State of Tennessee
Department of Intellectual and Developmental Disabilities

Greene Valley Developmental Center Closure and Community Transition Plan

Submitted by Debra Payne, DIDD Commissioner
Jordan Allen, DIDD Deputy Commissioner of Program Operations

TABLE OF CONTENTS

General Introduction p. 3

Chapter 1 p. 8
Greene Valley Developmental Center Profile

Chapter 2 p. 12
The Current Community Service System

Chapter 3 p. 19
Community Service System Development

Chapter 4 p. 23
The Transition Planning Process

Chapter 5 p. 33
The Closing of Greene Valley Developmental Center

Chapter 6 p. 36
Quality Management

Conclusion p. 48

GENERAL INTRODUCTION

The State of Tennessee is committed to ensuring that people with intellectual disabilities have a healthy, secure, meaningful and integrated life surrounded by family and friends. In fact, the Vision and Mission of the Department of Intellectual and Developmental Disabilities is to support all Tennesseans with intellectual and developmental disabilities to live fulfilling and rewarding lives and to become the nation's most person-centered and cost effective state support system. The department's recent accreditation by the Council on Quality and Leadership acknowledges the hard work by numerous, dedicated individuals at all levels who strive to have the best community service delivery system. In further alignment with our vision and as part of an Exit Plan to end a 19-year-old lawsuit, the state has decided that it will no longer be a willing provider of Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICF/IID) at Greene Valley Developmental Center (GVDC). Instead, current GVDC residents will receive appropriate services and supports in alternative, community-based settings.

> *"The Court concludes that the Exit Plan presented by the Parties is 'fair, reasonable and adequate' and provides the next iteration of improvement to the lives of those with disabilities in Tennessee. It will test political will and legislative leadership to continue that progress and to determine how best to care for those often left in the shadows."*
>
> Judge Kevin Sharp
>
> U.S. District Court, Middle Tennessee

The needs of people in Tennessee's public institutions are like those of the people served in private ICFs/IID and in the state's Home and Community Based (HCBS) Waiver programs for people with intellectual disabilities. Enteral (i.e. "tube") feedings are one indicator of medical complexities for people with intellectual disabilities. In Fiscal Year 2014, more people in private ICFs/IID received enteral services and

supports than in public ICFs/IID. In addition, more than twice as many people who receive enteral feeding supports are enrolled in HCBS waiver services for individuals with intellectual disabilities than in public and private ICF/IID facilities combined.

Per person costs at GVDC for FY 2015-16 are budgeted at $1,228.31 per day or approximately $448,333 per year. These costs are far higher than the current costs of supporting individuals with intellectual disabilities with similar needs and challenges in community residential settings. In the same budget projections for private ICF/IID facilities in Tennessee, the average daily rate is $420.32 per person, and the average annual rate is $153,416 per person. In the budget projections for the Comprehensive Aggregate Cap Waiver (the waiver in which all class members will be enrolled), the average daily rate is $427.90 per person, and the average annual rate is $156,184 per person.

As of February 10, 2015, 95 people received services at GVDC. The number of persons transitioning to either HCBS Waiver services or small ICF/IID living arrangements has increased in recent years. Since the announcement of the closure of GVDC, several conservators who were once completely unwilling to even discuss the possibility of a future in the community are now having those discussions with case managers and staff in the Transition Office.

People supported and their conservators are now beginning to discuss a future in the community.

Conservators and family members of former GVDC residents are satisfied with their decision to move their family members to community homes. In 2013, 21 people transitioned from GVDC to community settings. In the department's statewide satisfaction survey for these individuals, 19 of 21 conservators responded. Importantly,

all 19 expressed that they were satisfied with current services. In 2014, 13 of 21 conservators responded and 100% were satisfied with services in the community.

As of February 6, 2015 there are 2,415 people on the waiting list for HCBS Waiver services in the East Tennessee region. Meeting the needs of these people requires the state to ensure the most cost-efficient means to increase its service capacity. That includes greater reliance on less costly long term supports which are more flexible and person-centered.

People with profound intellectual disabilities and complex medical and behavioral challenges can be safely supported in smaller, private ICF/IID settings and in home and community-based settings under the HCBS Waivers. The state successfully closed the Arlington Developmental Center in West Tennessee in 2010 and is expected to finalize the closure of Clover Bottom Developmental Center in Middle Tennessee by the summer of 2015. The families and conservators of people who lived at these two developmental centers shared the same initial concerns regarding closure as the families and conservators involved in the upcoming closure of GVDC, but people who have already moved from these larger congregate settings to smaller community settings are very satisfied with their services and are being successfully and safely supported.

This policy direction follows a national trend that has resulted in a dramatic decrease in the census of state developmental centers in the past several years. Consequently, there is a corresponding increase in the number of people receiving long-term health supports in the community. As of June 30, 2012, 13 states (Alabama, Alaska, Hawaii, Indiana, Maine, Michigan, Minnesota, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont and West Virginia) and the District of Columbia had no state facilities with 16 or more residents. Many states previously closed or significantly downsized these facilities in favor of smaller, integrated community settings. Of the 354

large (16+ person) public ICF/IID facilities operating across the country between 1960 and 2012, 207 closed, converted to non-IDD use, privatized or downsized to 15 or fewer residents by June 30, 2014 with 14 additional projected closures through 2015. It is clear that best practices in the field of intellectual disabilities give people the opportunity to live in smaller, personalized and integrated community settings.

The state entered negotiations with the Clover Bottom lawsuit parties in the summer of 2014 with the intention to continue to provide services at GVDC. However, it became clear during negotiations that in order to agree on an exit plan with all of the parties, the closure of GVDC must be included.

Many factors were considered before agreeing to the closure including best practice in the field of intellectual disabilities, experiences of other states, increasing costs of providing services to a diminishing population and increasing preference for Medicaid waiver service delivery in the community. Based on these findings, as well as the experiences of Tennessee and other states, the state firmly believes that the decision to close GVDC is the right one.

This Closure Plan coincides with the initiation of the state's effort to ensure successful community transitions for GVDC's current residents. In developing this Closure Plan, the state is committed to a process that solicits and reflects input from stakeholder groups spanning the spectrum of involvement. This will include but is not limited to: Family Forums, Provider Meetings, Provider Fairs, individually scheduled meetings with conservators and advocacy groups and regular communication updates distributed by the department. Congregate meetings, such as the Family Forums and Provider Fairs, will be scheduled at multiple times and in multiple locations to ensure convenient participation from parties with varying schedules.

The department will encourage community provider agencies and persons who have experienced a transition to a community setting from a developmental center to participate in many of the described events. This will provide important opportunities for these valued parties to share their experiences with those who are in the same process. In developing this Closure Plan, the department has been careful to incorporate successful components previously utilized in our own developmental center closures as well as suggestions from stakeholder groups who actively participated in the negotiations relative to this closure. Drawing on both the national experience of the Department of Justice and the local experience of the Parent Guardian Association, this plan is inclusive of several best practice approaches to closure.

In addition to the already mentioned stakeholder feedback and informational meetings, the GVDC Chief Officer, Case Managers and Transition Team will hold meetings with conservators of every remaining GVDC resident. Meetings will occur over the course of the next two months and will give family members a more personal and private opportunity to raise their questions and concerns and to speak frankly about what they want most in a community service arrangement for their loved one.

Chapter 1

GREENE VALLEY DEVELOPMENTAL CENTER PROFILE

Greene Valley Developmental Center began providing services for people with intellectual disabilities on December 15, 1960 when approximately 40 people arrived from Clover Bottom Developmental Center. At its peak in the 1970s, GVDC provided services for approximately 1,100 people. This spanned a total of 17 cottages on the approximately 450 acre campus and four group homes each serving six to eight people in the Greeneville community. The last off-campus home was closed in December of 1995. Since then, the census has steadily declined as people transitioned to community agencies, moved in to the 16, four-person East Tennessee Homes or passed away. As of February 1, 2015, only 95 people live in five cottages at GVDC. All 95 people have lived at the facility for at least 15 years. Some have lived there for more than 50 years. Further demographic information is included in the chart below.

Federal law and regulation as well as the 1996 Settlement Agreement require professional annual assessments and on-site reviews of service delivery covering a variety of health care, functional, habilitative and environmental needs. The annual assessments are used as the basis for development of each person's Individual Support Plan (ISP). The ISP explains the services and supports each person needs to maintain and enhance their quality of life. It also includes the person-centered methods needed to successfully implement the plan. The department's own internal monitoring processes work in concert with these requirements to ensure quality services and care are continually provided to persons at GVDC as the facility downsizes to closure.

The following chart provides a brief descriptive overview (as of 2/10/15) of the needs of the 95 persons remaining at GVDC:

AGE	
Average Age	57.19
Number of Persons Over 90 years	1
Number of Persons Over 80 years	5
Number of Persons Over 70 years	12
Youngest Person	29 yrs.
LENGTH OF STAY AT GVDC	
Persons with 50+ years	19
Persons with 40+ years	31
Persons with 30+ years	27
LEVELS OF INTELLECTUAL DISABILITY	
Mild	2
Moderate	2
Severe	11
Profound	80
HEALTH RISK SCREENING TOOL (HRST)	
Average HRST	4.63
HRST score of 2 (least medical needs)	9
HRST score of 3	16
HRST score of 4	26
HRST score of 5	6
HRST score of 6 (highest medical needs)	44
HEALTHCARE NEEDS	
High Risk for Aspiration	40
Dysphagia	62
At Risk for Choking	88
Enteral Tube	44
Diabetes	9
At Risk for Bowel Dysmotility	92
Osteoporosis	60
Tracheostomy	11
Supplemental Oxygen	16
Non-Ambulatory	50
Mobility Impaired	72
Alternative Positioning Device/Equipment	55
Blind	33
Deaf	3
Seizure Disorder	60
At Risk for Status Epilepticus	39
Behavioral/Mental Health Needs	
Behavior Support Plans or Guidelines	15
Receiving Psychotropic Medication	31

Community residential options for GVDC residents already exist in East Tennessee. Multiple providers have already expressed interest in new development to accommodate growth. These options are available either through the HCBS Waiver or through private ICFs/IID. As of February 3, 2015, DIDD's contracted provider network includes 47 HCBS waiver providers that offer residential services in existing residential homes in the East region. A review of active cost plans effective January 31, 2015 found that 15 of those agencies, several in the Greene County and Tri-Cities area, already provide Medical Residential Services.

Many people with significant challenges, similar to those of people at GVDC, are already successfully supported in the community.

Medical Residential Services are for people with significant medical concerns who require available nursing services up to 24-hours a day. Many of these people are non-ambulatory, and many have very significant physical challenges. Most of these people need complete assistance to perform activities of daily life, and many cannot consume oral nutrition and are dependent on enteral tube feedings. These people may require on-going clinical therapy and registered dietician services. Some also require behavior specialist services. HCBS Medical Residential homes may not serve more than four people. As of February 20, 2015, 123 persons receive Medical Residential Services in East Tennessee. An additional 94 people receive daily nursing services of up to 12 hours per day.

There are five private ICF/IID providers that operate in East Tennessee with a total of 17 private ICF/IID providers statewide. Federal regulations are the same for all ICFs/IID, whether public or private, and regardless of the number of persons supported. Private ICF/IID providers are required to ensure the same level of services

as large, public institutions (i.e. GVDC) including "integration of health or rehabilitative services to help each individual function at his greatest ability" (42 C.F.R § 435.1010).

Chapter 2

THE CURRENT COMMUNITY SERVICE SYSTEM

The administration of the department's community services system is divided among the state's three regions: East Tennessee, Middle Tennessee and West Tennessee. The East Tennessee Regional Office (ETRO) is the department's local point of entry for the waiver-funded community service system. ETRO staff members provide assistance in transitioning people to an array of residential and day services, including both HCBS Waiver and ICF/IID homes.

The department is responsible for coordinating and overseeing all transitions for people who move from GVDC to the community. Families or conservators are encouraged to contact the ETRO director of transition for more information regarding the community services system or to address any issues or concerns. Information regarding the performance of the network of community agencies is available on the department's website or by contacting the ETRO.

Community Residential Options

As of February 1, 2015, 258 people who are members of the CBDC, et al. class live in East Tennessee Waiver-funded community homes, five class members live in their own or family home with supports, 126 class members live in ICF/IID homes other than Greene Valley. ICF/IID homes offer an all-inclusive package of residential supports, nursing services, clinical therapy, dietician and behavioral services. These homes are funded through an inclusive daily residential rate.

Waiver-funded community homes allow the selection of residential, day services, nursing, clinical therapy, dietician and behavioral providers separately. Some people

prefer this model as it allows more flexible choices of providers. For example, people may choose to change residential providers while maintaining the same ancillary providers.

In addition to the above two residential models, families may also choose to have their family member come home to live with them. If this option is chosen, the department will provide access to services and supports designed to occur in the home to help families care for their loved one.

Private ICF/IID Homes

There are currently five private ICF/IID provider agencies in East Tennessee:

- Comcare Inc. operates nine, four-bed ICF/IID homes in Greeneville and surrounding counties serving 36 people.
- Life Bridges operates five, four-bed ICF/IID homes serving 20 people in Cleveland.
- Michael Dunn Center (MDC) operates two, four-bed ICF/IID homes serving eight people in the Kingston area.
- Open Arms Corporation (OAC) operates eight, eight-person ICF/IID homes serving 64 people in and around Knoxville and Chattanooga.
- Orange Grove Center (OGC) operates 18, four to eight-person ICF/IID homes serving 80 people in the Chattanooga area.

Together, these providers support 208 people in private ICF/IID homes. 62 People supported in private ICFs/IID transitioned from GVDC.

Public ICF/IID Homes

Currently, the department operates 16 homes (East Tennessee Homes - ETH) in Greene County which provide support services for 62 people. Two people are in the

process of transitioning to ETH. When that move is complete, ETH will be at its full capacity of 64 persons supported.

Waiver Provider Residential Home Options

The department has contracted with community providers in Tennessee for residential services since the mid-1970s. As of February 1, 2015, 47 residential providers serve people in East Tennessee. For a complete listing of providers and the residential service options they offer, please refer to Appendix A.

Through the HCBS Waiver, the following residential options are available for selection to those who enter this service:

- ***Residential Habilitation***
  - Agency owns or rents the home on behalf of the person(s)
  - Room and board charges (80% of this year's SSI payment)
  - Home is licensed by DIDD
  - Requires supervisory visits to the home three times a month including sleep hours, holidays and weekends
  - No more than four people live in a home
  - Agency chooses housemates and staff

- ***Supported Living***
  - Person(s) supported own or rent home
  - Person(s) pay their own bills (with assistance from support staff)
  - The service provider is licensed by DIDD Requires supervisory visits to the home three times a month including sleep hours, holidays and weekends
  - DIDD housing inspection required prior to moving in
  - No more than three people live in a home
  - Person(s) have a voice in choosing housemates and staff

- ***Medical Residential***
  - Service is provided via Residential Habilitation or Supported Living

- Requires additional licensing by the Department of Health (Professional Support Services License)
- Requires RN oversight and supervision of LPN staff for skilled services rendered
- Requires provision of LPN or RN skilled nursing services as per doctor's orders
- Requires supervisory visits to the home three times a month including sleep hours, holidays and weekends

➢ ***FMRS – Family Model Residential Services***
- The person lives in caregiver's home (other than family of origin)
- Room and board charges (70% of this year's SSI payment)
- Required supervisory visits to the home twice a month including holidays and weekends
- Each living arrangement is screened yearly by provider agency utilizing DIDD approved monitoring tool
- Service is licensed by DIDD
- No more than three people live in a family model arrangement

➢ ***Semi-Independent Living Residential Service***
- Services appropriate for people who need intermittent or limited supports to remain in their own home independently
- Access to emergency supports as needed from provider on 24-hour basis
- Home inspection required
- May choose to live independently or with one or two other persons
- Minimum of 2 face to face direct service visits per week

DIDD Service Options

DIDD ancillary resources for people who receive home and community based waiver services include:

➢ ***Assistive Technology Services***
- Assessment, acquisition, customization and design, fitting and delivery of assistive devices based upon individual and environmental needs

- ***Durable Medical Equipment Lending Library***
  - A variety of assistive living, mobility, positioning, and augmentative communication devices and environmental controls
  - Equipment can be checked out on loan for trial or assessment, to temporarily meet needs related to replacement of owned equipment or while waiting for equipment to be obtained through insurance.

- ***Intensive Consultation Team Services***
  - Time-limited consultation with community providers to assist in management of impending or actual crises of a behavioral and/or psychiatric nature
  - Services may include but are not limited to: education pertaining to particular mental health diagnoses, training to address the needs of people with combined mental health and intellectual and developmental disabilities, time-limited consultation and assistance in community settings implementation regarding actual crisis situations, assisting with transition planning to community settings following psychiatric hospital discharges.

- ***Clinical Review Team***
  - Arranges consultation for people with multiple clinical or behavioral issues
  - Follows up review of data related to high rates of incidents
  - Provides specific consultation to agencies regarding review of findings
  - Makes referrals for the provision of person-centered facilitation to providers

- ***Community Clinician Consult***
  - Upon request, GVDC or ETRO medical staff will consult with medical providers chosen by the person during transition planning and up to 60 days after the person's move to their new home.

Provider Community Service Options

The department contracts with a wide array of providers in order to meet the support needs of people who receive HCBS waiver services. Ongoing review of service provision and consultative efforts by the department assists the community network in meeting the needs of people where they live. The services defined in the waiver and listed below can be found with the full definition in Appendix B.

- Behavior Analyst
- Behavior Specialist
- Day Services: Supported Employment, Community Based, In-Home and Facility Based
- Dental
- Environmental Accessibility Modifications
- Independent Support Coordination
- Individual Transportation
- Nursing
- Nutrition
- Occupational Therapy
- Orientation and Mobility
- Personal Assistance
- Personal Emergency Response System
- Physical Therapy
- Respite
- Specialized Medical Equipment, Supplies and Assistive Technology
- Speech, Language and Hearing

Supporting Service Expansion

Following the filing of the Joint Motion on January 6, 2015, the department began discussions with community provider network associations about making plans to develop service options for people transitioning from GVDC. Many of the existing East Tennessee providers have already expressed an interest in expanding to provide services to people leaving GVDC. In addition, providers who currently serve other regions of the state have also expressed an interest in development.

Programs to Assist With Community Transitions

All GVDC residents moving to HCBS Waiver homes may be eligible to receive additional residential supports and funding to facilitate their moves from GVDC to a community home. There are two programs through DIDD that provide assistance of up

to $2,500 to help the individual begin their life in the community. Establishment Funds is purely state-funded program. Money Follows the Person is a federal demonstration grant that was established under the Deficit Reduction Act of 2005. An individual who qualifies for participation in the Money Follows the Person Program cannot also qualify for money through Establishment Funds.

- Establishment Funds are authorized to help people furnish their homes, to purchase needed household supplies and linens and to cover special one-time start-up costs including rental and security deposits. Establishment Funds are limited to $2,500 per individual.

- The DIDD Money Follows the Person (MFP) program provides person-centered opportunities for individuals living in ICF/IID facilities to transition to qualified community-based settings. The goal is to have services and supports in place that will allow the person to remain within their community after the 365 day participation period is successfully completed. The DIDD MFP demonstration grant will help eliminate barriers that prevent persons with intellectual and developmental disabilities who reside in state or private inpatient facilities from accessing needed long-term community services and supports. This program provides a $2,500 Transitional Allowance (TA) that assists families with transition costs to a community based provider. It also helps to ensure that services and procedures are in place to provide continuous quality improvement in long term services for persons with intellectual and developmental disabilities.

Chapter 3

COMMUNITY SERVICE SYSTEM DEVELOPMENT

In addition to ensuring that people who live at GVDC and their conservators know about the available service options, the department will also engage in further expansion of supports in the community service system. There are several different facets of support that will be required.

Initial Provider and Other Stakeholder Outreach

Getting the provider community ready for the additional service need, like many of the other processes in this plan, is a multi-faceted engagement. With the public announcement of the closure of GVDC, there was a natural swell of interest from community providers, advocacy groups, legislators and other stakeholders. Each was curious about the placement alternatives available to persons transitioning from GVDC. The department engaged in meetings with multiple provider organizations, advocacy groups and concerned legislators. While preliminary in nature, these meetings provided the department the opportunity to begin the conversation with these parties and to set in motion a systematic development process. Of foremost importance in this process has been the overwhelmingly positive response from the existing provider community.

Preparing Vital Demographic Information to Identify Demand Concentration

In order to inform and assist providers in their development, the department is preparing a demographic study that will look at service needs in several different areas. Top priorities for service development include most requested services, concentration of medical needs, geographic placement preferences, location of legal representatives and the potential pairing desires of those requesting supports. Gathering detailed

information on the history of current staff members, their relationships with persons supported and their level of desire to relocate during the transition will also be of great impact to all parties.

As was described in the previous chapter, the department will collect individualized data during meetings with each person currently supported and their respective legal representatives. That data will be reviewed and organized in preparation for meetings with members of the contracted provider network. A letter requesting this information including deadlines for submission of information was mailed or hand delivered to all persons residing at GVDC and their representative by February 12, 2015.

Provider Development

When the information is organized into a useful form, the commissioner will set individual meetings with contracted provider agencies that have expressed interest in expansion. The information will be shared to give providers an idea of how to target their development to meet the specific areas of need for the GVDC transition population. As provider agencies are able to review this information and subsequently indicate their willingness to provide services and supports in the requested areas, this information will be shared with department's Regional Transition Teams. That will help the primary contact points within the transition process to effectively inform families and conservators about available services and providers. Ultimately, this service and supports information will serve as the foundation for individual information sessions and educational opportunities for all persons transitioning from GVDC.

Public Meetings and Family/Provider Familiarization Initiative

To help people make informed decisions about their service future, the department will work with the provider community on group meetings and fairs as well as one-on-one opportunities.

After individual meetings with families, conservators, persons receiving support and provider agencies, the final step in supporting persons in their transition desires will be first-person experiences. Because the availability of new service options will be diverse, the best opportunities will come through a multiple platform approach encompassing both group and individual sessions.

1. **Family Meetings**

   Many of the parties involved in this transition have very little exposure to any service delivery model other than GVDC, which is why it is important to hold regional information sessions for families and conservators before exposing them to the different provider options. These sessions will provide a thorough overview of both HCBS Waiver and ICF/IID services that are available to people who are transitioning from GVDC. Presenters will discuss the differences in the supports for each model and provide service definitions. The department will also have subject matter experts available during these sessions to ensure that all questions are answered and people make connections if people need any additional information. In addition to these resources, the department is bringing in people who have previously transitioned from GVDC to provide an opportunity for true testimonial experience. Finally, the department has worked with members of the advocacy community and local elected officials to have a presence at these meetings.

2. **Provider Fair**

   The department will organize a Provider Fair to give persons who are transitioning and providers an opportunity to get to know each other. Initially, these sessions will be held at GVDC and then as needed to provide opportunities for people, their families and conservators to hear presentations about the

multiple service options that are available. Additionally, these sessions will provide for an opportunity for people to ask questions and interact with Provider Agency representatives, to hear firsthand accounts of transition experiences from people who have already experienced a move from a developmental center, to discuss safeguards and oversight measures that are included in the transition and even to meet with local elected officials who have agreed to participate. DIDD staff will participate in these sessions to serve as guides or to help answer questions if needed.

3. Individualized Provider Experiences

Once people attend the group provider activities and as they begin to think about the different options, the natural next step is to see these settings directly. The department will work with families and provider agencies to schedule visits and individualized meetings upon request. Typically, these opportunities will involve a visit to a home/s in the community and/or the provider agency day services program and even the administrative office supporting these sites. Additional opportunities frequently include participation in agency activities or extended visits, sometimes overnight. Ultimately, these individualized sessions are intended to ensure that people who are making transition decisions better understand community-based settings and observe the atmosphere in which these services will be provided. Whether it is a community ICF/IID or a HCBS Waiver setting, each is unique and provides for a different and individualized service experience.

Chapter 4

THE TRANSITION PLANNING PROCESS

Each person transitioning from GVDC will have a detailed transition plan. The move will be carefully planned with the person supported, his or her Circle of Support, members of GVDC management and the ETRO Transition Team. As an additional measure of independent review, the Quality Review Panel (QRP) will work with the Transition Team. The ETRO Transition Team is comprised of professionals who have worked for many years in intellectual disabilities services. Most of the team members have several years of specialized experience in planning transitions for people from GVDC to community placements. Senior management and healthcare professionals at GVDC, including the Chief Officer and the Deputy Chief Officer for Residential Services, play an active role in transition planning for all people moving from GVDC to community placements. The ETRO Transition Team is committed to assuring safe and healthy transitions to community placements for all people living at GVDC.

Formal transition planning will occur over a period of time as determined by the needs of the person, the development of a chosen and appropriate community residential service arrangement and identification of other needed supports. Transition planning will also be determined by time frames within the Agreed Order and Exit Plan.

Regardless of the planning period, certain steps and activities associated with all transitions will occur in a routine order. This chapter outlines the steps and activities. A key element is the development of a person-centered Individual Support Transition Plan (ISTP). The ISTP thoroughly describes the required steps to support the person's move into a desired community living arrangement in keeping with their vision of a preferred life. All transitions will occur in accordance with the person's ISTP.

- **Step 1: Introductory Meetings**

Personal meetings will be held to ensure that all people, their family and conservators have a good understanding of the GVDC closure process. At these meetings, conservators learn about HCBS Waiver and ICF/IID residential options in the community, how the transition process flows and all steps in the process. During these meetings, the ETRO Transition Team will review the Residential Services Option document and select community informational material at the introductory meeting. The personal nature of these meetings allows conservators a comfortable, private setting to raise concerns and address fears and hopes. Meetings are facilitated by the person's GVDC case manager and a representative from the ETRO Transition Team.

- **Step 2: Choosing a Residential Service Model, a Provider Agency and a Home**

The introductory meeting initiates the process to assist conservators in deciding what kind of residential service best meets the person's needs and desires, choosing a residential provider agency, identifying the preferred geographic area(s) for services, choosing with whom the person would prefer to live and finding a prospective home.

A detailed provider selection form assists the conservator in determining the preferred geographic area where the person may reside. In addition, it identifies the available residential service providers and the types of residential services they offer. Freedom of choice between ICF/IID and HCBS Waiver is also discussed. Finally, the conservator will be provided with additional resources and contacts that may be helpful, and visits may be arranged to existing providers.

Through this process, the Transition Team will work closely with conservators and the identified residential provider to review and ultimately choose an existing residence

or develop a home in the community for the person. The team will also identify potential housemates or desirable housemate characteristics.

- **Step 3: Preparing the Individual Support Transition Plan (ISTP)**

A Transition Facilitator is assigned to each person whose conservator has indicated a geographic preference and selected a residential provider. The Transition Facilitator leads the process of gathering information and developing the ISTP. The Transition Facilitator is the conservator's primary contact in evaluating the available choices and making decisions in the transition process.

The Transition Facilitator gathers and reviews all current GVDC assessments, health care plans, treatment plans and other support documents including the person's current ISP and a draft of the ISTP prior to the first transition meeting. An agenda is prepared which identifies areas for additional discussion or decision-making.

The first transition planning meeting includes the person, their conservator, other involved family members, the Transition Facilitator, representatives from the chosen residential and day provider agency, the Independent Support Coordinator (if one has been selected), the person's GVDC Interdisciplinary Team and designated Regional Office staff as appropriate to the needs of the person. The planning team considers the person's vision of a preferred life and provides input to development of the ISTP initial draft.

Areas considered during the planning meeting include:

- The person's preferences, non-negotiables, habits and rituals
- The preferences regarding potential housemate and staff, the type of home, location, décor, visits prior to the move and other factors

- The person's day service preferences and desires, including vocational interests
- Staff support and training needs
- Family contacts and involvement preferences
- Medical services and medical professionals needed upon transition
- Medical insurance coverage issues
- Referral to SelectCommunity of TN as indicated
- Therapeutic supports needed including adaptive equipment
- Transportation supports needed
- Advocacy services needed
- Other support issues as indicated by the person, conservator or current plans

During the planning meeting, information is gathered to begin building the before-the-move, day-of-the-move and after-the-move checklists. The different checklists are key parts of the ISTP that specify concrete actions that must be taken to ensure a safe, effective and person-centered transition. The checklists also specify who is responsible for each action.

Following the planning meeting, the planning team reviews the draft ISTP to suggest revisions/additions as needed. As the person's transition becomes more imminent, the ISTP is continually updated and refined. Additional meetings may be scheduled to address specific issues or to make revisions to the plan. Meetings may involve the full planning team or specific members of the team as relevant to the issue.

Throughout the process, the Transition Facilitator remains in contact with the conservator to provide periodic updates on the status of the plan and completion of key action steps to support the person's move.

- **Step 4: Choosing an Independent Support Coordination Agency**

During the planning process, the person and his or her conservator will select an independent support coordination (ISC) agency. ISC agencies provide the service by

assigning an Independent Support Coordinator to work on behalf of the person before they move to the community. ISC agencies are charged with monitoring chosen services and supports for all class members following their move to the community.

Once ICF/IID services are chosen, the ISC selection will occur in the final months of the planning process. The ICF/IID provider is responsible for development of the initial community ISP. and for the coordination of services and supports for the person.

If the HCBS Waiver is chosen, the ISC selection occurs earlier in the process. In addition to monitoring the supports and services, the ISC works with the Transition Facilitator to assist the person and his or her conservator in the selection of needed providers. While the Transition Facilitator writes the ISTP to cover the initial transition period, usually 30 to 60 days, the ISC is responsible for developing the initial community ISP once the person has moved to their community home. The ISC's involvement during the planning phase allows them time to become familiar with the person and his or her support needs. The ISC assists the person and conservator to develop the person's Circle of Support to address specific service needs.

The ISC visits the person at minimum of every 21 days, including visits on the day the person moves to their new home and within five days of the move. The ISC also prepares a monthly review summarizing how the person is progressing toward meeting their outcomes and, if applicable, what steps were taken to resolve any problems or concerns. Finally, the ISC confirms all after-the-move tasks have been completed as described.

- **Step 5: Enrolling in SelectCommunity of Tennessee**

SelectCommunity of Tennessee (SCTN) is a Blue Cross/Blue Shield managed care organization designed to specifically address the needs of certain persons with intellectual disabilities within the TennCare system. Class members transitioning out of GVDC will be eligible for SelectCommunity if they enroll in an HCBS waiver program. SelectCommunity offers a nurse care manager to assist the ISC and provider agency to coordinate medical care and medical benefits. The benefits of SCTN enrollment will be described to the conservator prior to the ISTP being finalized. If the conservator chooses to enroll in the Waiver and in SelectCommunity, a SCTN representative will discuss his or her preferences with regards to a primary care physician, dental provider and other health care providers as well as any specific health care concerns.

Before the person moves to the community, SCTN and the residential provider ensure an initial community physical examination is scheduled with the person's primary care physician within the first month following the move. As warranted, all needed medical appointments are arranged prior to the person's move and reflected in the person's ISTP.

- **Step 6: Therapeutic Site Assessments and Accommodations**

A number of persons living at GVDC have significant physical challenges, and some may require physical accommodations to their homes in the community. Once people and their conservators have chosen the type of community residential service and provider agency, the next step is the choice of a specific home. ICF/IID services are provided in homes that are constructed to accommodate the needs of persons with significant physical challenges. If the person leaving GVDC chooses HCBS Waiver services, environmental accessibility modifications will be available to a maximum of

$15,000 per person over three consecutive waiver program years. Any specific modifications will be made prior to the person's move.

Once a potential home has been identified, the Transition Team will arrange for appropriate clinicians to complete a therapeutic site assessment with recommendations for needed renovations to increase accessibility and safety for the person. After the therapeutic site recommendations have been accepted by the Transition Director, the provider agency is responsible for ensuring all needed accommodations are in place before the person moves. Any needed accommodations will be identified in the person's ISTP as a before-the-move task.

Inspections performed by the department at Supported Living homes address safe lighting, smoke detectors, fire extinguishers, functional appliances, safe hot water temperatures and other key factors before the person moves. A new Residential Habilitation home must be licensed by DIDD Licensure before the person moves, and a similar inspection will be performed.

- **Step 7: Final Move Preparations**

In the last few weeks before the person moves to his or her new home, many final move preparations happen. During this time, GVDC staff and the ETRO Transition Team complete a number of administrative and preparatory tasks, including steps to ensure the person's Social Security/SSI benefits and GVDC personal funds are transferred and various identification cards are available and accurate. GVDC staff also coordinate arrangements for packing and moving the person's belongings and needed adaptive equipment to the new home.

The person and his or her conservator may play an active role in assisting the residential provider agency in furnishing the community home and in acquiring basic household items. People moving into HCBS Supported Living homes will have access to either MFP funding or Establishment Funds (up to $2,500) to help cover the initial costs associated with setting up their new home.

During this time, a cross-training plan is completed which describes person-specific training. The plan includes details on who will provide the training and whether the training should be completed at GVDC immediately prior to the move or at the person's new home. The cross-training plan is a component of the ISTP.

The final version of the ISTP is provided to the chair of the Quality Review Panel along with pertinent attachments and supporting documentation for review and comment. The Chair generally has 21 calendar days to review the ISTP and identify for the state any major deficiencies he believes exists with the placement. The state then must correct any major deficiency before it proceeds with the move.

The Quality Review Panel will review 100% of individual transition plans.

Any time within 14 days prior to the move date, a final transition meeting or "Closure Meeting" is scheduled. Participants include the person, their conservator, other involved family members, the Transition Facilitator, representatives from the chosen residential and day provider agency, the Independent Support Coordinator, the advocate (if one has been requested), the SelectCommunity Nurse Case Manager (if requested), the person's managed care organization, the person's GVDC Interdisciplinary Team and designated regional office staff as appropriate to the needs of the person.

The ISTP is reviewed, with emphasis on the before-the-move task list, the day-of-the-move task list and the after-the-move task list. Other areas of consideration include securing funds for the move, assigning staff for the transfer of personal documents, assuring the transfer of a complete personal record, arranging for a 30 day supply of medications, confirming initial PCP and other relevant appointments, confirming the cross-training plan and selection of a final move date. The person and the conservator's desire to be involved in the physical move will be integrated into the final transition plan.

- **Step 8: Moving Day**

GVDC staff who have worked with the person accompany him or her to their new home. At least one GVDC staff member stays with the person in their new home for a period of time as determined during the Closure Meeting. This arrangement assists the person's transition from GVDC to his or her new home and allows natural opportunities for the provider agency's staff to learn more about the person, their likes and dislikes, routines and support needs. Cross-training may also be conducted after the move as determined during the Closure Meeting.

- **Step 9: Post-Placement Monitoring and Oversight**

Once the person moves to their new home, the department will conduct post-placement monitoring visits to assure supports and services are being provided in accordance with the ISTP. The Transition Team and/or Operations Unit staff will conduct post-placement monitoring visits on the day of the move, on day five after the move, on day 30 after the move, on day 60 after the move and on day 90 after the move. These visits will happen using a Post-Placement Monitoring Tool based on the ISTP.

Additionally, the ISC will visit the person in his or her new community home on the day of the move and within five days after the move. The ISC will also have face-to-face visits with the person every 21 days thereafter. The Transition Team will make contact with the ISC following the first two visits and monthly thereafter through the monitoring period. The Transition Facilitator or designee will also attend the initial community ISP meeting scheduled by the ISC to ensure key support needs and strategies are effectively carried over from the ISTP to the ISP.

Completed Post-Placement Monitoring Tools will be provided to the Central Office Post Placement Monitoring Review Team on an ongoing basis for review. Any health or safety issues identified that place the person in immediate jeopardy will be addressed at the time they are identified, with resolution expected by the provider agency before the department monitor leaves the premises. Other issues of concern will be reported to the ISC and provider, with the expectation that they will be resolved by the time of the next monitoring visit. Any unresolved issues of concern will be addressed through the Regional Quality Management Committee, with administrative actions based on the recommendations of the committee.

Chapter 5

THE CLOSING OF GREENE VALLEY DEVELOPMENTAL CENTER

The planning and logistics of safely closing a large residential institution are a considerable undertaking, particularly when the institution supports people with a myriad of complex medical and behavioral needs. The department is committed to ensuring that the needs and wants of each person served remain the focus in our planning. The census of GVDC has decreased from 292 persons as of July 1, 2005 to the current census of 95 as of February 1, 2015. Staffing has decreased from 1,384 authorized positions on July 1, 2005, to 619 authorized positions as of February 1, 2015. The following table illustrates the reduction in number of persons served and authorized positions over the last ten years:

Year	Census	Authorized Positions
7/1/05	292	1384
7/1/06	284	1384
7/1/07	278	1388
7/1/08	267	1388
7/1/09	255	1396
7/1/10	244	1168
7/1/11	195	768
7/1/12	141	702
7/1/13	128	688
7/1/14	115	693
2/1/15	95	619

As the number of persons served on campus decreased, homes were closed, resources were reallocated and staffing levels were reduced. At GVDC's peak census of approximately 1,100 persons served, 17 cottages and 4 group homes in the Greeneville area were fully occupied. Now, there are only 5 cottages serving 95 persons. Over the years as homes were closed, careful planning and involvement by each person's Circle

of Support ensured a safe transition to a new home. That same careful planning and involvement will continue as the facility downsizes to closure.

As a part of the Approved Order, the annual review of GVDC by the Quality Review Panel was changed to focus specifically on the health and safety of persons remaining at GVDC during the period leading up to closure.
For years, GVDC has maintained a Move Committee comprised of various professional staff, persons served, family members and the Circle of Support. Significant planning, training, visits and careful attention to detail for each person's wishes and needs will continue as the facility downsizes to closure.

Part of the planning process is to ensure sufficient and well-trained staff are employed to meet each person's needs as the census, and commensurately the staffing, are decreased. As part of GVDC's downsizing, the department is committed to ensuring that affected staff are provided with sufficient information, resources and options best suited to their individual needs. Counseling, information, training, job fairs are all areas being developed to assist staff in preparing for their future options.

- Efforts are already underway to survey staff at GVDC as to their particular wants and needs. A Needs Assessment form has been submitted to all staff. The results will help develop assistance and services that staff request.

- After receiving the results of the Needs Assessment, representatives from the Department of Labor will visit GVDC to speak with employees regarding future opportunities.

- The Tennessee Consolidated Retirement System will schedule regular visits to the campus to meet with and advise employees who may be considering retirement.

- Free adult education classes are being organized for staff who do not hold a high school diploma or GED. Completion will help increase opportunities for future employment.

- The Employee Assistance Program has been contacted to meet with staff at least once a month as they seek other employment opportunities.

- The Tennessee Department of Labor and Workforce Development's mobile Career Coach will come to campus to assist staff with resume writing and online job applications as well as future job fairs.

- Labor and Workforce Development will hold workshops on applying for jobs through jobs4tn.gov utilizing the on-campus computer lab. They will also hold workshops on interview skills.

- Career center representatives will come to GVDC to hold workshops for staff who are interested in going to college and using the college tuition portion of their severance package.

- Employees will receive assistance in applying for unemployment benefits.

- The benefits package as part of a reduction in force will be available to those staff that remain with GVDC until their last assigned work date.

Chapter 6

HCBS WAIVER QUALITY MANAGEMENT

The primary purpose of the department's Quality Management System (QMS) is to provide a mechanism for achieving continuous improvement in both the quality of services and the performance of the service delivery system. In addition, the QMS measures compliance with state and federal requirements to ensure ongoing availability of federal funding, assists in documenting compliance with federal court orders and provides information that contributes to effective utilization of resources.

Quality management is not a static process. There is no beginning or end point. Rather, it is an ongoing circle of measurement, discovery, individual remediation, systemic improvements and re-measurement to determine the effectiveness of strategies employed for improvement of the system.

Ensuring quality in the provision of services and supports is the responsibility of all partners in the service delivery system (DIDD, TennCare, ISCs and Service Providers). As the agency charged with the operation of HCBS waiver services, DIDD is responsible for oversight to ensure that the services are meeting the needs of persons.

Providers that contract with the department are required to administer services in accordance with HCBS program standards, as delineated in the Provider Manual published March 15, 2014, the Provider Agreement, DIDD policies and in accordance with individual support plans created for each person. In order to ensure compliance with the requirements, providers must have a process for conducting self-assessments. Self-assessment is the process by which the provider identifies issues that affect the quality of services provided, as well as areas of operation resulting in non-compliance.

Providers must address self-assessment findings by determining the causes and taking action to improve quality or compliance.

Persons and their families, conservator and advocates have a role in assuring quality. They can participate in the service planning process, ensure that their needs are met and take advantage of available options for recourse when services and supports do not meet a person's needs or when unintended events or incidents occur.

Quality Management Activities

QMS activities and the corresponding data available to the QMS include:

1. New Provider Support Process
2. Provider Performance Surveys
3. Individual Waiver-Specific Record Reviews
4. Fiscal Accountability Review (FAR)
5. Personal Satisfaction Surveys
6. Protection from Harm-Incident and Investigation
7. Customer Focused Services
8. Death Reviews

A more detailed description of these QMS activities is provided below.

1. New Provider Support Process

It is the provider's responsibility to develop and implement policies, procedures and systems that are in line with DIDD, TennCare and CMS policies and regulations. To assist a new provider with these responsibilities, once that provider has a fully executed provider agreement, a member of the Regional Provider Support Team (RPST) will

begin to make periodic contacts with the new provider. The primary purpose of this process is to assist a new provider with administrative areas and program implementation applicable to HCBS regulations, state law, federal/state court orders and DIDD policies and procedures. RPST involvement in this process will continue at least until the initial Quality Assurance consultative survey and thereafter as determined by the Regional Quality Management Committee. The RPST documents its contacts using the New Provider Checklist.

2. Provider Performance Surveys

DIDD has established ten quality domains to evaluate provider performance. These domains are:

1. Access and Eligibility
2. Individual Planning and Implementation
3. Safety and Security
4. Rights, Respect and Dignity
5. Health
6. Choice and Decision-Making
7. Relationships and Community Membership
8. Opportunities for Work
9. Provider Capabilities and Qualifications
10. Administrative Authority and Financial Accountability

On-site provider surveys are conducted by departmental QA staff on an annual basis for each provider to determine performance related to the above domains. Each domain includes outcomes and indicators that measure specific areas of provider compliance with the provider manual, provider agreement and compliance with federally-mandated waiver assurances and the associated performance measures. A

representative sample of persons served by the provider will be selected for onsite review during each provider performance survey. The sample size may be increased if issues are identified within the sample population and more information is needed to determine the scope of the issue.

Less frequent surveys may be conducted for provider agencies that demonstrate ongoing proficient or exceptional performance in overall operation.

The on-site survey includes the following activities:

- An initial meeting between key provider staff and the survey team to discuss the logistics of the survey and to allow the provider an opportunity to give general information about the organization, including management and QI strategies that have been implemented since the last survey
- Observations of services and supports provided
- Interviews of persons, families and provider staff
- Review of the provider's records pertaining to the provision of supports and services

When survey activities are completed, survey team members will participate in a conciliation process to determine the provider's level of performance based on all information collected and reviewed during the survey. The survey will conclude with an exit conference. During the exit conference, the survey team will review major findings. When circumstances require further review of specific issues, the survey report will be issued when review is completed. A copy of the final report will be sent to the provider agency's board chair or chief officer.

3. Individual Waiver-Specific Record Reviews

Individual Record Reviews are conducted during each waiver year to collect data to demonstrate compliance for three of the six federally-mandated waiver assurances: Level of Care, Service Plan and Health and Welfare. Individual Record Reviews are conducted by departmental QA staff. The department is required to conduct these reviews annually.

During each waiver year, a statistically valid, random sample of individual persons will be selected for review from each waiver program. For each person selected, departmental QA staff will conduct a record review utilizing a data collection instrument design based on federally-mandated waiver assurances and CMS-approved performance measures. Following the record reviews, QA staff will report findings to department regional staff and/or appropriate provider management staff. Appropriate remediation strategies will be implemented. Providers are required to remediate all findings to resolution within 30 days of notification. Remediation actions will be validated by departmental Regional Office staff and by TennCare Quality and Administration staff to ensure successful and timely remediation of findings.

4. Fiscal Accountability Reviews (FAR) and Licensure

Annual FAR reviews provide information and data used to evaluate the overall financial status of the provider network, including provider competency in adequately documenting the provision of services to support claims submitted. Data pertaining to CMS-required performance measures is collected, analyzed and acted upon when there are findings during FAR. In addition, information regarding licensure of providers may be obtained by visiting the DIDD web site.

5. Satisfaction Surveys

Satisfaction surveys provide information about the quality of services and supports directly from the people who receive them. The person's perspective is a valued and essential component of the QMS. Interviews with the person and/or family members are utilized to obtain information about the impact of services and supports on quality of life during provider performance surveys and/or other monitoring processes.

Provider agencies and support coordination agencies are required to conduct annual satisfaction surveys and use the information to improve the quality of services and supports. Development of the satisfaction survey is the agency's responsibility. The results of these surveys are reviewed during provider performance surveys.

DIDD also contracts with an external entity to administer the annual People Talking to People (PTP) Survey. The PTP survey involves face-to-face interviews with persons and family members that are conducted by an independent evaluator employed by the contractor. Data from these surveys are collected, analyzed and trended. Results are used to document compliance with CMS-approved performance measures.

6. Protection from Harm-Incidents and Investigations

The Protection from Harm Unit oversees incident management and investigations. These processes assure the protection and safety of individuals who receive services. The Protection from Harm Unit collects data, performs focused trend analyses, generates provider-specific reports and participates with the state and

regional Quality Management Committees to recommend and provide needed assistance to provider agencies.

Provider agencies utilize the incident reporting and investigations systems to ensure that all critical incidents involving individuals are reported and that the necessary interventions to protect individuals from further harm are implemented in a timely manner. Every provider agency is required to have an Incident Management Coordinator and an Incident Review Committee that must meet at least every two weeks. Provider agencies must ensure that all incidents are reviewed by the committee and that appropriate corrective actions are identified, documented and implemented.

The Protection from Harm system requirements are the same for the community as they are for GVDC.

The department reviews all provider agencies' incident management procedures and activities at the time of the QA Survey. The department also maintains a statewide database of all filed incidents, and it ensures that all incidents of alleged or suspected abuse, neglect and exploitation are referred for full investigation by departmental investigators. The department also relies on its incident data base to identify significant trends or patterns in incidents for vulnerable persons, individual provider agencies, specific types of provider agencies and the entire service system.

The department has several additional requirements related to the prevention of incidents of alleged abuse, neglect and exploitation:

- Providers are required to submit a report of planned corrective or preventative actions called a Plan of Correction for all DIDD investigations to address the recommendations and incidental findings stated within the report. Designated department Regional Office personnel have the responsibility of ensuring that the provider identified in a DIDD Final

Investigation Report is responding with corrective and preventative measures.

- The department's Protection from Harm system utilizes the Tennessee Abuse Registry which includes names of persons involved in substantiated abusive or neglectful acts towards vulnerable persons. Provider agencies must check the registry before hiring an employee or volunteer. If the person is placed on the registry, that person cannot be hired or permitted to provide care. This ensures that the persons supported by DIDD are not subjected to repeat offenders. The Abuse Registry is maintained by the Tennessee Department of Health.

- Abuse and Neglect Prevention Committees (ANPC) exist in each region of the state. They were created to be independent entities that offer recommendations to departmental management to promote better care and protections for persons. ANPCs review the results of investigations of abuse and neglect and identify trends regarding these and other issues related to protection from harm.

7. Customer Focused Services

Complaints are handled by the Customer Focused Service Coordinators in each region of the state. Complaints are monitored to ensure timely and satisfactory resolution. Providers are required to establish a complaint resolution process to address complaints submitted by persons using services and families. Providers are also required to have an identified complaint contact person and to maintain documentation of all complaints filed. In addition, providers must inform people receiving services and their families of contact information for DIDD Customer Focused Service staff in the event that they wish to contact someone outside the provider agency to register a complaint.

8. Death Reviews

Death reviews are conducted by DIDD Regional Death Review Committees for all unexpected and unexplained deaths per the death review policy which is found on the DIDD web site.

Oversight and Resolution to Identified Issues

Data from all of the above activities are collected and analyzed by DIDD on a regular basis. The resulting information and recommendations are presented to the Regional Quality Management Committee (RQMC) and the State Quality Management Committee (SQMC) for consideration of actions such as technical assistance, sanctions or commendations. Information presented to both groups is tracked and discussed until resolution is achieved.

Regional Quality Management Committee

Each region maintains a Regional Quality Management Committee comprised of management-level staff of all units within the region. This group meets on a regular basis, at least monthly, to review provider performance and determine the need and frequency of provider support team follow-up. Results of each QA Provider Performance survey are reviewed along with information from other components of the QMS including complaint information, Incident and Investigation information and provider support team follow up information. If warranted, follow-up actions are planned based on review of provider performance or other issues.

State Quality Management Committee

The State Quality Management Committee is comprised of management-level staff of all units within the central office and includes representation from each regional office. This group meets monthly and reviews statewide data to determine trends and initiate follow up actions if warranted. Additionally, information on actions taken by the RQMC in response to specific provider performance or other issues is reported to the SQMC, which ensures statewide consistency and maintains oversight of regional QM activities.

CONCLUSION

This closure plan is designed to be a "living" document, recognizing the possibility of changes, most notably in the needs and situations of persons served and should allow for adjustments.

The commitment of the state will follow three main principles: all people will have a well-planned transition to a home in the community, the right to choose care options and individualized supports. The department is dedicated to ensuring a safe transition to the community for everyone who currently lives at GVDC. When that transition happens, the state affirms that people or their conservators will have the right to choose between community options (HCBS Waiver or ICF/IID). The department will work with each person or their conservator to produce a plan of supports to meet each individual need as identified.

Key Commitments:

- ***Well-Planned Transition to Community***
- ***Right to Choose Care Options***
- ***Individualized Supports***