



# **Permanency Planning Report**

**As Required By  
Senate Bill 368, 77<sup>th</sup> Legislature, Regular Session, 2001**

---

**Texas Department of Aging and Disability Services  
August 2016**

**Table of Contents**

1. Executive Summary ..... 1

2. Introduction and Purpose ..... 2

3. Permanency Planning Report..... 3

    3.1 Total Number of Children Residing in Institutions ..... 3

    3.2 Circumstances of Children Residing in Institutions ..... 4

    3.3 Permanency Plans Developed for Children in Institutions..... 7

    3.4 Number of Children Who Returned Home or Moved to a Family-Based Alternative..... 8

    3.5 Community Supports Resulting in Successful Return Home or to a Family-Based Alternative ..... 8

    3.6 Community Supports Unavailable but Necessary to Transition from Institutions ..... 10

4. Summary and Trend Data ..... 11

5. Systemic Improvement Efforts ..... 13

    5.1 Summary of State Agency Activities ..... 13

    5.2 Summary of Progress, Challenges, and Opportunities ..... 15

6. Conclusion ..... 16

## **1. Executive Summary**

Senate Bill 368 (S.B. 368), 77th Legislature, Regular Session, 2001, amended the Texas Government Code by requiring permanency planning for Texas children living in an institution:

- *Permanency planning* refers to a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship.
- *Children* is defined as individuals under the age of 22.
- *Institution* means long-term residential settings that serve from three to several hundred residents.

Following passage of S.B. 368, the state implemented permanency planning for children in institutions, which are defined to include Home and Community-based Services (HCS) group homes serving no more than four residents.

As of February 29, 2016, 1,186 children were living in all types of institutions, representing a 25 percent decrease since permanency planning was first implemented in 2002. Excluding children served in HCS, the decrease was 58 percent. Of the 1,186 children:

- the majority (67 percent) were young adults, ages 18 to 21;
- more than half (56 percent) were in HCS;
- a relatively small number (6 percent) resided in a nursing facility; and
- the majority (94 percent) had a current permanency plan.

Between September 1, 2015, and February 29, 2016, 79 children moved from institutions. Of those who moved, the majority (52 percent) returned home, with the remainder moving to a family-based alternative (FBA). Most of the 79 children benefitted from the specialized supports offered in one of several 1915(c) waiver programs that serve as an alternative to an institution, with the HCS waiver program selected most often. This is attributed to the availability of HCS program services and the HCS service array which includes “host home/companion care” through which a child can live in a family-like setting.

The state’s progress in permanency planning is attributed to systemic changes, improvements, and coordinated efforts throughout the system. Continuing efforts are needed to ensure that all children with a developmental disability are given the opportunity to live in a nurturing family environment.

## **2. Introduction and Purpose**

S.B. 368 amended Section 531.162 of the Texas Government Code (TGC) by requiring permanency planning for Texas children living in an institution. The TGC describes permanency planning as the state's policy "...to ensure that the basic needs for safety, security, and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. State and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being part of a successful permanent family as soon as possible."

In accordance with the statutory definition of "institution," permanency planning applies to individuals under 22 years of age residing in:

- small, medium, and large community intermediate care facilities for individuals with an intellectual disability or related conditions (ICFs/IID);
- state supported living centers (SSLCs);
- HCS residential settings (i.e., supervised living or residential support);
- nursing facilities; and
- institutions for individuals with an intellectual disability (ID) licensed by the Department of Family and Protective Services (DFPS).

To achieve transitions from those institutions to family life, the TGC recognizes two options for a child – to return to the birth family or move to an FBA, with the latter being a family-like setting in which a trained provider offers support and in-home care for children with disabilities or children who are medically fragile. While permanency planning for minor children (ages 0-17) focuses on family life, permanency planning for young adults (ages 18-21) acknowledges that another community living arrangement (e.g., one's own home or apartment) may be a more appropriate, adult-oriented goal towards independence. The planning process also recognizes that permanency goals may change over time, as a result of a parent or legally authorized representative (LAR) whose perspective changes following fuller exploration, exposure to alternatives, or changes in family circumstances.

The TGC requires submission of a semiannual report to the Governor and committees of each house of the Legislature with primary oversight jurisdiction over health and human services agencies on the:

- number of children residing in institutions in Texas and the number of those children for whom a recommendation has been made for transition to a community-based residence but who have not yet made the transition;
- circumstances of each child, including the type and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time in which the child has resided in the institution;
- number of permanency plans developed for children residing in institutions, the progress achieved in implementing those plans, and barriers to implementing those plans;
- number of children who previously resided in an institution and have made the transition to a community-based residence;

- number of children who previously resided in an institution and have been reunited with their families or placed with alternate families;
- community supports that resulted in the successful placement of children with alternate families; and
- community support services that are unavailable but necessary to address the needs of children who continue to reside in an institution in Texas after being recommended to move from the institution to an alternate family or community-based residence.

The Health and Human Services Commission (HHSC) submitted the first report in December 2002, followed by updates every six months. Effective December 1, 2015, HHSC delegated responsibility for the semiannual report to DADS. The current report is based on information as of February 29, 2016, and reflective of activities occurring during the six-month period beginning September 1, 2015, and ending February 29, 2016. The report also includes cumulative data since 2002 and other relevant historical information for evaluative purposes. The data provided in this report is based on the most current data available, which may be subject to timing and other limitations of the source data systems.

### **3. Permanency Planning Report**

Permanency planning, as a philosophy, refers to the goal of family life for children. The permanency planning process refers to the development of strategies and marshalling of resources to reunite a child with his or her own family or achieve permanent placement with an alternate family. The process involves families and children to help identify options and develop services and supports necessary for the child to live in a family setting. The Permanency Planning Instrument (PPI) captures the status of a child’s permanency plan at the time of a semiannual review. The following information is based on aggregated data from PPIs completed as of February 29, 2016.

#### **3.1 Total Number of Children Residing in Institutions**

Table 1 shows the number of children living in institutions as of February 29, 2016. Of the 1,186 children, 33 percent (397) were 17 years of age or younger and 67 percent (789) were young adults (ages 18 through 21).

**Table 1: Number of Children in Institutions, DADS and DFPS Combined  
As of February 29, 2016**

<b>Institution type</b>	<b>Ages 0-17</b>	<b>Ages 18-21</b>	<b>Total</b>
Nursing Facility	43	31	74
Small ICF/IID	35	136	171
Medium ICF/IID	3	38	41
Large ICF/IID	6	9	15
SSLC	75	108	183
HCS	200	461	661
DFPS-Licensed ID Institution	35	6	41
<b>Total</b>	<b>397</b>	<b>789</b>	<b>1,186</b>

The TGC defines institutions to include small ICFs/IID, which are group homes licensed to serve up to eight residents, and HCS, which represents small group homes serving up to four residents. In combining those categories, the data reveals that 70 percent (832) of all children resided in a setting with 8 or fewer residents. Of those 832 children, almost 20 percent (235) were minors, including 26 under DFPS conservatorship, and 72 percent (597) were young adults (ages 18 through 21), including 41 who were placed by DFPS.

Institutions with more than 8 residents served 30 percent (357) of all children. Of those 357 children, 46 percent (163) were minors, including one child under DFPS conservatorship in a medium ICF/IID, and 54 percent (194) were young adults, including 9 young adults placed by DFPS.

### 3.2 Circumstances of Children Residing in Institutions

The following charts provide summary information on children residing in institutions. As shown in Chart 1, the majority were young adults as of February 29, 2016. Additional detail is available upon request to DADS.

**Chart 1: Age Distribution of Children, DADS and DFPS Combined as of February 29, 2016**

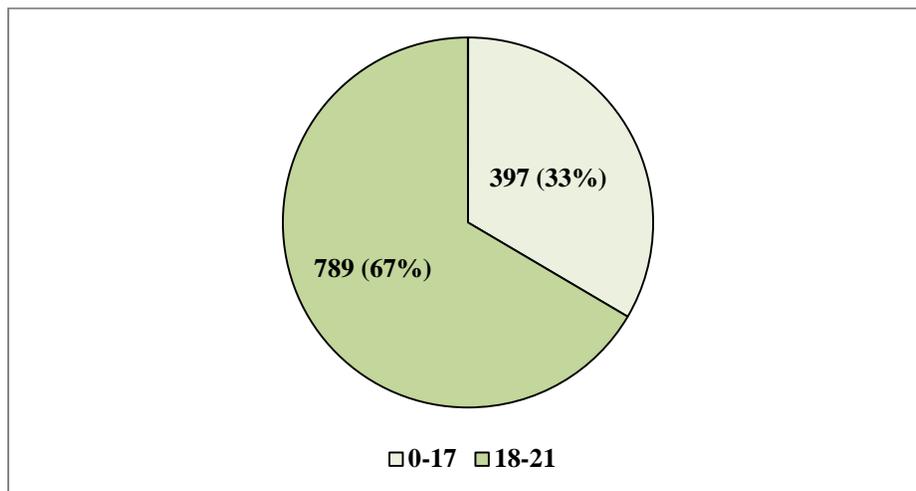
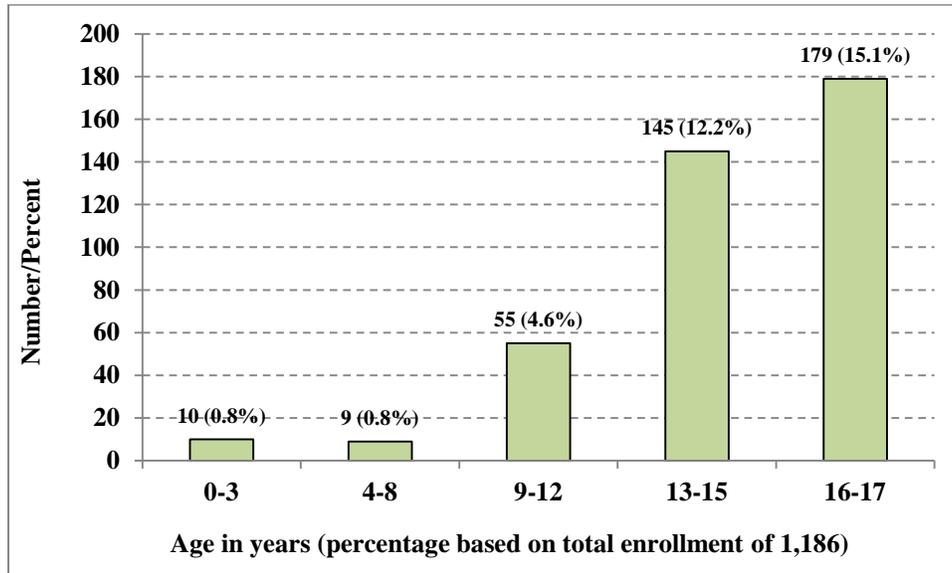


Chart 2 shows the number and percent of minors in institutions, DADS and DFPS combined. As the chart shows, 15 percent of minors were 16 to 17 years of age, followed by 12 percent who were 13 to 15 years of age, and 6 percent who were 12 years of age or younger.

**Chart 2: Age Distribution of Minors in Institutions, DADS and DFPS Combined as of February 29, 2016**



As shown in Chart 3, there were more young adults than minors in all institutions, except nursing facilities and DFPS-licensed ID institutions. Compared to all other institutions, the percentage of young adults in medium ICFs/IID was the highest (93 percent) followed by small ICFs/IID (80 percent) and HCS (70 percent).

In DFPS-licensed ID institutions, there were significantly more minors (85 percent) than young adults. Nursing facilities also served more minors (58 percent) than young adults.

**Chart 3: Age of Children by Institution Type, DADS and DFPS Combined as of February 29, 2016**

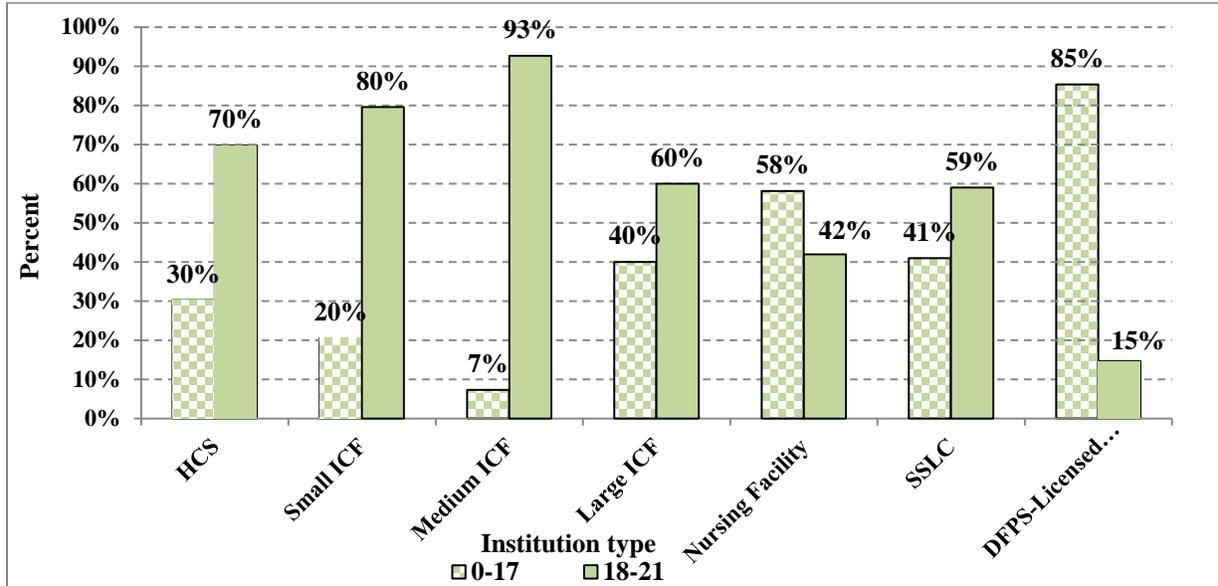
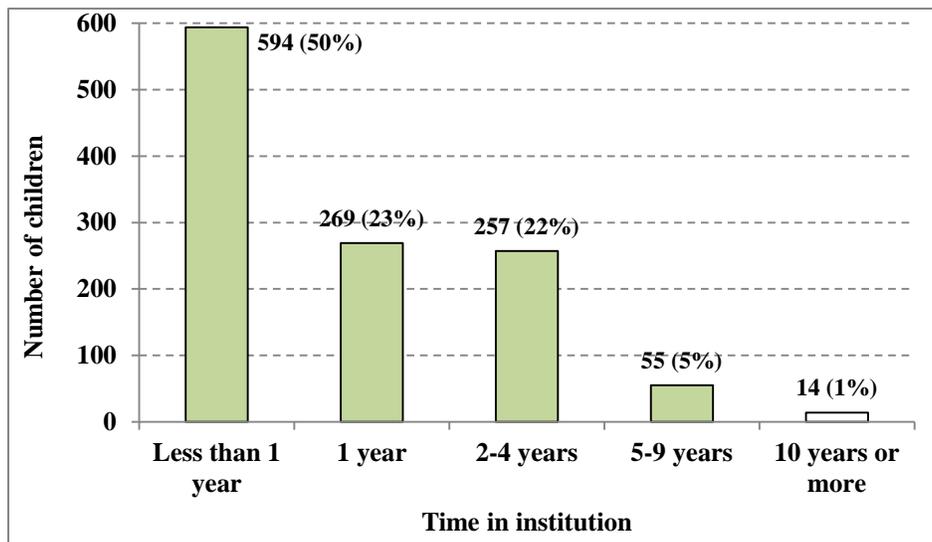


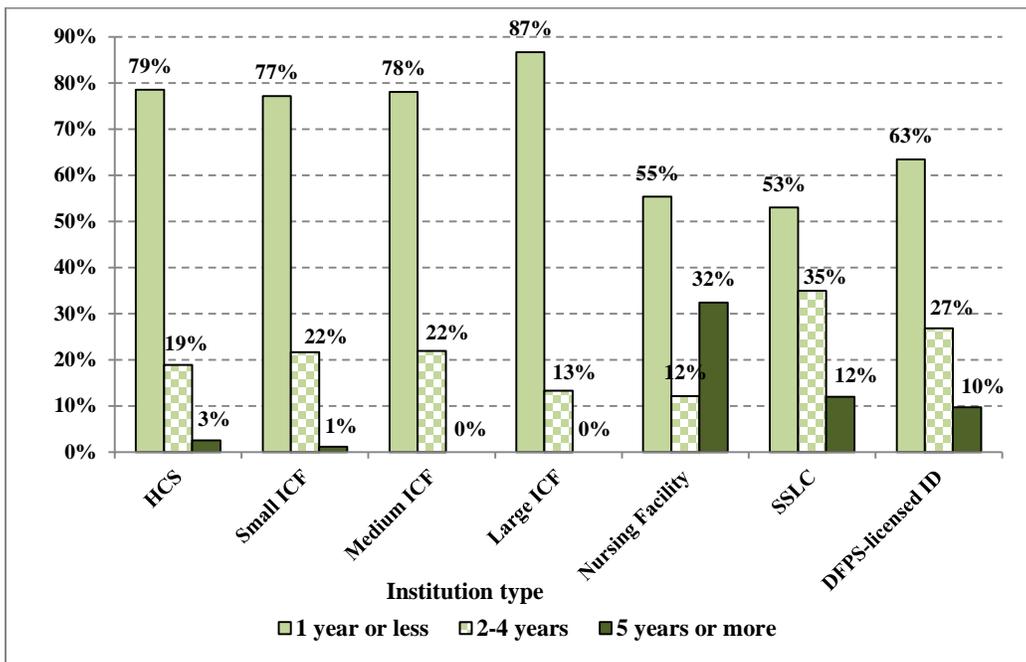
Chart 4 summarizes children’s lengths of stay (LOS) in all institution types combined. A child’s LOS is based on the date of the child’s most recent admission to the institution in which he or she resided on February 29, 2016. As the chart shows, about half of the children had resided in their institution for less than one year. The relatively high percentage may be due to movement between institution types (e.g., from ICF/IID to HCS) and not new admissions. As of February 29, 2016, 23 percent of children had resided in their institution for 1 year and 22 percent for 2 to 4 years. The remaining 6 percent had a LOS of 5 years or more.

**Chart 4: Length of Stay in Institutions, DADS and DFPS Combined as of February 29, 2016**



As shown in Chart 5, the majority of children had a LOS of 1 year or less across all types of institutions, including large ICFs/IID with the highest percentage (87 percent) and SSLCs with the lowest (53 percent). Nursing facilities served the largest percentage of children (32 percent) with a LOS of 5 or more years. There were no children in medium or large ICFs/IID with a LOS of 5 or more years.

**Chart 5: Length of Stay in Years by Type of Institution as of February 29, 2016**



### 3.3 Permanency Plans Developed for Children in Institutions

The TGC requires the state to ensure that children in institutions have permanency plans developed and updated semiannually.

The state has assigned responsibility based on where children reside:

- service coordinators employed by local intellectual and developmental disability authorities (LIDDAs) conduct permanency planning for children in HCS and ICFs/IID (including SSLCs);
- developmental disability specialists are responsible for plans of children in DFPS-licensed ID institutions; and
- EveryChild, Inc., is responsible for plans of children in nursing facilities.

Table 2 reflects the number of children for whom a permanency plan date occurring within the reporting period had been entered into the applicable automation system. Data indicate that plans had been completed for the vast majority of children (94 percent). The number of children without a permanency plan is attributed to a combination of delayed data entries for completed plans and children whose admission date was on or immediately before February 29, 2016, the last day of the current reporting period.

**Table 2: Permanency Plans Completed as of February 29, 2016**

<b>Institution Type</b>	<b>Number of Children in Institutions</b>	<b>Number of Permanency Plans Completed</b>	<b>Percent of Permanency Plans Completed</b>
<b>Nursing Facility</b>	74	66	89%
<b>Small ICF/IID</b>	171	157	92%
<b>Medium ICF/IID</b>	41	37	90%
<b>Large ICF/IID</b>	15	13	87%
<b>SSLC</b>	183	173	95%
<b>HCS</b>	661	640	97%
<b>DFPS-licensed ID institution</b>	41	33	80%
<b>Total</b>	<b>1,186</b>	<b>1,119</b>	<b>94%</b>

### **3.4 Number of Children Who Returned Home or Moved to a Family-Based Alternative**

The TGC encourages parental participation in planning and recognizes parental or LAR authority for decisions regarding living arrangements. Goals established during the planning process reflect the direction in which permanency planning is moving (e.g., return to birth family). While every effort is made to encourage reunification of children with birth families, families or LARs are sometimes unable to bring the child home. In those situations, the preferred alternative for a child may be an FBA. HHSC, DADS, DFPS, EveryChild, Inc., and their partners (e.g., waiver program providers and child placement agencies) have continued working together to enable children in institutions to move back home or to an FBA. Table 3 shows that of the 79 children who left an institution during the past 6 months, the majority (52 percent) returned home.

**Table 3: Children Returned Home or Moved to a Family-Based Alternative as of February 29, 2016**

<b>Agency</b>	<b>Returned Home</b>	<b>Family-Based Alternative</b>	<b>Total</b>
DADS	20	33	53
DFPS	21	5	26
<b>Total</b>	<b>41</b>	<b>38</b>	<b>79</b>

### **3.5 Community Supports Resulting in Successful Return Home or to a Family-Based Alternative**

Children who return home or move to an FBA often require specialized community supports that are identified during the permanency planning process. Examples of specialized supports include architectural modifications, behavioral intervention, mental health services, durable medical equipment, personal assistance, and specialized therapies.

The supports needed by a child and his or her family or LAR vary not only by type, but also in frequency and intensity. The supports can be provided through a variety of ways, depending on the needs of a child and the family or LAR, and the setting to which the child moves.

The supports needed by children who moved from an institution were met through a combination of Medicaid and a Medicaid waiver program. Table 4 shows the service array of waiver programs as of February 29, 2016. The services available in a given waiver program are subject to change based on legislative direction and approval by the Centers for Medicare and Medicaid Services (CMS).

Although all of the services in Table 4 have been necessary and used by one or more children leaving an institution, one service in particular stands out. Within the HCS program, “host home/companion care” provides children the opportunity to live with a family when the birth family is not an option.

**Table 4: Medicaid Waiver Services**

<b>Specialized Supports</b>	<b>HCS</b>	<b>Medically Dependent Children Program</b>	<b>Community Living Assistance and Support Services</b>	<b>Deaf Blind with Multiple Disabilities</b>	<b>Texas Home Living</b>	<b>STAR+ PLUS</b>
Adaptive aids	Yes	Yes	Yes	Yes	Yes	Yes
Behavioral support	Yes	No	Yes	Yes	Yes	No
Community support services*	No	No	No	No	Yes	No
Day habilitation	Yes	No	No	Yes	Yes	No
Dental	Yes	No	Yes	Yes	Yes	Yes
Employment assistance	Yes	Yes	Yes	Yes	Yes	Yes
Flexible family support	No	Yes	No	No	No	No
Minor home modifications	Yes	Yes	Yes	Yes	Yes	Yes
Host home/ companion care	Yes	No	No	No	No	No
Nursing	Yes	No	Yes	Yes	Yes	Yes
Professional therapies	Yes	No	Yes	Yes	Yes	Yes
Residential habilitation*	No	No	Yes	Yes	No	No
Respite	Yes	Yes	Yes	Yes	Yes	Yes
Supported employment	Yes	Yes	Yes	Yes	Yes	Yes
Supported home living*	Yes	No	No	No	No	No
Transition assistance services	Yes	Yes	Yes	Yes	Yes	Yes

*\*Effective March 20, 2016, transportation is the only billable activity.*

### **3.6 Community Supports Unavailable but Necessary to Transition from Institutions**

Specialized supports are identified in the PPIs, but not all waiver programs offer a service array that enables a child to live with an alternate family. Also, even though a certain waiver service may be available, there may be service limitations. For example, behavioral supports may be available, but not at the level required by a child with high needs. Also, a child may not have access to trained and qualified professionals due to where the child lives (e.g., in a rural area).

## **4. Summary and Trend Data**

Progress has been made since legislation was first introduced in 2001. Longitudinal data demonstrate the success of permanency planning, with the number of children moving from institutions to smaller family-like settings (i.e., the family home or an FBA) continuing to increase.

Table 5 provides the number of children residing in institutions at three points in time, with the percentage of change:

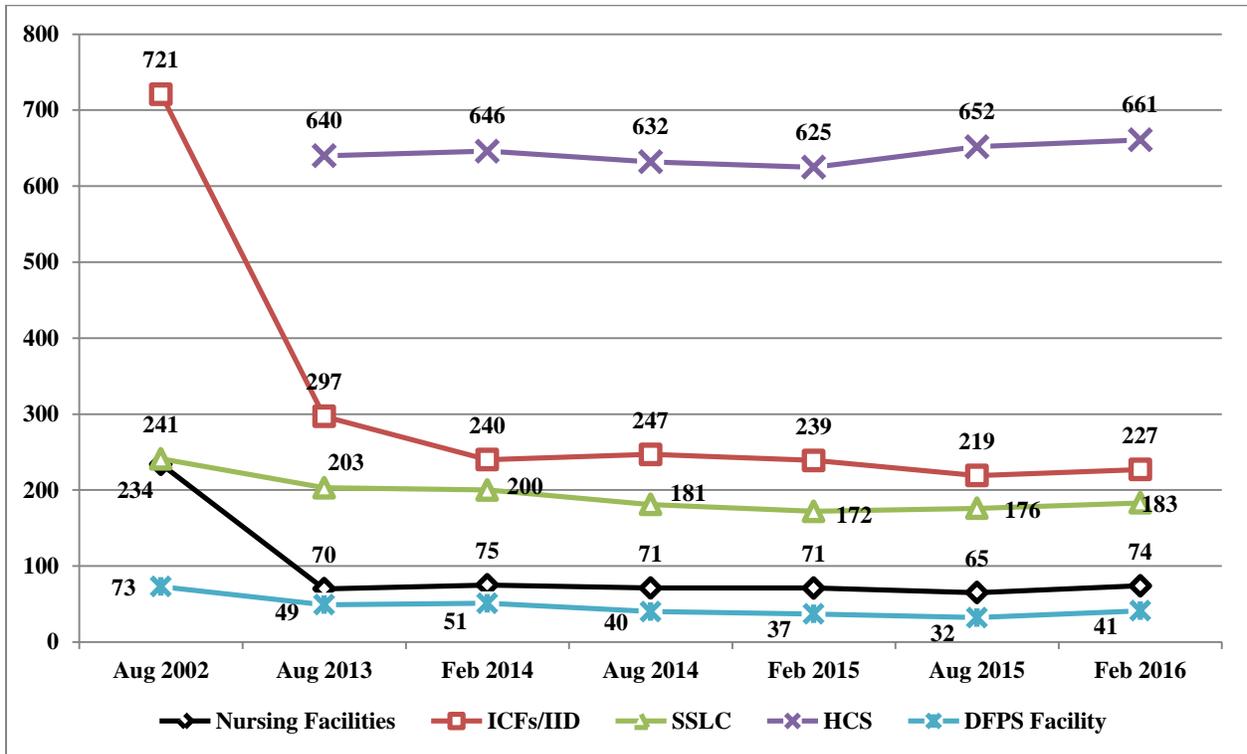
- Compared to August 31, 2015, the number of children in all institution types combined increased by four percent. In contrast, compared to August 31, 2002, the total number of children in all institution types combined decreased by 25 percent.
- Excluding HCS group homes from the total, compared to August 31, 2015, the number of children in all other institution types combined increased by seven percent. In contrast, compared to August 31, 2002, the total number of children in all other institution types combined decreased by 58 percent.

**Table 5: Trends in the Number of Children by Institution, DADS and DFPS Combined**

Institution Type	Baseline Number as of 8/31/02	Number as of 8/31/2015	Number as of 2/29/2016	Percent Change Since August 2002	Percent Change in Past Six Months
Nursing Facilities	234	65	<b>74</b>	-68%	14%
Small ICF/IID	418	154	<b>171</b>	-59%	11%
Medium ICF/IID	39	45	<b>41</b>	5%	-9%
Large ICF/IID	264	20	<b>15</b>	-94%	-25%
SSLC	241	176	<b>183</b>	-24%	4%
HCS	312	652	<b>661</b>	112%	1%
DFPS-Licensed ID Institutions	73	32	<b>41</b>	-44%	28%
<b>Total</b>	<b>1,581</b>	<b>1,144</b>	<b>1,186</b>	-25%	4%
<b>Total with HCS Excluded</b>	<b>1,269</b>	<b>492</b>	<b>525</b>	-58%	7%

Chart 6 displays trends from August 31, 2002, through February 29, 2016. As seen in the chart, the number of individuals residing in an HCS group home increased while the number of children in other institutions declined or remained comparatively stable.

**Chart 6: Number of Children in Institutions by Type of Institution August 2002 - February 2016**



## **5. Systemic Improvement Efforts**

The significant shift since 2002 in the number of children with developmental disabilities living in institutions is directly related to systemic improvements. During the current reporting period, improvement efforts continued to build on previous years' accomplishments. New areas of focus also emerged.

### **5.1 Summary of State Agency Activities**

Since the passage of S.B. 368, HHSC, DADS, and DFPS have worked collaboratively to refine and improve permanency planning activities. During this reporting period, the agencies continued working to achieve systemic changes through a variety of activities.

#### **Health and Human Services Commission**

- HHSC continued working on implementation of S.B. 7, 83<sup>rd</sup> Legislature, Regular Session, 2013, designed, in part, to transition identified services to managed care.
- As required by S.B. 200, 84<sup>th</sup> Legislature, Regular Session, 2015, HHSC continued efforts to restructure the health and human services agencies to make them more efficient, effective, and responsive.
- HHSC provided administrative support to child-focused groups, including the:
  - Children's Policy Council, which is charged with developing, implementing, and monitoring long-term supports and services programs for children with disabilities and their families (House Bill 1478, 77<sup>th</sup> Legislature, Regular Session, 2001); and
  - STAR Kids Managed Care Advisory Committee that was created to advise HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The goal of STAR Kids is to improve coordination and customization of care, access to care, health outcomes, cost containment, and quality of care for children with disabilities who have Medicaid coverage (S.B. 7, 83<sup>rd</sup> Legislature, Regular Session, 2013).

#### **Department of Aging and Disability Services**

- As required by the TGC, DADS added a child's name to the CLASS and MDCP interest lists (for children under age 22) upon admission to a nursing facility and to the HCS interest list upon admission to an ICF/IID.
- DADS required LIDDAs to complete at least 95 percent of required permanency plans for children in an ICF/IID or HCS group home within timeframes described in the performance contract and provided technical assistance to LIDDAs to ensure compliance with permanency planning guidelines.
- DADS required EveryChild, Inc., to complete at least 95 percent of required permanency plans for children in NFs within timeframes described in its contract.
- DADS approved plans for all children under the age of 10 to ensure compliance with permanency planning.

- DADS continued working to release HCS slots approved by the 84th Legislature for the 2016-17 biennium, which includes an additional:
  - 25 HCS slots for children transitioning from a DFPS General Residential Operation (GRO). Of those, DADS approved enrollment of one child as of February 29, 2016, and an additional 6 children are in the process of enrollment;
  - 216 HCS slots for children aging out of DFPS foster care. Of those, DADS approved enrollment of 41 children as of February 29, 2016, and an additional 37 children are in the process of enrollment; and
  - 400 HCS slots for crisis/diversion from an SSLC.
- DADS received funding to establish crisis intervention teams and respite services at LIDDAs. LIDDAs were eligible if not already receiving 1115 waiver delivery system reform incentive payment funding for crisis intervention and respite projects. Implementation is scheduled for mid-2016.
- In response to notification in March 2015 that CMS agreed to fund a three-year grant to enhance medical, behavioral, and psychiatric supports and community coordination, DADS contracted with eight LIDDAs to provide support services statewide. All teams became fully operational on September 1, 2015. The goal of the teams is to provide the following support services to the 39 LIDDAs and service providers across all 254 Texas counties:
  - Quarterly webinars, videos, and other educational activities focused on increasing the expertise of LIDDAs and providers in supporting targeted individuals;
  - Technical assistance pertaining to specific disorders and diseases with examples of best practices for individuals with significant challenges; and
  - Case-specific support to service planning teams needing assistance to provide effective care for an individual. Assistance may include addressing any unique regional or cultural issues and challenges, and reporting to DADS about any gaps in medical, psychiatric, and behavioral resources.
- During the 84<sup>th</sup> Legislative Session, DADS received \$5.9 million for services to individuals with high medical needs. Funding includes a daily add-on rate for small and medium ICF/IID providers to serve individuals with high medical needs transitioning from a nursing facility. Funding for FY 2017 will be used to expand the initiative to the HCS program. HCS rules are being revised to address high medical needs and are scheduled to be effective in December 2016.
- DADS agreed to host five workshops entitled “Positive Behavior Management and Supports,” taught by instructors from the Behavior Analysis Resource Center at the University of North Texas. The curriculum emphasizes proactive approaches to establishing a positive relationship with an individual with challenging behaviors. DADS is offering these trainings free of charge to caregivers, families, professional staff, and others across Texas. One workshop was held in Abilene, with others scheduled in Ft. Worth, Austin, Houston, and Tyler later in 2016.
- DADS participated as an agency representative to the groups administratively supported by HHSC.

## **Department of Family and Protective Services**

- DFPS Child Protective Services (CPS) approved 14 children for placement in a DFPS GRO.
- CPS continues to collaborate with EveryChild Inc., on finding families for children in conservatorship who are residing in a DFPS licensed GROs. During this reporting period, 4 children moved from the GROs to families with HCS funding, 9 children are in the process of moving to a family, and identification of a family is underway for 32 other children.
- DFPS monitored completion of permanency plans developed by DFPS developmental disability specialists.
- DFPS participated as an agency representative to the groups supported by HHSC.

## **5.2 Summary of Progress, Challenges, and Opportunities**

Since 2002, systemic improvements have brought Texas closer to realizing the goal of family life for children envisioned by S.B. 368. Although significant progress has been made in supporting family life for children with developmental disabilities as an alternative to institutions, challenges remain.

### **System Progress Since 2002**

Since 2002, progress has been achieved as evidenced by a reduction in the number of children in institutions serving more than four persons. Specifically, there was a 94 percent decrease in large ICFs/IID; a 68 percent decrease in nursing facilities; and a 58 percent decrease in the number of children in all institutions serving more than four persons.

Data show that the vast majority of children continue to have a current permanency plan. The permanency planning process continues to create awareness that children are physically and emotionally healthier when they grow up in well-supported families. Families and LARs have been able to choose family-based care instead of institutional care as a result of increased resources. Among those resources, both reserved capacity in the HCS waiver program (e.g., for children at risk of admission to an SSLC) and the HCS host home/companion care service have increased opportunities for children to move to, or remain in, the community. Coordinated efforts by EveryChild Inc., and waiver program providers also have expanded FBA options in Texas.

Stakeholders continue working to better support children with challenging behaviors and co-occurring developmental disabilities and mental health conditions. Legislative action and recent appropriations will increase access to specialized services through Texas Medicaid programs, including services for individuals with high medical needs and community-based crisis support services.

### **Challenges to Continued Progress**

Despite the overall decline in the number of children in institutions serving more than four persons, challenges remain. Interest lists for waiver programs continue to grow. Children with high medical needs continue to be at risk of institutionalization when they age out of children's Medicaid and are no longer eligible for certain Medicaid services (e.g., private duty nursing). Responsibility for transition planning may be fragmented across multiple parties.

### **Opportunities for Further Progress**

Children with high behavioral support needs would benefit from dedicated resources to develop more intensive and creative ways to address their needs, such as positive behavior support specialists, in-home behavior supports, and statewide training for families and professionals on positive behavior support.

Children with high medical needs would benefit from additional funding for services that enable them to remain in their communities and with their families as they transition to adulthood.

### **6. Conclusion**

Through the efforts of the Texas Legislature, HHSC, DADS, DFPS, EveryChild, Inc., and their partners, children's access to Medicaid waiver programs increased. Access to HCS is beneficial due to its host home/companion care service, which allows specially trained alternative families in the community to provide homes for children who are unable to live with their birth families.

Agencies continue to work collaboratively to increase the number of children who transition to a community setting and to achieve the ultimate goal of ensuring that all children with a developmental disability live in a nurturing family environment.