in the Spring of 1997 beyond the current brisk pace resulting in meeting the year-end census goals. However, MH&DD will closely monitor the progress of these agencies to ensure any future problems are identified early and dealt with in a timely manner.

Additional detailed information regarding closure activities can be obtained by reading *Operations Plan for Placement from State Mental Retardation Hospitals and Closure of Winfield State Hospital and Training Center* and *Report on DD Systems Activities Related to Closure of Winfield State Hospital and Training Center*.

Date: February 3, 1997

Contact Person: Rick Shults

MH&DD Commission

Docking State Office Building

915 SW Harrison, 5th Floor North

Topeka, Kansas 66612-1570

Phone: (913) 296-3476 FAX (913) 296-6142

**DUAL DIAGNOSIS TREATMENT
AND TRAINING SERVICES
PARSONS STATE HOSPITAL & TRAINING CENTER**

It has been estimated as many as 20-30% of all non-institutionalized persons with mental retardation are currently diagnosed as mentally retarded and mentally ill. When these individuals engage in behaviors that are problematic for community agencies, they are often incarcerated, placed in psychiatric hospitals, or placed on inappropriate medications. In order to provide more appropriate treatment services for these individuals, the Kansas Department of Social and Rehabilitation Services Commission of Mental Health and Developmental Disabilities (SRS/MH&DD) is establishing Parsons State Hospital and Training Center (PSH&TC) as the statewide resource center for persons with a dual diagnosis of mental retardation and mental illness.

To begin the process of providing better services to such dual diagnosed individuals, the Commission has outlined the following goals for PSH&TC to accomplish during FY97:

1. Establish outreach teams to go to the community in response to referrals from community care givers (e.g., parents, Community Mental Health Centers, schools, DD agencies), to develop an effective behavioral program for the individual and train care givers in the home and staff in the referring agencies to effectively serve the person;
2. Develop a residential unit on the PSH&TC campus to provide crisis stabilization for children and adults of both genders;
3. Transfer persons with a dual diagnosis (MR/MI) in State Mental Health Hospitals to PSH&TC; and,
4. Establish the capability to support a very small group of individuals on campus who require long term intervention following the period of crises stabilization.

In order to manage the above goals, a new program, the Dual Diagnosis Treatment and Training Services (DDTTS), is being developed. The DDTTS will consist of twenty-seven (27) staff dedicated to this during FY97. Services will be provided with existing FTE, contractual services, and seven (7) new professional level staff who will be recruited to fill existing but reclassified vacancies. The services will be directed by a doctoral level psychologist. The DDTTS will serve the entire state of Kansas and be the primary referral point for persons with a developmental disability and mental illness or other severe behavior problems whose needs are not being met by existing community resources. The DDTTS initiated a pilot outreach effort in October, 1996, and expect to have two (2) fully operational Outreach Teams by March 1, 1997.

Outreach Team staff will go to communities where agencies have requested help to effectively serve an individual to conduct behavioral analysis of the problem and develop and demonstrate effective treatment strategies. The staff will train the local care givers (e.g., families, CMHCs, schools, community developmental disabilities providers) to sustain the treatment and collaborate with other agencies to provide the support to maintain the individual in his/her preferred community placement. The outreach effort is expected to help eighty (80) persons per year with a dual diagnosis in Kansas communities receive appropriate behavior interventions.

HOUSE HEALTH/HUMAN SERVICES

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If an individual has reached a stage where effective treatment cannot be implemented in the community, even with the support of the Outreach Team, the person may be placed at PSH&TC for short term crisis stabilization. PSH&TC expects to complete renovation of a current residential unit in time to begin providing short term crises stabilization on campus by July 1, 1997. The unit will consist of thirteen (13) beds configured in a manner to allow services to be provided to children and adults of both genders. The services will include the opportunity for staff from local agencies who are serving an individual to participate and receive training on campus during the period of crisis stabilization. It will also provide the opportunity for parents to participate as desired. The individual's community supports, including his/her parent/guardian, will be able to participate in transition planning and receive training to accomplish a smooth transition to community services. The crisis stabilization effort is expected to average sixty (60) days per individual, with the crises stabilization unit serving about forty-five (45) to fifty (50) persons on campus per fiscal year.

In keeping with its mission to provide back-up capacity to community services, a very small number of persons may require admission and longer term intervention by the DDSTS.

Date: January 30, 1997

Contact Person: Darvin Hirsch, Ed.D.

MH&DD Commission
Docking State Office Building
915 SW Harrison, 5th Flr. North
Topeka, Ks. 66612-1570
Phone: (913) 296-3476 FAX: (913) 296-6142

Or

Gary Daniels, PhD
Superintendent
Parsons State Hospital & Training Center
2601 Gabriel
Parsons, Ks. 67357
Phone: (316) 421-6550