Advisory Committee Strategy Report

November 2024

November 12, 2024

To whom it may concern,

We are pleased to issue the following draft report written and developed by the Strategy Report Advisory Committee. As required by the Settlement Agreement between the State and the Disability Law Center in Christensen v. Miner, the report includes "recommendations for policies and practices that the state may choose to implement to further reduce the institutionalized population of individuals with intellectual and developmental disabilities in ICFs over the subsequent ten years."

While all Committee members do not agree with each provision, the Advisory Committee has agreed with the publication of the report as a compilation of recommendations to state policymakers to consider "policies and practices that the State may choose to implement to further reduce the institutionalized population of individuals with intellectual and developmental disabilities in ICFs."

As required by the Settlement Agreement, the Committee included a representative of the defendants (DHHS), plaintiffs (DLC), individuals living in the community and ICFs, family members, a large and medium sized ICF provider, providers of HCBS residential services, providers of HCBS supported living services, and HCBS support coordinators. The Committee also includes representatives of the Utah Parent Center (UPC), and the Institute for Disability Research, Policy, & Practice (IDRPP) at Utah State University.

While this report was being researched, reviewed and written, the Department of Health and Human Services (DHHS) continued to address identified issues and recommendations. In Attachment 1, on page 24 of this report, there is an outline of efforts made by the State in the five specific topic areas that this report highlights, including : strategies for (1) further reducing the number of ICFs and licensed ICF beds in Utah; (2) further reducing the number of large ICFs in Utah and shifting to greater reliance on small ICFs (6 beds or fewer); (3) increasing funding and resources for community-based services; (4) ensuring competency of staff and appropriate staffing levels in ICFs; and (5) identifying barriers to community-based services for individuals residing in, or at risk of residing in, ICFs and strategies for removing those barriers.

If you have questions, concerns, or comments regarding this report, please contact the executive committee at dspdinfo@utah.gov or ncrippes@disabilitylawcenter.org.

Sincerely,

Strategy Report Advisory Committee, Executive Committee

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Executive Summary

As required by the Settlement Agreement between the State and the Disability Law Center in Christensen v. Miner, the State created an advisory committee in March of 2021 to draft a report that "shall include recommendations for policies and practices that the State may choose to implement to further reduce the institutionalized population of individuals with intellectual and developmental disabilities in ICFs over the subsequent ten years."

The report looks at five specific topics to address this, which are the following: strategies for (1) further reducing the number of ICFs and licensed ICF beds in Utah; (2) further reducing the number of large ICFs in Utah and shifting to greater reliance on small ICFs (6 beds or fewer); (3) increasing funding and resources for community-based services; (4) ensuring competency of staff and appropriate staffing levels in ICFs; and (5) identifying barriers to community-based services for individuals residing in, or at risk of residing in, ICFs and strategies for removing those barriers. The report also includes, in Attachment 1, the efforts the State has made to this point in addressing those concerns.

Based upon discussions with other states, looking at data and trends in Utah during the term of the Settlement Agreement, and gathering input from Committee members, the Committee developed numerous recommendations, which are detailed in the report. In all of the work of the Committee, the overall recommendation is that DHHS continues to work toward serving more individuals in the community. Also, the most common response from committee members about ways to reduce ICF beds and transition to smaller ICFs was to increase access to HCBS in a variety of ways, e.g., increasing HCBS funding, getting more people off the waiting list, and expanding waiver programs.

The Committee also recommends that the State increases its funding for HCBS, including looking for a dedicated funding source for the waiting list. The Committee noted that developing a statewide plan to ensure compliance with integration mandate of the ADA is one way we might accomplish this.

With respect to barriers to transitioning from an ICF to HCBS, the Committee recommendations focused heavily on the efforts the State has already made, including ensuring dedicated funding to transition, continuing with the in-reach and education about HCBS for ICF residents, and addressing discouragement by ICF staff. In addition, once again, the Committee suggests addressing gaps in the HCBS system. Similarly, the Committee recommends looking at wages and other incentives to ensure staffing levels are appropriate in ICFs.

Each of these recommendations and the information behind them are detailed in the full report. The Committee appreciates the work of all of the members and the support from DHHS staff in the development of this report.

Background and introduction

On January 12, 2018, the Disability Law Center (DLC) filed a class action lawsuit (referred to as "Christensen v. Miner") against the former Utah Department of Health and Utah Department of Human Services. The two departments were later combined into a single agency known as the Department of Health and Human Services (DHHS). The DLC's lawsuit alleged that the way DHHS managed the State's private system of intermediate care facilities for individuals with intellectual or developmental disabilities (ICFs) was in violation of Title II of the Americans with Disabilities Act (ADA), particularly under the U.S. Supreme Court's decision in *Olmstead v. L.C.*, which held that the unjustified institutionalization of people with disabilities is discrimination under the ADA.[1]

The class includes Medicaid-eligible individuals living in ICFs. The lawsuit sought the following actions from the state:

- Develop and implement a working plan to identify and transition individuals out of private ICFs and into Home and Community Based Services (HCBS) by providing appropriate information and supports, and by conducting appropriate assessments of all residents to determine their individual preferences;
- Evaluate, improve, and expand the services to support individuals residing in private ICFs to move to integrated, community-based settings; and
- Reduce the state's reliance on care provided in private ICFs.

On March 9, 2018, the parties jointly filed to stay the proceedings in order to engage in settlement discussions. Over the course of the next several months, the parties reached an agreement that was approved by the Legislature in the 2019 Utah General Legislative Session. Effective December 19, 2019, a Settlement Agreement between the DLC and DHHS went into effect, after approval by the Court.

Under the terms of the Settlement Agreement, *Item 6. Advisory Committee on pages 11-12*, DHHS agreed to:

- Establish an advisory committee through administrative rule for the purpose of developing proposed policies and practices, including potential legislative and administrative changes, to further reduce the institutionalized population of individuals with intellectual or developmental disabilities in ICFs in Utah.

[1] 527 U.S. 581, 597 (1999).

- Address the following topics with the advisory committee:
    1. Strategies for further reducing the number of ICFs and licensed ICF beds in Utah;
    2. Strategies for further reducing the number of large and medium size ICFs in Utah, and shifting to greater reliance on small ICFs (6 beds or fewer);
    3. Strategies for increasing funding and resources for community-based services;
    4. Identification of barriers to community-based services for individuals residing in, or at risk of residing in, ICFs, and strategies for removing those barriers;
    5. Strategies for ensuring competency of staff and appropriate staffing levels in ICFs.

The advisory committee was also tasked with drafting a report with their recommendations to reduce the ICF population over the ten-year period following the Settlement Agreement.

Strategy Report Advisory Committee Development and Implementation

In March 2021, DHHS implemented the Strategy Report Advisory Committee (the "Committee"). The Committee meets every other month for the purpose of discussing the items required in Item 6 of the Settlement Agreement. As required by the Settlement Agreement, the Committee includes a representative of the defendants (DHHS), plaintiffs (DLC), individuals living in the community and ICFs, family members, a large and medium sized ICF provider, providers of HCBS residential services, providers of HCBS supported living services, and HCBS support coordinators. The Committee also includes representatives of the Utah Parent Center (UPC), and the Institute for Disability Research, Policy, & Practice (IDRPP) at Utah State University. In October 2021, the administrative rule R539-11 "Strategy Report Advisory Committee" went into effect.

In July 2022, an executive committee to the Committee was formed to help develop meeting topics and agendas. Members of the executive committee include a class member, the Utah Parent Center Director, the DLC Legal Director, DSPD Division Director, and a DHHS Executive Director's Office designee. DHHS completed research and compiled information from other states across the country on a variety of disability services topics, including elimination of HCBS waiting lists, how ICFs operate in other states, etc.

DHHS employees provide the administrative support for the Committee including scheduling meetings, preparing agendas, keeping minutes, etc. Meeting materials are available upon request.

Strategy Report Requirements

Under Item 6 of the Settlement Agreement, DHHS agreed that no later than the termination of the Settlement Agreement, the Committee will prepare a written report, *"which report shall include recommendations for policies and practices that the state may choose to implement to*

further reduce the institutionalized population of individuals with intellectual and developmental disabilities in ICFs over the subsequent ten years."

In response to Settlement Agreement requirements, the Committee has written this *Advisory Committee Strategy Report,* which is formatted to address each item listed in Item 6 of the Settlement Agreement. As noted above, those topics are the following:

- Strategies for further reducing the number of ICFs and licensed ICF beds in Utah;
- Strategies for further reducing the number of large and medium size ICFs in Utah, and shifting to greater reliance on small ICFs (6 beds or fewer);
- Strategies for increasing funding and resources for community-based services;
- Identification of barriers to community-based services for individuals residing in, or at risk of residing in, ICFs, and strategies for removing those barriers; and
- Strategies for ensuring competency of staff and appropriate staffing levels in ICFs.

Each of the Strategy Report required topics is addressed below.

However, the Committee also wants to acknowledge that DHHS has taken many actions to address these topics during the term of the Settlement Agreement. The full list of accomplishments will be detailed in Attachment 1, but following are highlights of some major accomplishments.

First, DHHS has reduced ICF bed capacity significantly. Prior to the lawsuit, the ICF bed capacity in the State was at 655. The Settlement Agreement required DHHS to reduce the number of licensed ICF beds down to 465, but DHHS, for a variety of reasons, has seen the number of ICF beds reduced down to 198. At the time of filing, there were 18 licensed ICFs, and the current expected number at this time is 7 ICFs. In addition, a permanent moratorium on new ICF beds was put in place during the 2021 Utah General Legislative Session.

Further, the Settlement Agreement required DHHS to move approximately 300 individuals from ICFs, and, at present, 501 individuals have moved from ICFs into HCBS. For those who remain in ICFs, DHHS has reduced the number of residents per room, including an Administrative Rule that prohibits more than one roommate for individuals under 22.

Aside from those major changes in ICFs, DHHS has also implemented the Limited Supports Waiver to help with ICF diversion and the Community Transitions Waiver to help with nursing services for those who transition from ICFs to HCBS. There have also been efforts to address capacity for the HCBS system, including raising provider rates, implementing Caregiver Compensation, and several studies to look at system capacity.

In addition to the actions already taken, the Committee makes the following recommendations in an effort to help the State improve the service system for Class Members. The following recommendations come from research from other states, input from both ICF/ID providers, as well as providers of HCBS, individuals who have received services from both parts of the system, and from disability advocates familiar with the long-term services and supports system.

With all of these recommendations, the Committee recognizes that some actions may require Legislative approval, while others may be accomplished through administrative rule by the DHHS (or another State Agency). The Committee did not specify how each recommendation could be implemented, leaving that to the discretion of the Utah State Legislature and DHHS. Additionally, some Committee recommendations will help with more than one of the required topics, so they might be recommended more than once.

Required Topics

Strategies to further reduce the number of ICFs and licensed ICF beds in Utah

Committee Recommendations

As of the date of the report, the State currently has 7 ICFs and 198 beds licensed. The Settlement required the State to have no more than 465 beds, and it required a moratorium on licensing new beds, which was passed into law in the 2021 Utah General Legislative Session. In addition, the State also continues to operate a public ICF at the Utah State Developmental Center with 260 beds.

Data gathered by the State also suggests that some of the current residents in private ICFs may not oppose moving to HCBS. Thus, the current number of beds may exceed the current desire to remain in an ICF as a long term option, and a further reduction in beds should be considered.

The most common response from committee members about ways to reduce ICF beds was to increase access to HCBS in a variety of ways, e.g., increasing HCBS funding, getting more people off the waiting list, and expanding waiver programs. While expanding access to HCBS is not the only answer, it is important to note that it is the preferred alternative to ICFs and other institutions under the ADA and *Olmstead*, if it can meet an individual's needs and they do not oppose it. In fact, the overarching recommendation of the Committee in all of this is that DHHS continues to work toward serving more individuals in the community.

In addition, the Committee made other recommendations to reduce the number of ICF beds, including the following:

- The State should continue funding to allow transitioning beds from ICFs to HCBS, as they were able to do with American Rescue Plan Act funds during the pandemic.
- The State should continue to provide dedicated funding every year for individuals to transition from ICFs to HCBS if they want to, as they did under the Settlement Agreement. While the Settlement contemplated an average of 50 individuals transitioning a year, that amount of funding may not be plausible or even necessary with reduced numbers of ICF residents. However, dedicated funding will ensure that individuals can move as they are ready, and the State will not force individuals to remain institutionalized in violation of the ADA. [2]
- The State should also continue to gather data to inform decisions around funding and measurable goals for transitioning individuals from ICFs to HCBS. Funding should not remain static, and, if the population increases again, the State may need to increase funding to assist a larger number of individuals interested in moving to HCBS.
- Increase awareness about the benefits of community living for individuals with disabilities. This might involve educational campaigns aimed at families, caregivers, and the general public. They could promote an awareness of self-directed, family-directed, and other more flexible options as one area of focus, and include regular, in-depth, informative guardian/family sessions that provide an informed choice of residential setting. These sessions should show the objective evidence of the better quality of life for individuals in HCBS settings and integrated employment/ day activities.
- Crisis services are not widely available to individuals with ID/DD, nor is there a robust system of mental health services. Individuals often enter ICFs when a crisis occurs, hoping to access better mental health services. Providing crisis services for those with ID/DD would help prevent admissions.
    - One committee member noted that there seem to be complicated cases that cannot be served in the community under the current DSPD service codes. This is sometimes because of high medical needs, behavioral needs, mental health crises, or a combination of these. USDC and the State Hospital are rarely options. HMHI is

[2] DHHS has already taken action to accomplish this recommendation through an interagency agreement to annually transfer funding from Medicaid to DSPD equal to the number of people who transitioned from ICFs into HCBS in a given year. This process has been in place since DHHS began moving individuals into HCBS beyond the 300 agreed to in the Settlement Agreement, after the legislative appropriations for the 300 individuals were spent.

turning many of these cases away. The State should create a better option to serve all clients in the community.

- The State should increase the availability of nursing services for those in HCBS. A waiver was approved, the Community Transitions Waiver (CTW), to add nursing for those who transitioned from an ICF to HCBS; however, the same nursing services are not available to everyone in HCBS. This disparity likely encourages some individuals to enter an ICF in order to get nursing services . Ensuring that individuals do not have to enter an ICF to get nursing services in HCBS will cut down on those who may feel the need to enter, which can help keep the need for beds down.
    - To this same end, the State should consider a State Plan Amendment or other option to ensure individuals who would otherwise qualify for HCBS, but for a medical need, like a trach, can access the full array of HCBS services. Preventing the need for institutionalization will help keep the need for beds low.
- The State should consider enhanced transition programs, e.g., develop and implement programs to facilitate the transition of residents from ICFs to community-based settings.
    - This could include providing resources and support for housing, health care, and other necessary services. It could also include providing visits to HCBS settings for ICF residents.
- Consider regulatory changes.
    - Review and possibly revise state regulations to encourage the development of alternative care options and make it less financially attractive to maintain or expand ICF beds.[3]
- Continue with programs that provide quality improvement initiatives.
    - Implement quality improvement initiatives in community settings to ensure that these alternatives are viable and appealing for individuals currently in ICFs. All providers should have some quality metrics that are gathered annually by an independent third party. An annual provider report card would help people better understand where they can get the best care.
- Encourage collaboration with stakeholders.
    - Engage with stakeholders, including individuals with disabilities, their families, care providers, and advocacy groups, to understand their needs and perspectives and to develop effective strategies.

[3] Some efforts to address this have been completed. Through a statute change described in Attachment 1, which details DHHS actions during the Settlement Agreement period, the law prohibits the number of ICF licensed beds from being increased.

- Utilize research and data analysis.
    - Conduct research and data analysis to better understand the needs of the population in ICFs and to identify best practices for transition and community-based care.
    - The current LTSS study by the Human Services Research Institute may offer some new data and research that could be useful.
- The State should ensure and support adequate workforce development.
    - Invest in training and development of the workforce required for expanded community-based services, ensuring there are enough qualified professionals to provide high-quality care.
- Look at options to support individuals earlier to provide better outcomes.
    - Utah could invest in programs like early childhood intervention programs and programs that promote healthy lifestyles, possibly in collaboration with the Utah Disability and Health Program. This can help reduce the number of people who need long-term care, including institutional care in ICFs. These strategies would require a multifaceted approach, involving policy changes, funding reallocations, and collaborative efforts among various governmental and non-governmental entities.

Strategies to further reduce the number of large and medium size ICFs in Utah, and shifting to greater reliance on small ICFs (6 beds or fewer)

Committee Recommendations

National standards consider ICFs large at 16 or more beds, medium at 7-15 beds, and small at 6 or fewer beds. Prior to the Settlement Agreement, and during its term, the State has never had any small ICFs. Currently, of the 7 ICFs remaining, 5 ICFs are large and 2 are medium. Of the large ICFs, 3 will have 16 beds, with West Jordan Care Center as the only facility larger with 82 beds and Medallion Manor (Provo) with 41.

DHHS staff sought data from other states on their definition of large, medium, and small ICFs and how many of each their state had. Specific data can be found in Attachment X, but states varied greatly on their definitions and numbers of each. However, many of the states surveyed noted that a shift toward smaller ICFs led to a better quality of life for residents, services that were more individualized and integrated in the community, better outcomes for individuals (including more individuals with jobs), and less scrutiny or pushback from advocacy organizations.

Once again, the Committee recommends that the State continue to work toward serving more individuals in the community by investing heavily in the HCBS and workforce development to ensure that people can access services outside of an ICF. The state should continue to educate and assist individuals to transition to the community while also pursuing funding and policy options to ensure ICFs can remain financially viable at levels below maximum bed capacity to prevent future Title II violations.

Further, in order to reduce the number of large ICFs and/or transition large ICFs to small ICFs, the Committee also had the following recommendations:

- DHHS or the Utah State Legislature can establish policies that require individuals residing in an ICF to have their own room or, at a minimum, require that rooms have no more than 2 residents. This especially helps medium ICFs get to smaller levels and could significantly reduce the number of people in large ICFs, as some ICFs have had 3-4 people in a room. Large ICFs could transfer some of their licensed beds to other sites, further expanding small ICFs in the State, perhaps in more areas outside the Wasatch Front.
- The State could provide funding, or look for creative ways to utilize federal funds, to help ICFs transition beds into HCBS or transition large ICF beds to small ICF beds.
- The State could increase daily rates across the board, but also higher rates for smaller ICFs. This would also help ensure ICFs did not have to remain full to be viable.[4]
- The State could consider tax incentives or zoning changes to allow ICF's the same opportunities as other community-based service providers.
- Minnesota noted that their shift from large ICFs "accelerated" with the creation of a statewide *Olmsted* Plan by their legislature. The State should consider that as an option to help move away from large ICFs.
- The state could also consider changes to staffing ratio requirements.

  "[Committee member supports] continuing the transition program so that individuals that want to move out of the ICFs are able to do that and reduce the amount of larger ICFs. He stated he wasn't sure exactly how to reduce the amount of large ICFs, but used to live in a facility where there were 4 people to a room and now lives in a facility where some people live 2 to a room or have their own room and that is much better. He thinks that smaller ICFs are the right direction."

[4] Through legislative appropriation described in Attachment 1, which describes DHHS actions during the Settlement Agreement period, DHHS sought and received appropriations to increase ICF daily rates, with a higher rate paid to ICFs with 16 or fewer beds.

"Utah would not need small ICF's if they were to strengthen the community providers. DSPD community providers can already serve people in 4-bed homes."

Strategies to increase funding and resources for community-based services

Committee Recommendations

In one of the Committee meetings, data on services for people with intellectual and developmental disabilities (ID/DD) from around the country was presented. That data reflected a report from 2017, which was updated in 2019.[5] The report found that, nationally, 22% of people with ID/DD are known to or served by their long-term services and supports (LTSS) agency, and 19% received LTSS from their agency.[6] In Utah, 10.6% are known to or served by DHHS, and 7.7% are receiving LTSS.[7] Thus, Utah is well below the national average in terms of serving this population.

In a presentation to the Utah State Legislature during the 2024 Utah General Legislative Session, DHHS indicated that 6,851 individuals are in HCBS and 4,764 individuals are on the waiting list. The Legislature funded approximately 250 individuals to come off the waiting list, so those numbers will likely change slightly over the next year. However, the waiting list has more than doubled over the last 10 years despite receiving some amount of funding most years, so a meaningful reduction in those waiting is unlikely.

In addition to just funding individuals on the waiting list, HCBS providers and support coordinators also sought funding increases in the 2024 Utah General Legislative Session. Those were not funded; however, HCBS providers for those in DSPD services did receive a rate increase during the 2022 Utah General Legislative Session to enable them to pay staff approximately $16-17/hour. While that increase did help recruit and retain staff, without meaningful increases moving forward, staff recruitment and retention will continue to be a challenge.

The information above highlights some of the gaps in the HCBS system and the need for the State to increase funding and resources to this system. The State has an obligation to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities,"[8] and, as *Olmstead* made clear, the

[5] Larson, S.A., Neidorf, J., Pettingell, S., Sowers, M. (2022). Long-term supports and services for persons with intellectual or developmental disabilities: Status and trends through 2019.
Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. 10.13140/RG.2.2.23116.08320.
[6] *Id*.
[7] *Id*.
[8] 28 C.F.R. Sec. 35.130(d)

unjustified institutionalization of individuals with disabilities is segregation, and thus discrimination, in violation of the ADA.[9]

Having an HCBS system that is adequately funded and is providing the resources necessary to serve individuals with a variety of needs helps to improve waiver capacity. With that in mind, the Committee makes the following recommendations to increase HCBS funding and resources:

- The State should create a statewide *Olmstead* Plan with action steps and measurable outcomes.
    - As noted above, Minnesota's legislature created a statewide *Olmstead* Plan, which helped them make some improvements to their system. By creating a plan, the State would effectively be looking at the whole system of services for individuals with disabilities throughout the State and determining what is necessary to serve them in the most integrated setting appropriate to their needs.
    - Essentially, the Working Plan developed as a part of the Settlement Agreement was a scaled down version of an *Olmstead* Plan for class members. Expanding the scope of a plan like that to the entire state and the entire population of those with disabilities would show that Utah is committed to the promises of the ADA.
    - This plan would necessarily include a plan to eliminate the DSPD waiting list, which was another suggestion from committee members, or at least a plan to reduce wait times for those on the list.
- A strategy for increasing HCBS resources is addressing the workforce shortage and lack of quality HCBS services. The State should implement a career ladder for DSPs with required training and implement required contract language to increase reimbursement rates reflective of higher quality services.
- The State has expanded access to nursing services for those exiting ICFs with the CTW; however, those services should be expanded to the entire HCBS population. Some states have specific group homes for those with higher medical needs.
    - For example, Arizona was a state that was mentioned with group homes specific to those with higher medical needs.
- The Settlement Agreement required that individuals moving from ICFs to HCBS were moved into settings that were compliant with the HCBS Settings Rule at 42 C.F.R. sec. 441.301(c)(4), essentially meaning they should look like settings those

[9] 527 U.S. 581, 597 (1999).

without disabilities would live in rather than institutional settings. The State has obligations under the HCBS Settings Rule; however, the Committee recommends that individuals moving from ICFs to HCBS moving forward should still be moved into compliant settings.
    - In addition, the State, in expanding its HCBS system, should seek to ensure HCBS settings are smaller than nationally recognized standards for small ICFs, meaning fewer than 6 beds. Committee members learned of HCBS residences that had up to 8 residents and expressed concern at the size of those settings.
- The State should also try collaborating and working with other states that have a higher rate of funding for disability related programs, i.e., Washington, Colorado, and create a similar system that has been proven to work.
    - Colorado has, among other things, increased funding for HCBS programs.
- Caregiver compensation has been helpful for many families, and one suggestion was to expand the availability of that program to more family members, i.e, siblings. One committee member noted, "As a sibling, I cannot receive money for helping my brother even though I have a Masters in Special Education and 25 years working in the field. If there was a path for me to become [sic] a licensed provider for my brother, I could provide better services at a lower cost than the current ICF's and Community Service providers."[10]
- Some efforts to find dedicated funding sources for the DSPD waiting list have been successful in other states. Some efforts in Utah have been proposed or considered. For example, a constitutional amendment was passed in 2020 that allows income tax funding to be used for disability services when previously only allowed for education. Other measures have been considered, like H.B. 393 from the 2024 Utah General Legislative Session, that would have created a perpetual trust fund to bring people off the waiting list. This effort failed, but the State should continue to look for dedicated funding sources for the waiting list and other HCBS needs
- There have been discussions at DHHS about streamlining the HCBS application process, and that could also help individuals access HCBS.
    - Other states have made it easier for people to apply for HCBS by streamlining the application process and reducing the amount of paperwork required.
- Another option would be for the State to consider prioritizing certain populations for HCBS services.

[10] Siblings are already allowed to, and are, providing services to HCBS recipients under the Self-Administered Services model.

    - Some states prioritize certain populations for HCBS services, such as children and young adults with disabilities, people with complex needs, and people who are at risk of institutionalization. For example, Minnesota has also prioritized children and young adults with disabilities for HCBS service, and as noted above, their HCBS waiting list has significantly decreased. Once again, we also note that Minnesota has a statewide *Olmstead* Plan.
    - DHHS has also discussed a mid-tier waiver, as we already have the full array of services on the Community Supports Waiver/CTW, and there is currently a limited supports waiver. The State could add capacity to that waiver.
    - The State could also consider adding another tier with more than limited supports, but less than the full array, which may be all some families need.
    - DHHS has also considered a maximum number of years that a family must wait. This is another option the State should consider, as some families wait more than 20 years.
- Some states use alternative services to meet the needs of individuals on HCBS waitlists, such as state plan HCBS, community-based mental health services, and respite care. Utah could consider this as well.
    - One example in Utah is the small pilot project that the Utah Parent Center and the Utah Developmental Disabilities Council ran of a peer-to-peer network. That program showed increased stability for families by providing them with natural supports and peers. The State could look to expand upon this and fund a larger program, as was requested in the 2024 General Legislative Session.
    - Many states have Katie Beckett Waivers, or something similar, to provide Medicaid services to individuals while they waitt. An effort to do this in Utah has been proposed since the 2023 Utah General Legislative Session. Currently, only about half of those on the waiting list have access to Medicaid, so many of those waiting still do not. Many families have indicated to committee members that having access to Medicaid, even while they wait, would be a great benefit.
- The State should consider partnering with community organizations.
    - Others have partnered with community organizations to provide HCBS services to people on waitlists. This can help to expand the capacity of the HCBS system and serve more people.

"More social media pages highlighting the services, fun activities, and missions of community-based services. Use news and media companies to raise awareness for the need of funding for community-based services, including interviewing clients and staff."

“DHHS needs to gain support from the Governor’s office to advocate for funding of the waitlist and the provider system. I have witnessed many legislative sessions where DSPD has been unable to advocate for services because the Governor didn't put waitlist or provider based services in the budget. Seems like DSPD/DHHS needs to really make a strong push with the state government. A plan should be developed by stakeholders to eliminate the waitlist. Maybe it's a 5-10 year plan, but a comprehensive plan should be developed and advocated for by DHHS and stakeholders.”

Identify barriers to community-based services for individuals residing in ICFs, and strategies to remove those barriers

Committee Recommendations

The DLC’s impetus for bringing this lawsuit was that, as Utah’s Protection and Advocacy Agency, their staff spent a lot of time in ICFs talking with residents for years prior to filing their complaint. Residents frequently expressed a desire to move out of their ICF to be near family or friends, to have fewer people living with them, or just to have more independence. Unfortunately, there were many barriers to those individuals moving into HCBS.

After the DLC’s complaint was filed, and the State agreed to have settlement discussions, the parties spent months working through solutions to these barriers. The parties came up with solutions to address those barriers at that time, and many residents have been able to move since. Simply, removing barriers to community-based services for ICF residents was a core principle of the Settlement Agreement.

The Parties have learned a lot about reducing barriers for ICF residents during the term of the Settlement Agreement. Barriers that prevent people from leaving ICFs, when they very much want to, are a violation of the ADA. Continuing to assess and remove barriers is fundamental to the State meeting its obligations moving forward.

Given those considerations, the following are the recommendations from the Committee in identifying new barriers to HCBS for ICF residents, and what the State can do to remove them:

- The dedicated funding provided during the term of the Settlement for individuals to transition from ICFs to HCBS should be continued by the State.
    - The Settlement Agreement specified a number of residents to move over its term. While that number may now be too high given the reduced number of ICF residents, individuals who want to move must still be given an opportunity to do so.
    - The State should continue to assess the number of individuals who have expressed any level of interest in learning more about, or moving to community-based services, and then fund an appropriate number of transition slots based on that information.[11]
- In-reach and education efforts borne out of the Settlement Agreement, both for residents and staff, should continue.
    - One identified barrier has been individuals, family members, guardians, and ICF employees' lack of knowledge regarding the capacity of HCBS services. Many of these populations believe that ICFs are the only place the needs of the individuals with disabilities can be met. This barrier can be overcome through proper training and information dissemination regarding the service capacity of HCBS settings.
    - Additionally, residential staff have low expectations for individuals with disabilities and a lack of community-based support skills. This can be overcome through intentional training and direct technical assistance with the residents in community settings. This can also be mediated through consulting with the organization about their organizational culture surrounding disability.
    - The State's in-reach and education efforts should include the option for ICF residents to visit HCBS settings. Allowing residents to have that experience can address a lot of the concerns they and their families have.
    - This opportunity to visit HCBS settings should be provided for all ICF residents, and not only those who have already signaled a desire to move.
    - Another option the State should pursue is to increase access to peer supports. Residents and their families can learn a lot from those with lived experience, and the peer mentors who have worked with families over the Settlement's term have been very successful.[12]

[11] DHHS has made efforts to accomplish this recommendation through an interagency agreement to annually transfer funding from Medicaid to DSPD equal to the number of people who transitioned from ICFs into HCBS in a given year. This process has been in place since DHHS began moving individuals into HCBS beyond the 300 agreed to in the Settlement Agreement, after the legislative appropriations for the 300 individuals were spent.
[12] DHHS is already committed to continuing in-reach and education efforts beyond the Settlement Agreement period. Education and in-reach efforts will continue to include offering individuals opportunities to visit HCBS settings.

- Efforts to address discouragement by ICF administrators and staff must continue, and the State should continue to monitor the situation and address any discouragement appropriately.
    - Discouragement by ICF staff was a major barrier prior to and during the Settlement. The State monitored the discouragement and provided that information to the DLC, and steps were taken to address the problem. Discouragement ranged from misinformation to ICF administrators actively encouraging guardianships of residents to prevent them from leaving.
    - DHHS did enact regulations to prohibit discouragement and to provide ramifications if it happened. At a minimum, these efforts should continue. In addition, the State should take any action appropriate to ensure that ICF residents are not discouraged from HCBS.
    - Several individuals, family members, and HCBS service providers commented in Committee meetings that they had experienced discouragement and even hostility from ICF staff when exploring transition to HCBS for themself, a loved one, or potential client.
- The State can increase HCBS access to nursing services for those in HCBS.
    - Lack of nursing services in HCBS was a barrier in the past. As noted above, the State did get the CTW for those coming out of ICFs, which does offer nursing services. However, one of the large ICFs remaining does have a lot of medically complex individuals, and more nursing services could help them move to HCBS.
- Other gaps in the current HCBS system need to be addressed by the State.
    - It is widely accepted that the State has a shortage of affordable housing, particularly deeply affordable housing. Individuals in HCBS will need access to deeply affordable housing, as many of them rely on public benefits to pay for their living expenses. Without more deeply affordable housing, the HCBS system cannot expand and meet the needs of those on the waiting list, to say nothing of those residing in ICFs.
    - There is a lack of crisis services available to individuals with ID/DD, as well as a lack of access to mental health services. Individuals often enter ICFs due to crisis, and these behaviors can make it difficult to find placement in HCBS. Access to better mental health services and crisis services for those with ID/DD is a major barrier.
    - It is also widely accepted that direct support professionals who provide the support for those in HCBS are underpaid. Ensuring that wages can remain competitive, i.e. regular increases, will help ensure there are staff.

- In addition, rates for HCBS providers to ensure their administrative staff receive a competitive wage is important to the system.
- The State currently has two ongoing studies, one of the entire LTSS system and one rate study. These studies will help inform decisions, and will hopefully provide policy-makers with more recommendations on how to address these gaps.

"Start working with younger kids to ensure that they are aware of the resources and support available to them, such as DSPD, CUE, other day programs, etc. Increase awareness of Vocational Rehabilitation, Paratransit, and other work programs and how they can support individuals with disabilities in their goals to work."

"I believe all individuals residing in ICF's can be served in the community if it were to be prioritized."

Strategies to ensure competency of staff and appropriate staffing levels in ICFs.

Committee Recommendations

As part of the provider rate increase mentioned above from the 2022 Utah General Legislative Session, ICF staff were also included in the attempt to get wages near to $16-17/hour. However, also similar to HCBS providers, ICFs have struggled with recruitment and retention of staff, and, without future increases, those problems will likely continue.

Currently, federal regulations dictate minimum staffing ratios for ICFs, which can depend on the age and needs of the residents of the ICF.[13] State law has not added any additional staffing requirements, and there have been instances of ICFs failing to meet the minimum staffing requirements.[14] However, there is no required training for ICF staff.

While the overarching message from the Committee is to serve more individuals in HCBS, as long as the State continues to have ICFs as a part of the service delivery system, there must be standards for ensuring the highest quality of care for those who remain. Individuals who reside in ICFs should live in safe and healthy conditions, and they should have sufficient support from the staff.

These are the recommendations from the Committee on ICF staffing:

[13] 42 CFR §483.430(d)(1) and guidance.
[14] *See*, https://disabilitylawcenter.org/wp-content/uploads/2023/06/DLC_The-License-to-Mismanage_draft-4a.pdf

- Require all ICF staff to have relevant training and certification.
    - This could include training on state and federal regulations, person-centered care, and trauma-informed care.
    - Certification could be required for certain positions, such as nurses, social workers, and direct care staff.
    - Training should include an understanding of HCBS, as committee members noted ICF staff's lack of familiarity with that side of the system. This misinformation was sometimes used to discourage residents from moving to HCBS.
- Provide financial incentives for ICFs to hire and retain qualified staff.
    - This could include competitive salaries, benefits, and tuition reimbursement.
    - Offer tuition reimbursement to ICF staff who are pursuing relevant certifications. The state could also offer financial incentives to ICFs that hire certified staff.
- Develop a statewide database of ICF staff qualifications and experience.
    - This database could be used to match ICFs with qualified staff and to track staff turnover.
    - The state could work with ICFs to develop this database and to make it accessible to ICFs and job seekers.
- Conduct regular inspections of ICFs to assess staffing levels and staff competency.
    - These inspections could be conducted by state or private agencies.
    - The state could use a variety of tools to assess staffing levels, such as staffing ratios and staff turnover rates.
    - To assess staff competency, the state could use interviews, observations, and performance reviews.
    - Annual auditing of facilities and compliance (with penalties for non-compliance).
- Provide ICFs with technical assistance and support on staffing issues.
    - This could include training on how to recruit, hire, and retain qualified staff.
    - The State should require all ICF staff to have at least 40 hours of training on state and federal regulations, person-centered care, and trauma-informed care within their first six months of employment. The State could provide this training or it could be provided by accredited training providers.
    - The state could hire staffing experts to provide ICFs with one-on-one assistance.

    - The state could also develop online resources and training materials on staffing issues.
- Partner with community colleges and universities to develop training programs for ICF staff.
    - This could help to create a pipeline of qualified ICF workers.
- Work with ICFs to develop career paths for staff.
    - This could help to retain qualified staff and reduce turnover.
- Support efforts to raise awareness of the ICF profession and to promote it as a rewarding career choice.
    - This could help to attract new people to the field. By taking a comprehensive approach to ensuring competency and appropriate staffing levels in ICFs, the state can help to improve the quality of care that ICF residents receive.
- Wage increases should be regular and tied to a metric, ensuring they adjust regularly with the cost of living, similar to the approach taken with state liquor store staff.
    - This is true for staff on the HCBS side, too.
- Implement person-centered Quality of Life assessments for residents.
- To ensure the rights of ICF residents to access integrated community settings, a revision in regulation could be made to mandate that ICFs allocate a minimum, quantifiable amount of time for residents to spend in community settings of their choice. Through administrative rule or other regulatory mechanisms, ICFs must be held accountable for providing residents with meaningful and consistent access to community life, promoting their social inclusion and overall well-being.

“[Committee member] stated that the staff have to be aware and want to work in the environment that they are entering into. There should be an emphasis on being a people person and understanding that the residents become attached to the staff. The staff need to be able to stay. [Committee member] also believes that the staff need to be fully trained and understand that they will need to do things like passing out medication, doing changes, showering, feeding, etc. [Committee member] believes that there should be training on respect and proper ways to talk to and work with people with disabilities. There needs to be more training on the expectations of working in an intermediate care facility.”

“I'm amazed that there is no professional competency required for people who provide services. Management, supervisors, etc. are mostly composed of people who have worked their way up the company structure. This would include agencies that provide support coordinator services. This is a pretty limiting environment to gain critical skills

and knowledge. Again, it comes down to the ability to set higher standards and provide the funding for that."

Additional Committee topics and recommendations

The Committee has the following comments or recommendations on additional topics:

While not directly related to one of the topics, the Committee also wants to note that, during the term of the Settlement Agreement, some individuals residing in ICFs were found not to meet the level of care necessary for placement in an ICF. Some of these individuals were those with serious mental illness and were improperly admitted. In addition, there may also be individuals residing in nursing facilities that have ID/DD who would benefit from HCBS. The Committee reiterates the recommendation for a statewide *Olmstead* Plan to address the needs of these populations, as it would ensure that there were appropriate community-based services for those with serious mental illness and a pathway out of nursing facilities for those who might reside there.

The Committee also wants to note that any training requirements, or expectations of service providers across the system, must be enforced with compliance measures.

Attachment 1: Actions Taken by DHHS to Address Topic Areas

1. **Strategies for further reducing the number of ICFs and licensed ICF beds in Utah**

   Under the Settlement Agreement *Item 4. Objectives and Plan Implementation, Page 8* and Working Plan, *Item 4. Moratorium and Reductions of Privately-owned ICF Beds and Modifications to Licensing Rules, Page 7,* DHHS was required to take the following actions related to reducing the number of ICFs and ICF beds in Utah:

   - Implement a permanent moratorium on licensing additional ICF beds
   - Reduce the total number of licensed private ICF beds to no more than 465.

   DHHS has successfully achieved these Settlement Agreement requirements resulting in significant reduction in the number of licensed beds and the number of facilities:

   - Permanent moratorium in ICF beds - during the 2021 Utah General Legislative Session, HB 333 passed. This bill placed a permanent moratorium on any new or additional ICF beds.
   - Reduction in number of licensed ICF beds - At the filing of the DLC lawsuit in January 2018, there were 655 licensed ICF beds. With the recent closure of four additional private ICFs, representing 171 licensed beds, as of the publishing of this report, there were 198 licensed beds remaining. This has resulted in a reduction of more than double the number agreed to in the Settlement Agreement; a 70% reduction of ICF beds since January 2018.
   - Reduction in number of ICFs - While there was no specific requirement about the number of ICFs in the Settlement Agreement, at the filing of the DLC lawsuit in January 2018, there were 18 licensed ICFs. Currently, there are only 7 ICFs that remain in operation. This has resulted in a 61% reduction in the number of ICFs since January 2018.

   Under the Settlement Agreement *Item 4. Objectives and Plan Implementation, Page 8,* DHHS was required to move approximately 300 people from private ICFs to HCBS by the end of the Settlement Agreement. As of the publishing of this report, DHHS has successfully moved 501 individuals from ICFs into HCBS, well above the number required in the Settlement Agreement.

2. **Strategies for further reducing the number of large and medium size ICFs in Utah, and shifting to greater reliance on small ICFs (6 beds or fewer)**

   While there was no specific requirement about the number of ICFs in the Settlement Agreement, at the filing of the DLC lawsuit in January 2018, there were 18 licensed ICFs. These facility closures will reduce the number of ICFs to 7. Of the remaining 7 facilities, 5 of the 7 will have 16 beds or fewer.

   The advisory committee recommended increasing ICF rates to ensure providers have sufficient funding to maintain operations when a facility is not fully occupied. In addition, committee members recommended structuring ICF payments to incentivize smaller facilities. During the 2023 general session, DHHS sought and received a legislative appropriation to increase ICF rates. ICF rate increases went into effect on July 1, 2023, and included an enhanced payment for facilities with 16 beds or less, and has the ability to offer an additional incentive payment to any facilities with 6 beds or less, although none currently exist.

3. **Strategies for increasing funding and resources for community-based services**

   During the Settlement Agreement period, DHHS took several actions to address HCBS funding and resource issues, including:

- Implemented the Limited Supports Waiver (LSW)
  - Based on feedback from families describing they wanted options earlier and that the system has been "all or nothing", and a desire to move beyond that.
  - Services were developed based on the priority needs of families.
  - Brings people into services early, before they reach a crisis.
  - With a cap in the total amount of services provided, more people can receive services.
- Implemented the Community Transitions Waiver (CTW)
  - Adding nursing services to the CTW to support a person with more complex medical needs will add a resource to help people safely transition into the community. In fact, a few people have chosen to transition into the community even when they were on hospice.
- Increased HCBS provider rates 19.5%
  - Funding was increased in direct care services specifically to increase the pay of direct support professionals (DSPs). Retaining DSPs, reducing turnovers and vacancies, is necessary for:
    - Sustaining the provider model as an option for families.
    - Creating an environment where they can grow and increase their capacity.

- Implemented Caregiver Compensation as an ongoing option
    - Increases options for a person receiving supports.
    - Increases system capacity by creating additional paid supports
    - Anecdotal information from families is that this service has led to increased skills and decreased anxiety for their loved one, in part due to stability and predictability in supports.
- Conducting LTSS Study/Direct Care Workforce Study
    - A long-term services and supports study is being completed for the aging and disability service systems. This will identify needs, gaps in services or processes, and will result in a report at the end of the study.
    - Coupling its results with the rate studies will increase professional, credentialed organizations' assessments, providing reliable information when identifying needs and developing requests in the future.
- Conducting HCBS Services Rate Studies
    - Having an understanding of the cost to provide services, as well as the quality and outcomes of those services, will help when developing and requesting funding.
    - Some services, such as respite, have been difficult to access for many years, creating gaps in choice and capacity. Addressing services like this allows people to remain in their communities and connected to people who know them.
- Conducting annual support coordination surveys regarding service availability
    - This survey gathers information about the capacity and health of the service system. Examples include how long it takes for someone to access a service, time without services due to capacity, and time without a service even when the service and provider are consistent over time, and the frequency people are given a 30-day notice.
    - The baseline data was established during a significant reduction in staffing availability. By tracking this data regularly, the information will be used to recognize trends and make data informed decisions before issues become critical.
- Continuing cost reporting on a semi-annual basis
    - Maintaining data on the use of appropriations and demonstrating its effectiveness over time ensures the availability of reliable data when requested by interested parties and when making requests. By adding this to the annual survey information, this will increase insight into the impact of resources and potential needed increases.
- Implementing service delivery pilot

    - Non-lapse funding is being used to fund approximately six organizations to identify and pilot ways to increase the availability of respite and supported living services.
    - Keeping a breadth of service options is critical to supporting people in a way that helps them receive the least intrusive supports and remain connected to existing relationships and supports.
    - The intent is to understand how to make this service viable.
- Contracting with the State Employment Leadership Network (SELN)
    - SELN works with our state and partner organizations to identify how to successfully implement employment supports for people with disabilities. Each year, DHHS and SELN identify needs and focus on addressing them.
    - This has helped to develop tools, offer training, and provide insights that help to maintain and increase employment as an option for people.
    - Increasing this option helps to keep people supported and connected in their communities.

4. **Identification of barriers to community-based services for individuals residing in, or at risk of residing in, ICFs, and strategies for removing those barriers**

   During the Settlement Agreement period, DHHS took several actions to address HCBS funding and resource issues, including:

   - Increase HCBS access to nursing services

     DHHS is working to use existing appropriations to increase nursing services rates in the Community Transitions Waiver to be the same as rates paid for Medicaid state plan home health nursing rates. To address this barrier, DHHS is working to submit a waiver amendment to CMS to authorize this rate increase.
   - Take steps to reduce DSPD waiting list

     DHHS has taken the following steps:
       - Requested and received unprecedented waiting-list funding during the Settlement period.
       - Used attrition funding to bring new people into services.
       - Developed a strategy, based on previous studies and surveys (including the Utah Developmental Disability Councils *End the Wait* campaign), to engage partners on how to address needs for people waiting for services. It has been presented internally to DHHS leadership and to the Governor's Office. DHHS is engaging with a variety of community partners to collaborate and receive public input.
   - Assure minors receive HCBS

    - Efforts to reduce the number of minors currently living in ICFs - DHHS has taken significant strides to reduce the number of minors living in ICFs. In June 2021, 43 people under age 22 lived in ICFs. As of June 30, 2023, there are 11 individuals under 22 living in ICFs. Of these:
        - 4 live in their own room;
        - 5 have 1 roommate; and
        - 2 have more than 1 roommate.
    - Rebuttable presumption that individuals under 22 shall not be admitted to ICFs - When an individual under 22 or their guardian expresses interest to move into an ICF, the individual cannot move into the facility until meeting with staff from DHHS. Through this process DHHS staff provide HCBS education and perform an additional evaluation of HCBS options. If alternate options, including HCBS, are unavailable or ICF admission is still preferred, staff provide a case summary to the Medicaid Director and the DSPD Director (or designees). The Directors (or designees) authorize, in writing, all ICF admissions of individuals under age 22.
        - From July 1, 2022, through June 30, 2023, 23 individuals under age 22 received HCBS education; 19 of these individuals either received HCBS (18) or elected to stay in the community without HCBS provided by DHHS (1). Four elected to be admitted to an ICF, despite DHHS offering HCBS and providing extensive education on its benefits.
- <u>Address ICF discouragement</u>
    - During the settlement agreement period, DHHS has taken several action to address ICF discouragement, including:
        - Held multiple meetings with ICF administrators and staff to discuss alleged discouragement, discussed ways of addressing discouragement.
        - Met with ICFs and clinical staff to discuss safe and orderly discharges, including discharge orders for medication, home health, and durable medical equipment or supplies.
        - Sent requests to the court to schedule court visitors in cases where a disagreement exists between the individual's and guardians stated preferences.

        - Sent letters to guardians and providers in January 2023, reiterating that "to the extent known, a guardian, in making decisions about the ward, shall consider the expressed desires, preferences, and personal values of the ward. U.C.A §75-5-312."
        - Sought guardianship through the Office of Public Guardian in cases where no family or friends were willing to help a person with their decision making and there was concern that guardianship may be sought with the purpose of having the individual remain in the ICF.
        - Amended ICF licensing rules to specifically address ICF discouragement.
        - Amended the ICF transition program rule to specifically address ICF discouragement as well as defining the assisted-decision making steps for individuals identified as unable to determine.
- <u>Improve education and awareness of DSPD services</u>
    - Continue to attend school transition fairs for youth with disabilities who are aging out of school services, to educate them on available services and resources.
    - Expand outreach to underserved (e.g. homeless, refugee) populations throughout the state to help connect people before problems become crises.
    - Increase outreach to health systems, mental health conferences and events, and community partners (e.g. police, pediatricians).
    - Implement "guilty with mental conditions (GMC)" legislation to help identify and refer individuals needing services allowing DHHS to intervene and reduce incarceration and recidivism.
    - DSPD recently presented at the 2023 Annual Judicial Conference to improve awareness of the DSPD system as it relates to people with disabilities involved in the justice system.
    - DSPD has been presenting with DHHS' American Indian Liaison to tribes in Utah to make them aware of services and work with them when they are interested.
- <u>Develop a strategy to address all emergency cases that go to DSPD (to reduce reliance on ICFs)</u>
  DHHS has taken the following actions:

    - Use attrition funding to bring people into services when their needs change suddenly, or for people who were previously unknown to DSPD.
    - Developed and recently updated a directive to prioritize emergency cases.
    - Use appropriated funding to broaden services, such as the LSW to get services to people earlier, which is intended to help reduce crises which lead to the need for more intensive services.
    - Prioritize specific funding to prevent youth from moving to ICFs if that is not their preference.
- <u>Increase ways for people in ICFs and their families to visit HCBS</u>
  During the Settlement Agreement period, DHHS has provided many opportunities for people residing in ICFs and their families to visit/tour HCBS options. The majority of these HCBS visits have been provided to individuals who have expressed interest in learning more about HCBS or in moving to HCBS.
    - DHHS is developing ways to expand these tour options for all people who are still in the exploratory stages. This will include increasing training to state staff for supporting people on tours. This will ensure objective information is shared and choice is clear.
    - In developing this, we are working to address privacy for people living and participating in programs, as well as compensation for the time providers use in providing tours.
    - DHHS plans to continue to educate support coordinators and providers about the importance of maintaining relationships once people move out of ICFs, including inviting friends and family to visit with them in their homes.
- <u>Address barriers to affordable, accessible housing</u>
  While DHHS acknowledges the multi-faceted problems with affordable, accessible housing being experienced by local communities, the state and the nation, DHHS has taken the following steps related to its service delivery system:
    - Providing state-funded housing assistance - people moving from ICFs who have needed it, have received funding from the state-funded housing assistance program (HAP). This is a unique DHHS program that is separate from funding through a housing authority, and can help bridge a gap when a person is waiting for assistance through a housing authority. While receiving this

assistance, people are expected to apply for assistance through their local housing authorities.
    - Seeking to use non-lapse funding this year over the next three years to pilot providing additional housing assistance to people receiving services.
    - Working with housing authorities to have a small number of units set aside specifically for people receiving services through DSPD, including accessible units.
    - Employing two housing specialists who assist people with housing-related issues.
    - Conducting quarterly housing round tables with DSPD contracted providers for education on how to access and maintain housing vouchers for people in services.
- <u>Address barriers to accessing mental health services</u>
  DHHS is:
    - Developing a contract to develop treatment for substance use disorders. There is not a national standard and we are looking forward to establishing a resource and expertise for people with disabilities.
    - Developing a contract to specifically treat people with sexual misconduct. There is not a national standard and we are looking forward to establishing a resource and expertise for people with disabilities.
- <u>Develop a pathway for people with high nursing needs to move from CSW to CTW to prevent institutionalization</u>
  This recommendation has been implemented. The current CTW state implementation plan allows for 25 people to move from the CSW to CTW each year, when criteria related to the need for nursing services is met. This provision has not been used yet.

- <u>Increase access to peer supports</u>
    - At the beginning of the Settlement, DHHS hired two part-time employees with lived experience, to provide peer support and mentoring. These positions are temporary, time-limited positions, and we continue to look at ways to maintain these positions. These peers participate in quarterly meetings and meet one on one with people living in ICFs.
    - DHHS has also received approval in the ARPA plan to contract with a parent peer mentor.
- For sources outside of DSPD and DHHS, the PRIDE Center has presented information regarding their support groups.

5. Strategies for ensuring competency of staff and appropriate staffing levels in ICFs

Under the Working Plan, *Item 4. Moratorium and Reductions of Privately-owned ICF Beds and Modifications to Licensing Rules, Page 8,* DHHS agreed to require specialized training to ICF staff working with individuals under age 22 residing in ICFs.

DHHS engaged in a contract with Utah State University, Institute for Disabilities Research, Policy & Practice (IDRPP) to develop a hybrid training curriculum and corresponding training modules for ICF staff. This initiative aims to meet the unique needs of individuals under age-22 who reside in ICFs. The scope and purpose of the training is to provide ICF staff information and resources related to providing age-appropriate services to individuals under age-22, including the following:

1. Background and history related to creating meaningful, age-appropriate opportunities to engage in integrated community settings and activities.
2. Need to ensure rights and privacy of individuals with disabilities and the need to engage in person centered planning.
3. Need to coordinate services and supports.
4. Need to develop age-appropriate, systematic instructions and supports to teach independent and community-based skills.
5. Need to develop positive behavior supports.

USU developed the online training platform and recorded all modules. USU hosted 2 in-person training sessions for the purpose of soliciting feedback on the curriculum.

Materials have been refined and in-person training opportunities have been provided to several ICFs. DHHS provided information to all ICF administrators on how the online curriculum is accessed. Current ICF support staff are required to complete either the in-person or online training, and new support staff are required to complete upon hire.

DHHS is implementing additional activities to train ICF staff about HCBS including:

- Providing formal invitations to ICF staff to attend E&I group sessions and offer additional HCBS training to any interested staff.
- Adding HCBS training requirements to DHHS administrative rules.
- Using the USU contract to provide additional HCBS training to ICF staff.