MHMR Authority of Brazos Valley

LIDDA
Local Provider Network Development Plan

Fiscal Years
2024 and 2025

MHMR Authority of Brazos Valley's
Mission, Vision, and Values

- **MISSION**

"To provide the highest quality services, which promote dignity and independence, to individuals and their families who are challenged with issues related to mental health and intellectual disabilities."

- **VISION**

The MHMR Authority of Brazos Valley (MHMRABV) is committed to providing the highest quality of services to persons that receive services through available resources. We envision this community to be a place where full participation and inclusion of each individual are realized. To accomplish this goal, we are committed to endeavors which:

- ✓ Highlight mutual dignity, respect, and cooperation in our relationships
- ✓ Foster positive experiences and opportunities for clients, staff, Board, and the community
- ✓ Educate clients, families, and the community at large
- ✓ Provide quality treatment and habilitation services
- ✓ Promote a safe environment for clients and staff

- **VALUES**

To achieve our vision of full participation and inclusion in the community for people challenged with issues related to mental health and/or intellectual disabilities, the MHMR Authority of Brazos Valley values:

- ✓ The individuality, dignity, and respect for those we serve and their efforts to achieve maximum independence in their home communities
- ✓ The importance of teaching and promoting independence, learning, and self-esteem skills
- ✓ Client choice of and access to services
- ✓ The strength and therapeutic value of the treatment team approach
- ✓ Recovery as a life-long process of better health and quality of life
- ✓ Our responsibilities as stewards of public monies in the provision of our services

- **LIDDA DEMOGRAPHIC PROFILE & ORGANIZATIONAL STRUCTURE OVERVIEW**
  - ✓ **Service Area** - MHMRABV serves Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington Counties

  - ✓ **Governed by a Board of Trustees**

  MHMRABV has a nine-member Board of Trustees appointed by the Commissioner's Court of the respective county each member represents. The Board members include elected county government officials, elected law enforcement officials, sheriffs serving as Ex Officio non-voting members, city government, and family and community members. The Board's role is to establish a policy that servesas the infrastructure by which the organization operates. The Board hires the Executive Director who is responsible for the organization's day-to-day operations and implementation of policies and processes.

  MHMRABV employs 180 full-time and hourly employees providing administrative and

clinical services for residents of the Center's seven county service area for Behavioral Health (BH) and Intellectual and Developmental Disabilities (IDD) services.

- **Local Planning Process**

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

In developing the local service area plan, MHMRABV's LIDDA solicits information regarding community needs from a variety of sources and is also held to standards and requirements of funding and accreditation bodies. The approach chosen by MHMRABV involves not only individuals receiving community-based IDD services and their families but also referral sources, local community representatives and services, advocacy groups, advisory committees, and employees. In addition to these various stakeholders, the LIDDA also solicits information regarding community needs from consumers of services at Brenham SSLC, members of families of Brenham SSLC consumers, and members of Brenham SSLC's volunteer services councils, and other interested persons. This reflects MHMRABV's commitment to understanding the needs of all its constituents.

The initiatives of MHMRABV are based on elements of governance, which support the Center in its obligation as a public steward. These initiatives are developed as part of the planning process and are further defined as they flow into the development of objectives and strategies to ensure all placement is in the least restrictive environment appropriate to need and goals that will divert individuals from the criminal justice system. Monitoring and evaluation activities support the need for ongoing assessment of responsiveness, effectiveness, and efficacy. The plan and the progress of the plan is monitored by our Executive Management Team, the Board of Trustees, IDD supervisory team, and community advisory committees.

- **Citizens/Network Advisory Committee (CNAC)**

The Citizens/Network Advisory Committee (CNAC), composed of at least 9 members, 50% (MH/IDD) consumers/family members as well as community members are responsible for assessing local needs, and making recommendations to the Board that ensures the implementation of a comprehensive quality service delivery system of services and supports to address those needs. This Committee has distributed and compiled needs assessments data that was sought from a broad base of stakeholders including consumers of services, family members of consumers, providers of services, human services agencies, governmental agencies, the community at large, Center staff, etc. that is being used for both local and quality management planning and improvement strategies. The CNAC serves as a resource to MHMRABV, objectively evaluating services for quality of care and best value, and assuring an appropriately developed provider network and sound procurement practices. The CNAC members receive initial and ongoing training and information necessary to achieve the Center's expected outcomes relevant to local service area planning. The CNAC also makes operational, the authority functions of network development, oversight, resource development, resource allocation, and consumer empowerment, while assuring public input in these processes. The Admissions and Placement Coordinator at Brenham SSLC serves as a member on the CNAC and provides

input in the development of this Plan.

Additional stakeholder involvement and participation in assessing our organization is sought through a variety of other mechanisms. Formal meetings are held with city and county government officials and community members to gather input on community needs and prioritization of our service array, including solicitation of funding to achieve successful outcomes. In the past, legislative forums have been sponsored by the Center to bring together a variety of stakeholders including legislators, consumers, family, staff, advocacy groups, etc. to provide input on issues that relate to both local services and state funding issues. It is anticipated that this type of forum will resume. A direct approach to educate legislative staff about local and state-wide service needs has been utilized with staff, individuals receiving services, family members, and other stakeholders including members of the Board of Trustees.

- **Local Intellectual and Developmental Disability Authority**

Within MHMR Authority of Brazos Valley's administrative office in Bryan Texas is where the Local Intellectual and Developmental Disability Authority (LIDDA) Services Unit offices are located and serve as the entry or "front door" for individuals with IDD beginning with Eligibility Determination at Intake, Service Coordination for the development of Individual Person Directed Plans, and a variety of community services intended to promote independence. LIDDA Services has responsibilities in Continuity of Services, including implementing the Community Living Options Information Process (CLOIP) for residents of the Brenham State Supported Living Center (SSLC), Permanency Planning for children in residential facilities, Home and Community Based Services (HCS) and Texas Home Living (TxHmL) Community Interest List maintenance, and enrollment into Intermediate Care Facilities (ICF), TxHmL Waiver and HCS Waiver programs. MHMR Authority of Brazos Valley's provider functions include TxHmL, HCS, ICF, and PASRR specialized services programs. All provider programs include the full array of high-quality services typical to the program.

Throughout the seven-county service area, the HCS program contracts with numerous individuals to provide host home service for individuals enrolled into the HCS program and operates two 4-bed residential homes in Washington County for individuals needing a higher level of care and supervision. In the ICF/ID program, the MHMRABV operates one 8-bed co-ed residential facility. The day habilitation (DH)and individualized skills and socialization (ISS) programs serves individuals across all programs with locations in Brazos, Madison, and Washington Counties and contracts with Private Providers to provide day habilitation to individualsin their programs. Day Habilitation and Individualized Skills and Socialization offers a wide variety of activities including volunteer opportunities, community involvement, a resource library, and numerous individualized andgroup activities designed to further educational, social and/or adaptive skills, and to accommodate individual needs for community integration.

We work to ensure that individuals with intellectual and developmental disabilities have every opportunity to make choices concerning the services and supports he or she considers essential for meeting his or her personal goals or outcomes, rather than having to accept a pre-determined, non-individualized set of services. MHMRABV is utilizing Person Directed Planning process to facilitate the development of the individual's service plan. All individuals served will have services authorized and evaluated. In addition to making sure that the individual is making personal choices, we must ensure that MHMRABV meets the standards

of safety, health care, abuse and neglect on a highly consistent basis. Although MHMRABV has procedures and LIDDA Unit processes for direction, consistent information, documentation, and best practices, this in no way can replace the internal thought process of staff which must be trained and knowledgeable of what the individuals' needs are and how to help think outside the box to best help persons achieve their desired outcomes. It is essential that we demonstrate our ability to listen to people and use this information to design and improve services and supports.

- **Values that Guide the IDD Service System**

  Individuals with intellectual and developmental disabilities choose among flexible, dependable services that meet each individual's needs and support each individual's goals and dreams for a lifestyle of full inclusion, interdependence and respect. Families of individuals with intellectual and developmental disabilities are supported in their efforts to help family members meet their individual outcomes, goals and dreams. The service system supports individuals in their choices by offering support services that are:
  - ✓ Valued by the individuals served;
  - ✓ Responsive to their needs;
  - ✓ Available and easily accessed;
  - ✓ Consistent with each individual's dreams and goals;
  - ✓ Used by other members of the community; and
  - ✓ Respectful of cultural values and dignity.

The opinions of the people we serve are considered most important when we evaluate the quality of the services. Individuals with intellectual and developmental disabilities make choices about how their needs are met and how their goals/dreams are supported. This means that individuals:

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

Also, each child with intellectual and developmental disabilities receives the benefits of being part of a permanent family. Individuals with intellectual and developmental disabilities have the same legal and human rights as all citizens and are not deprived of their rights without due process of the law.

ARRAY OF IDD SERVICES AND SUPPORTS

- **Screening and Referral**

The process of gathering information through structured interview and by reviewing medical and school records to determine potential eligibility for IDD services. The majority of individuals for whom information is gathered move toward eligibility determination. For those who clearly will not be eligible for services, referrals to the most appropriate service resource are made. During the screening process, the individual's initial service preferences are documented and placement on the interest lists for HCS and TxHmL programs are discussed. This service is performed face-to-face or by telephone contact with persons.

- **Benefits Eligibility**

  MHMRABV provides individuals with assistance in completing applications for Medicaid,

Medicare, Medicare Part D, and other third party assistance. The initial and annual fee assessment identifies individuals who may be eligible for benefits, but who are not currently receiving benefits. Identified individuals are referred to the Benefits Eligibility unit and staff work through the entire process of application, approval, and when necessary, appeal.

- **Eligibility Determination of IDD**:

Any individual residing in MHMRABV's 7-county service area suspected of or known to have an intellectual or developmental disability or to have a related condition are eligible for services based on an interview and assessment or endorsement criteria set by the Texas Health and Human Services Commission (HHSC) and the Texas Administrative Code. The priority population for intellectual and developmental disabilities (IDD) services includes those persons who request and need services and possess one or more of the following conditions:

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

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

- ✓ Nursing facility residents eligible for PASRR mandated services for individuals with intellectual disabilities or a related condition per federal guidelines.

For persons with IDD and autism, the priority population includes only those individuals whose needs for services can be most appropriately met through programs currently or potentially offered by the IDD services division of HHSC. Individuals are discharged only after appropriate services have been obtained; upon the individual's/LAR's request; or referral to appropriate services are made.

- **Continuity of Services**

Provide discharge planning and follow-along treatment planning for the individual with intellectual and developmental disabilities returning from a State-Supported Living Center facility to promote a smooth reintegration into the community. Continuity of Services coordinate and assist with community and state facility residential placement and through the diversion process, also identify and arrange community services to divert individuals, when appropriate, from admission into State Supported Living Centers and nursing facilities. At MHMRABV Continuity of Services also provides Permanency Planning, which is a philosophy and planning process that focuses on achieving family support for individuals under 22 years of age by facilitating permanent living arrangements that include an enduring and nurturing parental relationship. Activities are performed in accordance with:

- 40 TAC Chapter 2, Subchapter F, for an individual residing in a SSLC whose movement to the community is being planned or for an individual who formerly resided in a state facility and is on community-placement

status, or;

- Article II. B. 6 of the current HHSC Contract for an individual enrolled in the ICF/ID program to maintain the individual's placement or to develop another placement for the individual;
- HHSC-LIDDA Performance Contract, which requires the completion of PASRR Level II evaluations and the implementation of Habilitation Coordination to residents of Nursing Facilities.

- **Service Coordination for Persons with IDD**:

Assistance in accessing medical, social, educational, and other appropriate services and supports that will help an individual achieve a quality of life and community participation acceptable to the individual as described in the plan of services and supports. Service coordination is provided to people in the General Revenue, HCS, TxHmL, and Community First Choice (CFC) programs. Service coordination functions are:

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

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

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

A service coordination assessment is completed to determine if the individual has at least two unmet needs to qualify for the service. Service Coordination serves all age groups and individuals are admitted based on need. Individuals are discharged if they move out of MHMRABV's service area, request discharge, death, or the Planning Team or individual decides they are no longer in need of service.

- **PASRR Evaluation & Habilitation Coordination to Individuals residing in Nursing Facilities**.

Individuals suspected of having an Intellectual Disability and/or Developmental Disability are referred to the Local Authority prior to or within 72 hours of admission into the Nursing Facility for a PASRR Evaluation. This evaluation is conducted to determine medical necessity and to ensure that the individual/LAR and/or family has been provided information

on services provided in the community can assist meeting the individual's needs in a less restrictive environment. During the evaluation, should staff observe or be provided with information to verify the individual may have an ID or IDD diagnosis; habilitation coordination will be provided to the individual.

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

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

Should the individual be discharged from the Nursing Facility back into the community, the Service Coordinator will continue to provide intensive service coordination for six months, before discharging into Community Service Coordination.

- **Community Living Options Information Process (CLOIP)**

In Fiscal Year 2009, DADS (now known as HHSC) added CLOIP requirements to those Centers with a State Supported Living Center (SSLC) within its local service area. The Brenham State Supported Living Center is located in MHMRABV's service area. The CLOIP unit has the specific responsibility for annually providing specific community living program and resource information and education about community-based living options for them to make informed choices about where they wish to live to residents of the SSLC or their LAR, and to help facilitate provider tours and transition activities.

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

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

providing transportation to an individual so that he/she can get to medical and psychiatric appointments, or providing supervision for an individual in the home so that thefamily can attend a sibling's school functions;

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

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

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

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

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

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

✓ **Specialized Therapies** – optional. These include assessments and treatments by

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

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

- ➢ **Crisis Intervention Services**

The 84th Session of the Texas Legislature provided LIDDAs with funds to support individuals with IDD with significant behavioral and psychiatric challenges. These individuals often exhibit significant needs requiring additional support beyond the array of services typically provided within community programs. The funds will expand resources to address crises with individuals who have IDD. Crisis Intervention Services, including IDD Crisis Respite, are mandated and funded through the HHSC Performance Contract. These services are intended to be used in a waythat allows people with challenging behaviors or at risk of crisis the support they need to avoid interactions with law enforcement and subsequent admission to emergency rooms or inpatient mental health treatment facilities.

- ✓ **Lead Crisis Intervention Specialist (CIS)** at MHMRABV is a Licensed Clinical Social Worker who works with service coordinators and Waiver service providers in the community to identify people with IDD who are most likely to require crisis services. Many of these individuals have a difficult time finding someone in the communityto fulfill the need for behavior support, and the CIS will step in to offer services and referrals. The CIS will assess crisis, write crisis intervention support plans, complete individual skills training related the plans, and train provider staff and families on methods to avoid crisis or address significantbehavioral issues, provides education about the manner in which to engage individuals with IDD and their unique needs; identify prevention strategies to avoid or lessen crisis event, provides consultation to an Mobile Crisis Outreach Team (MCOT) as needed or as clinically indicated regarding a crisis event involving an individual with IDD; collaborates with an MCOT to develop criteria for referring an individual with IDD to crisis respite; participate in planning team to review services the individuals are receiving and make recommendations to providers or the individual/LAR for services and strategies that may assist the individual to avoid a crisis. CIS also provides information about IDD programs and services; collaborates with LIDDA staff and Regional Transition Support Team members to determine best options or resources available to the individual and their families. Individuals are discharged from crisis intervention services once the crisis has

subsided; progress has been made in avoiding crisis; and/or upon request to be closed from services.

- ✓ **Crisis Respite Services – IDD Local Authority & Provider Services**
  The Crisis Intervention Specialist serves as the "gate keeper" for individuals to be referred to Crisis Respite. Individuals at risk or in crisis may be referred for in home respite with staff working in the individual's home environment if it is felt that the crisis can be resolved within seventy-two hours. Should out-of-home respite be recommended the individual may receive up to fourteen days of out of home respite. A designated room at MHMRABV's Family Tree ICF-ID residential home can serve one individual at a time in crisis respite; four contracts with HCS private providers also provide for additional out of home crisis respite sites. The intent being that the individuals may need a short period of time to deescalate before returning to their home; this is a valuable diversion from lengthy ER stays or even psychiatric inpatient admission. During the respite stay the individual will receive therapeutic support. The individual will be dischargedfrom out of home crisis respite within fourteen days or upon individual's request. Individuals will be discharged from in home respite within seventy-two hours or upon request.

- ➢ **Medicaid Waiver Programs**

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

- ✓ **Home and Community-based Services (HCS) Program:** The HCS Program provides services to individuals with IDD who live with their family, in their own home, in a foster or companion care setting, or in a residence with no more than four individuals who also receive services. The HCS Program provides services to meet an individual's needs so that they can maintain themselves in the community and have opportunities to participate as a citizen to the maximum extent possible. Services consist of adaptive aids, minor home modifications, counseling and therapies, dental treatment, nursing, residential assistance, respite, day habilitation, employment assistance and supported employment. In the HCS Program, individuals who are in a residential program contribute to their room and board. Service coordination is provided to the individual by the Local Authority. There is a cost-cap to the yearly cost of services provided through the HCS Program. MHMRABV provides HCS to 41 individuals.

- ✓ **Texas Home Living (TxHmL) Program:** The TxHmL Program provides essential services and supports so that individuals with IDD can continue to live with their families or in their own homes in the community. TxHmL services are intended to

supplement instead of replace the services and supports an individual may receive fromother programs, such as the Texas Health Steps Program, or from natural supports suchas his or her family, neighbors, or community organizations. Services consist of community support, nursing, adaptive aids, minor home modifications, specialized therapies, behavioral support, dental treatment, respite, day habilitation, employment assistance, and supported employment. Service coordination is provided to the individual by the Local Authority. Like HCS, TxHmL Program services are limited to an annual cost cap. The cap is lower because there is no residential option in TxHmL. MHMRABV provides TxHmL to 18 individuals.

- An individual is typically on both the TxHmL Waiver IL and the HCS IL. If the individual accepts an offer to enroll in the TxHmL program, their name will remainon the Interest List for the HCS program.
- If an individual is offered an opportunity to enroll in either the HCS or TxHmL Program, the Center will provide information about the applicable timelines forenrollment.
- If an individual receiving services in the General Revenue program is offered eitherTxHmL or HCS and declines participation, the LIDDA will terminate General Revenue services in accordance with the rules governing the HCS and TxHmL programs.
- A review of the Medicaid Estate Recovery Program is provided by the Center's enrollment staff in accordance with Texas Administrative Code, Title 1, Part 15,Chapter 373 Medicaid Estate Recovery Program (MERP), to all individuals andtheir legally authorized representatives, who seek enrollment in a SSLC, a community ICF/ID, HCS or TxHmL

- **Intermediate Care Facilities for Individuals with Intellectual and DevelopmentalDisabilities (ICF/IDD)**

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

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

MHMRABV provides ICF-ID residential services at our 8-bed facility named Family Tree in Bryan Texas.

- **Improving and Protecting the Health and Welfare of Individuals**

Health and safety needs are identified during the discovery process in service coordination provision. Unmet needs receive a plan to monitor and improve. The service coordination

assessment is reviewed annually to re-assess needs. Factors such as safe housing, access to medical care, awareness of local infectious threats, emergency preparedness, medication adherence and preventative medicine are considered. Additionally, MHMRABV's Quality Management Committee, Waiver Community Advisory Committee, Human Rights Committee, IDD Utilization Management Committee, Safety Committee, and Infection Control Committee identify area risks to drive preparedness activity at the MHMRABV.

MHMRABV Standing Committees: Several oversight committees within MHMRABV assess the Center's performance and make recommendations to the Executive Management Team and LIDDA Supervisory Team on results of audits, surveillance, reporting, investigations and surveys. The Safety, IDD Utilization Management, Community Advisory and Infection Control Committees are made up of staff from all service areas; The Center's Safety Officer, Compliance Officer, Rights Officer, and Quality Management Committee regularly monitor our systems, programs, and occurrences to ensure compliance and our safety practices and incidents do not have the potential to put individuals at risk. Compliance review includes but not limited to corporate compliance activities, privacy, rights, and abuse prevention functions. These committees all have the potential to identify needs for improvement, reporting to Management Teams and identifying issues, which include input from employees, consumers, and consumer's families.