March 22, 2007

To All Interested Parties,

The New Jersey Division of Developmental Disabilities is proud to share a copy of the draft document *Path to Progress (Olmstead) Plan* for comment from stakeholders. If you have already provided input through the four public hearings held in January 2007, we want to thank you and invite you to provide additional comments.

As you are aware, the *Path to Progress* is the plan that will be used to transition interested persons from Developmental Centers to communities throughout New Jersey. This Plan is in response to PL 2006, c.61 which mandates the DDD prepare a plan, distribute it for comment and provide a report of its findings to the Governor and the Legislature by May 2, 2007.

We encourage the public to provide feedback on the plan. You will find the document at [http://www.state.nj.us/humanservices/ddd](http://www.state.nj.us/humanservices/ddd). If you do not have access to the internet, you may access the document through your public library’s internet connection. Comments are to be sent via email to dddolmstead@dhs.state.nj.us. You may also send written comments to the address above to the attention of Stephen J. Smith. If your comments are specific to certain pages of the plan, please provide the page number you are referring to so that we may understand the context of the feedback. We appreciate your response by 5pm on March 29, 2007.

The Division is committed to adhering to the May 2, 2007 timeline and appreciates the effort you will make to review this document. We value your input, so please be assured that every comment will be reviewed to present the most comprehensive plan possible.

Sincerely,

Kenneth W. Ritchey
Assistant Commissioner

Cc: Jennifer Velez

New Jersey Is An Equal Opportunity Employer
I. Introduction

A. Purpose of the Plan

“Path to Progress” is the New Jersey Department of Human Services’ Division of Developmental Disabilities (DDD) action plan for systems change. The systems change will provide opportunities for residents of State Developmental Centers who want to live in the community to do so over the next eight years. The Plan was developed in response to PL 2006, c.61 which requires DDD to:

- Establish benchmarks to ensure that within eight years of implementation, each resident in a State developmental center who expresses a desire to live in the community and whose individual habilitation plan so recommends, is able to live in a community-based setting.
- Review and establish objective criteria to identify those persons with developmental disabilities who are appropriate candidates for living in community-based settings;
- Identify the resources needed to ensure that those persons can reside in the community and receive needed community-based services and supports in a manner that enables them to live as independently as possible;
- Set forth how the necessary funding, services and housing will be provided.
- Solicit public input in developing the plan by conducting four public hearings at or in close proximity to the State's developmental centers in each of the Division’s four regional service areas. Public input must include the amount and type of supports and housing needed and how they are to be provided.
- Provide the plan and a report of its findings and recommendations to the Governor and, pursuant to section 2 of P.L. 1991, c.164 (C, 52:14-19.1), to the Senate Health, Human Services and Senior Citizens and Assembly Human Services committees no later than nine months (May 2, 2007) after the effective date of the act.
B. Background

1. History of Community Services Development

For nearly three decades, DDD operations have been focused on expanding the development of services in community settings, while reducing the use of institutions. As a result, the number of individuals in Developmental Centers was reduced from 7,317 in 1980 to 3,027 in 2007 while the number of institutions was reduced from eleven to seven. With the closure of North Princeton Developmental Center, the Division learned from those who made the transition that quality of life improved after moving to a community setting. Community Participation, Autonomy (including choice), Safety and Productivity were all enhanced when individuals moved from the center to a home in the community. Self Care ability improved and mortality did not increase for those moving.

The challenge for the division to continue this reduction has been the dramatic increase in the number of people receiving division services. In 1986, there were 13,140 people on the caseload of the division. By 2007, that number had expanded to 37,359. There has been a 1400% increase in the number of people living in community residences from 471 in 1980 to nearly 7,200 in 2007. The number of people provided with community services has increased from 6,720 in 1986 to 33,627. Now more than 92% of the people served by DDD are served outside of the institutions. (See Appendix _____.)

The approach that DDD continues to employ, prior to moving people out of institutions, is to first prepare community supports and services. Additionally, the division works to provide the necessary supports to people who have never entered institutions to continue living in communities and to reduce the potential risk of an institutional placement. Building the level of services and supports available in community settings is the critical element to the reduction in reliance on the institutions.

In spite of DDD’s efforts, Braddock’s studies show that New Jersey uses state institutional placements for people with developmental disabilities at a rate of 36.3 people per 100,000 citizens of the general population. In order to achieve a further significant reduction in institutional populations there is a need to expedite statewide community services expansion. Reinforcing existing community services and supports and expanding the types of available services will be necessary so that people with greater health, behavioral and mental health needs can move from institutional settings to the community and so that those living with their families in their own communities can continue to do so.

2. Developing the Path to Progress Plan

The DDD recognizes that planning for needed services and supports requires stakeholder input and participation in order to be successful. Path to Progress draws on this

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stakeholder input, the operational experience of the division, and the experiences associated with closing four state-operated institutions for people with developmental disabilities between 1988 and 1998. This Plan expands upon a number of stakeholder input processes including:

a. The Waiting List Plan 1998

The Waiting List Planning Workgroup developed a 10 point plan to eliminate the Waiting list for community Residential Services by 2008. The Workgroup’s recommendations were offered with the hope of not only eliminating the Waiting List but also to enhance community prevention and support services.

- Support and inform people with developmental disabilities and their families
- Give people with developmental disabilities and their families more choices
- Support people moving from developmental centers into the community and re-deploy resources currently tied to developmental centers
- Commit adequate fiscal resources
- Strengthen the community infrastructure
- Enhance linkage services and support direct care workers
- Simplify and streamline business practices and clarify decision making protocols
- Enhance interagency collaboration
- Engage in ongoing data collection, analysis and planning
- Monitor and respond to changes in social policy

b. New Jersey’s “Governor’s Stakeholder Task Force on the *Olmstead v. L.C.*

The New Jersey “Governor’s Stakeholder Task Force on the *Olmstead v. L.C.* Decision” was convened in November 2001 to guide state efforts to shape a comprehensive plan that reflects a statewide vision for achieving community integration for people across all disability groups. The Governor’s Stakeholder Task Force on Olmstead issued its report in December 2002: *Achieving Community Integration for People with Disabilities*. The report contains the principles and desired outcomes, developed through the collaborative work of key stakeholder groups, whose interest is to make it possible for people with disabilities to live successfully in their communities, participate in making decisions about their lives and have the services and supports they require. The report contains 16 separate topics with a total of 62 recommendations. A number of these recommendations have been implemented by DDD. Path to Progress further incorporates these recommendations in the effort to move institutional residents to community homes and reduce reliance on institutions.

C. PL 2006, c.61 Public Hearings

The most recent stakeholder input process was conducted as a result of PL 2006 c.61. The four hearings were held as follows:
• January 9, 2007 at Union County College;
• January 11, 2007 at New Lisbon Developmental Center;
• January 16, 2007 at Middlesex County College and
• January 18, 2007 at North Jersey Developmental Center.

A total of 264 people attended the hearings with 76 people and organizations offering written and or verbal testimony. Although the Division did not restrict the scope of comments, those offering testimony were asked to address three key areas: 1) Services and supports needed to transition individuals from Developmental Centers; 2) Services and supports needed to successfully integrate and maintain individuals in the community; and 3) Concerns held regarding accessing and receiving services in the community.

Services and supports needed for transition
• Transition planning is critical. It should involve individuals and their families and guardians and ensure that they are informed of their choices and options. It should thoroughly prepare clients, their families, their service and support providers and placements for the transition.
• A team independent of the institution should be in place to assist individuals to make the transition to the community.
• Individuals need transitional services (e.g. security deposits, tryouts in different types of settings; transportation).
• Family members/parents need support during the transition (family education, peer and family mentors etc.).
• Require all info be shared with parent/guardian and follow the person into the community in a timely way
• Community needs to be prepared with how to be a “good neighbor” to developmentally disabled individuals
• Guardianship should be established

Services and supports needed to integrate and maintain people in the community.

• The system needs to provide a continuum of care throughout the person’s life.
• Comprehensive community services and supports must be available throughout the lifespan so people are integrated as participating members of the community.
• Services and supports should build skills people need to thrive in the community such as travel training and budgeting skills.
• Services should be appropriate to each lifespan stage including the opportunity for people to retire.
• Services needed include: transitional services, healthcare, nursing, transportation, mental health services, behavioral supports OT, PT, speech, individual support staff, assistive technology, increased number and variety of
accessible housing options, jobs, volunteer work, meaningful work opportunities, day activities, social and recreational options

- New resources and assessment tools should be developed for individuals with autism

**Concerns and Recommendations regarding the community service system**

- There is high staff turnover.
- Community providers do not have medical or behavioral resources.
- Community providers need appropriate funding with annual increases to cover increasing costs.
- Provider staff needs training (including training in self-direction and crisis management) and better pay to combat high staff turnover.
- Community providers and skill sponsors should collaborate with the State in joint planning.
- The DDD should involve self-advocates in all aspects of individual service planning, system design, monitoring and evaluation
- DDD should review and revise funding and contracting mechanisms
- The definition of abuse should be clarified and information about how adult protective services should function should be disseminated.
- Explain how to be a good neighbor/friend
- Any institutional downsizing should see reinvestment
- DDD should use the resources and expertise of the institutions whenever possible to support, and become part of, the infrastructure of the community system.
- Individuals living in Developmental Centers who testified overwhelmingly spoke of their desire to leave and live in the community. Individuals who had previously lived in Developmental Centers and who made the transition also spoke of the need to ensure that those who want to leave are able to do so.
- A number of family members told DDD that they did not want their specific family member to leave the Developmental Center.
- Family members, despite written and verbal assurances that the Division would not transition people who did not want to move now or in the future, expressed concern that the state would close the Developmental Centers. They believe the developmental centers are a “one-stop-shop” that supports all needs of the individual offering consistent staff, a safe environment and most importantly, quality medical care through the availability of on-site medical staff. The lack of quality medical care in the community is a critical concern for families.
3. The Context of Plan Implementation

a. Systems Transformation

Since 2002, the Division with its stakeholders has begun to address critical systems issues by working on creating a platform and an infrastructure that will make it possible to expand choice and service options to individuals with developmental disabilities. (“New and Expanded Options for Individuals with Developmental Disabilities and Their Families” published in September 2002.) Although the focus has been on individuals living with family or living independently with services and supports in the community to prevent institutional placement, the systems transformation is also critical for transitioning individuals from Developmental Centers.

The DDD Vision, Mission, Values and Operating Principles will serve as a framework for the systems change required by this Action Plan. The elements presented here are contained in a draft document prepared by DDD for discussion purposes; they do not represent a finished product. Rather, they are a continuation of a dialogue that first resulted in the “New and Expanded Options Plan of 2002”. These draft vision, mission, values and operating principles statements are based on the feedback and input we have received from our ongoing dialogue with consumers, their families, providers and Division staff. As a key member of a community committed to supporting individuals with developmental disabilities, the Division recognizes the need to develop consensus around the vision, mission, values, operating principles and strategies contained within this document. Towards that end we will embark on a plan development process beginning in January 2007 culminating in a Strategic Plan by July 2007.

Vision

Children and adults challenged by developmental disabilities will have opportunities to live their own lives, participating fully in their communities – to live as independently as possible; to work meaningfully; to have meaningful relationships with family and friends.

Mission

To partner with individuals who are challenged by developmental disabilities to establish across all settings, a system that maximizes each individual’s ability to express his or her preferences and desires and their ability to self direct his or her services and supports to the greatest extent possible. DDD will provide leadership for and effectively manage the design and equitable delivery of high quality, outcome based, culturally competent, person centered services and supports.
Values

The following set of values provides the context for the Division’s policies, service design and operations. These values provide the framework for the DDD to assure that individuals with developmental disabilities and their families have access to needed community services, individualized supports, and other forms of assistance that promote self-direction, independence, productivity, and integration and inclusion in all facets of community life including work. We believe that individuals with developmental disabilities should:

- direct their services whenever possible and be supported to make informed choices and decisions about their lives across all settings;
- live in homes, communities and settings in which such individuals can exercise their full rights and responsibilities as citizens;
- pursue meaningful and productive lives;
- contribute to their families, communities, and States, and the Nation;
- have interdependent friendships and relationships with other persons;
- be safe, living free of abuse, neglect, financial and sexual exploitation, and violations of their legal and human rights;
- achieve full integration and inclusion in society through relationships and work, in an individualized manner, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of each individual; and
- receive services and resources equitably, based on vulnerability and need.

Operating Principles:

Because we hold these values, the Division of Developmental Disabilities, its staff and leadership is committed to making fundamental system change so that:

- Individuals with developmental disabilities will be full participants in all aspects of the planning and delivery of services and supports so that they are empowered to exercise control over their own lives.
- The system will be person-centered with the needs of the individual dictating the types and mix of the available services and supports.
- Information about Division services as well as general community services will be readily available to assist individuals with developmental disabilities and to make the concept of choice and independence a reality.
All individuals with developmental disabilities will have access to community-based services provided in the least restrictive setting appropriate to their needs.

Individuals with developmental disabilities will have access to a comprehensive array of services that address their physical, emotional, social, educational and vocational needs.

Services and supports will be flexible, habilitative, creative and innovative and delivered in a culturally sensitive manner whether provided by traditional provider agencies or natural supports.

Individuals with DD will be provided with case management or care coordination to ensure that multiple services are delivered in a coordinated and habilitative way and to ensure that they can move through the system in accordance with their changing needs over the span of their lifetime.

Children with developmental disabilities will be assured a coordinated transition to the adult service system.

Services and supports should focus on people acquiring skills that are practical and useful and promote individual competence.

The workforce serving individuals with developmental disabilities will have the necessary training to ensure they have the attitudes (including cultural sensitivity), knowledge and skills to be effective.

The Division will advocate so that individuals with DD will have access to the same services and supports that are available to all.

The Division’s quality management strategy will address outcomes for people by developing structures that measure quality, provide feedback loops and that has the capacity to respond. These structures will emphasize that quality “is all our responsibility”, promote best practice and continual improvement of services.

Quality data from multiple sources will track performance including satisfaction, improve services and remediate systemic problems.

The Division’s commitment to transparency through public reporting promotes trust and accountability among persons served, families, taxpayers who support the system and the community within which the system operates.

C. Organization of the Planning Document

Path to Progress specifies the necessary activities to be accomplished, during the eight year implementation period of the Plan. Planning will of course evolve, based upon ongoing evaluation of the outcomes during initial implementation to include any needed adjustments that become evident. The plan specifies the desired outcomes, the corresponding action steps and the target dates to achieve the outcomes. While specifics of the timeframes are contingent upon external factors, such as budget allocations and private service provider contracting, the intent is to use this plan as a framework to
outline the necessary resources and track the progress toward achieving the desired outcomes.

The Plan is organized in three sections corresponding to the legislative requirements. The sections are:

**Assessment** – This section will present the Division’s review of criteria used by other states and describe the objective criteria for use in New Jersey to identify people with developmental disabilities who are appropriate candidates for living in community-based settings.

**Resource Needs**- This section will identify the resources needed to ensure that individuals with developmental disabilities who wish to transition to the community can reside in the community and receive needed community-based services and supports in a manner that enables them to live as independently as possible.

**Implementation** – This section will set forth how the necessary funding, services and housing will be provided. It will describe the benchmarks, the actions steps necessary to achieve the benchmarks and the timeframes within which the benchmarks will be accomplished.
II. Assessment

This section will present the DDD’s review of criteria used by other states and describe the objective criteria for use in New Jersey to identify people with developmental disabilities who are appropriate candidates for living in community-based settings. It will also describe the characteristics of individuals in developmental centers, the assessment tool and the assessment process.

A. New Jersey Criteria

In New Jersey, the primary criteria presently used to identify individuals who can move from developmental centers to a community setting are:

- The person expresses a desire to live in the community
- The Interdisciplinary Team recommends a move to a community setting

Because placement of the number of people who meet these two criteria is very large, we are using the following criteria to prioritize the groups:

- The family/guardian supports the plan to transition the person to the community.

B. Criteria Used By Other States

The Division queried the membership of the National Association of State DDD Directors to review the criteria from other states. To date, DDD received responses from Wisconsin, North Carolina, Minnesota and Kentucky. Wisconsin passed legislation in 2005 that requires every individual's place of residence be in the most integrated setting (vs. least restrictive), and requires the preparation of an annual community plan, accompanied by a court order stipulating the plan's recommendations. The individual, as well as their guardian/family are part of the team that puts the plan together. Wisconsin assumes everybody should, wants, or is entitled to choose to live in smaller integrated settings.

Any opposition to transitioning from the institution requires evidence that the guardian is 1) knowledgeable about community options, and 2) is actively involved in the person's life. The facility interdisciplinary team has virtually no say. Everyone who is eligible for continued stay in an ICF, is also automatically eligible for HCB Waiver services.

Beyond guardian resistance, only cost-effectiveness would prevent (force) movement: i.e. if services and supports in a community setting are more than the cost in the facility. There are also financial disincentives for counties (counties are fiscally responsible) to maintain individuals at Wisconsin Developmental Centers. They incur a daily charge if the person does not transition to the community (when knowledgeable guardians don't object, and the cost is not prohibitive.)
Kentucky, North Carolina and Minnesota’s criteria are similar to New Jersey’s i.e.:

(a) The treatment professionals determine that an SCL placement is appropriate for the individual; and

(b) The SCL placement is not opposed by the individual or his or her legal representative.

C. Characteristics of Individuals in Developmental Centers

The Developmental Disabilities Planning Institute (DDPI) at the New Jersey Institute of Technology (NJIT) conducted an assessment of all individuals (over 3,000 people) living in New Jersey’s seven developmental centers (DC). The original assessment instrument used with a large sample of people living in the DCs in 2000/2001 was modified after consultation with key staff of the Division, including senior level and program people from each DC. Informants in eight programmatic areas at each DC who knew each person well were trained in the use of the instrument and completed that module specific to their programmatic area. The programmatic areas were Social Work, Psychology, Physical Therapy, Occupational Therapy, Habilitation, Nursing, Nutrition, and Speech. Assessments were completed in late spring of 2006. The assessment instruments are in Appendix ______.

The assessment provides the Division with:

a. A standardized tool for use by all developmental center staff members to describe the unique abilities and needs of each resident;

b. A statewide database which includes information regarding the abilities, preferences and support needs of each resident of the developmental centers; and,

c. The information necessary to identify specific obstacles which may influence the decision-making of staff members who determine, in the Individual Habilitation Plan (IHP), the potential for an individual’s community placement.

Assessment Process Findings

a. Number of Targeted Individuals

- A successful transition process includes a number of key steps. The first and perhaps most critical is for the individual and their guardian to make an informed choice. There are 2,457 individuals who have a recommendation for Community Placement in their IHP. This is about 81% of the people living in the developmental centers. Of these 2,457 individuals, 2,303 individuals do not oppose community placement. As such, the Division will be planning for
placement of 2303 individuals. This is about 75 % of people living in the developmental centers.

The Division’s experience has been that transition to community placement is most successful when the transition process is supported by the individual’s family members. A strong support system is formed for these individuals. It is for this reason that the Division has decided to place those with family support in the community first. When family/guardian support is factored in the number of individuals ready to begin the transition process is reduced. Of the remaining 2,303 individuals, the family/guardians opposed an individual leaving the center in 1,298 cases, even though the IDT and the person did not oppose moving. Further, from the legal point of view, it is unsettled in this State whether a guardian has the legal ability to keep an individual in a developmental center despite the individual’s interest in community placement.

There are **1,005** individuals whose family/guardians do not oppose community placement. This group will be prioritized to make the transition to community residences first. DDD will begin the independent support coordination process with these individuals.

The success of a community placement can depend on the support and involvement of the person and the individual’s family members. DDD has done considerable work in preparing families of people living in institutions to evaluate community options. DDD contracted with the UMDNJ School of Public Health to assist in the preparation of families by providing information and relaying family concerns to DDD. UMDNJ’s Developmental Disability Family Education Project will continue to provide support to all 2,457 individuals and their families/guardians. Emphasis will be placed on the 1,298 families/guardians that do not support community placement at this time. This support and education will ensure they gain an understanding of the services and supports available in the community. This will provide families with the information they require to adequately support their family member through informed choice about transition.

The Division has chosen to work with the 1,005 people where the IDT, person and family do not oppose moving from the center first. This approach seems most feasible given the need to expand community infrastructure to accommodate this first group of people. The Division is committed to serving individuals in the least restrictive setting while providing safety and protection from harm. A reasonable pace of community placements from the developmental centers must be established, while ensuring that supports and services are available before moving forward. In reviewing the supports and services required for first 1,005 people, many individuals require high level support needs. Individuals determined to have medium or high self care needs requiring assistance with virtually all self care activities such as personal hygiene, household chores and community activities comprise 69.9 % of the group. About 64.1% have medical needs which require specialized staff training (not a nurse). Approximately 76.4 % of the people have severe behavior needs that require a formal behavior plan (43.2%) or have behaviors that are extremely high risk to themselves or others (33.2%).
Developing the capability to serve over 2,303 people from developmental centers in a community setting over the course of this 8 year plan is an impossible task. It would mean a reduction of services for all people on the waiting list and those requiring emergency placements. For example, the Division is challenged to place about 340 people in emergency placements each year. During the four year interval from FY1997 through FY2000 the Division increased the number of people living in group homes and apartment programs by about 1,100. An additional one to two years was required to develop the supports and community infrastructure for these individuals. Thus, even during its most intense community development period in recent years, encompassing the closure of the North Princeton Developmental Center in 1998 and the funding of waiting list initiatives serving 500 people each year, the Division was only able to accommodate about 1,100 people in new community programs over an approximate six year period or at a rate of about 183 individuals per year. This number is slightly more than the 1,005 people initially identified in developmental centers today where the IDT, person and family do not oppose moving from a center. Promising to serve 2,300 people from developmental centers alone in new community programs within 8 years would require the Division to place an average of 287 per year. In the Division’s opinion, this would be doing a disservice to those people because such a high rate of new community development has never been sustained in New Jersey. Further, prioritizing deinstitutionalization over individuals who are waiting for residential placement does a tremendous disservice to many of those individuals as well as the 3,683 people on the priority residential services waiting list living at home.

For all of these reasons, this plan is to place 1,005 individuals in 8 years and to continue to educate and prepare the remaining 1,298 for community placement. These individuals will be added to the 1005 plan, continuing the rate of placement in the five to six years beyond the eight year plan, or as long as it takes to move everyone who meets the placement criteria.

The Division has seen individuals and families change their minds about community placement when the transition is imminent. A community placement once seen as favorable is now not so desirable. It is expected through education, information and successful transitions that the number of community requests will increase over time. Additionally, community placement is discussed with all individuals annually at their IHP. It is anticipated that the numbers of individuals seeking community placement will be fluid throughout the years.

Annually the Division will determine the number of individuals ready to begin the transition process because their families made the choice to move from the developmental centers after participating in the informed choice education process with UMDNJ’s Developmental Disability Family Education Project. This will allow the Division to plan for resources to meet their needs. They will be added to the projected numbers for the next fiscal year. The Division will provide all individuals wishing to move to communities throughout New Jersey the opportunity to move. Adequate resources to support all people must be in place prior to initiating a transition.
Once this plan has been actualized, the Division will reassess our approach based on experience gained from this process. We will continue to provide community opportunities for individuals if they so desire.

b. Demographics

Some of the basic demographic information, support needs and preferences of individuals from the assessment are below. Findings from all people living in the DCs and the group of 1,005 where the IDT, consumer, and family have no opposition to the person moving to a community setting are provided for comparison. There are few differences between the groups.

<table>
<thead>
<tr>
<th></th>
<th>All People Living in the Centers</th>
<th>1,005 People Where IDT, Consumer and Family Do Not Oppose Community Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age (Years)</td>
<td>49.2</td>
<td>47.8</td>
</tr>
<tr>
<td>% Female</td>
<td>40%</td>
<td>42%</td>
</tr>
<tr>
<td>% with a Psychiatric Diagnosis</td>
<td>53%</td>
<td>57%</td>
</tr>
<tr>
<td>% with Cerebral Palsy</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>% with History of Epilepsy</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>% with Active Epilepsy</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>% with Visual Impairment</td>
<td>43%</td>
<td>39%</td>
</tr>
<tr>
<td>% with Health Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>involving the cardiovascular/circulatory, digestive, muscular/skeletal or epidermal systems.</td>
<td>40 – 62%, depending on the condition.</td>
<td>40 - 60%, depending on the condition.</td>
</tr>
<tr>
<td>% Using a Behavioral Specialist</td>
<td>29%</td>
<td>39%</td>
</tr>
<tr>
<td>% with special dietary requirements or special food preparation.</td>
<td>65 – 71%, depending on the supports needed.</td>
<td>61 – 74%, depending on the supports needed.</td>
</tr>
<tr>
<td>% needing regular assistance turning or positioning the body.</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>% using a wheelchair.</td>
<td>47%</td>
<td>45%</td>
</tr>
<tr>
<td>% using physical therapy</td>
<td>24%</td>
<td>23%</td>
</tr>
<tr>
<td>% taking antipsychotic medication.</td>
<td>37%</td>
<td>40%</td>
</tr>
<tr>
<td>% who could benefit from environmental adaptations in lighting, cabinets, closets, faucets or doors.</td>
<td>19 – 25%, depending on the environmental adaptation.</td>
<td>14 – 21%, depending on the environmental adaptation.</td>
</tr>
</tbody>
</table>
% with personal preferences, such as living with someone of the same sex or age, having their own room, a smoke free home or a calm/quiet home. | 36 – 53%, depending on the preference. | 32 – 47%, depending on the preference.

### c. Utilization of the Assessment

Some of the information from the assessment has been combined to give indices relating to the supports an individual may need. The three indices include levels of Self Care Support Need, Medical Support and Behavioral Support. In many instances these are related. For example, it is likely that a person who needs high levels of Self Care Supports also has a high level of medical support needs. In other instances the relationship may be the opposite. For example, in some cases, individuals who have very few Self Care Support Needs (i.e., they are independent in terms of self care) may require high levels of behavioral support.

The assessment is one of the first steps in the self directed planning process. These indices of support needs for Self Care, Medical and Behavioral areas provide an initial indication of the budget required as well as the degree and types of supports an individual may use. However, the specific details of the person’s self directed support plan will be completed after full involvement of the individual, family and the support team.

#### 1. Self Care Support Need

The four levels of Self Care Support Need are indicators of the amount of support time an individual require. The support levels vary from an individual who is independent in virtually all areas of self care activities, requiring little support time (Level 1) to a person who needs assistance with virtually all self care activities (Level 4). Self care activities include those related to personal hygiene, household chores and community activities. See Appendix _____ for a more detailed description.

The following table shows that most people living in the DCs have relatively high levels of self care support needs (i.e., they fall into Levels 3 or 4).

<table>
<thead>
<tr>
<th>Self Care Support Need</th>
<th>All People Living in the Centers (%)</th>
<th>1,005 People Where IDT, Consumer and Family Do Not Oppose Community Placement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest Level of Need (Level 1)</td>
<td>10.1%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Low Level of Need (Level 2)</td>
<td>16.8%</td>
<td>16.3%</td>
</tr>
</tbody>
</table>
2. Medical Support Levels

There are 6 levels of Medical Supports identified (See Appendix _____for a more detailed description.)

Individuals in Levels 1, 3 and 5 are able to walk independently with/without corrective devices or are able to use a wheel chair independently, without requiring assistance transferring to or from the wheel chair.

Individuals in Levels 2, 4, and 6 can walk only with assistance from another person and/or use a wheel chair and need assistance moving in and out of the wheel chair.

People in Levels 1 and 2 may or may not have medical conditions. If they have a medical condition, no unusual or specialized training is needed to provide medical care.

Individuals in Levels 3 and 4 have one or more medical conditions that require some specialized training by staff (non nursing) supporting the person (e.g., dressing or wound care, monitoring of oxygen use, insulin administration, etc.).

Individuals in Levels 5 and 6 have one or more medical conditions that require nursing staff to be present or involved in support of the individual (e.g., oral/nasal suctioning, intravenous medications, tube feeding or catheterization).

The following table indicates that most people living in the developmental centers are in Medical Levels 3 and 4. They have medical conditions that can be supported if staff have some specialized training. A nurse is not required to provide medical supports.

<table>
<thead>
<tr>
<th>Medical Level of Support</th>
<th>All People Living in the Centers (%)</th>
<th>1,005 People Where IDT, Consumer and Family Do Not Oppose Community Placement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Level 1</td>
<td>19.8%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Non Ambulatory Level 2</td>
<td>1.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Ambulatory Level 3</td>
<td>39.4%</td>
<td>37.0%</td>
</tr>
<tr>
<td>Non Ambulatory Level 4</td>
<td>28.8%</td>
<td>27.1%</td>
</tr>
<tr>
<td>Ambulatory Level 5</td>
<td>1.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Non Ambulatory Level 6</td>
<td>7.4%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>
3. Behavioral Support Levels

Four levels of Behavior Support were identified.

Individuals in Level 1 do not currently exhibit any inappropriate, rule violating, property destruction, self injurious or aggressive behaviors.

Individuals in Level 2, have minimal behavioral disruptions and do not require any special behavioral supports or environmental modifications.

Persons who are in Level 3 exhibit one or more behaviors that require formal behavioral support and/or environmental modifications that can be provided by support staff with appropriate training.

Individuals in Level 4 have behavioral conditions that are extremely high risk to themselves or others and that require very intensive, high level of behavioral supports by specialized highly trained staff. These supports may include use of one-on-one supervision, personal controls, and a high level formal behavior plan.

The following table shows that most individuals living in the developmental centers require Levels 3 and 4 behavioral supports based on their living environment at this time.

<table>
<thead>
<tr>
<th>Behavioral Level of Support</th>
<th>All People Living in the Centers (%)</th>
<th>1,005 People Where IDT, Consumer and Family Do Not Oppose Community Placement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Special Behavioral Supports - Level 1</td>
<td>21.9%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Minimal Behavioral Supports – Level 2</td>
<td>1.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Formal Behavioral Supports – Level 3</td>
<td>45.1%</td>
<td>43.2%</td>
</tr>
<tr>
<td>Intensive Behavioral Supports – Level 4</td>
<td>31.6%</td>
<td>33.2%</td>
</tr>
</tbody>
</table>

The IHP is the primary vehicle for assessing people on an ongoing basis. The Developmental Centers began using a revised IHP in September 2006. The assessment will be updated at the time the annual IHP is completed. The IHP was revised to include elements of the Essential Lifestyle Planning document. It is expected that the revised IHP, along with the assessment process, will allow for the creation of data-based reports, detailing the supports that would be necessary for each individual in the community.
III. Resource Needs

This section will identify the resources needed to ensure that individuals with developmental disabilities who wish to transition from the Developmental Centers can reside in the community and receive needed community-based services and supports in a manner that enables them to live as independently as possible. The resource needs identified are based upon the experiences of individuals who have made the transition from the DC to the community as well as the input from the public hearings conducted in January 2007. The Division asked those offering testimony to address three key areas: 1) Services and supports needed to transition individuals from Developmental Centers; 2) Services and supports needed to successfully integrate and maintain individuals in the community; and 3) Concerns held regarding accessing and receiving services in the community. It is clear from the recommendations that the system serving people with developmental disabilities must increase the capacity of its infrastructure (both internal to the DDD as well as community capacity) to successfully transition individuals from the DCs.

A. Building Infrastructure

Infrastructure is the underlying base or foundation of an organization or system i.e. the basic structures and processes underlying operations; the basic services and supports needed for the system to function. The infrastructure serving people with developmental disabilities therefore must:

- evolve in sync with changes in the system or organization’s environment
- be based on technology’s uses and user perceptions
- focus on quality of service; dependability and accountability;
- promote simplicity and ease of operability and interoperability
- be managed to ensure its effectiveness

Since 2002, the Division with its stakeholders has begun to address these issues and work on creating a platform for the future. To create this new platform the DDD recognizes the need to re-organize its many operational activities into interrelated components. These components form the underlying infrastructure that will support the Division in its efforts to meet the goals set forth in Path to Progress.

1. The Redesign of DDD Community Operations

In order to better address the needs of consumers currently living in the community, as well as to prevent future admissions to developmental centers, DDD is in the process of redesigning its community services system of case management. The goal of the redesign is two-fold. First, to ensure that a system of triage is in place so that individuals with a high level of vulnerability can receive the case management they need. Second, to put in place care coordination with a state of the art call center (Connections) so that families can receive information, support, and access to education and community
services. Connections will also provide face-to-face information, training and support sessions for families allowing individuals and their families to receive the level of care commensurate with their needs.

The number of individuals on the community caseload has grown every year by approximately 1500 people. The caseload as of December 2006 is 33,627. Approximately 80% of the individuals new to the caseload are under 22 and in school. The caseload was assessed using a uniform tool. Case management ratios were developed based on level of need. Individuals were identified who could benefit most from information, education and support. A triage system was developed to ensure that individuals with the highest levels of vulnerabilities be identified and plans put in place to meet their needs.

Connections is a call center. It is being created to provide information, education and support for families and consumers with low vulnerabilities, most of whom are under 22 and in school. Families have asked for a service that can provide them with information and support throughout the life cycle of their family member with a developmental disability. Connections is a response to this request. Procedures will be in place to identify individuals who exhibit a change in their level of risk. They can be quickly transferred to case management to access more intensive services. Connections will be supported by a web-based information system with up to date information about community resources for individuals with developmental disabilities.

As people’s needs change and vulnerabilities are identified, they can move to a higher level of service. Under Interim Case Management, a short term plan will be developed; services and supports will be arranged with referrals to the crisis system and clinical resource teams as needed. The goal of this process is to support the person where they currently live whenever possible. Interim Case Management will utilize the concept of person-centered planning, consumer self-directed services and direct access to regional budgets to quickly access supports. Long term planning can include returning to Connections for information and education as needed, or transferring to on-going case management.

New caseload ratios will be put in place based on the level of vulnerability of the individual and/or where they live. A triage system will ensure that individuals with risk factors receive the level of case management they need. Individuals with vulnerabilities or in waiver services will have case managers with the lowest ratios. They will receive the level of oversight and access to services that they need. CMS requires that all individuals receiving waiver services receive case management.

The expected outcome of this redesign is better access to and equity of services, with support for consumers where they currently live. Multiple levels of care coordination will ensure changing needs are addressed. The new system works smarter and prioritizes those with the highest needs. The implementation of the System Redesign is highly dependent on adequate staffing resources and information technology capacity. The statewide hiring freeze and the reorganization of information technology units will slow
the rate of implementation of these important system changes and may necessitate alternative measures to reach the expected outcomes.

2. Community Residential and Support Options

The development of community residences for individuals with developmental disabilities is undergoing a major change in New Jersey. A transformation in the way that special-needs housing is developed has created a number of partnerships in which resources are leveraged to support individuals in integrated community settings. Individuals currently residing in developmental centers and moving into community settings will benefit from the new expanded residential options by offering individuals the opportunity to live in the least restrictive environments that foster growth, independence and choice.

Residential options can be characterized in two different ways: provider owned and operated or consumer owned and self-directed. People moving from the developmental centers will have access to residences that fall under each of these two categories thereby providing more choices than in the past including the opportunity to live in supportive housing and self-direct their own services and supports.

The shift towards enhanced personal choice and control and the move from a program-based approach to a person-centered approach has led to a separation of housing and supports options. During SFY2007, the “Olmstead Individualized Community Supports and Services” Request for Proposals (RFP) was issued which introduced several new processes for transitioning people from developmental centers to communities. A provider qualifying process is used to qualify agencies that have experience and expertise in specialized medical and behavioral supports and services leading to a network of agencies for individuals to choose from even those with the highest levels of medical and behavioral support needs. The planning process begins with an Independent Support Coordinator who will assist the individual and his/her family/guardian to choose the type of community living environment and supports based upon the person’s Essential Lifestyle Plan. Funding is associated with the person allowing the flexibility to move or make modifications to his/her supports.

Prior to the Olmstead RFP, the Division of Developmental Disabilities implemented the Supportive Housing Moving-On Project during SFY2006. This project included 50 people that were living in group homes, which are congregate settings. The project participants are moved into their own residences, applied for a Section 8 rental-subsidy vouchers, obtained leases in their own names and received supports separate from their housing costs.

The Moving-On project served two purposes: first, to allow more choice to individuals living in congregate settings and second, to shift control from the community agency to the individual. The Moving On project has helped the division and the agencies learn
about the benefits of supportive housing for people with developmental disabilities including those moving from developmental centers who will have the option to move into supportive housing residences with a full range of supports and services to meet their needs. The advantages of supportive housing as an option include increased choice, community integration and expedited development of the residence.

Another development within the State of New Jersey is the increased focus from the Governor’s Office in creating a capital funding stream in SFY2005 for a $200 million. These funds are referred to as the Special Needs Housing Trust Fund in which 10,000 permanent supportive housing units and community residences will be developed for individuals with special needs. The Trust Fund is one of the outcomes of the New Jersey Governor’s Task Force on Mental Health. The Trust Fund provides 50% to 80% of the capital financing of the project and requires that at least 50% to 20% of the project utilize other funding sources from local, county, state, federal and private sources.

The requirement for leveraging funds has mobilized various groups to work together to share resources and develop many innovative projects that include positive community assets such as developing housing in locations near jobs, transportation, community resources and services. Emphasis is also placed on utilizing high quality building and renovation materials as well as incorporating universal design, energy efficiency, low maintenance and durable features that add to the buildings longevity. The Special Needs Housing Trust Fund is administered through the New Jersey Housing and Mortgage Finance Agency (NJHMFA) in conjunction with partnerships established with the Department of Community Affairs and the Department of Human Services. Technical assistance is provided by the State to private agencies developing projects with these funds.

Over the past several years, agencies developing community residences for individuals with developmental disabilities have been more successful in applying for and being awarded funds from the U.S. Department of Housing and Urban Development (HUD) for project-based funding. Agencies have also been successful in obtaining funding through the Community Development Block Grants. When agencies develop projects through these entities, the results are stronger relationships with Public Housing Authorities and with local leadership in communities across the state. These relationships lead to more opportunities to develop creative housing options. Private for-profit construction companies are interested in receiving Council on Affordable Housing (COAH) tax credits to reduce large tax bills and are interested in working with agencies to build projects that meet the needs of special populations. The result of these relationships with communities and with builders is an increase in housing opportunities that will benefit individuals moving from developmental centers.

In 2003, the implementation of a new option in services entitled “Real Life Choices” became an option for individuals who are on the DDD waiting list for services and living at home with family members or guardians. This option provides a budget, based on an individual assessment, which determines one of four “levels of need.” This option was created based upon the increased desire of individuals and families to continue to be fully
integrated in the community and not separated or isolated in large congregate settings. Individuals and family members have raised awareness of their desire for residences to be smaller in size, more person-centered, allowing more privacy and individualization.

Over the years, DDD has developed a variety of housing options for people living in community settings including: group homes, supervised apartments, supportive housing, supported living, independent living, self-determination, rental subsidy and skill development homes. Additional residential support options are available from affordable housing opportunities offered by other government agencies including: Section 8 rental assistance, public housing and a home ownership program.

In the early stages of community residential development that began in the late 1970s, similar to most other states, New Jersey’s efforts focused on the development of group homes. For many years, group homes were most frequently requested by family members since these homes offer round-the-clock care, supervision and community participation with the assistance of the staff members. While it will be necessary to add some group homes to the array of community residential options, it will be important to focus on developing the more recent options such as supportive housing and supervised apartments. Offering these newer housing options is the goal of the division in addition to including people currently residing in group homes, which have an average of 4-5 residents, the option to move to more independent settings with less people living together with the appropriate supports. (See Appendix ___)

An additional focus of DDD will be to enhance existing living environments to ensure adequate supports are available to the individuals living in the home. As the needs of the residents change, due to age or changes in the disabling condition, efforts may need to be included to add additional services or supports to existing residences including supports to skill sponsor homes. There will also be a need to explore the available options in making renovations to homes to provide increased physical accessibility.

There are several challenges that confront housing development. Housing costs are at an all time high, making negotiations for existing homes and apartments more difficult and more costly. In low-income housing programs, such as Section 8 Housing, people with developmental disabilities compete with people with other disabilities for available space. There is an increasing demand for accessible housing for people who use wheelchairs or for people who are unsteady on their feet. One of the most cost-effective and least disruptive ways in which to deal with these needs and challenges is to properly maintain, repair and renovate new and existing homes.

In FY2007, funds have been designated to modify existing community residences to make them accessible for individuals transitioning from developmental centers who require ambulation supports. The funding is targeted for residences that have funded vacancies. Additional operating funds are also available for increased staff supports and accessible vehicles due to the anticipated higher level of needs displayed by the individuals filling the vacancies from the developmental centers. With the successful
completion of this initiative, it is planned to continue modifying a specified number of existing homes each fiscal year, as funds will allow, to make them accessible.

For people living in all of the various residential programs, there are a variety of services and supports necessary. The goal of the division is to be able to provide flexible, individualized supports that meet the various needs and choices of people with developmental disabilities in community settings. While services are tailored to an individual’s current needs and choices, ideally, these services and supports should be flexible, changing as a person’s needs change. The goal is to provide what the individual needs to be fully integrated in the community, with an emphasis on individual empowerment, independence and self-sufficiency.

The Division is also developing the resources to provide residential services in a crisis. This service, known as emergency capacity can be provided when a caretaker is suddenly unavailable or can no longer provide care due to challenging behaviors. Emergency capacity is available in three of the DDD service regions and an RFP for the remaining region and expansion throughout the state is forthcoming.

Additionally, the Developmental Centers have the potential to be an important resource for people with developmental disabilities who live in community settings. The Division foresees an evolution of the Centers toward being a regional resource with a focus on more specialized supports such as medical and dental services. One benefit to this approach will be the avoidance of out of state placements.

Wherever people with developmental disabilities are served in their communities, they need to be able to get to work, to medical appointments, to shop, to recreational activities and to visit with family and friends. Often people need accessible and sometimes specialized transportation. Transportation for people living in group homes is arranged by the community provider agency. In other settings, the provider agency may assist with transportation or may support the person to use public transportation. As more people with complicated physical problems enter communities, supports will need to be included that reflect transportation needs.

3. Community Supports for People with Co-occurring Mental Illness and Developmental Disabilities

The DDD’s strategy for providing community mental health services to people with developmental disabilities is to collaborate with the community mental health system building upon the existing mental health infrastructure of expertise and services. As a result DMHS and DDD have developed a 10-bed community inpatient program as well as step-down program capacity for people with developmental disabilities currently receiving treatment at Ancora Psychiatric Hospital to provide alternatives to a longer hospital admission for mental health reasons.
The DDD is also collaborating with DMHS to develop a crisis response system that will provide a uniform response throughout the state to individuals in crises that are linked with the Division of Developmental Disabilities. This program will provide a quick response to a behavioral or psychiatric crisis, conduct a face to face assessment and link to a network of agencies that will meet the identified needs of the individual. The program is committed to addressing the behavioral or mental health needs of individuals with developmental disabilities in order to maintain them in the community. The SCCAT Crisis Response Program will build on the services for the developmentally disabled that are already established at Trinitas Hospital.

The crisis response system is critical because expanding the capacity and availability uniformly across the state will help to reduce the number of referrals to developmental centers and will aid in supporting individuals who are moving from centers into community residences. The following outlines the crisis response system.

**Crisis Response System**

1. This service will be directly available to DDD, provider agencies and families through a 24/7 toll-free phone line.

2. SCCAT clinicians will conduct a face-to-face assessment of the consumer within the crisis setting(s) in order to develop a crisis management plan. SCCAT clinicians will provide on-site intervention in order to lessen the acuity of the crisis. This may include staff/ family/ sponsor training, environmental adaptations, helping the support staff to develop a crisis protocol, behavioral intervention. On the basis of the assessment and crisis intervention, recommendations will be generated regarding linkages to relevant longer term supports. The goal is to manage the crisis in place, equip support staff and families so that they can better manage the behavioral crisis and equip the consumer to gain better behavioral control. Once the level of acuity is lessened, the consumer will be ready for referral to agencies that can stabilize the consumer to lessen the likelihood of crisis re-occurrence.

3. Based upon recommendations derived from assessment and crisis intervention, SCCAT will work with DDD staff and Resource Teams to fast-track consumers to relevant providers. SCCAT would like to have direct access to DDD Community Development staff in order to secure the necessary services from DDD provider agencies. This includes residential settings, emergency respite, day programs, and other behavioral support services. SCCAT will secure services from non-contracted agencies, such as psychiatric treatment and other services that may be obtained through insurance.

4. The SCCAT Network Provider Relations staff will work directly with DDD Community Development staff in securing the necessary resources from DDD provider agencies. The Network Provider Relations staff will make recommendations to DDD Community Development staff regarding agencies and services that may be a good fit in addressing the problems of the individual.
5. SCCAT Network Provider Relations staff will collect data regarding the resources needed. This information will be utilized to develop the primary resource agencies. There will be primary resource agencies for various services as such as residential settings, emergency respite, day programs, and other behavioral support services. We will look to develop services from agencies with particular strengths that will promote stabilization and circumvent future crises.

6. Providers will be expected to abide by a Crisis Management Plan including, accepting training and consultation from SCCAT and implementing recommendations. A policy requiring providers to demonstrate adequate effort to work with SCCAT to manage behavioral problems in place prior to granting requests for outside placement is being considered.

4. Quality Management
Supporting the transition to the community requires a quality management system that ensures a continued focus on quality of services and supports. The system needs to enable people to have choice in designing supports and services that they need and want live in safe environments, free from abuse, neglect and exploitation, ensure fiscal and programmatic accountability; produce reliable information about performance and valued outcomes for individuals and families.

Several changes have occurred in recent years at DDD to enhance choice and the quality of services and supports for people. In 2001 an Office of Quality Improvement (OQI) was established to address, develop, monitor and improve the provision of service delivery and facilitate in building a person centered system of supports for people with developmental disabilities. This office is supported by the Office of Quality Management and the Division’s leadership and has developed strategies to enhance the Division’s monitoring and oversight capabilities and effectively assesses key performance indicators. The development of more effective, non-intrusive methods of monitoring the effectiveness of self directed services and developing methods to evaluate natural supports is currently underway.

In 2002, following a review of service delivery by major DDD stakeholder groups, DDD announced a plan for system change that would provide: greater choice and equity in services, enhance person-centered planning and introduce self directed models into the system. This system change was the beginning of the Real Life Choices option for people on the Division’s waiting list who desire to live at home as long as possible. Real Life Choices gives people the option to self-direct services and supports.

In 2003, DDD began to develop its Information Technology (IT) system to allow data from a variety of monitoring sources to be brought together and analyzed using web-based technology. This system when fully implemented will enable the OQI to analyze data from multiple sources for patterns and trends and to recommend and implement actions to address them. This effort is described in charts appended to this plan (see
Appendix --). Currently, DDD; in partnership with the Department of Health and Senior Services, will utilize an almost five million dollar CMS System Transformation Grant award to continue to build the necessary IT infrastructure to facilitate service delivery to people of all ages with all types of disabilities; with unobstructed access to services and allowing the consumer to choose supports and services they desire.

In 2004, DDD was the recipient of a CMS Real Choice System Change Grant. This grant has given DDD the opportunity to develop a Quality Management Steering Committee that includes families, consumers, advocates and other stakeholders in the review of quality management issues. After an extensive review, this committee has recommended that the National Core Indicators serve as a benchmarking tool for NJ’s DD community. Participation in the National Core Indicators Project will begin in July 2007.

The OQI is currently developing performance indicators for the support coordination model. This model, in addition to traditional models, will be utilized to transition and provide ongoing support to people who choose to leave a developmental center and move to the community. Clearly, knowing and/or developing mechanisms for knowing “how” a person would like to live precedes where they “should” live. Person-centered planning is one way to learn about what a person wants and discern the balance between what is important “to” and important “for” the person. With these tenets in mind, the OQI is working with the Independent Supports Coordination Team in developing strategies for achieving positive outcomes for people leaving developmental centers.

The importance of building and strengthening community infrastructure needed to under gird a system of supports cannot be overlooked. DDD has begun the Redesign of the Regional System, which includes case management services to improve the quality and the responsiveness of this service. Caseloads will be restructured and with IT developments that will utilize a uniform assessment, single monitoring tool which captures data and streamlines information the case managers will be able to move from a caretaker role to a role of support that can identify systemic problems and provide the case manager with the ability to focus on the individual needs of the entire caseload.

The Redesign will also include 4 regionally based Quality Improvement Units that will support the case management system through resource development, provision of technical assistance to licensed providers when problems or risk factors are evident, providing training to service providers, review and ongoing monitoring of day activities and programming in the community, development of continuous quality improvement planning with licensed providers and implementing all aspects of quality improvement in the Region.

A Regional Resource Team for long term case management and a Statewide Crisis System to provide an immediate response, complete assessment, provide treatment and refer as necessary; will also be developed to enhance the infrastructure of the regional system.
In June 2006, the DDD Office of Risk Management was established within the OQI. This office now provides a system that is coordinated and comprehensive, that aligns activities and functions and improves the ability to identify and reduce risks to individuals in the service delivery system. It is vital for the organization to be committed to risk management.

Analysis and interpretation of risk management information that allows managers to make informed decisions and to be accountable for the results of action taken is fundamental to the DDD risk management process. The DDD risk management system provides the structure that measures quality, provides feedback loops and has the capacity to respond. Elements of this structure include an “Early Alert” process that identifies systemic breakdowns and provides technical assistance to licensed providers; review and analysis of incidents of abuse, neglect and exploitation, follow up on investigations and promotion of best practices and continual improvement.

5. Recruitment and Retention of Direct Service Staff Members

The recruitment and retention of direct service, paraprofessional and professional staff members with specialized training to provide community services has a vital role in reducing reliance on institutions. Compensation and training have been identified as the two most critical areas of concern.

Considerable research regarding compensation has been done nationally regarding the amount of wages paid to direct support professionals. One survey identifies New Jersey wages for direct service workers at an average of $13.25 in the public sector and $9.77 in the private sector, based on 2002 data. While averages for both public and private sector direct care wages in New Jersey are well above the national averages ($11.67 public and $8.68 private), wages of direct support professionals, as a proportion of the general state hourly average wages, were 63.1% for state direct support professionals and 46.5% for private sector direct support professionals.

New Jersey has made efforts over the past several years to improve direct service worker salaries utilizing the Cost of Living Adjustment (COLA) to provide additional funds above the COLA to direct to the salaries of the direct service workers in the provider agencies.

While there have been some significant efforts in New Jersey to address the concern regarding the salary of direct service workers as a major contributing factor to the high turnover and difficulties for community provider agencies in the recruitment of direct service employees, there is still a gap between the current starting pay for direct service

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3 “Policy Research Brief” pages 5-6.
workers in the private sector versus the public sector. The current hourly wage is $10 an hour for the direct service worker in the community agencies and the starting pay for state direct service workers is $13.51 an hour in the developmental centers. The recent history of compensation efforts is shown in the following chart:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>1.8% for all private direct service workers</td>
</tr>
</tbody>
</table>
| 2001       | 2% on direct care salaries  
1.6% COLA to direct care salaries  
$1.00 per hour direct care salary bonus |
| 2002       | 1.6% COLA  
$1.00 bonus |
| 2003       | 2% COLA with stipulation that direct care salaries go up at least  2%       |
| 2004       | None                                                                      |
| 2005       | 3.5% COLA with stipulation that if health care is paid, direct care salaries must receive at least 50% of the COLA. If no health care, they must receive 75%.  
.5% additional COLA later in year. |
| 2006       | 1% COLA unrestricted                                                      |

While wages are critically important to the recruitment and retention of direct service workers, studies show that there are other factors that deplete the numbers of direct service personnel, such as stress and the inability to take time off when needed. New Jersey and nine other states were recipients of “Real Choice” grants from the Federal Centers for Medicare and Medicaid Services (CMS) in SFY 2001 to utilize for initiatives that are intended to improve recruitment and retention of direct service staff. The grantees focused on recruitment efforts, extrinsic reward (wages and benefits), training and career ladders, changes in culture and systems administration and planning.

New Jersey’s 2001 Real Choice Grant focus was to develop a Medicaid provider as a rapid response agency to provide a roster of part-time workers to provide direct service workers “on-call” in emergency situations or to replace workers with scheduled absences. This initiative led to an informal arrangement with a staffing agency that was willing to train temporary staff in DDD policies and procedures. That agency responds to requests for staffing by private providers around the state. A pool of trained temporary staff can help service provider agencies avoid mandatory overtime demands on their permanent staff as one way significant strategy to reducing stress and improving retention.

**Staff Members Competencies and Skill Acquisition**

Professional, paraprofessional and direct service staff members are important contributors to the success of reducing reliance on developmental center placements. They need to be well-informed about the growth of community opportunities, the diversity of options, the
process for building high-quality, person-centered IHPs, the transition process for people moving out of the centers and ways in which to support individuals and their families in making important life choices.

Some excellent work has already been done regarding building these worker skills by the University of Medicine and Dentistry-(UMDNJ) - NJ School of Public Health pertaining to building competencies and skills in these areas. The next step is to develop a process and establish a timeline for teaching these skills to staff members, and educating them in this plan. The next needed step is a process for teaching these skills and this plan, to staff members. In collaboration with the Boggs Center, DDD co-chairs a Statewide Training Advisory Committee (STAC). The STAC reviews core training modules and updates them based on best-practice and national research. Statewide Clinical Consultation and Training (SCCAT) program through Trinitas Hospital provides an annual six session training series on to mental health providers and developmental disabilities services providers, care coordinators and case managers on various mental health topics.

In 2004, DDD was awarded a three-year “Real Choice Systems Change Grant” from CMS to help NJ build the infrastructure that will support people with developmental disabilities in their communities and allow individuals to exercise meaningful choices. One goal of the grant is to develop an interactive training CD which will help facilitate a cultural shift to emphasize person-centered planning. In addition, this training CD will teach a continuous quality improvement model which is consistent with the CMS Home and Community Based Services Quality Framework and teaches business process redesign.

Direct support staff members need continuous training opportunities to assure they have the necessary skills and competencies to address both the day-to-day needs of the people they serve as well as the more challenging aspects of care. One resource available to and utilized by providers in several states outside of New Jersey is the College of Direct Support. This an on-line service developed at the University of Minnesota with courses that have been reviewed by national experts. DDD is working with the New Jersey provider community in exploring the opportunities and benefits associated with the College of Direct Support.

IV. Implementation

This section will set forth how the necessary funding, services and housing will be provided. It will describe the benchmarks, the actions steps necessary to achieve the benchmarks and the timeframes within which the benchmarks will be accomplished.
A. Number Targeted for Transition

The DDD has identified 1005 people with developmental disabilities who currently reside in New Jersey’s Developmental Centers (DC’s) for transitioning to the community. DDD is committed to enabling these people to:

- live in the most integrated community setting appropriate to their individual requirements and preferences,
- exercise meaningful choices about their living environment, their providers of support and services, the types of supports they use, and the manner by which services are provided; and,
- obtain the supports and services they want to enable them to achieve their desired results and outcomes, all of which will permit them to live as fully participating citizens of their communities.

The yearly transition benchmarks will be as outlined below. The yearly transition benchmarks will be reviewed and adjusted to include new individuals who decide to make the transition from the Developmental Center.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2008</td>
<td>100</td>
</tr>
<tr>
<td>SFY 2009</td>
<td>100</td>
</tr>
<tr>
<td>SFY 2010</td>
<td>100</td>
</tr>
<tr>
<td>SFY 2011</td>
<td>125</td>
</tr>
<tr>
<td>SFY 2012</td>
<td>125</td>
</tr>
<tr>
<td>SFY 2013</td>
<td>152</td>
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<tr>
<td>SFY 2014</td>
<td>152</td>
</tr>
<tr>
<td>SFY 2015</td>
<td>153</td>
</tr>
</tbody>
</table>
B. The Elements of the Transition Process

This transition process will include the following elements:

1. Promoting Informed Choices by Individuals and their Families

The success of a community placement can depend on the support and involvement of the individual and the individual’s family members. In order to agree to the concept of moving to a community residential placement, the family needs to feel that their loved one will not be abandoned or neglected, will receive the needed services, and will be free from abuse and neglect. Families have often heard stories about community placements that did not work out, or they may have personally experienced a community placement, that was made for their loved one in the past, that was not successful.

Supporting families to enable them to gain an understanding of available services, services under development and the evolution of services generally is an important responsibility. Families must be confident that health and safety issues are addressed and family members need to be included in the planning for people who will be transitioning from developmental centers to the community.

The Developmental Disabilities Planning Institute of the New Jersey Institute of Technology was engaged by the Division of Developmental Disabilities to do a study of the outcomes for the former residents of the North Princeton Developmental Center (NPDC). Their report, “Life After North Princeton Developmental Center: Final Outcomes,” published in November 2003 describes the experiences of people moving to community settings. The study concluded that “despite opposition to the closure of NPDC by some family members, there is now strong support of community living by a clear majority of NPDC family members.” The experience of other families plays an important role to those who are considering a community residence for their loved one and evaluating the options.

DDD has done considerable work in preparing families of people in institutions to evaluate community options. DDD contracted with the UMDNJ School of Public Health to assist in the preparation of families by providing information to families and relaying family concerns to DDD. UMDNJ’s Developmental Disability Family Education Project (DDFEP) has developed a workbook called “Moving On” that outlines the transition
The workbook, which is based upon the experiences of New Jersey families, is undergoing revisions and has been renamed "New Beginnings in Community Living: A Workbook for Your Family Member's Transition from a Developmental Center to Community Living." These revisions will reflect the new person-centered approach as well as the support coordination model that is being utilized by DDD. When completed, it will provide user-friendly, step-by-step modules that can support families go through the community placement process. One of the modules in the workbook would be a directory of qualified agencies. DDFEP also provides a quarterly newsletter “New Beginnings” which features articles and stories about community living and the process. The DDFEP conducts orientations for families of transitioning individuals to provide an overview of person-centered planning, support coordination, and the transition process. An appropriately modified orientation is also provided for DC staff identified as part of the person’s transition process. Family forums that are open to all interested family members are held to offer opportunities to hear from and ask questions of those who have experienced transition, agencies who provide community services, and to network with other families. Information is also disseminated by the mail and phone contact with the families.

Assisting individuals to make informed choices is also a key component of transitioning to a community home. Institutionalized individuals often lack sufficient information regarding the available options. Additionally, as a result of long term institutionalization, individuals may lack sufficient skills to weigh choices and may lack confidence in their own ability to both make choices and assert their desires. Prior institutional closures within the State of New Jersey have demonstrated that a vigorous self advocacy movement supporting institutionalized individuals is the most effective intervention to promote making informed choices. Therefore, an expansion of self advocacy supports will be an integral aspect of the Olmstead effort.

**Independent Support Coordination Team**

The Independent Support Coordination Team will be the vehicle to assist people in fostering self-direction as they transition from developmental centers. It is an independent process that facilitates planning and coordinating services and supports. Support Coordination empowers the individual and their team by promoting meaningful choices about where to live, the types of supports they will use, and the manner by which these supports will be provided.

Through a Request for Proposal process, the Division has contracted with two agencies to provide Independent Support Coordination. Contracts should be finalized in March 2007 and the agencies should be operational by July 2007.

Neighbours Incorporated has been providing Support Coordination in the community since 2005. They will be involved in the training of the new Independent Support Coordination agencies. They will be actively involved in the planning of independent
support coordination services for individuals ready to move from Woodbridge and New Lisbon Developmental Centers beginning January 2007. The primary purpose is to develop the procedures that will then begin to be implemented state-wide through the new Support Coordination agencies beginning July 2007.

January through July 2007 the Division will solidify the procedures for the interface between the DCs and the Independent Support Coordination Teams and implement the planning process for individuals leaving the DCs. Procedures will then be implemented in the other DCs. The Division is committed to a uniform process state-wide that focuses on the needs and wishes of the individuals moving from the Developmental Centers. The key element of planning utilizing Independent Support Coordination Teams is the ability of the individual to choose how and where they want to live and receive the services and supports to achieve that goal.

The Support Coordination Agency will function as part of a team that facilitates the process for the individual. The person is the center of the process and must take an active role as much as possible along with those who care about them. A “relationship map” will be developed to identify those who are important to the individual and have a close relationship with her or him. A transition case manager will initiate this process. They will play a key role throughout the planning. Transition case managers will be the primary connection between the developmental center and the independent team. The person, their family and/or guardian, support coordinator, transition case manager, peer and family mentor and identified developmental center staff could be members of the team. This team will be the decision making body during the transition process. A person centered plan will be developed for each individual. An Essential Lifestyle Planning (ELP) process will be the critical vehicle for identifying supports and services. All team members will be required to attend ELP trainings and demonstrate knowledge of the ELP model and the person-centered thinking philosophy.

The Support Coordination role within the team process includes the following:

- Attend information sessions where individuals learn about ELP
- Make initial contact with the individuals and their teams to introduce their Support Coordination role
- Arrange follow-up meetings, both group and individual, to continue development of the Plan of Care
- Assist individuals with the ELP process
- Work with the individuals and their teams and the mentors in identifying outcomes
- Assure the plan of care addresses health and safety issues
- Assist in identifying, through the Qualifying Individuals and Agency Process, services and supports that would achieve the individual’s stated outcomes.
- Assist individuals in assuring that services they have identified will really meet outcomes
• Mediate between individuals and providers to insure that individuals have been given supports and services based on identified outcomes, rather than those based on what program may be available
• Assist in using the budget to achieve outcomes
• Insure that supports and services identified are in the correct waiver category
• Assist and facilitate Learning Communities
• Enter all data into the electronic record, and send information to the individual and their team for approval
• Make revisions to the plan as requested by individual
• Participate as a member of the team in the annual renewal process

3. Peer and Family Mentors

The Peer and Family Mentors currently play a critical support role within Real Life Choices and will play a critical support role in the transition process as well. The Mentor focuses on creating a strong support network around an individual and his/her family. Ultimately, the Family Mentor is responsible for forging relationships with the individual and his/her family, supporting them by sharing personal experience and helping to develop community connections. The Mentors participate in orientation and support coordination team meetings.

4. Plan of Care Development through Essential Lifestyle Planning (ELP)

DDD has incorporated Essential Lifestyle Planning (ELP), a nationally and internationally recognized life-planning tool, as the Plan of Care model for people who are self-directing their supports and services. The ELP will be the document used for people as they transition from the developmental centers to the community. While it is true that like needs are directly linked to like supports and services, the types of services need to be very individualized. ELP starts with identifying how a person wants to live (Important to), and balances that with any health and safety issues (Important for). ELP is a guided process for learning how someone wants to live and for developing a plan to make it happen. The Essential Lifestyle Plan, developed through a process of asking and listening, provides a snapshot of how someone wants to live today, and serve as a blueprint for how to support them tomorrow.

Unlike any tool used in the past, the Plan of Care that is developed through this ELP process, talks about the individuals’ strengths, not weaknesses. It allows individuals with disabilities and their families to discuss great things about the person. What are their strengths mentally, physically and spiritually? What do others like about the person? What is important to the person? What are the characteristics of people who support the
person best? What do others need to know or do to support the person? In this model, the individual is the focus, not the service or the program.

Individualized Support Coordination is a critical element in fostering self-direction for individuals transitioning from institutions. Support Coordination assists the individual and their team through the process and allows them to remain in control of their plan. This function is provided by individual Support Coordinators who work face-to-face with the individuals and their team. Peer and Family Mentors also assist with the development and implementation of the plan by developing a relationship with the individual through the sharing of their own real life experiences.

A partnership is formed with all team members who are ultimately responsible for assisting individuals in the development and implementation of the Plans of Care. Decisions made by one individual or single agency’s do not offer the breadth of creativity that can come from a group process. A team of equal partners working together for the same goal can generate more comprehensive, successful outcomes. Not only does the team concept foster participation on the part of the individual, it brings the system partners to the table. The discussions and decisions can be made as a team, with an immediate feedback loop that does not require layers of agency approvals.

These teams, made up of the critical partners, generally meet during the initial stages of Plan of Care development. As the process continues, a sub-team works face-to-face with the individuals on implementation and monitoring of their Plans of Care.

The agencies’ roles will be led by the individuals and their selected team members, to facilitate the planning and development of services and supports. Payments for supports and services will be paid through existing contract payment methods or by fee for service via a fiscal agent. All supports and services will be provided by Qualified Providers; these could include housing, employment, residential and staff supports. Quality will be measured by the successful implementation of the desired outcomes of the individual. In order for the Support Coordination to succeed, ongoing technical assistance and training will be provided to each of the selected agencies.

5. Individualized Budgets

Once a level of need is determined, this information is used to develop an individualized budget. There is a strong correlation between individualized competencies and the amount of support time needed. Individuals with developmental disabilities with the lowest competencies need the most support time and have the highest need for services. The assessment and individual budget build equity into the system by determining who needs more support and by ensuring those with like needs receive like resources.
6. Fiscal Agent

Since the state cannot give funds directly to individuals to pay for their services, DDD utilizes a fiscal agent to pay for the services and supports identified by people who are self-directing their services and supports. The major functions of the fiscal agent are to disburse the public funds allocated to individuals via payments to service providers and to act as employer of record for staff hired directly by the individuals. Easter Seals of New Jersey is the agency that is currently providing fiscal agent services on behalf of individuals who are self-directing their services transitioning from developmental centers and in Real Life Choices. An RFP is being developed and will be distributed to expand the capacity of the fiscal agent.

7. Community Services and Supports through Qualified Individuals and Agencies

Individuals may choose to self-direct their services or choose service options that are provider managed. Historically, services could only be accessed by providers under contract with DDD. This limited any choices for the individual with a developmental disability and their family. As part of the systems change to expand the ability for self-directed services and choice, DDD created a process for qualifying individuals and agencies (see page of Appendix DDD-contracted providers are pre-qualified; and, non-contract providers, including individuals, can now apply for qualification and be approved to provide an array of services. Applications for qualification can be found online through the website of the Family Support Center of New Jersey [www.fscnj.org].

In addition, through the “Olmstead Individualized Community Supports and Services RFP”, agencies were qualified to provide residential, employment/day, housing, behavior and medical supports for persons with varying levels of behavior and/or medical needs. These agencies will also be included on the qualified provider list. An Open Enrollment process has been initiated and will be available three times a year. Agencies wishing to be qualified under the Olmstead RFP can access an application through the DDD website [www.state.nj.us/humanservices/ddd/index.html]. A goal of the Division is to have one qualifying process for all supports and services.

This process has not only increased the number of agencies and individuals to serve people with developmental disabilities, but the types of services have grown as well. There has been expansion of the more traditional services, such as home health agencies, and DDD is beginning to qualify more generic types of agencies and businesses to provide services to individuals. Local YM- and YWCA’s and community colleges have been qualified, for example, along with county parks, fitness centers, and art and dance studios.
The specific transition services that will be available include peer and family mentors, housing specialists/job specialists, community connector, staff connector, vehicle modification, appliances such as microwaves that would facilitate safety and independence as well as one-time services such as security deposits, utility set-up and installation, furnishing and moving expenses.

8. Management Information Systems (MIS)

The DDD is in the process of creating one integrated relational database for client information. All data is entered through Internet browsers using a secure website. Division staff, Support Coordinators, and staff of the fiscal agent all have access and input information using a role-based system that authorizes level of access and protects privacy in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This electronic record contains the Plan of Care, which has been developed with input from Quality Improvement staff as well as families, participants, provider, and stakeholders.

C. The Transition Process

DDD will use the following process to transition individuals from the Developmental Centers to communities in NJ.

Step 1

**DDD Starts the Process of Transitioning from Developmental Centers**

- DDD identifies individuals to be transitioned to the community from individuals who express a desire to live in the community and whose IDT recommends community placement.
- Individual Resource Tool establishes the Level of Need of the individual.
- Level of Need determines individual budget.
- DDD insures that the individual is added to the Community Care Waiver.

Step 2

**Transition Case Managers at DC’s begin to assist individuals with identifying their team, including family, friends, those that know and care about the person.**
- Each individual, family and or guardian has an information and education meeting to discuss person centered planning and the support coordination process.

- Orientation meetings are held with the IDT members of each of the individuals who have been identified to move. The goal of these meetings is to acknowledge the work of the DC, ensure receipt of the information that has been completed and review the Independent Support Coordination Team process. Information from the IHP and the Comprehensive Assessment will be given to the Support Coordination Teams. These meetings will be the beginning of the process to identify DC staff who will be participating as members of the Independent Support Coordination Teams.

- Transition case managers will develop a “relationship map” to begin to identify individuals who are important to and care about the person.

- Individuals and their team learn about writing person-centered descriptions and Essential Lifestyle Planning (ELP). The goal of this training is to assist the individual and their team to discuss what is important to the individual and what is important for the individual prior to developing a Plan of Care.

**Step 3**

**Support Coordinators begin work with individuals and their teams to develop Plan of Care.**

- Plan of Care includes identified outcomes and specific actions needed to support the individual to better live and function within the community. It includes the services and supports that are needed to achieve these identified outcomes.

- Plan of Care is developed, based on how the individual wants to live, needed supports and the individual budget. Support Coordinator submits Plan of Care to State Monitor for review and approval.

- Services and Supports need to be covered by the DDD Community Care Waiver.

**Step 4**

**Support Coordinator utilizing the Plan of Care assists individuals and their teams to access services and supports**

- Individual and their team decide through the Plan of Care the amount and kinds of services and supports they need based on the outcomes established in the ELP.

- Support Coordinator works with individuals and helps them to access services and supports.
• Computer database can be used to learn about availability of services and supports, and qualified agencies to deliver services.

• Individual, members of their team, and/or their Support Coordinator contacts organizations to discuss potential services that would achieve the personal outcomes identified in the Plan of Care.

• The person, their family, and other members of their team make decisions about who will deliver services and supports, and the Plan is finalized.

Step 5

Ongoing quality assurances, quality improvement and monitoring/review of resource utilization in the Plan of Care. The Plan of Care is reviewed annually.

• Information on the individual and their Plan of Care will be shared by DDD, Support Coordinator, and fiscal agent through the electronic record, and will be organized to facilitate billing for the DDD Community Care Waiver

• If an individual chooses to change services and/or supports prior to the annual review, the Support Coordinator will facilitate changes

• If needs of an individual change, Support Coordinator will notify the Division and the Individual Resource Tool will be utilized to revise the budget. Changes in Plan of Care will occur based on an individual’s changing needs

• Annual Plan of Care review is facilitated by Support Coordinator; Plan of Care is reviewed and approved by the DDD State Monitor.

F. Managing and Ongoing Planning

The Path to Progress is intended to be a working plan, providing the framework that individuals will use to build meaningful lives in their communities. As the plan progresses over time and action steps reach their targeted outcomes, there will be a need for evaluation of that success and formulation of the next action step.

There is also an expectation that there will be a need for recalibration or replacement of some action steps if it is required. This will occur in cases where an opportunity becomes available that may enhance the goals of the plan. This would necessitate the action steps be updated to take advantage of that opportunity. Should there be the recognition that a
planned action is not having the desired effect; that action step will be revised with one that is anticipated to have a better chance of success.

If a substantive change is needed in any of the action steps of the plan, key stakeholders will be contacted. Through collaboration with the stakeholders, the action steps will be revised, modified or additional actions will be added.

The implementation of Path to Progress necessitates the proper management of the action steps to be successful. To insure the success of this plan, DDD has appointed a full-time manager who is responsible to oversee the implementation, report on achievements and liaison with other state agencies as may be necessary. This manager assures that stakeholders are kept informed, that DDD operational efforts are in line with the timeframes and that questions and concerns are addressed. Access to upper management is transparent and facilitates removing barriers to progress as the plan moves forward.

Path to Progress is a plan to organize some of the most important activities necessary to transition people from Developmental Centers to communities throughout New Jersey. Its design is meant to be flexible in terms of planning and recognizes that the needs of the persons who will utilize it will be wide and varied. As planning develops for each individual, it is anticipated that new opportunities for collaboration will surface which must be fully explored in order to best meet the individual’s outcomes.

There will be a continual need to develop resources for the individuals served through the plan. It is through individuals choosing the services they need and want that the person will become empowered to a level not previously seen. The shift is from the person fitting the resource to the resource fitting the person.

On a more individualized level, an individual’s essential lifestyle plan is a true living document, being adjusted easily and quickly to meet the persons needs and outcomes. There will also be flexibility in the individual’s budget that will provide ease in the purchase of supports and services.

**G. BUDGET CONSIDERATIONS**

Section G will contain specific cost information for implementation of the Path to Progress Plan.
<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Elements</th>
<th>Target Date</th>
<th>Date Completed</th>
<th>Outcomes</th>
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</thead>
</table>
| Identify the Supports and Services that will be needed to serve individuals moving from Developmental Center living to Community living | • New Jersey Institute of Technology developed an assessment of all individuals currently residing in New Jersey’s seven Developmental Centers which was completed by DC staff.  
• The information gathered was used to prepare a report which identifies the descriptive characteristics of the individuals and then analyzes the data to determine needed supports and services. | 9/1/06      | Draft report received 2/6/07 | NJIT report received               |
| Interviews completed to gain clarification of assessment information.                              | • NJIT conducting interviews with individuals from the assessment who can participate and provide answers in an interview format.  
  o Interviews completed during initial assessment as follows:  
    ▪ 24 Individuals from Woodbridge interviewed - 2/6/07  
    ▪ 36 individuals from New Lisbon interviewed – 2/6/07 | 6/1/07      |                |                    |
<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Elements</th>
<th>Target Date</th>
<th>Date Completed</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Interviews completed to gain clarification of assessment information, cont’d. | o Interviews to be completed with individuals as follows:  
  10 at Greenbrook  
  14 at Hunterdon  
  9 at New Lisbon  
  39 at North Jersey  
  21 at Vineland  
  28 at Woodbine | | | |
| Incorporate completion or update of the assessment | • Information gathered from the NJIT assessment will be shared with       | | 7/07          |          |
Incorporate information into the annual IHP process

Developmental Centers.

- NJIT assessment information will be incorporated into each individual’s IHP beginning with 6/07 IHPs
- Annually, DC staff will update the NJIT assessment and incorporate changes into the IHP
- As NJIT assessments are updated the information will be incorporated into the database.

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<tr>
<th>Action Steps</th>
<th>Elements</th>
<th>Target Date</th>
<th>Date Completed</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Incorporate the assessment information into the electronic record of each individual.</td>
<td></td>
<td>6/08</td>
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</table>

**RESOURCE NEEDS**
Expansion of Community Supports (RFP to expand agencies qualified to provide housing, residential, employment/day, medical, behavioral supports)

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Olmstead RFP</th>
<th>Olmstead RFP Outcomes</th>
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<tbody>
<tr>
<td></td>
<td>RFP posted and Bidders’ Conference information posted on DDD website.</td>
<td>9/19/06</td>
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<tr>
<td></td>
<td>Pre-qualify new agencies (develop review tool, complete reviews, notify agencies).</td>
<td>9/22/06</td>
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<tr>
<td></td>
<td>Conduct Bidders Conference for Olmstead RFP.</td>
<td>10/3/06</td>
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<tr>
<td></td>
<td>Interviews of Olmstead applicants conducted and completed.</td>
<td>12/06</td>
</tr>
<tr>
<td></td>
<td>Notifications of Qualification sent to Olmstead RFP applicants.</td>
<td>1/12/07</td>
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<tr>
<td></td>
<td>134 Agencies in attendance</td>
<td>DDD Website updated to reflect outcome:</td>
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<tr>
<td></td>
<td>211 persons in attendance</td>
<td>101 applications received by 11/3/06</td>
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<td></td>
<td></td>
<td>69 interviews conducted during 12/06</td>
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<tr>
<td></td>
<td></td>
<td>55 agencies qualified to provide housing</td>
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<td></td>
<td>73 agencies qualified to provide residential supports</td>
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<td></td>
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<td>63 agencies qualified to provide employment/day supports</td>
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<th>Action Steps</th>
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<th>Target Date</th>
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Olmstead RFP Outcomes

- 134 Agencies in attendance
- 211 persons in attendance

DDD Website updated to reflect outcome:
- 101 applications received by 11/3/06
- 69 interviews conducted during 12/06
- 55 agencies qualified to provide housing
- 73 agencies qualified to provide residential supports
- 63 agencies qualified to provide employment/day supports
<table>
<thead>
<tr>
<th>Expansion of Community Supports cont’d</th>
<th>Support Coordination RFP</th>
<th>Support Coordination RFP</th>
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<tbody>
<tr>
<td>o Olmstead qualified providers included on the Family Support Center (FSCNJ) website.</td>
<td>• RFP Posted and Bidder’s Conference information posted on DDD website</td>
<td>• 25 agencies in attendance</td>
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<td></td>
<td>• Mandatory Supports Coordination Bidders’ Conference and Optional Technical Assistance Session.</td>
<td>• 40 people in attendance</td>
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<td></td>
<td>• Interviews of Independent Supports Coordination applicants completed.</td>
<td>• 18 applications received and reviewed</td>
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<td></td>
<td>• Support Coordination contracts awarded.</td>
<td>• 18 agencies interviewed</td>
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<td>• 4/1/07</td>
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<tr>
<td>• 38 agencies qualified to provide medical supports</td>
<td>• Support Coordination contracts awarded to 2 agencies:</td>
<td>• Caregivers of New Jersey</td>
</tr>
<tr>
<td>• 47 agencies qualified to provide behavior supports</td>
<td>o Values into Action</td>
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<tr>
<td>• 25 agencies qualified in all categories</td>
<td>• Of those agencies qualified:</td>
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<tr>
<td>• Of those agencies qualified:</td>
<td>o 15 do not currently have a contract with DDD</td>
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<tr>
<td>o 15 do not currently have a contract with DDD</td>
<td>o 7 new to NJ</td>
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<td>o 7 new to NJ</td>
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<td>Action Steps</td>
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<tr>
<td>Increase and expand availability of Community Services and Supports</td>
<td>• Open enrollment process initiated.</td>
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<td></td>
<td>• Draft of DDD Vacancy policy developed to ensure agencies are accountable for filling vacant beds.</td>
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<td>• Contract and budget developed for the expansion of the Statewide Clinical Consultation and Training program to form a Crisis Response System to work primarily with DDD provider agencies on behavioral issues and overlapping psychiatric problems.</td>
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<td>• NJIT completing a Community Resource Inventory. Interviews to be conducted during 2/07 and 3/07 in all regions to determine the availability of resources throughout the state.</td>
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<tr>
<td>Increase community residential options and capacity to ensure a variety of choices are available in self-</td>
<td>• Community Development is underway to increase community capacity for people transitioning from developmental centers. A total of 80 people will move to the</td>
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directed and provider-managed residences.

- In order to divert people from entering the developmental centers, community capacity is also being developed for

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</table>
| Increase community residential options and capacity to ensure a variety of choices are available in self-directed and provider-managed residences. cont’d | - 40 people on the Community Services Waiting List, 11 aging out of educational residential entitlements, 80 emergencies due to sudden loss of caregivers and 8 moving out of structured settings into their own apartments.  
- A total of 30 people will be moving into supportive housing units in which the lease is in their name and a percentage of personal benefits pay for their own expenses.  
- Depending upon available funds in FY 2008, the potential increased community capacity of projects with realistic plans totals 248.  
- Of the 248 in increased capacity, approximately 100 units are affordable housing apartments | 6/30/08 | | |
• A portion of the apartments will be supportive housing units in which the lease will be in the individuals’ names.

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<tr>
<td>Increase community residential options and capacity to ensure a variety of choices are available in self-directed and provider-managed residences. cont’d</td>
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<td>- 6 homes are planned for people requiring specialized medical needs.</td>
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<td>- 5 of the 6 medical supports homes will have a maximum capacity of 4 residents.</td>
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<td>- 6 community residences will be designated for people currently in out of state Purchase of Care (POC) facilities in order to bring them back to their home state. This will enable DDD to include these individuals in the Residential CCW.</td>
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<tr>
<td>- Develop better mechanisms for repair and maintenance of the existing housing stock.</td>
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<td>- Expand the pool of existing skill sponsor homes.</td>
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<td>- Evaluate transportation needs and include in support planning.</td>
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<td><strong>Ongoing</strong></td>
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</table>
| Leverage funding to include multiple resources in order to maximize the number of projects funded with DDD state funding. | • Accessing alternate sources of funding for community projects has increased each fiscal year for the past several years as more and more agencies become educated in the funding options available.  
• In FY 2007, 5 projects are funded by HUD, 6 projects receive COAH funds, 3 are financed by the Special Needs Housing Trust Fund, 2 are supportive housing projects with state rental assistance vouchers and 5 homes are agency purchased utilizing only DDD state funds for services and supports.  
• Most of the residences designated to be developed during FY 2008 leverage one or more funding resources other than DDD state dollars.  
• 18 projects are funded by COAH funds, 14 projects are funded with 50% to 80% capital funds from the Special Needs Housing Trust Fund, | 6/30/07      | 6/30/08       |          |
12 projects are funded by HUD and several of the apartment projects have state rental assistance vouchers.

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</thead>
</table>
| Leverage funding to include multiple resources in order to maximize the number of projects funded with DDD state funding. cont’d | • Five projects are identified to be in the early planning stages and will not be available until FY 2009 or FY2010.  
• One project with 18 apartments is geared towards senior citizens requiring a continuing care retirement community setting. This project is partially funded with COAH funds.  
• Another project is a cluster of community residences for people with autism on donated property.  
• Two projects are for people moving back from out of state POC facilities.  
• Another project is a joint partnership between a DDD contract agency and community developer for multiple apartment units to be funded by the Special Needs | 6/30/10 | | |
| **Education and Information Sharing** | • Community Service cross training including training on placement options and OLI for Woodbridge Staff during August, September and October 2006.  
  o 148 staff toured group homes  
  o 178 staff attended community placement training | • 10/06 |
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</thead>
</table>
| **Education and Information Sharing cont’d.** | • Schedule community services cross training including training on placement options and OLI for other DCs.  
• Effective 10/06, monthly updates regarding Olmstead shared with contracted providers.  
• Effective 10/06, dialogue with Division Director regarding Olmstead.  
• Effective 12/06, regular meetings with DC CEO’s and regional staff to provide updates re: Olmstead progress:  
• Meetings with Division Staff and Court Monitor for Settlement Agreements with DOJ at the onset of each six month review.  
• Progress becomes agenda item at bi-weekly DDD Operations meeting.  
• UMDNJ Developmental Disabilities Family Education and Information | | Ongoing | • Ongoing  
• Ongoing  
• Ongoing  
• Ongoing  
• Ongoing  
• Ongoing  
• Ongoing |


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<tbody>
<tr>
<td>Education and Information Sharing cont'd.</td>
<td>• UMDNJ Developmental Disabilities Family Education and Information Program are updating training materials to reflect DDD’s new approach to development of community services.</td>
<td>6/07</td>
<td>10/06</td>
<td>• Met with 2 self advocates and 2 Project Advisors/Representatives. They will meet with their constituencies to determine how they want to partner with DDD throughout the transition process.</td>
</tr>
<tr>
<td></td>
<td>• Members of the Self Advocacy group from Woodbridge attended a presentation on community living at New Lisbon Developmental Centers Fall Conference.</td>
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<td></td>
<td>• Meeting with NJ Self Advocacy Project self advocates.</td>
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<td></td>
<td>• Presentation to Family Associations regarding Independent Support</td>
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<tr>
<td>Receive and Implement Money</td>
<td>Meetings held to formulate proposal for DDD to participate in the Money</td>
<td></td>
<td>10/27/06</td>
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<tr>
<td>Follows the Person Grant</td>
<td>Follows the Person Grant</td>
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</table>
- Submitted Response to Request for Additional Information
- Expand Fee for Service model.
  - Contract awarded to assist in the development of a strategic plan

<table>
<thead>
<tr>
<th>Finalization of Path to Progress</th>
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<tbody>
<tr>
<td>(DDD plan to move individuals from institutional living to community living)</td>
</tr>
<tr>
<td>- Public Notice published in New Jersey Register, and on the DDD and DHS web sites announcing Public Hearings to be held in 1/07.</td>
</tr>
<tr>
<td>- Letters sent to DC residents and families/guardians notifying them of the Public Hearings.</td>
</tr>
<tr>
<td>- Public Hearings held as required by S1090 on the following dates:</td>
</tr>
</tbody>
</table>
  - 1/9/07 Union County College
  - 1/11/07 New Lisbon DC
  - 1/16/07 Middlesex County College
  - 1/18/07 North Jersey DC |

<table>
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<tr>
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<th>Outcomes</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>2/26/07</td>
<td>3/07</td>
<td></td>
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<td></td>
<td></td>
<td>12/18/06</td>
<td>12/22/06</td>
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<td></td>
<td></td>
<td>1/18/07</td>
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</table>

**Public Hearings Outcomes:**
- 246 people in attendance
- 76 people and organizations offered written and/or verbal testimony.
| Finalization of Path to Progress cont’d | Testimony requested to address 3 areas:  
  o Services/supports needed to transition from DCs  
  o Services/supports needed to successfully integrate and maintain individuals in the community  
  o Concerns re: accessing and receiving services in the community  
  • Summary of Public Hearings posted on the DDD website.  
  • Draft plan forwarded to Department of Human Services for comments.  
  • Path to Progress finalized and submitted to Legislature | 5/1/07  
  • 3/14/07  
  • 5/2/07 |
|---|---|---|
| Ensuring Informed Choice | Information materials for families include  
  o Newsletter “New Beginnings in Community Living” (ongoing)  
  o Family Workbook on Community Living (revision SFY 2007)  
  o Project website for information dissemination | Ongoing  
  • 6/30/07  
  • Ongoing |
<table>
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<tr>
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<th>Target Date</th>
<th>Date Completed</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ensuring Informed Choice cont’d</strong></td>
<td>• Outreach to transitioning families</td>
<td></td>
<td></td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>o Family orientation sessions at the beginning of the transition process (ongoing).</td>
<td></td>
<td></td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>o Family information forums focusing on community living and what that can actually look like for people today</td>
<td></td>
<td></td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>o Individual family working sessions</td>
<td></td>
<td></td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>o Telephone and mail information outreach</td>
<td></td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• Feedback to DDD on the status of families and their concerns during the transition process (ongoing).</td>
<td></td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• Identification of family mentors from families whose family members have already moved to community living and peer mentors who have transitioned to the community</td>
<td></td>
<td>6/30/07</td>
<td>Ongoing</td>
</tr>
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</table>
community. The mentors will be available to support current individuals and their families in the transition process (SFY 2007).

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<tr>
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<tbody>
<tr>
<td><strong>Ensuring Informed Choice cont’d</strong></td>
<td>• DDFEP will provide orientations for staff identified as important to the person’s successful transition. The orientations give an overview of person-centered planning and the support coordination access</td>
<td></td>
<td>• Ongoing</td>
<td></td>
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</table>
### Implementation of Independent Support Coordination Teams for Transition

- Establish Olmstead Team with Project Manager to plan and review issues.
- Woodbridge and New Lisbon Developmental Centers selected to pilot Independent Support Coordination for transitioning people to the community due to commitments regarding community placement in Settlement Agreements with DOJ.
- Implement Independent Support Coordination Team approach to all developmental centers on a gradual basis.
- Person-centered Thinking and Essential Lifestyle Planning, and Team Building training for members of support coordination teams.

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<tr>
<th>Action Steps</th>
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<th>Outcomes</th>
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<tbody>
<tr>
<td></td>
<td>Establish Olmstead Team with Project Manager to plan and review issues.</td>
<td>8/06</td>
<td>Ongoing</td>
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<td></td>
<td>To be phased in</td>
<td>12/06</td>
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<td>12/18/06,</td>
<td>12/19/06,</td>
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<td></td>
<td></td>
<td>1/13/07</td>
<td>ongoing</td>
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</table>
### Implementation of Independent Support Coordination Teams for Transition cont’d

- Meetings initiated with two new Independent Support Coordination Agencies.

- Briefing paper entitled “Implementing Independent Support Coordination to Facilitate the Olmstead Plan” developed to provide:
  - Background of Olmstead in NJ
  - Role of Developmental Centers
  - Creation of Independent Support Coordination (ISC) to move people from DCs
  - Procedures for Implementing ISC
  - Next steps, Long and Short Term goals

- Support Coordinators and Transition Case Managers are identified to begin working together for Woodbridge.

- Support Coordinators and Transition Case Managers are identified to begin working together for New

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>3/16/07</td>
<td>2 training sessions held 3/07</td>
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<tr>
<td>3/31/07</td>
<td>3 training sessions held 2/07; 2 additional sessions scheduled for 3/07</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Document sent out to Regional Administrators, Developmental Center CEOs, and Kim Friend</td>
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Lisbon.
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<tr>
<th>Action Steps</th>
<th>Elements</th>
<th>Target Date</th>
<th>Date Completed</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Implementation of Independent Support Coordination Teams for Transition cont’d</td>
<td>• UMDNJ provided training sessions for Woodbridge staff regarding Support Coordination.</td>
<td></td>
<td>2/21/07</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• UMDNJ provide training sessions for New Lisbon staff regarding Support Coordination.</td>
<td></td>
<td>3/8/07</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• UMDNJ provided training for Woodbridge families and guardians regarding Support Coordination.</td>
<td></td>
<td>2/24/07</td>
<td>ongoing</td>
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<tr>
<td></td>
<td>• UMDNJ to provide training for New Lisbon families and guardians regarding Support Coordination.</td>
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<td>Ongoing</td>
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<td></td>
<td>• UMDNJ to provide training on Support Coordination for families and guardians at all other DCs.</td>
<td>4/2/07</td>
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<td>Ongoing</td>
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<td></td>
<td>• To be phased in</td>
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<td>Ongoing</td>
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<td>Action Steps</td>
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<tr>
<td>Implement procedures to guide transition from Developmental Centers</td>
<td>• Draft procedures to address the pre-placement IHP, what is to occur between pre-placement and the day of discharge and the 30 day IHP to be developed.</td>
<td>3/20/07</td>
<td></td>
<td>Policies finalized and implemented</td>
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</table>
- Procedures to address the pre-placement IHP, what is to occur between pre-placement and the day of discharge and the 30 day IHP to be developed finalized

<table>
<thead>
<tr>
<th>Timeframes for Transitioning Individuals</th>
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<tr>
<td><strong>Phase 1: Education and Decision Making</strong></td>
<td><strong>Phase 1: Education and Decision Making</strong></td>
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<tr>
<td>- People to move are identified and included on a published list. Informal conversations take place, assessment information is confirmed, and assessments are completed. Formal education is provided for the individual, family/guardian/staff. Relationship maps are started.</td>
<td>- People confirm their choice to move forward, are assigned a Support Coordinator, an up to amount of budget is assigned and people are listed on the e-record.</td>
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- Independent Support Coordination teams going out with and getting to know individuals.
- People and their Support Coordinator are included on the e-record.
### Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont’d

| Phase 2: Plan Development | • To be completed within 90 days | • Activities of Independent Support Coordination team w/ each person available on the e-record.  
Planning team meeting regularly – evidence on e-record  
Plan is approved and placed on the e-record |
|---------------------------|---------------------------------|--------------------------------------------------------------------------------------------------|
| • The Independent Planning Team meets with the person and important people in the person’s life and the Essential Lifestyle Plan is initiated during which:  
o The Independent Support Coordination team meets the person and gets to know them  
o The Independent Support Coordination team develops the description and does some planning  
o Person-centered description is completed  
o The Independent Support Coordination team tests the information in the description by getting the person experience with parts of the plan in different places...so “vision of my life emerges.”  
o coordination of services begins  
o all necessary supports are identified:  
  ▪ housing  
  ▪ day program/activities  
  ▪ transportation |
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</table>
| **Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont’d** | - community supports/services/medical  
- funding streams for supports and services  
- fiscal intermediary identified |  |  |  |
| • The first plan is completed laying out the action plan/roadmap and it is placed on the live record.  
  o An action plan/roadmap is laid out  
  o The selection of supports and services is initiated. (What you are hiring for/who you are hiring) | • To be completed within 60 days. |  |  | • Transitional services are being utilized/expenditure of dollars |
| **Phase 3: Plan is put into Action** | • Person is connected to support or service  
  o Needed supports and services are selected and interviews conducted with businesses, |  |  | • Supports and services are in place 30 days prior to scheduled move. |
<p>|  | • Completed 30 days prior to |  | | • Completed 30 days prior to |</p>
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</table>
| Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont’d | • Person selects where they are going to live and put supports in place.  
  o Community connections are established  
  o Person visits their new home, day activities and community resources |             |                | • Address change is made on the e-record.                                |
|                                                                              | • Move date identified  
  o Roles and responsibilities are communicated to all parties.  
  o Resources are prepared for transition.  
  o Transition Case Manager prepares necessary paperwork and makes arrangements for each persons move. |             |                | • Revisions 30, 60, 90 days for follow-up meeting/event.                 |
| Phase 4: Move and Long Term follow-up                                         | • Person moves into the community                                          |             |                | • Independent Support                                                   |

Total Transition = 6 months
actual move.
- Follow-up/along meetings initiated/held to check in with those who have moved to ensure what people wanted is working for them and that their outcomes are being met or addressed.

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</table>
| Coordinator only stays past the 90 day time frame following move if the individual has not chosen a traditional community placement.
Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd

- Quarterly follow-up provided to DDD from Support Coordination Agencies regarding:
  - number of individuals served
  - phase of service for each individual
  - follow-up status (in accordance with the waiver standards, Support Coordinator is to document provision of follow-up to ensure all supports are in place throughout the transition process and into the future.
  - Support Coordination Agency to monitor for ongoing quality and needed improvements to assure:
    - changes in the Plan Of Care (POC) are based on the individuals changing needs
    - the Individual Resource Tool is utilized to revise the budget
    - service and support changes are timely
    - POC is reviewed/completed annually, facilitated by the Support Coordinator and reviewed/approved by DDD
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| Quality assurance system developed to ensure supports and services are delivered once someone moves to the community. | • Monitor Support Coordination as people move out of DC’s at 30, 60, and 90 days post movement.  
• Implementation of a Consumer Satisfaction Survey, which will be linked to the National Core Indicators Project, to gather input from the consumer and their family regarding quality of life, choice and supports and services  
• Evaluate the data collected through the NCI Project to identify areas needing improvements  
• Provide evaluated data collection to the coordinated system of quality improvement committees, consisting of the Statewide Quality Management Steering Committee and Regional Continuous Quality Improvement Committee’s, to explore and pilot ways to improve services delivery and consumer outcomes and satisfaction  
• If funding allows, an independent research group would conduct consumer and family surveys  
• Case manager oversees and monitors development, implementation, and |             |                |            |          |
effectiveness of Service Plan
- Management of Service Plan compliance through the expanded IT Action Steps

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<tr>
<td></td>
<td>• capacity</td>
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<td></td>
<td>• Service monitoring and oversight, including provider agency compliance with policies and procedures, Division standards and performance reviews</td>
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<td></td>
<td>• Technical Assistance for providers</td>
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<tr>
<td>Managing Action Steps</td>
<td>• Create a report to measure progress based on plan benchmarks</td>
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<td></td>
<td>• Share with Stakeholders and provide opportunity for comments</td>
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<td></td>
<td>• Based on comments review plan annually and make adjustments as may be needed</td>
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