OMB: 0980-0162

# North Carolina Council on Developmental Disabilities

# Five Year State Plan

## For year 2014

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## Section I: Council Identification

PART A: State Plan Period:
October 1, 2011 through September 30, 2016

PART B: Contact:
Person:
Kelly Bohlander, Director for Systems Change Management

| | |
|---|---|
| Telephone: | (919) 850-2901 |
| E-Mail: | kelly.bohlander@dhhs.nc.gov |

PART C: Council Establishment:

| | |
|---|---|
| Date of Establishment: | 1973-Jul-01 |
| Authorization: | State Statute |

Authorization Citation:
NC State Statute 143(B), Sections 177 - 179

PART D: Council Membership [Section 125(b)(1)-(6)]

(i) Council Membership Rotation Plan:

The North Carolina Council on Developmental Disabilities' non-agency and public at large members are appointed by the Governor for a four (4) year term and may serve up to two (2) consecutive terms. The Senate and House of Representative members serve at the pleasure of the Governor. State entities that administer funds provided under federal law related to individuals with developmental disabilities, non governmental, not for profit, and Department of Corrections and Division of Social Services representatives are typically the division or agency director and serve at the pleasure of the Governor while employed in that position.

(ii) Council Members

| # | Name | Code | Organization | Appointed | Term Date | Alt/Proxy State Rep Name |
|---|---|---|---|---|---|---|
| 1 | Harrington, Linda | A1 | Division of Vocational Rehabilitation | 2002-Mar-05 | 2014-Jun-30 | Jim Swain |
| 2 | Watson, Mary | A2 | Department of Public Instruction | 2002-Apr-30 | 2014-Jun-30 | Thomas Winton |
| 3 | Streets, Dennis | A3 | Division of Aging and Adult Services | 2006-May-19 | 2014-Jun-30 | Mary Edwards |
| 4 | Larson, Tara | A4 | Division of Medical Assistance | 2007-Nov-20 | 2014-Jun-30 | Susan Johnson |
| 5 | Smith, Vicki | A5 | Disability Rights of North Carolina | 2007-Jul-01 | 2014-Jun-30 | |
| 6 | Bodfish, James | A6 | UNC at Chapel Hill, Carolina Institute on DD | 2009-Jun-25 | 2013-Jun-30 | Deborah Zuver |
| 7 | Whitley, Mike | A7 | InReach, Inc | 2005-Jul-01 | 2013-Jun-30 | |
| 8 | Ryan, Kevin | A8 | Maternal and Child Health | 2004-May-21 | 2014-Jun-30 | Danielle Matula |
| 9 | Carter, Christina | A9 | Black Mountain Center - Private Non-Profit | 2012-Feb-15 | 2016-Jun-30 | |
| 10 | Carbone, John | A9 | Department of Corrections | 2011-Jul-30 | 2014-Jun-30 | Laura Yates |
| 11 | Bradsher, Sherry | A9 | Department of Health and Human Services/ Div. of Social Services | 2011-Mar-18 | 2014-Jun-30 | Rick Zechman |
| 12 | Insko, Verla | A9 | House of Representatives | 2003-Aug-14 | 2014-Jun-30 | |
| 13 | Jarrard, James | A9 | NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services | 2012-Aug-01 | 2016-Jun-30 | Walt Caison |
| 14 | Renate Macchirole | A9 | Public at Large | 2011-Oct-21 | 2014-Jun-02 | |
| 15 | Mansfield, Eric | A9 | Representative of Senate | 2012-May-01 | 2016-Jun-30 | |
| 16 | Delia, Al | A9 | Secretary of the Department of Health and Human Services | 2012-Jul-01 | 2014-Jun-30 | Deputy Director Maria Spaulding |
| 17 | Ambrose, Caroline | B1 | | 2009-Jul-14 | 2013-Jun-30 | |
| 18 | Bradstock, Robert | B1 | | 2007-May-21 | 2012-Jun-30 | |
| 19 | Brown, Adonis | B1 | | 2007-Jul-13 | 2014-Jun-30 | |
| 20 | Byrd, Lisa | B1 | | 2009-Oct-26 | 2013-Jun-30 | |
| 21 | Chavis, Eric | B1 | | 2011-Sep-01 | 2015-Jun-30 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 22 | Ellis, Jonathan | B1 | | 2005-Apr-25 | 2013-Jun-30 | |
| 23 | Finks, Wilson | B1 | | 2006-Aug-17 | 2014-Jun-30 | |
| 24 | Foreman, Crystal | B1 | | 2008-Dec-11 | 2012-Jun-30 | |
| 25 | Groves, Michael | B1 | | 2011-Aug-29 | 2015-Jun-02 | |
| 26 | Harpootlian, Elizabeth | B1 | | 1969-Dec-31 | 2016-Jun-30 | |
| 27 | McNeill, Michael | B1 | | 2005-Jul-21 | 2013-Jun-30 | |
| 28 | Peterson, Desiree | B1 | | 2009-Aug-18 | 2013-Jun-30 | |
| 29 | Powell, Randy | B1 | | 2007-Jul-16 | 2013-Jul-08 | |
| 30 | Taylor, David | B1 | | 2007-Jul-16 | 2012-Jun-30 | |
| 31 | Bowe, Crystal | B2 | | 2011-May-20 | 2015-Jun-30 | |
| 32 | Fernandez, Lourdes | B2 | | 2008-Dec-11 | 2012-Jun-30 | |
| 33 | Miller, Samuel | B2 | | 2011-Jun-08 | 2015-Jun-30 | |
| 34 | Reeves, I. Azell | B2 | | 2009-Oct-06 | 2013-Jun-30 | |
| 35 | Ruff, Walter | B2 | | 2009-Mar-10 | 2013-Jun-30 | |
| 36 | Sagerman, Paul | B2 | | 2009-Jul-14 | 2013-Jun-30 | |
| 37 | Wagoner, Amanda | B2 | | 2009-Jun-10 | 2013-Jun-30 | |
| 38 | Willetts, Tracey | B2 | | 2009-Dec-11 | 2013-Jun-30 | |
| 39 | Reeve, Ronald | C2 | | 2012-Apr-04 | 2016-Jun-02 | |

(iii) Council Staff

| # | Name | Position or Working Title | FT/PT % |
|---|---|---|---|
| 1 | Bohlander, Kelly | Assistant Director Program Management | 100.00% |
| 2 | Gibson, Cora | Administrative Assistant | 100.00% |
| 3 | Shayna Simpson-Hall | Program Manager | 100.00% |
| 4 | Strom, Steve | Program Manager | 100.00% |
| 5 | Swartz, Melissa | Program Manager | 100.00% |
| 6 | Toomey, JoAnn | Asst. Director for Operations | 100.00% |
| 7 | VACANT | Executive Director | 100.00% |
| 8 | Vasquez, Yadira | Business Officer | 100.00% |
| 9 | Young, Letha | Office Assistant | 100.00% |

## Section II: Designated State Agency

PART A: The designated state agency is:

| | |
|---|---|
| Agency Name: | Office of the Secretary, NC Department of Health and Human Services |
| Agency Address: | Adams Bldg., 101 Blair Drive |
| Agency City: | Raleigh |
| Agency State/Zip: | NC, 27699 |
| Telephone: | (919) 855-4800 |
| Fax: | (919) 715-4645 |
| Email: | Al.Delia@dhhs.nc.gov |

PART B: Direct Services: [Section 125(d)(2)(A)-(B)]
The DSA does not provide direct services to persons with developmental disabilities.

PART C: Memorandum of Understanding/Agreement: [Section 125(d)(3)(G)]
The DSA does not have a Memorandum/Agreement with the Council.

PART D: DSA Roles and Responsibilities related to Council: [Section 125(d)(3)(A)-(G)]
The role of the Office of the Secretary is consistent with the description in the DD Act of the responsibilities of the DSA. See also Assurances, attached <br/>

PART E: Calendar Year DSA was Designated: [Section 125(d)(2)(B)]
1973

## Section III: Comprehensive Review and Analysis [Section 124(c)(3)]

INTRODUCTION: A broad overview of the Comprehensive Review and Analysis conducted by the Co
The NC Council on Developmental Disabilities (NCCDD) sought an approach to the 2011-2016 State Plan that engaged the Administration on Intellectual and Developmental Disabilities (ADD) Network in NC (i.e., NCCDD, Carolina Institute on Developmental Disabilities (CIDD), and Disability Rights NC (DRNC)), stakeholders and the public in a collaborative process to produce the Comprehensive Review and Analysis. The Council members themselves discussed emerging trends and practices with diverse, national experts and among themselves throughout the eighteen-month process, such that members were prepared to formulate meaningful responses to information gathered from stakeholders in the service delivery system (e.g., self-advocates; families; policymakers; providers; Local Management Entities) and from the public-at-large and to direct the development of goals and objectives. The CIDD's assistance to the NCCDD in document review and with stakeholder interviews offered the Council a breadth of information. That information was complemented by robust survey responses and a public input process that assured the NCCDD that the course it charted was responsive to the constituency it represents.

During the period in which the analysis took place, the NCCDD adopted the "Route to Success," an innovative logic model for assisting Councils in developing, implementing, and evaluating initiatives, such that investments indeed produce the systems change with which Councils are charged under the Developmental Disabilities Bill of Rights and Assistance Act (DD Act, P.L. 106-402). The Council was well supported during this period by the Designated State Agency, charged with the receipt, disbursement and accounting for funds: Office of the Secretary, NC Department of Health and Human Services; by technical assistance from the National Association of Councils on Developmental Disabilities, representing the country's 55 Councils on Developmental Disabilities; and by guidance from the United States Administration on Intellectual and Developmental Disabilities. In the subsequent sections of this document and in the attachments, the NCCDD discusses and provides documentation of the initiative to produce the Comprehensive Review and Analysis that underpins the 2011-2016 State Plan for this Council. The State Plan guides the Council's investments in systems change for this period.

PART A: State Information:
(i) Racial and Ethnic Diversity of the State Population:

| **Race/Ethnicity** | **Percentage of Population** |
|---|---|
| White alone | 68.5% |
| Black or African American alone | 21.5% |
| American Indian and Alaska Native alone | 1.3% |
| Asian alone | 2.2% |
| Native Hawaiian and Other Pacific Islander alone | 0.1% |
| Hispanic or Latino of any race | 4.3% |
| Some other race alone | 2.2% |
| Two or more races: | 8.4% |

(ii) Poverty Rate:
16.2%

(iii) State Disability Characteristics:
a) Prevalence of Developmental Disabilities in the State:
172304

Using the Gollay formula

b) Residential Settings:

| Year | Total Served | A. Number Served in Setting of 6 or less (per 100,000) | B. Number Served in Setting of 7 or more (per 100,000) | C. Number Served in Family Setting (per 100,000) | D. Number Served in Home of Their Own (per 100,000) |
|---|---|---|---|---|---|
| 2009 | 238 | 190.000 | 49.000 | 90.000 | 112.000 |
| 2008 | 227 | 179.000 | 48.000 | 82.000 | 98.000 |
| 2007 | 219 | 169.000 | 50.000 | 62.000 | 80.000 |
| 2006 | 226 | 179.000 | 50.000 | 48.000 | 49.000 |
| 2005 | 257 | 204.000 | 50.000 | 44.000 | 98.000 |

c) Demographic Information about People with Disabilities:

| People in the State with a Disability | Percentage |
|---|---|
| Population 5 to 17 years | 5.6% |
| Population 18 to 64 years | 11.3% |
| Population 65 years and over | 39% |

| Race and Hispanic or Latino Origin of People with a Disability | Percentage |
|---|---|
| White alone | 13% |
| Black or African American alone | 14.8% |
| American Indian and Alaska Native alone | 19.8% |
| Asian alone | 4.6% |
| Native Hawaiian and Other Pacific Islander alone | 0% |
| Some other race alone | 4.8% |
| Two or more races | 10.8% |
| While alone, not Hispanic or Latino | 13.5% |
| Hispanic or Latino (of any race) | 5.4% |

| Employment Status Population Age 16 and Over | Percentage with a Disability | Percentage without a Disability |
|---|---|---|
| Employed | 21.6% | 64.9% |
| Not in Labor Force | 73.3% | 27.5% |

| **Education Attainment Population Age 25 and Over** | **Percentage with a Disability** | **Percentage without a Disability** |
|---|---|---|
| Less than High School graduate | 31.5% | 12% |
| High School graduate, GED, or alternative | 31.7% | 26.3% |
| Some college or associate's degree | 25.7% | 31.4% |
| Bachelor's degree or higher | 11.2% | 30.3% |

| **Earnings in the past 12 months Population Age 16 and Over with Earnings** | **Percentage with a Disability** | **Percentage without a Disability** |
|---|---|---|
| $ 1 to $4,999 or loss | 34.5% | 21.4% |
| $ 5,000 to $ 14,999 | 11.9% | 8.9% |
| $ 15,000 to $ 24,999 | 18.2% | 17% |
| $ 25,000 to $ 34,999 | 12.6% | 15.4% |

| **Poverty Status Population Age 16 and Over** | **Percentage with a Disability** | **Percentage without a Disability** |
|---|---|---|
| Below 100 percent of the poverty level | 22.7% | 21.4% |
| 100 to 149 percent of the poverty level | 15.9% | 8.9% |
| At or above 150 percent of the poverty level | 61.4% | 0% |

PART B: Portrait of the State Services [Section 124(c)(3)(A and B)]:
(i) Health/Healthcare:
Services for children with special health care needs: North Carolina Family-to-Family Health Care Information Center (HIC) is a project of Exceptional Children's Assistance Center (ECAC), a federally funded Parent Training and Information Center providing training and resource to NC families of students with disabilities. They provide information, education, outreach, and support to and for families with children across the state of NC. Services that NC DHHS provides include: 1) Specialty Clinic at UNC School of Dentistry for children, providing diagnostic, surgical, dental, orthodontic and therapy services; 2) early hearing screening at birth for all children enrolled in Medicaid;3) kindergarten health assessments within 12 months of entering school, with payment determined by income and insurance type; 4) newborn home visit services for which all newborns are eligible; and 5) WIC programs for children up to age 5, with eligibility based on income. Carolina Institute for Developmental Disabilities; provides; assessment, consultation and treatment for people with behavioral, learning and developmental needs across the lifespan. NC Infant Toddler Program provides services for children up to age 3 who have a developmental delay or an established condition.

National Core Indicator Data (NCI, 2009) for NC:

People living in the community or at home have less attention to health care than those in institutions:

complete physical exam in past year: 96% (institution), 92% (community-based), 86% (independent home), 80% (parent's home).

Women 18 and over who had Pap test in past 3 years: 78% (institution), 65% (community-based), 56% (independent home), 32% (parent's home).
Had routine dental exam in past year: 99% (institution), 79% (community-based), 60% (independent home), 59% (parent's home)

Have poor health: 15% (institution), 6% (community-based), 5% (independent home), 6% (parent's home).

Have primary care doctor: 100% (institution), 100% (community-based), 97% (independent home), 98% (parent's home).

Had vision screening in past year: 63% (institution), 46% (community-based), 39% (independent home), 33% (parent's home)

Had hearing test in past 5 years: 65% (institution), 31% (community-based), 28% (independent home), 26% (parent's home)

Had flu vaccination in past year: 96% (institution), 52% (community-based), 47% (independent home), 39% (parent's home)

Ever had vaccination for pneumonia: 49% (institution), 9% (community-based), 12% (independent home), 16% (parent's home)

Women over 40 who had mammogram in past 2 years: 78% (institution), 58% (community-based), n/a (independent home), 33% (parent's home)

Men over 50 who had PSA test within past year: 68% (institution), 29% (community-based), n/a (independent home), n/a (parent's home).

People 50 and over who had screening for colorectal cancer within past year: 19% (institution), 3% (community-based), 9% (independent home), 15% (parent's home)

Information from NC Office on Disability and Health and Children and Youth Branch of NC Division of Public Health (DPH) addresses access to care for individuals. Nearly 28% of adults with a disability report that within the past 12 months they could not see a doctor because of cost in comparison to 13.4% of adults without a disability. Only 53% of persons with developmental disabilities had a routine dental exam in the past 6 months (NCI, 2007-2008). NC Health Choice insurance is available to children in low-income families. A special needs plan includes some benefits for children with special health care needs, including children with developmental disabilities. Some services that are covered by NC Health Choice may be provided in settings outside a provider's office, such as home and school therapies, caregiver education, case management and other developmental disabilities services.

(ii) Employment:
For FFY 2008, the NC Department of Vocational Rehabilitation (VR) reported serving 15,345 individuals with cognitive disability, which represents 31.16% of all those served The Occupational Course of Study is a diploma pathway available to high school students with an Individualized Education Plan (IEP). Requirements include 300 hrs. of classroom job readiness, 240 hrs. of work in

the community, and 360 hrs. of competitive work. Of all clients served, 14% were identified as living in "institutions for the mentally retarded" [Note: The NCCDD discourages the use of the term "mental retardation."] Of the individuals supported, 1,760 had a signed Individual Plan for Employment (IPE); 448 exited in employment; 311 exited without employment after services; 518 exited after eligibility was determined but before the IPE. Of those determined to have a "major impairment and cause of mental retardation," 7,668 individuals had a signed IPE. Of these, 1,558 exited in employment; 968 exited without employment; 995 exited with eligibility determined, but before IPE development. Supports to individuals with autism: 878 had a signed IPE; 119 exited in employment; 53 exited without employment after services; 87 exited after eligibility was determined, before IPE development. According to APSE (formerly, Association for Persons in Supported Employment), most supported employment services in NC are funded by VR, which pays for job assessment, development activities, and initial, on-the-job training. VR does not hire and manage employment specialists directly; instead, supported employment is contracted to community rehabilitation programs that provide employment services. The long-term vocational support phase (on-going, follow-along after successful employment) is sustained through a number of funding sources, administered through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS). By July 1, 2008, 177 supported employment programs had contracts with VR to deliver supported employment services across the state. VR federal funds are matched with state dollars. Federal oversight means more uniform service delivery because regulations and standards are driven by federal policies and supported by state policies and procedures. VR's demographics in NC indicates that 13.48% were reported as having some type of disability; of these, 4.96% had a cognitive disability. The demand for traditional middle jobs that typically provide decent wages for people with limited education (e.g., textiles, apparel, furniture) is reduced due to globalization and technological changes. This has implications for individuals with I/DD, whose education level is "below GED," as competition for these jobs has increased.. In FY 2008, 2,164 consumers served by the Independent Living Program reached independent living goals; a successful employment, outcome was achieved by 6,218 consumers. The average weekly earnings of consumers before employment services was $40; upon employment, the average increased to $293. In FY 2008, successfully employed individuals earned combined total of $1.8 million per week through employment gained with VR assistance. Close to half (48.40%) indicated that transportation has been an extreme or sizeable challenge. According to National Core Indicator 2009 data for NC, 85% individuals are satisfied with their community-based job, but 52% in community-based employment would like to work elsewhere. Of those employed, most (77%) work in the 4 common community jobs: 31% (food prep), 25% (cleaning/maintenance), 9% (retail), 12% (/manufacturing); and 23% other work. The number of workers receiving paid vacation/sick leave at their job is significantly below the average range, at 14% Those earning at or above state minimum wage in a community–based job was 39%. The NC Alliance for Full Participation state team drafted an highly endorsed "Employment First" position statement.

(iii) Informal and informal services and supports:
The Annual Statistical Report for NC Developmental Centers indicates that, despite a continuing downward trend in census, 83 admissions to the Developmental Centers were recorded during fiscal year 2010, an increase from 2009's 73 admissions. The largest group of referrals was made by private licensed community residential settings (78.3 %). Regular admissions accounted for over 83.1% of total admissions in fiscal year (FY) '10. Males constituted 65% of admissions. Of the total admissions, 39% were non-white. Most clients who were admitted were in the special education category. The largest single age group was 0-14 years. This is a reflection of individuals served in the Murdoch Center specialty programs, including: STARS (Specialized Treatment for Adolescents in a Residential Setting) serving adolescents, ages 13 through 17, who have a dual diagnosis (developmental disability and mental illness); and PATH (Partners in Autism Treatment and Habilitation), serving children, ages 6 to16, with autism spectrum disorder and serious behavioral

challenges.

From the NCI 2009 data for NC, a majority of individuals report that a service coordinator helps them get what they need: 87% (community-based), 93% (independent home), 89% (parent's home). They have met their service coordinator: 95% (community-based), 100% (independent home), 93% (parent's home). A service coordinator calls back right away: 78% (community-based), 83% (independent home), 82% (parent's home). They get needed services: 67% (community-based), 64% (independent home), 55% (parent's home).

The NC DMH/DD/SAS State Strategic Plan (2010-2013) indicates that new consumers of DD services rose from 41% to 52% during the previous three-year planning period (2007-2010). Dual Mental Health (MH)/DD services provided rose from 33% - 41% during this same period.

The North Carolina Medical Journal, November/December 2009, Volume 70, Number 6, describes current service delivery barriers. The availability and quality of services and supports varies across the state. The complexity of the current system makes it difficult for many people with I/DD and their families to identify and obtain needed services and supports. Services are often fragmented across agencies. People with I/DD need coordinated services/supports. Interagency planning and coordination is particularly important during transitions.

Local Management Entities (LMEs/Managed Care Organizations (MCOs) are agencies of local government responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the catchment area served. LME/MCO responsibilities include offering consumers 24/7/365 access to services, developing and overseeing providers, and handling complaints and grievances.

Medicaid Data – Estimated, 2010
Service Adult Child
Case Management: Adult-14,441 Child-7,501
Case Support: Adult-65 Child-68
Community Support: Adult- 70 Child-350
Developmental Therapies: Adult- 1,693 Child- 1,360
ICF_MR: Adult- 3,855 Child- 305
Other_CAPMRDD waiver: Adult- 2,126 Child- 1,575
Respite: Adult- 4,769 Child- 3,802
Supported Employment: Adult- 2,886 Child- 31

(iv) Interagency Initiatives:
NC State Independent Living Council (SILC) is the governing council for the Centers for Independent Living. It oversees statewide independent living services. A majority of SILC members must be people with a disability; other members represent a range of agencies, including the NCCDD. The NC Rehabilitation Council works in partnership with the Division of Vocational Rehabilitation Services by providing guidance in developing and expanding vocational rehabilitation services to maximize employability and independence of individuals with disabilities.

The Interagency Coordinating Council (ICC) brings policy makers, service providers, and parents together to ensure a coordinated system for children, 0-5, with disabilities or developmental delays and their families. Its members work to ensure that the supports and services offered to families are in line with their needs. Since 1989, statewide early intervention planning and service delivery for infants, toddlers and preschoolers has been based on a formal interagency agreement. This agreement was developed by the thirteen state agencies involved in providing or paying for services to young children and their families.

Community Resource Connections for Aging and Disabilities (CRC) is North Carolina's implementation of the federal Aging and Disability Resource Center initiative. NC's approach reflects one of the main goals of this initiative: community collaboration. Through this collaboration, agencies and organizations within the community work together to provide information about, assistance with, and access to services for individuals who are aging or have a disability.

In 1992, North Carolina was awarded a Head Start State Collaboration grant from the US Administration for Children and Families; the NC HSSC is housed in the Office of School Readiness with the other state or federally funded Pre-K programs administered in NC, including Title I, Even Start Family Literacy, and Preschool Exceptional Children. The State Transition Team, facilitated by the NC Department of Public Instruction, supports successful transition from high school to the community for students with an Individualized Education Plan (IEP).

The NC Practice Improvement Collaborative (NCPIC) seeks to promote evidence-based practice for those receiving services through the Division of MH/DD/SAS. The collaborative, inclusive of NCCDD, comprises representatives of all three disability sectors; it meets quarterly and provides an annual public forum.

Other state-initiated councils and committees include the Victims with Disabilities Task Force (DMH/DD/SAS and NC Department of Justice); and the Commission for Mental Health, Developmental Disabilities, Substance Abuse Services, which adopts rules regarding licensing, "care and treatment" of consumers, professional requirements, hearings and appeals, and review of state plans. The commission also advises the Secretary of DHHS. The State Consumer and Family Advisory Committee is composed exclusively of adult consumers and family members of MH/DD/SA services. It advises the DHHS and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

(v) Quality Assurance:
The NC MH/DD/SAS Quality Systems Report for first quarter of 2011 indicates that the percentages of persons in need of I/DD services that were provided publicly-funded services and in their communities exceeded the SFY 2011 statewide goal both for adults (40% served, compared to the statewide goal of 38%) and for children (22% served, compared to the statewide goal of 20%). The percentages remained the same for adults and increased for children compared to the prior quarter. The Division began piloting Provider Performance Reports in October 2010, starting with providers approved as Critical Access Behavioral Health Agencies (CABHA) with a mental health service continuum.

As the state's Protection and Advocacy (P & A) agency, Disability Rights North Carolina (DRNC) monitors where people with disabilities receive services for health and safety issues, to ensure residents and staff are aware of the rights of individuals, and for quality of life issues. During the fiscal year that ended Sept. 30, 2010, staff monitored 29 facilities where people with I/DD live. Those facilities included 3 state-operated facilities, one prison for I/DD offenders, and 25 privately-operated ICF-MRs or group homes. DRNC monitored in other facilities, such as neuromedical centers, state-operated and community psychiatric hospitals, nursing homes and adult care homes, and have provided advocacy on behalf of individuals with I/DD in those placements. DRNC has increased its advocacy, thanks to a grant received in February 2011 from the National Disability Rights Network to monitor specifically in community placements (6 beds or less) where people with I/DD live. That project, which ended on Sept. 30, 2011, required monitoring in at least 26 community settings, focusing some of that monitoring and advocacy on individuals who have transferred from an institutional setting into the community. During the last fiscal year, DRNC added a new focus to monitoring in settings that serve individuals with I/DD, community rehabilitation programs, to ensure that employees/trainees in these facilities are provided the most appropriate, most progressively integrated services in a safe and healthy environment.

DRNC monitors death reports. The NC Department of Health and Human Services and all state-operated facilities are required by state law to provide these to the P&A. Investigations follow in cases where there are concerns about the care and treatment the decedent was receiving. In FY 2009, monitoring involved more than 50 deaths involving people with I/DD; as of June of 2011, nearly 50 had been reviewed.

Training is delivered in a number of venues. Exceptional Children's Assistance Center (ECAC) is North Carolina's Parent Training and Information Center and provides a range of workshops and resources to families across the state. The state Consumer Empowerment Team at the DMH/DD/SAS works with the State Consumer and Family Advisory Committee (SCFAC), a 21-member, self-governing and self-directed advisory organization, composed entirely of consumers and family members to involve consumers and receive input. The Association of Self-Advocates of NC (ASANC) is the state self-advocacy organization promoting leadership and self-determination among self-advocates across the state and offering training. The training page at the DMH/DD/SAS web site offers a listing of training resources across the state.

(vi) Education/Early Intervention:
NC Department of Public Instruction (DPI) reviewed personnel and teachers who provide special education/related services to children with disabilities. DPI found that of special education para-professionals for ages 3-5, approximately 916 were qualified and 32 were not; for special education para-professionals for ages 6-21, 6735 were qualified and 1034 were not. With regard to special education teachers: for ages 3-5, 787 were highly qualified and 58 were not; and for ages 6-21, 10,331 were highly qualified and 319.50 were not.

DPI annually reports progress to the U.S. Department of Education in several areas of exceptional children education through the Annual Performance Report (APR). The APR has twenty indicators, one of which (Indicator 14) addresses effective transition of students with Individualized Education Programs (IEPs) out of high school. Specifically, Indicator 14 addresses the "percent of youth who had IEPs, are longer in secondary school and who have been competitively employed, enrolled in some type of postsecondary school, or both, within one year of leaving school. Recent Indicator 14 data includes a 2009 sampling survey of students with IEPs who left school within the previous year. Of those who responded to the survey, 48% of students with an intellectual disability had been competitively employed, enrolled in some type of postsecondary school, or both, within one year of leaving school. This group was lowest as compared with those with Learning Disabilities (76%) or Emotional Disturbance (55%). Some leaving students with IEPs, regardless of disability, were classified as 'dropouts'. The most frequently reported reactions by students who dropped out when asked why they left high school was no response/I don't know and I didn't like school. A clear reason for these students dropping out of high school is not apparent.

NC Institute of Medicine Recommendations (2009) include: Improve educational outcomes for children with I/DD; expand postsecondary education opportunities for persons with I/DD; and improve transitional services for children in foster care.

The North Carolina Early Intervention Branch is a part of the Division of Public Health. It is the lead agency for the N.C. Infant-Toddler Program (ITP). The ITP provides supports and services for families and their children, birth to three, who have special needs. Eighteen Children's Developmental

Services Agencies (CDSAs) serving infants/toddlers collected early intervention data from the 2008-09 and all children improved significantly. Pertinent indicators are: Indicator 1: 98% of infants/toddlers with an Individual Family Support Plan, (IFSP) received the early intervention (EI) services on their IFSP in a timely manner; Indicator 2: 99% of children received services in the home or programs for typically developing children. Indicator 3: Infants/toddlers with an IFSP: 73% entered below age expectations for positive social-emotional skills and increased the rate of growth for these skills by 3 years of age; 80% entered below age expectations for acquisition and use of knowledge, skills and increased rate of growth by 3 yrs; 77.6% entered below age expectations in use of appropriate behaviors to meet their needs and increased rate of growth by 3 yrs; and 57% of all children were functioning within age expectations by 3 yrs. Indicator 4: Results from National Center for Special Education Accountability Monitoring (NCSEAM) Parent Involvement Modules Family Survey revealed that 74% of families knew their rights, 70% effectively communicated their children's needs, and 83% helped children learn.

(vii) Housing:
According to the 2008 report, Where Does North Carolina Stand, by Human Services Research Institute, the number of individuals who received out-of-home residential services grew in a ten-year period; 41.3% growth in NC compared to 25.4% nationally. Given that NC provided residential services to 10,581 people in 2008, the need to serve an additional 1,360 people amounts to a shortfall in capacity of about 13%. Residential services claim the majority of state expenditures for DD services. Nationally, 27% of those receiving residential services own or lease their own home, compared to only 16% in NC; Medicaid-funded services, HCBS waivers and ICFs/MR went to 13,876 individuals in 2008. Given the NC population of 9,222,414, this totals 150 people per 100,000 general population; leaving North Carolina 26% below the national marker. Total Medicaid dollars available for ICF/MR and HCBS services was greater in NC. In 2008 this amounted to $66,279 per service recipient annually compared to $55,433 nationally, likely explained by the NC's reliance on costly public/private ICFs/MR services relative to other states' greater use of less expensive HCBS waivers.

According to the NC Institute of Medicine (NCIOM), NC needs more housing options that could substantially alleviate the issue of co-location with the frail elderly. As stated in the NCIOM report from its Task Force on Colocation of Different Populations in Adult Care Homes (ACH) more than 60% of ACH residents have a mental illness, I/DD, or an Alzheimer/dementia diagnosis. Individuals with disabilities often end up in an ACH because there is no place else to go. Co-location of individuals with disabilities with the frail elderly has resulted in issues and created conflicts because this setting is not designed to meet needs for both populations. The NCIOM reports a difference in program rules for those in ACHs and those who remain at home - this creates an institutional bias—providing greater financial coverage/health benefits for those who move into an ACH. Most individuals with disabilities can't afford independent housing w/o housing subsidy, as most are living on SSI. In 2010, SSI was $674/mo or $8,088/yr. – not enough for individuals to purchase non-subsidized housing. Initially, people who left larger state psychiatric hospitals and/or developmental centers might be placed in larger ICF-MRs (with 16 or more beds) or in larger 122C group homes for people with mental illness, I/DD, or substance abuse. Currently, most people living in a 122C facility are in group homes that house 6 or fewer. NC data from 2009 National Core Indicators (NCI) surveys with individuals not living in large institutions report that they like where they live: 83% (community-based), 89% (independent home), 94% (parent's home). Less than one-third would like to live somewhere else: 33% (community-based), 27% (independent home), 28% (parent's home). Recent residential data for Local Management Entities (LMEs) from NC Client Data Warehouse indicates 87% of clients served by LMEs are in a private residence (children and adults combined); 85% of adults are in a private residence, 5% homeless. Anecdotal information reported by Disability Rights NC indicates that an increased number of individuals with an MR/MI diagnosis are presenting at hospitals. A General Assembly housing task force reviewed cost-effectiveness of supportive housing as an alternative to institutionalization. An interim plan for financing and developing independent and supported living apartments for persons with disabilities was presented to MH/DD/SAS LOC, in 2009. The Task Force on Housing for NC Commission on MH/DD/SAS, presented the Welcome Home Report on Housing for North Carolinians with Disabilities in August, 2004; none has been issued since. The report cited a weak public/private sectors connection for coherent planning and program development and a lack of clear vision. The report noted limited resources.

(viii) Transportation:
Nationally, accessible transportation remains an ongoing barrier for individuals with I/DD. The Kessler Foundation/NOD 2010 Survey of Americans with Disabilities, data based on US Survey of 1001 adults with disabilities and 788 adults without disabilities indicates that 34% of people with disabilities consider transportation to be a problem, compared to 16% of people without disabilities. Lack of transportation access adversely impacts the ability of people with disabilities to fully participate in their communities. In fact, nearly two million Americans with disabilities never leave their homes (US DOT, 2003). Inaccessible transportation negatively impacts quality of life of people with disabilities by limiting access to employment, political participation, entertainment, religious activities, and other community participation (Harris Poll, 2000). NC data from the National Core Indicators indicates that individuals report having adequate transportation when they want to go somewhere: 87% (community-based), 73% (independent home), 84% (parent's home).Public Transportation systems in North Carolina are operated by local, regional transit and intercity public transportation services. Public transportation systems are operated directly by local and regional transit agencies in all 100 North Carolina counties. The NCDOT classifies the existing 99 public transportation services agencies responsible for delivering transit services to the state's residents into 3 categories:1.19 Urban and 3 small urban public transportation systems all providing fixed-route bus service 2.7 regional (multi-county) public transportation systems providing transportation for the general public and human service agency clients. In terms of ridership estimates, NC DOT data shows 67.6 million one-way transit trips in NC in FY 2010, with 60.5 million recorded on the urban side of transit (including urban paratransit services), and the remaining 7.1 million transit trips recorded by the rural general public transportation systems statewide. Available accessible transportation services and supports in NC include:
- 21 fixed-route bus systems in NC serving only urban communities
- "Travel training" for people with disabilities to learn how to use fixed-route bus systems in only 3 communities
- Reduced fares for people with disabilities
- Complimentary paratransit services in communities that have fixed-route bus service
- Dial-a-Ride services
- Taxi subsidies
- Shuttle services coordinated by neighborhood and community organizations
- Volunteer drivers
- Accessible taxi cabs
- Caregiver transportation.

Unmet transportation needs for services and supports in NC include:
- Lack of public transportation in rural areas
- Lack of "travel training" in all communities with fixed-route bus systems

Lack of maintenance of accessibility features (e.g., accessible lifts)
- Improper securing of mobility devices in vehicles
- Lack of transit-related information in accessible formats for individuals with sensory and cognitive disabilities (e.g., drivers calling out stops)
- Accessible bus stops, sidewalks and crosswalks not a priority in transit planning

•Budget cuts are resulting in reduction of bus routes, stops and service hours, including nights and weekends
•Due to budget cuts, paratransit is increasingly limited to only the minimum service required by the Americans with Disabilities Act (ADA)
•Due to budget cuts, eligibility standards for paratransit are increasingly stringent. Some people with I/DD (particularly individuals with intellectual disabilities) are deemed not to meet new eligibility requirements
•Policies at some transit agencies disqualify a rider for Para transit if they can use the fixed route bus system
•Lack of ongoing disability awareness training for transit staff
•Individuals with disabilities do not know their rights

(ix) Child Care:
Between 1266 and 1528 children with special needs received a subsidy from the state for child care services during fiscal year 2010-2011. This is out of a total of over 80,000 children who receive services in NC each month. Over 250,000 children are in care each month in NC (preschool and before/after school care). Eligibility for the subsidy is based on income. It is possible that more children with special needs received this benefit because there is no requirement that the family provide information as to whether their child has an identified developmental disability.

Additional data may be available regarding children with special needs receiving preschool and before/after school care from the Exceptional Children's Services and Head Start programs. Some of these children might also be captured within the data sets mentioned above.

(x) Recreation:

PART C: Analysis of State Issues and Challenges [Section 124(c)(3)(C)]:
(i) Criteria for eligibility for services:
Access to primary health care for people with I/DD is assisted by Community Care of NC (CCNC), an innovative "Medical Home" model serving NC's Medicaid population. Of concern is the lack of primary care physicians trained to meet the needs of people with I/DD. Psychiatrists and behavior analysts are also in short supply. With Mountain Area Health Education Center, NCCDD is working to develop the US's first curriculum in adult developmental medicine.

The Children's Developmental Services Agency (CDSA) is the local lead agency that administers, supervises and monitors local activities for Early Intervention Services Program (EISP). There are 18 CDSAs in North Carolina, serving all 100 of the state's counties. Parents/caregivers, physicians and others can refer a child to the CDSA if there are concerns about the child's development. After a referral is made, the CDSA will contact the family to discuss the child's medical and developmental history.

Vocational Rehabilitation (VR) serves individuals with a "cognitive" disability. Services are also provided to students eligible for an Individualized Education Plan (IEP). Both definitions would include some people with I/DD, but it is not clear how many. VR has a strong track record in supported employment, but long-term, follow-along funds to support continued success continue to elude the state. VR manages a robust Independent Living Program, but there is limited access to Independent Living Centers (ILCs), consumer controlled, community-based organizations that provide services for people with all types of disabilities and their families.

Long-Term Services and Supports: Eligibility for Medicaid is based on a family's monthly income and their resources. Participation in Home and Community Based (HCBS) waiver services for people with I/DD (the 1915(c) CAP-MR/DD and the 1915(b)(c) Innovations waivers) depends on funding availability. While eligibility for waiver services and ICF-MR are the same, a strong institutional bias continues to be evident in NC. The NCCDD has produced a gap analysis and "action steps" document in an effort to advance more inclusive, cost-effective approaches to services/supports.

Housing: The NC Institute of Medicine reports a difference in program rules for those in Adult Care Homes (ACH) and those who choose to remain at home or in their communities. That difference creates an "institutional bias," providing greater financial coverage and health benefits for those who move into an ACH. Section 8 housing eligibility is generally 50% of area median income (AMI), but can be up to 80% in some cases; 75% of new vouchers must go to families with incomes below 30% AMI. Waiting lists are long, however. In Raleigh, e.g., the wait is estimated at 4–6 years.

Transportation: Paratransit riders must meet eligibility requirements and complete an application for certification. Some areas are eliminating paratransit services. Raleigh ended its program due to cost, but the county maintains a transportation program to medical appointments for those living in rural areas and meeting eligibility requirements.

Education: With the approval of the NC Department of Public Instruction's Policies Governing Services for Children with Disabilities (11/07), research-based interventions are now more frequently required to determine eligibility for special education and related services. In addition, a child must not be determined to be a child with a disability if the determination is based on a lack of appropriate instruction in reading.

Child care: Eligibility for a child care subsidy is based on income. It is possible that fewer children with I/DD receive this benefit because there is no requirement for information as to whether the child has an identified I/DD.

(ii) Analysis of the barriers to full participation of unserved and underserved groups of individuals with NCCDD identifies this group from ongoing NCCDD activities, survey results and key documents. These are: 1) People/families affected by I/DD with limited English proficiency. NC has the most growing Hispanic/Latino community in the US. 2) Individuals living in public ICFs-MR. NC is 10th highest user of ICF-MR in the US and risks violation of the ADA's integration mandate; 3) People with I/DD in Adult Care Homes (see "Short and Long-Term Solutions for Co-Location in Adult & Family Care Homes" (NCIOM 2011)). More than 60% of those in ACHs have a mental illness, I/DD, or Alzheimer's/dementia. People with I/DD in ACHs are likely not in the most integrated setting. Staff lack necessary I/DD competencies; and people may face or create health/safety issues). 4) Aging adults with I/DD living at home with aging parents. These adults risk having few/no services as parents age or die.

Education/Early Intervention: Surveys indicate "school attitude" is not welcoming re: inclusion. DPI acknowledges a need for stronger collaboration re: inclusion.

Transition: issues for children/youth demand attention so that successes occur across NC for all ages. Transition outcomes must include, e.g., competitive employment and post-secondary education, where programs inclusive of students with I/DD are emerging, but must be expanded. The NCIOM (vol. 70, no.6) describes current barriers to transition for those with I/DD as varying across the state.

Housing: Most people with disabilities can't afford independent housing without a housing subsidy, as most rely on Supplemental Security Income (SSI). In 2010, SSI was $674 per month ($8,088/yr.). SSI doesn't provide enough monthly income for most people to purchase nonsubsidized housing or support services.

Health: Obesity rates for those with I/DD are high. The majority of people in the I/DD system in NC are overweight (27 percent) or obese (30.8 percent). The Division of Public Health (DPH) notes that steps have been taken, but services were also cut. Nearly 28% of adults with a disability report that within the past year they couldn't see a doctor due to cost, compared to 13.4% of adults without a disability. Only 53% of persons with I/DD had a routine dental exam in the past 6 months (NCI, 2007 - 2008). NCI data indicates that nearly half (47%) of those receiving services in NC are prescribed medications to control mood, anxiety and/or behavior, with the largest cohort (67%) being in group homes. It is unclear if medications are for the person's benefit, or if factors such as staff convenience are an influence.

Relationships: NCI data indicate that 39.9% of people feel lonely some/most of the time; those in group homes were more likely to report feeling lonely some/most of the time (47%) compared to those living in their own homes (35 %) or living with family members (38 %).

Employment: VR surveys identify several barriers to serving individuals with disabilities: lack of employer education about working with people with disabilities results in unwillingness to hire or make workplace accommodations; opportunities for people to learn skills on the job are limited; and there is a lack of jobs in the current economy.

Workforce: Direct support staff need cost-effective, statewide access to competency based training to improve recruitment, retention, and career paths. Many agencies face staffing shortages, turnover, staff without necessary competencies, and lack of funding to hire.

General: The complexity of the current system makes it difficult for many people with I/DD/families to identify and obtain needed services/supports. Services are often fragmented. People with I/DD need coordinated services/supports and staff who are I/DD trained to provide these. Stakeholders perceive complex policy shifts, such as the 1915(b)(c) waiver, as a threat to services and describe the pace of change as too rapid, not planful, and not inclusive of consumers/families.

(iii) The availability of assistive technology:
NC Assistive Technology Program (NCATP) serves people of all ages and abilities. Twelve centers across the state serve children, adults, and older adults with disabilities and their families. Free services include device demonstration, device loan, device reutilization, training/technical assistance and public awareness. Fee-based services are provided to agencies and schools/other organizations and include assistive technology assessment, community-based assessment, feature matching and device trial, and training on specific devices/software consultation, workshops and training. The NCATP web site offers information and resources, including funding information. Easter Seals/United Cerebral Palsy of NC/VA, for example, provides funding if no other resources are available to individuals who live in the community, including those with long-term disabilities, I/DD, of all ages. Waiting lists are a barrier: in 2009, 10,015 individuals received short-term loans for assistive devices and device demonstrations. Training and support services were provided to 45,391. NCATP ranks 2nd in the nation for short-term device loans; 4th in the nation for device demonstrations, and 8th in the nation for savings due to reutilization.

(iv) Waiting Lists:
a. Numbers on Waiting Lists in the State:

| Year | State Pop. (100,000) | Total Served | Number Served per 100,000 state pop. | National Averaged served per 100,000 | Total persons waiting for residential services needed in the next year as reported by the State, per 100,000 | Total persons waiting for other services as reported by the State, per 100,000 |
|---|---|---|---|---|---|---|
| 2009 | 9.500 | 7049 | 1.300 | 213.000 | | |

b. Description of the State's wait-list definition, including the definitions for other wait lists in the chart
The State of North Carolina does not currently maintain an official waitlist.
See Waitlist Attachment

c. To the extent possible, provide information about how the State selects individuals to be on the wait l
The State of North Carolina does not currently maintain an official waitlist.

d. Entity who collects and maintains wait-list data in the State:
- [ ] Case management authorities
- [ ] Providers
- [ ] Counties
- **[x] State Agencies**
- [ ] Other:

e. A state-wide standardized data collection system is in place:
- **[x] Yes/No**

f. Individuals on the wait list are receiving (select all that apply):
- **[x] No services**
- [ ] Only case management services
- [ ] Inadequate services
- [ ] Comprehensive services but are waiting for preferred options (e.g., persons in nursing facilities, institutions, or large group homes waiting for HCBS)
- [ ] Other: see description below

Other services:

Other services description(s):
The State of North Carolina does not currently maintain an official waitlist.

g. Individuals on the wait list have gone through an eligibility and needs assessment:
- [ ] Yes/No

Comments for the above:
The State of North Carolina does not currently maintain an official waitlist.

h. There are structured activities for individuals or families waiting for services to help them understand use of supports when they become available (e.g. person-centered planning services):
[ ] Yes/No

i. Specify any other data or information related to wait lists:
From 2001-2009, North Carolina enrolled an additional 4,303 people in HCBS and ICF-MR services (478 people per year on average). North Carolina has increased its system capacity in this period, but the rate falls well below the national average. Between 2000-2009, North Carolina increased service capacity by 44%, compared to the national increase of 60%. This pace of growth contributes to a low overall service use rate (151 people per 100k population), and results in a waitlist for services.

In response, the 2009 General Assembly Session for North Carolina passed House Bill 673, calling for LMEs to develop waiting lists. Information to be gathered includes numbers of persons who are: a) waiting for residential services; b) potentially eligible for CAP-MR/DD; and c) in need of other services and supports funded from State appropriations to or allocations from the DMH/DD/SA, including CAP-MR/DD.

j. Summary of waiting list Issues and Challenges:
The State has developed a methodology to begin to capture data about individuals waiting for, but not receiving Medicaid-funded services. In October 2010, MH/DD/SAS presented plans for collecting and analyzing data. At that time, MH/DD/SAS noted that LME/MCOs were providing data to the State regarding the number of people waiting for services in the different regions. As of October 2010, a reported 8,191 individuals were waiting for, but not receiving services. The data presented, however, are not so easily interpreted, largely due to the absence of information related to the urgency of need for services which can greatly alter one's understanding of projected service need. Of the 8,191 individuals on the waitlist, it is not known how many need services urgently, in the near term, or at some unspecified time in the future. Further, the present waitlist data offers little understanding of what services it is for which individuals are waiting.

(v) Analysis of the adequacy of current resources and projected availability of future resources to fund s
The state's budget crisis continued to swell during 2011. Projections indicated that NC would have a deficit of $2.4 billion. 2011 was the first in nearly 100 years that NC had a Republican-controlled legislature in both the State House and State Senate. These conservative law makers pledged not to raise taxes. This deficit, combined with pledges not to raise revenue, will certainly result in continued cuts to health and human services. Cuts to the Medicaid reimbursement rates, changing infrastructure of the provision of services (1915 (b)(c) waiver expansion), and other legacy factors, including institutional bias, continue to indicate significant barriers for individuals and their families to receive support.
The state serves far fewer than the national average of individuals with intellectual/developmental disabilities per 100,000 (i.e., 100K) in the general state population. In 2009, NC provided Medicaid-funded services (home and community- based waiver services (HCBS)) and services in ICFs-MR to 14,178 individuals. This amounts to 151 people per 100K in the general population in North Carolina. NC serves 29% fewer than the national average of Medicaid-funded individuals. In October, 2010, a reported 8,191 individuals were on a waitlist; but it is not known how many need services urgently. This data was collected from the LME/MCOs, and included individuals waiting for support but not receiving Medicaid-funded services. There are other issues in NC, including the projection of

population growth; between 2000-2009, NC population grew 17 %. In comparison, during this same time, the U.S. population increased by only 9%.

NC has participated in the "Money Follows the Person" demonstration project since the funds were available to support individuals to live in the community, in one of the Medicaid waivers. In 2009, NC completed 35.6% of their transition goals, and within the first six months of 2010 (January-June), NC transitioned 16 individuals to HCBS, of which 14 persons were individuals with I/DD. The overall ranking for NC compared to other states for the MFP initiative, was 26th out of 30 participating states. Many factors are cited as barriers to the initiative, including cuts to Medicaid HCBS. NC reported significant cuts to case management, which is a critical support to an individual's transition back into community. Another obstacle noted is that the number of community homes for 4 or less people are limited. NC began to engage small group home providers to reduce their size in order to qualify as a provider of support to an MFP participant. Institutional support to individuals with I/DD continues to be on the forefront of obstacles to supports within the community. According to the institutional census in 2008, 16 individuals out of 1,666 were moved out of large-state operated developmental centers into other residential placements during FY 2009. This is 0.96% of the total center population . While persons were transitioning to the community from state-run facilities, other individuals were begin admitted to the state run facilities. During the period of July 1, 2007-June 30, 2008, 32 people moved from the developmental centers to the community. During this same period of time, 52 individuals were admitted, many of whom resided in licensed community settings, including ICF-MR group homes. The NC system, with the recent legislative session, approved a state-wide expansion of the 1915 (b)(c) waiver. The system has been re-shaping itself for the past decade, and this constant change has its own challenges and obstacles. With continued population growth, budgetary deficits, service reduction, and new service delivery models being introduced, the service system will continue to present barriers.

(vi) Analysis of the adequacy of health care and other services, supports, and assistance that individuals facilities receive:
In the 2011 report, Strategic Analysis for Change, Human Service Research Institute (HSRI) reported that in comparison to national averages, NC uses orth Carolina utilizes ICFs/MR and large congregate facilities for individuals with I/DD at a significantly greater rate than is being done nationally. This included use of public ICFs/MR, private ICFs/MR, neuro-medical centers, and skilled nursing facilities. HSRI also reported that nearly half (47%) of those receiving services in North Carolina are prescribed medications to control mood, anxiety and/or behavior. Sadly, this is not atypical, but akin to findings across all National Core Indicators (NCI) states. HSRI noted:
~ In 2009, NC spent $104.85 per citizen for I/DD services. The nationwide average ($121.40 per citizen) was $16.55 dollars, or 15.7 percent, per person higher.
~ NC's 2009 spending for I/DD services would have had to have been $155,253,630 higher to match the nationwide average.
~ NC serves 29 percent fewer people per 100k of population than the national average (151 in NC versus 213 per 100K population nationwide).

The system's reliance on developmental centers and ICF/MR in general is, HSRI noted, is "unwarranted and inefficient."
~ 1,593 individuals resided in state-run developmental centers, or 17.0 individuals per 100K, compared to 10.7 nationally. The utilization rate for developmental centers in NC is 57 percent higher than the national average.
~ Data presented by DHHS to the legislature reveals that from 2008-2010, the census for the three centers grew by 28 people. When the census for neuro-treatment centers is factored in, Lakin et al. (2010) reports an overall decrease in census of 71 people in 2009, though 55 of this total were discharged due to death.

~ Between 1999-2008, NC showed a steady decrease in the number of people with I/DD served in nursing homes. However, between 2008 and 2009, the number reported more than doubled, from 400 in 2008 to 949 in 2009. In 2009 the state served 10.1 individuals per 100K of general population in nursing home facilities, compared to 7.7 nationally.
~ NC provided residential services to 3,854 people in ICFs/MR and another 10,333 through HCBS waiver funding. ICF/MR placements comprise 27 percent of those receiving residential services, compared to 14 percent nationally. ICF/MR use in NC is nearly double the national average.
~ 1,798 individuals resided in community ICFs/MR. This amounts to 14.8% of the 12,131 served either in community ICFs/MR or receiving HCBS. This is more than twice the national average of 6.5%.
~ 2,141 individuals, including the 1,593 in state-run developmental centers, live in facilities of 16+ people. This amounts to 21.4% of all those receiving residential services in NC. This compares to 13.6% nationally who receive residential services.
~ Interview respondents indicated that initiatives to reduce reliance on ICFs/MR in favor of increased reliance on HCBS services continue to struggle. HSRI noted that reasons included an absence of consensus, state level commitment to such change; fiscal and administrative barriers to change; and perceived weaknesses in the present HCBS waiver that dissuade ICF/MR providers moving to the HCBS waiver.
~ NC expended $69,331 per person on average for HCBS and ICF/MR services. In 2009, the national average was $57,126 per person. NC spends 21.3 percent more per person than the national average.
~ Average costs of service illustrate that the cost of serving an individual in a developmental center amounts to $175,000 per year, compared to $92,906 in a community ICF/MR and $61,291 for CAP/MR-DD waiver services.
~ Experience elsewhere suggests that anyone with I/DD can be served within appropriate HCBS alternatives.
~ Experience shows that among the 20 states with the lowest use of ICFs/MR, 17 have a lower cost per person than NC. Eight of these states have no state institution.

(vii) To the extent that information is available, the adequacy of home and community-based waivers se the Social Security Act (42 U.S.C. 1396n(c)):
In NC, there are 4 home and community based waivers used by persons with I/DD: 1) The Community Alternatives Program for Children (CAP/C): home care for medically fragile children (through age 18) who would otherwise require long-term hospital care or nursing facility care. 2) The Community Alternatives Program for Disabled Adults (CAP/DA): services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. 3) CAP-MR/DD, a 1915(c) waiver, which provides community-based services to individuals of any age who qualify for care in an ICF-MR. Under the CAP-MR/DD waiver, NC also offers a Supports Waiver for individuals not requiring residential services. The Supports Waiver provides day services, respite services, personal care and supported employment. The maximum amount an individual can receive in the Supports waiver is $17,500/year, compared to $135,000/year maximum in the CAP/MR-DD waiver. 4) Innovations, the soon-to-be-statewide 1915(b)(c) waiver for managed long-term services.

In NC, the average cost of serving an individual in a community ICF-MR in NC in 2010 was $92,906 and the average cost of the CAP/MR-DD waiver in North Carolina was $61,291. This translates to $104.85 per citizen for I/DD services in NC, 15.7% lower than the national average ($121.40 per citizen). NC serves 29% fewer people per 100K of population than the national average (151 in NC vs. 213 per 100K nationwide).

NC relies on ICFs-MR and large congregate facilities for individuals with I/DD at a significantly higher rate than the national average, with 27% of recipients utilizing ICF-MR services and 73% receiving HCBS waiver services. Nationally, 14% receive ICF-MR services and 86% receive HCBS waiver services. Since 2000, NC increased service capacity only 44%, compared to 60% nationally. As a result, 8,191 individuals were waiting for, but not receiving services in 2010. It is not known how many on the wait list need services urgently, or what specific services are needed.

According to the National Core Indicators Survey, only 66% of NC service recipients report getting the services they need (compared to 86% nationally). For those who do get services, 89% like where they live; 88% like their neighborhood; 92% are satisfied with their job; and 91% are satisfied with their day program or activity. However, 49% to 60% of family members report turnover in direct support staff. NC also falls short of achieving outcomes for integrated employment, with less than one -third of individuals supported in community-based employment. A majority of adults that do not have community-based employment (62%) report they would like a job in the community. Of those that do work, most do so in facility-based locations (45%). There is also limited success in supporting people in relationships beyond service providers, and relationships that reduce risk of abuse and neglect, decrease loneliness and positively impact physical and mental health. Approximately 40% report they feel lonely some or most of the time.

The 2011 NC General Assembly passed legislation to direct the statewide expansion of a 1915(b)(c) waiver and managed care system by 2014. PBH, an LME/MCO that oversees public services in 15 counties has been operating the 1915(b)(c) waiver since 2005 . Under this waiver, all Medicaid HCBS I/DD beneficiaries will be enrolled in managed care plans; local entities will manage services under aggregate funding, providers can be restricted with selective contracting; and additional services (for those on waiting lists) can be generated through cost savings. Administrative consolidation will reduce the total number of LME/MCOs statewide. Processes to develop a resource allocation methodology for service recipients are also underway.

PART D: Rationale for Goal Selection [Section 124(c)(3)(E)]:
6/09: NCCDD staff began assessing objectives in the current State Plan for "carry forward" initiatives in the FY 2011-2015 State Plan. NCCDD granted funds to the University Center on Excellence in DD, Carolina Institute for Developmental Disabilities (CIDD), beginning 11/09. The grant launched "Vision 2016"; national experts (Rud Turnbull, Julie Petty, Bob Gettings, Dave Hasbury, and John Agosta) informed members re: emerging trends. "Vision 2016" engaged the Council in generating a shared vision for 2011 – 2016 and created collective vision for the Plan. At each meeting, the NCCDD brought in an expert to address an area of emphasis highlighted at "Vision 2016." S/he related national trends to the policy/practice environment in NC. Areas addressed included the direct support workforce (Amy Hewitt); waiting lists (Celia Feinstein); employment (Bill Kiernan); aging (Leigh Ann Kingsbury); self-advocacy (Julie Petty); community inclusion (Mike Mayer); waiver development (state officials); and strategic gap analyses and family support (John Agosta).

At the 8/10 meeting, Alan Bergman highlighted member roles/responsibilities, relating these to the Plan. The Council then engaged CIDD in a development grant to implement steps to produce a Plan. CIDD primarily culled data from key national/state documents and assisted in stakeholder interviews. For the first time in NCCDD history, surveys (attached) were developed and distributed across the state soliciting input to the five-year state plan. "Listening to North Carolina: Be Heard. Be the Change" was launched in June 2010. The survey was distributed in many ways: one-on-one; group forums; telephone; and news media, PSAs and the newsletters of many Council network resources. NCCDD widely distributed electronic surveys, soliciting input for the Plan. The greatest response came through the NCCDD website and as a response to attachment of the survey information to outgoing email. In total, 800 surveys arrived between 8/10 and 10/10. In a day-long, working forum, the Council reviewed survey results key document summaries; Disability Rights NC (P&A) forum information; and results of interviews with agency personnel and others. Members discussed past presentations, data, pressing issues, and their own lived experience. The Council's priorities and future goals began to emerge. The CIDD then organized information and created an Executive Summary (attached), incorporated into the Plan's Comprehensive Review and Analysis.

With the National Association of Councils on DD's Sheryl Matney and HSRI's Lee Vorderer, the Executive Committee and NCCDD and CIDD staff spent two days in 1/11 setting priorities and creating draft goals and objectives. At the 2/11 quarterly meeting, the members spent a half day reviewing, discussing and revising the draft goals and objectives, using the Route to Success model, in preparation for public release in 3/11. Again, the NCCDD Communications Initiative implemented a detailed marketing plan. The 45-day public release of the draft goals and objectives attracted 141 responses, with the vast majority confirming that NCCDD was on track. The results of public comment were distributed at the 5/11 quarterly meeting. In 8/11, having reviewed and discussed the Plan, the Council endorsed it. June 2009: NCCDD staff drafted the first assessment of the objectives in the current state plan for items that could potentially roll into the 2011 -2016 state plan. These staff assessments were on-going until member development of the draft goals and objectives for the 2011 – 2016 State Plan. Also, at this time, Council staff began developing the "Contact and Documents List" (attached) to track stakeholder participation.

PART E: Collaboration [Section 124(c)(3)(D)]
(i) As a Network:
NC's Administration on Intellectual and Developmental Disabilities Network (AIDD/NC) is comprised of the NCCDD, Disability Rights NC (DRNC, Protection & Advocacy System, P&A) and the Carolina Institute for Developmental Disabilities (CIDD, University Center on Excellence in DD, UCEDD). The Network is joined by any AIDD Project of National Significance (PNS) that may be operating in NC. Setting the stage for working together, the AIDD/NC Network initiated the 2011-2016 Plan as a collaboration among the 3 organizations. The NCCDD, e.g., participated in DRNC's priority-setting process to inform Plan goals/objectives, while CIDD assisted NCCDD with stakeholder interviews and data collection. This approach set the stage for future joint endeavors among the Network. The Network continues to share information; examine opportunities to, e.g., leverage grant funds; and identify venues for co-joint participation (e.g., NCIOM Task Forces on Co-Location in Adult and Family Care Homes (DRNC, NCCDD) and on Successful Transitions for People with DD (CIDD, NCCDD, DRNC)). Each of the Network members is on the board/advisory of the other, with NCCDD serving ex-officio on DRNC's board and on the CIDD advisory. Both CIDD and DRNC are NCCDD members. This cross-fertilization promotes the Network in taking a shared approach to advancing evidence-based and promising policy/practice, along with human/legal rights. The State Plan environmental scan suggests the following areas as likely for collaboration: access to primary health care; post-secondary education; workforce development and training; application of the ADA's integration mandate in the context of congregate facilities for sheltered work and Adult Care Homes (aging);competitive employment; HCBS waiver design and implementation; and strengthening of the statewide self-advocacy.

(ii) With each other: (e.g. Describe the plans the Council has to collaborate with the UCEDD(s). Descril with the P&A.)
NCCDD participates in the Post-Secondary Education Alliance, convened by CIDD. In 5/11, CIDD presented to NCCDD, which was used to inform NCCDD's fund release (Goal I.2). CIDD is part of the NCCDD-funded Alliance for Full Participation effort to double competitive employment for people with I/DD by 2015 and is leading efforts to leverage funds that would assist the NCCDD's work in this area (Goal I.3). Both organizations share an interest in next generation leadership in the field of I/DD; there is a natural fit between CIDD's LEND program and the NCCDD's investments in workforce initiatives (Goal III.4). CIDD is actively engaged in the NCCD 's mini- fellowship in adult developmental medicine (Goal III.5). With the evolution of the fellowship into the National Curriculum in Developmental Medicine and the advent of the Affordable Care Act, CIDD will,

doubtless, continue to partner with the NCCDD and the Association of University Centers in Disability to refine the curriculum. CIDD has a strong track record in securing AIDD's PNS funds to advance self-advocacy; their partnership with NCCDD in strengthening a statewide self-advocacy program has also been valuable (Goal IV. 2). NCCDD and DRNC have key areas in which collaboration will strengthen the knowledge and the effectiveness of our mutual advocacy efforts. NC's plans to expand statewide Innovations, a 1915(b)(c) managed care waiver, have raised concerns among self-advocates and families re:, e.g., access to services and Medicaid appeals.

(iii) With other entities: (e.g. network collaboration with other entities in the State, including both disab
as the State agency responsible for developmental disabilities services)
The AIDD network has diverse linkages to a variety of disability and non-disability organizations in the state. NCCDD and CIDD have regular meetings with policymakers in the Department of Health and Human Services (DHHS) and the state DD authority, the Division of Mental Health, Developmental Disabilities and Substance Abuse. Each organization works on an on-going basis with the NC General Assembly. Both NCCDD and DRNC are part of efforts such as the Employment First Work Group; the "Money Follows the Person" Initiative; the Housing Work Group; the Traumatic Brain Injury Council; the Aging Disability Resource Center work group; the Statewide Independent Living Council; various endeavors to support the Association of Self-Advocates of NC; and efforts to strengthen such cross-disability coalitions as NC Disability Action Network and the Disability Policy Work Group. NCCDD and CIDD similarly participate in many external collaborations. These include: the Post-Secondary Education Alliance; the Autism Alliance; and the Alliance for Full Participation. All three organizations have worked with the NC Institute of Medicine (NCIOM) and are part of the state's Developmental Disabilities Consortium and the broader Coalition for mental health, developmental disabilities and substance abuse. These partnerships will continue to be active during the period FY 2011-2016.

The AIDD/NC Network will continue to collaborate with its partners in a variety of ways. These include offering a perspective informed by the DD Act and the organizations' expertise; sponsoring self-advocates' and families' participation in various conferences and at "policymaking tables;" supporting meetings between the Association of Self-Advocates and the Division of MH/DD/SAS and other stakeholders; offering information and resources to other organizations; hosting trainings; mentoring students; and providing staff support or appointed representatives to boards, committees, work groups, and councils.

## Section IV: 5-Year Goals [Section 124(4); Section 125(c)(5) and (c)(7)]

GOAL # 1: Transition

Advocacy, capacity building, systems change efforts of the Council will give people with intellectual and other developmental disabilities and their families more access to the services and supports they need to make life transitions.

Areas of Emphasis:

- [x] **Quality Assurance**
- [x] **Education and Early Intervention**
- [ ] Child Care
- [ ] Health
- [x] **Employment**
- [ ] Housing
- [ ] Transportation
- [ ] Recreation
- [x] **Formal and Informal Community Supports**

Strategies to be used in achieving this goal:

- [x] **Outreach**
- [x] **Training**
- [x] **Technical Assistance**
- [x] **Supporting and Educating Communities**
- [x] **Interagency Collaboration and Coordination**
- [x] **Coordination with related Councils, Committees and Programs**
- [x] **Barrier Elimination**
- [x] **Systems Design and Redesign**
- [x] **Coalition Development and Citizen Participation**
- [x] **Informing Policymakers**
- [x] **Demonstration of New Approaches to Services and Supports**
- [ ] Other Activities

Objectives/Implementation Activities/Timeline:

| **Objectives** | **Implementation Activites** | **Timeline** |
|---|---|---|
| 1.1 Council will provide funding/resources so that individuals with I/DD will have more opportunities for choice in post-secondary education. | 1) Develop Request for Application for stakeholder group to assist in the assessment of policy barriers to post-secondary education (PSE) options for students with I/DD.<br>2) Select grantee(s) and negotiate grants.<br>3) Council will participate in Carolina Institute on Developmental Disabilities Post Secondary Education (PSE) Alliance stakeholder group to assist in the assessment of policy barriers to PSE options. | 1) By 05/51/2012<br>2) By 06/30/2012<br>3) By 06/30/2012 |

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| 1.2 Council will provide funding/resources so individuals with I/DD will have more post-secondary education opportunities in the community college system. | 1) Develop Request for Application for transition to community college/post-secondary education. Identify and convene stakeholder group to assist in the assessment of policy barriers to Post-Secondary Education (PSE) options for students with I/DD.<br>2) Select recipient(s) of funding and enter into contracts(s).<br>3) Provide technical assistance to enhance the effectiveness of advocacy/systems change efforts.<br>4) Promulgate findings and target selected strategies for advocacy/system change. | 1) 07/01/2012-12/31/2013<br>2) 07/01/2012-12/31/2013<br>3) 07/01/2012 12/31/2013<br>4) By 12/31/2013 |
| 1.3 Council will provide funding/resources to increase access in the community to economic opportunities, inclusive of competitive employment for people with I/DD. | 1) NCCDD adopts "Employment First" Policy;<br>2) NC Alliance for Full Participation (NCAFP) delegation attends the National AFP Summit;<br>3) Educate policymakers and general public, in collaboration with stakeholders, about benefits of securing Employment First legislation.<br>4) Develop, in partnership with stakeholders, strategic policy/practices and social agenda in support of full participation for people with I/DD in integrated employment at a competitive wage;<br>5) Implement strategic policy/practices and social agenda in support of full participation for people with I/DD in integrated employment at a competitive wage;<br>6) Assess effectiveness of the implementation of the strategic policy/practices and social agenda in support of full participation for people with I/DD in integrated employment at a competitive wage;<br>7) Council will provide funding/resources for public awareness of transition to work and integrated employment initiatives. | 1) 10/01/2011 - 09/30/2013<br>2) 10/01/2011 - 09/30/2013<br>3) 10/01/2011 - 09/30/2013<br>4) 10/01/2011 - 09/30/2013<br>5) 10/01/2011 - 09/30/2013<br>6) 10/01/2011 - 09/30/2013<br>7) 10/01/2011 - 09/30/2013 |
| 1.4 Council will provide funding/resources to advance strategies that support family capacity to leverage the family's resources to achieve the life goals of an individual with I/DD. | 1) Identify and promote policies and practices that support family capacity to leverage the family's resources to achieve the life goals of an individual with I/DD. | 1) 01/01/2011 - 09/30/2016 |
| 1.5 Council will provide funding/resources to increase access in the community for economic opportunities, inclusive of competitive employment for people with I/DD. | 1) With Department of Public Instruction (DPI), identify three Local Education Agencies (LEAs) to participate in developing and testing a model, beginning at the Middle School level, for improving transition outcomes for students with intellectual disabilities (ID).<br>2) Create a paper prototype that provides a transition-focused curricula and outcomes for students with ID between 12 and 21 and for all levels of support needs and conduct evaluation. | 1) 9/1/2013-8/31/2014<br>2) 9/1/2013-8/31/2014<br>3) 9/1/2014-8/31/2015<br>4) 9/1/2015-8/31/2016<br>5) 9/1/2014-8/31/2015<br>6) 9/1/2014-8/31/2015 |

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| | 3) Develop initial, web-based version of the model and field-test, and conduct evaluation in 6 original schools and 12 additional schools in 3 partner LEAs.<br>4) Present the results of the initiative to date to one or more state conferences for LEA Exceptional Children's directors.<br>5) Create a management environment for the system that will allow it to be used within LEAs on a fee-for-service basis.<br>6) Use outreach from DPI to incorporate outcome data from pilots and to promote the system within LEAs. | |
| 1.6 Council will provide funding/resources that shall bring together state Developmental Disability agencies for sharing, educating and providing guidance on practices and policies around employment to its members. | 1) The State Employment Leadership Network (SELN) staff will conduct an in-state assessment, in collaboration with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).<br>2) Assist DMH/DD/SAS to analyze employment policies and practices and potential options for change.<br>3) Implement policies and practices across DMH/DD/SAS that advance competitive employment of people with disabilities in integrated, community workplaces. | 1) 10/1/12-9/30/16<br>2) 10/1/12-9/30/16<br>3) 10/1/12-9/30/16 |
| 1.7 Council will provide funding/resources to implement a high school transition initiative which is a business-led, one-year, school-to-work program that combines classroom instruction, career exploration, and relevant job-skills training through strategically designed internships for students with I/DD. | 1) Increase the number of licensed Project SEARCH program sites in North Carolina by adding 6 new programs.<br>2) Encourage family involvement in Project SEARCH through Family Involvement Curriculum implementation in existing 4 Project SEARCH sites.<br>3) Collect data on all Project SEARCH program sites on student enrollment, job placement and job retention during funding cycle.<br>4) Convene at least one statewide meeting(s) to bring together representatives from all North Carolina Project SEARCH program sites for training and sharing innovations and best practices.<br>5) Promote and deliver course offerings of the Project SEARCH Training Institute. | 1) 9/30/13-9/30/16<br>2) 9/30/13-9/30/16<br>3) 9/30/13-9/30/16<br>4) 9/30/13-9/30/15<br>5) 9/30/13-9/30/16 |
| 1.8 Council will provide funding/resources to assist families and students with I/DD in understanding options and opportunities for work and post-secondary education through a series of regional and statewide summits presenting best practices and policies. | 1) Development of a statewide steering committee.<br>2) Literature review of evidence-based transition and competitive employment practices.<br>3) 3 strategic planning summits in 3 different regions of the state.<br>4) Develop preliminary, strategic plan including implementation strategies that will lead to enhanced employment and post-secondary education outcomes for youth and young adults with I/DD. | 1) 10/1/12-9.30.13<br>2) 10/1/12-9/30/16<br>3) 10.1.12-9/30/13<br>4) 10/1/12-9/30/15<br>5) 10/1/13-9/30/14 |

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| | 5) Hold a statewide conference, in partnership with the Post-Secondary Education Alliance, to continue to expand the knowledge base among parents, students and education professionals. |

Intermediaries/Collaborators Planned for this goal (if known):

[x] **State Protection and Advocacy System**
[x] **University Center(s)**
[x] **State DD Agency**

DHHS Division of Medical Assistance
Colleges and Universities
Business Leadership Network
National Alliance for Full Participation
Self-Advocates and Families
NC Department of Public Instruction
State Employment Leadership Network
NC General Assembly
NC Division of Vocational Rehabilitation
NC Division of Aging and Adult Services
NC Local Management Entities
NC Providers of Services and Supports

GOAL # 2: System Response to People's Needs

Advocacy, capacity building and systems change efforts of the Council will improve the ability of service delivery systems to respond to the needs of people with intellectual and other developmental disabilities and their families.

Areas of Emphasis:

[x] **Quality Assurance**
[ ] Education and Early Intervention
[x] **Child Care**
[ ] Health
[ ] Employment
[x] **Housing**
[ ] Transportation
[ ] Recreation
[x] **Formal and Informal Community Supports**

Strategies to be used in achieving this goal:

[x] **Outreach**
[x] **Training**
[x] **Technical Assistance**

[x] **Supporting and Educating Communities**
[x] **Interagency Collaboration and Coordination**
[x] **Coordination with related Councils, Committees and Programs**
[x] **Barrier Elimination**
[x] **Systems Design and Redesign**
[x] **Coalition Development and Citizen Participation**
[x] **Informing Policymakers**
[ ] Demonstration of New Approaches to Services and Supports
[ ] Other Activities

Objectives/Implementation Activities/Timeline:

| **Objectives** | **Implementation Activites** | **Timeline** |
|---|---|---|
| 2.1 Council will fund training, consultation and technical assistance for organizations to support the development of policies and practices that advance integration, productivity, independence, and inclusion for people with I/DD and their families. | 1) Allocate funding to identify barriers to the development of healthy, safe relationships for people with I/DD;<br>2) Convene stakeholder group to make recommendations re: the development of policies and practices that advance healthy, safe relationships for people with I/DD;<br>3) Target selected strategies for advocacy/capacity building/systems change;<br>4) Assess effectiveness of advocacy/capacity building/systems change efforts;<br>5) Allocate funding to identify barriers to the inclusion of children and youth with I/DD in typical child and afterschool care settings or programs;<br>6) Convene stakeholder group to make recommendations re: the inclusion of children and youth with I/DD in typical child and afterschool care settings or programs:<br>7) Target selected strategies for advocacy/capacity building/systems change;<br>8) Assess effectiveness of advocacy/capacity building/systems change efforts. | 1) 10/01/2011 - 12/31/2011<br>2) 10/01/2011 - 09/30/2012<br>3) 10/01/2011 - 09/30/2012<br>4) 10/01/2011 - 09/30/2012<br>5) 10/01/2011 - 06/30/2012<br>6) 10/01/2011 - 06/30/2012<br>7) 10/01/2011 - 06/30/2012<br>8) 10/01/2011 - 06/30/2012 |
| 2.2 Council will fund training, consultation and technical assistance for parents and self-advocates to affect policies and practices that support integration, productivity, independence, and inclusion for people with I/DD and their families. | 1) Allocate funding for Partners in Policymaking™ program | 1) 10/01/2011– 06/30/2016 |
| 2.3 Council will provide resources to support the development of policies and practices for people with I/DD to have more options for living in the community, including living in a home that they or their families rent or own. | 1) Locate individuals with I/DD living in adult care homes in North Carolina who may be eligible for Home and Community Based waiver services, state-funded services, or any available Medicaid State Plan (i) option.<br>2) Provide advocacy, support to individuals with I/DD living in adult care homes to facilitate their transition from adult care homes to homes in community settings.<br>3) Assist at least six (6) individuals with I/DD in transitioning from an adult care home to home in the community. | 1) 9/1/2013- 8/31/2014<br>2) 9/1/2014- 8/31/2015<br>3) 9/1/2014- 8/31/2016<br>4) 9/1/2014- 8/31/2015<br>5) 9/1/2015- 8/31/2016 |

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| | 4) Identify and assess barriers to community living for individuals with I/DD.<br>5) Develop a "blueprint" to close the front door of adult care homes to people with I/DD and ensure the successful transition for people with I/DD who wish to live in the community. | |
| 2.4 People with I/DD have transportation options that are affordable, accessible, reliable, flexible and safe. | 1) Promote the participation of people with I/DD on local transportation boards to ensure local, state, and federal policy implementation. | 1) by 09/30/2016 |
| 2.5 People with I/DD will have access to the full range of needed primary and specialized health care services. | 1) Engage stakeholders in 6-7 information-gathering sessions.<br>2) Develop 6 data-informed, consumer profiles to improve the knowledge base on understanding the population, needs, utilization, costs and outcomes.<br>3) Identify process, cost and outcome data available and analytic options to improve the knowledge base re: relevant data.<br>4) Establish Community-Academic-Provider Consortium to support policy entrepreneurs in promoting quality assurance and sustainable system change.<br>5) Identify I/DD Medical and Health Home competencies necessary to the development of social strategies that contribute to robust professional expertise, enhanced practice support and educational requirements.<br>6) Develop actionable NC model of care, with readiness assessment tool.<br>7) Pilot test and evaluate enhanced medical/health home elements. | 1) 9/1/2013-8/31/2014<br>2) 9/1/2014-8/31/2015<br>3) 9/1/2014-8/31/2015<br>4) 12/1/2014 -3/31/2014<br>5) 3/1/2014-8/31/2016<br>6) 3/1/2014-8/31/2016<br>7) 6/1/2014-8/31/2016 |
| 2.6 People with I/DD will have access to the full range of needed primary and specialized health care services. | 1) Identify core content for a curriculum for training in pre-medical, medical, and post-graduate medical education in adult developmental medicine.<br>2) Develop an advisory group.<br>3) Secure Family Medicine residency training sites to pilot the curriculum.<br>4) Identify physicians within the practices who will participate in the study.<br>5) Residents in training will demonstrate care to patients that is reflective of the training in adult developmental medicine.<br>6) Curriculum and outcomes are presented at professional conferences.<br>7) Faculty and residents to complete an evaluation and self -assessment of the program. | 1) 1/1/2011-12/31/2011<br>2) 1/1/2011-12/31/2011<br>3) 1/1/2012 -3/31/2012<br>4) 4/1/2012 -5/31/2012<br>5) 6/1/2012 -5/31/2013<br>6) 6/1/2012 -5/31/2013<br>7) 12/1/2012 - 5/31/2013 |
| 2.7 Council will provide funding/resources that ensure accountability, advocacy, and outreach for its programs which improve the ability of service delivery systems to respond to the needs of people with I/DD and their families. | 1) Develop a stakeholder group that is cross-disability in mental health, developmental disabilities and addictive disease and is reflective of the geographic and ethnic diversity of the state.<br>2) Facilitate up to six stakeholder | 1) 9/1/2013 -10/31/2013<br>2) 11/1/2013 – 06/30/2014<br>3) 11/1/2013 -08/31/2014 |

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| | meetings/forums.<br>3) Prepare and disseminate white papers based on group discussions. | |
| 2.8 Council will fund training, consultation and technical assistance to support the development of policies and practices, relative to guardianship and alternatives to guardianship, that advance integration, productivity, independence, integration, inclusion and self-determination for people with I/DD. | 1) Develop Request for Application addressing guardianship and alternatives to guardianship for individuals with I/DD.<br>2) Select recipient(s) of funding and enter into contract(s).<br>3) Provide technical assistance to enhance the effectiveness of advocacy/systems change efforts.<br>4) Promulgate findings and target selected strategies for advocacy/system change interventions. | 1) 1/1/2014 – 3/31/2014<br>2) 7/1/2014 – 7/31/2014<br>3) 9/1/2014 – 8/31/2016<br>4) 5/1/2016 – 8/31/2016 |
| 2.9 Council will provide funding/resources to promote opportunities for people with I/DD to advance economic self-sufficiency by developing financial literacy and asset building skills. | 1) Develop Request for Application to assist in the assessment of policy barriers and benefits related to financial literacy/asset development and perseveration for individuals with I/DD.<br>2) Select recipient(s) of funding and enter into contract(s).<br>3) Provide technical assistance to enhance the effectiveness of community capacity building efforts.<br>4) Promulgate findings and target selected strategies for sustainable community capacity building. | 1) 1/1/2014 – 9/30/16<br>2) 1/1/2014 – 9/30/16<br>3) 1/1/2014 – 9/30/16<br>4) 1/1/2014 – 9/30/16 |
| 2.10 Council will provide funding/resources to implement and maintain an emergency preparedness program that is inclusive of persons with I/DD and that builds capacity for disaster preparation, emergency response, and related procedures and systems. | 1) Convene a Technical Advisory Board to advise with regard to persons with I/DD.<br>2) Communication - assess current emergency preparedness communication tools and trends to assure receipt of information and methods can be readily communicated and used effectively by persons with I/DD.<br>3) Medical - assess the incorporation of emergency preparedness training and disaster management.<br>4) Functional Independence - identify emergency preparedness programs in which persons with I/DD can be educated on early disaster response.<br>5) Supervision - establish a statewide standard to influence policy change, enabling the creation of an emergency preparedness plan for individuals with I/DD.<br>6) Transportation - in collaboration with NC Department of Transportation and NC Department of Public Instruction, survey, throughout the state, methods of transportation during evacuations or disasters for persons with I/DD. | 1) 9/1/2013-9/30/2014<br>2) 9/1/2013-9/30/2016<br>3) 9/1/2013-9/30/2016<br>4) 9/1/2013-9/30/2016<br>5) 9/1/2013-9/30/2016<br>6) 9/1/2013-9/30/2016 |
| 2.11 Council will provide funding/resources to provide people with I/DD with information to assist them in being safe from abuse, neglect, and harm and to equip direct support professionals and | 1) Release RFA on domestic violence to support the development of best practice-based, training curricula for direct support staff and domestic violence response staff to develop skills to improve prevention efforts | 1) 9/1/2013 – 12/1/2013<br>2) 11/2013<br>3) 1/1/2014 – 9/30/2016 |

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| domestic violence support staff with the tools to meet the needs of victims with I/DD. | and meet the needs of victims with I/DD<br>2) Select grantee<br>3) Execute first year of initiative according to grantee's approved work plan | |
| 2.12 Council will provide funding/resources to support groups led by people with disabilities to conduct initiatives that promote voluntary compliance with the Americans with Disabilities Act (ADA) in their local communities. | 1) Consult with groups of people with disabilities to develop ADA community initiative plans.<br>2) Provide follow-up, technical assistance and training to local groups to carry out their plans.<br>3) Conduct leadership and ADA training for 2 new, grassroots groups.<br>4) Processes reimbursement requests and in-kind match documentation from the NC ADA Network within 15 days or less of remittance. | 1) 7/1/2012-9/30/ 2016<br>2) 7/1/2012-9/30/2016<br>3) 7/1/2012-9/30/ 2016<br>4) 7/1/2012-9/30/ 2016 |

Intermediaries/Collaborators Planned for this goal (if known):
- [ ] State Protection and Advocacy System
- [ ] University Center(s)
- **[x] State DD Agency**

Division of Mental Health, Developmental Disabilities, Substance Abuse Services
Division of Aging and Adult Services
Grassroots advocacy groups
People with developmental disabilities
Human Services Research Institute
Partnerships in Assistive Technology
South Eastern Disability Technical Assistance Center

GOAL # 3: Supports - Workforce - Leaders/Professionals

Advocacy, capacity building and systems change efforts of the Council will improve the knowledge and skills of the workforce that serves people with intellectual and other developmental disabilities and their families.

Areas of Emphasis:
- **[x] Quality Assurance**
- [ ] Education and Early Intervention
- **[x] Child Care**
- **[x] Health**
- [ ] Employment
- [ ] Housing
- [ ] Transportation
- [ ] Recreation
- **[x] Formal and Informal Community Supports**

Strategies to be used in achieving this goal:

- [x] **Outreach**
- [x] **Training**
- [x] **Technical Assistance**
- [ ] Supporting and Educating Communities
- [x] **Interagency Collaboration and Coordination**
- [x] **Coordination with related Councils, Committees and Programs**
- [x] **Barrier Elimination**
- [x] **Systems Design and Redesign**
- [ ] Coalition Development and Citizen Participation
- [x] **Informing Policymakers**
- [x] **Demonstration of New Approaches to Services and Supports**
- [ ] Other Activities

Objectives/Implementation Activities/Timeline:

| **Objectives** | **Implementation Activites** | **Timeline** |
|---|---|---|
| 3.1 Council will expand, beyond the current number, the learners utilizing validated, evidence- and competency-based curricula for direct support workers who support people with I/DD. | 1) Allocate Funding to expand implementation of the College of Direct Support (CDS)/Direct Course to at least 14 or more sites;<br>2) Allocate funding to conduct research in 4 sites re: curriculum and learner development to improve model coherency;<br>3) Allocate funding to provide targeted technical assistance and consultation to CDS sites (CDS TA);<br>4) Present CDS to state Practice Improvement Collaborative as an evidence-based practice to promote statewide adoption;<br>5) Provide necessary supports to community college system to test pilot CDS curriculum, advancing career paths for DSPs;<br>6) Advocate for CDS to be a state-approved training and identify funding strategies for advancing CDS statewide as an approved training;<br>7) Assess effectiveness of CDS initiative; | 1) 10/01/2011 - 10/01/2016<br>2) 10/01/2011 - 10/01/2016<br>3) 10/01/2011 - 09/30/2012<br>4) 10/01/2011 - 12/31/2011<br>5) 10/01/2011 - 10/01/2016<br>6) 10/01/2011 - 10/01/2016<br>7) 07/01/2013 - 09/30/2016 |
| 3.2 Council will fund strategies to promote competency-based training for Care Coordinators and Community Guides who support people with I/DD. | 1) Develop Request for Application(s) for Care Coordination/Community Guides for individuals with I/DD.<br>2) Select recipient(s) of funding and enter into contract (s).<br>3) Provide technical assistance to enhance the effectiveness of advocacy/systems change efforts.<br>4) Promulgate findings and target selected strategies for advocacy/system change. | 1) 1/1/2014 – 3/31/2014<br>2) 4/1/2014 – 4/30/2014<br>3) 7/1/2014 – 8/31/2016<br>4) 5/1/2016 – 8/31/2016 |
| 3.3 Council will fund leadership training for I/DD professionals. | 1) Allocate funding to the National Leadership Consortium in Developmental Disabilities to modify Advancing Strong Leaders in DD, three-year curriculum to inform and educate NC professionals in the field of I/DD. (Advancing Strong Leaders Class I);<br>2) Allocate funding to the National Leadership | 1) 10/01/2011 - 12/31/2011<br>2) 10/01/2012 - 09/30/2016 |

| | | |
|---|---|---|
| | Consortium in Developmental Disabilities to modify Advancing Strong Leaders in DD curriculum to a one-year training, designed to inform and educate NC professionals in the field of I/DD. (Advancing Strong Leaders, Class II)<br>3) Assess effectiveness of initiative.<br>4) Present recommendations to Council.<br>5) Develop strategies for continuing to promote the development of leaders in the field of I/DD. | 3) by 09/30/2015<br>4) by 05/31/2016<br>5) by 09/30/2016 |
| 3.4 Council will fund training of other professionals that increases their ability to provide quality services to meet the needs of people with I/DD. | 1) Collaborate with the American Academy of Developmental Medicine and Dentistry and the Wal-Mart Foundation; the Family Medicine Education Consortium; the Assoc. of University Centers on Disability; and other strategic partners to advance the goal of embedding adult developmental medicine into the training of physicians in NC and the nation.<br>2) Recruit NC pilot sites for curriculum.<br>3) Collaborate with other Councils on Developmental Disabilities that are conducting primary health care initiatives, the AADMD, and other strategic partners to expand pilot demonstration of the curriculum to other states.<br>4) Host meeting with steering committee to consider next steps. | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - 09/30/2016<br>3) 10/01/2011 - 09/30/2016<br>4) 10/01/2011 - 09/30/2016 |
| 3.5 Council will explore approaches to provide funding/resources so that employment professionals will have the support, knowledge, skills, and values that will allow them to provide improved services in the area of employment to individuals with I/DD. | 1) Develop Request for Application for stakeholder group to assist in the assessment of policy barriers and benefits related to employment supports for individuals with I/DD.<br>2) Select recipient(s) of funding and enter into contract (s).<br>3) Provide technical assistance to enhance the effectiveness of employment professionals in community capacity building efforts.<br>4) Promulgate Findings and target selected strategies for sustainable community capacity building. | 1) 1/1/2014 – 9/30/2016<br>2) 1/1/2014 – 9/30/2016<br>3) 1/1/2014 – 9/30/2016<br>4) 1/1/2014 – 9/30/2016 |
| 3.6 Council will enhance the status of direct support professionals and promote the development of a highly competent human services workforce supporting individuals with I/DD. | 1) Plan and convene no less than 4 regional forums and one state-wide conference to educate the direct support workforce and general public about the benefits of a NADSP chapter in North Carolina.<br>2) Establish 501 (c)(3 ) status for a NC NADSP chapter with a board of directors, bylaws, and 100 members.<br>3) Assist in transitioning the NC NADSP chapter from being grant-supported to being independently supported. | 1) 3/1/2014 – 12/30/2014<br>2) 1/1/2015 – 12/30/2015<br>3) 1/1/2016 – 12/30/2016 |

Intermediaries/Collaborators Planned for this goal (if known):

**[x] State Protection and Advocacy System**
**[x] University Center(s)**
**[x] State DD Agency**

University Of Delaware
Muskie School of Public Policy
College of Direct Support

National Association of Direct Support Professionals
Faith Communities
National Health Law Project
Access Dental Medicaid EPSDT Training

GOAL # 4: Supporting/ Strengthening Self Advocacy Organization

Council will strengthen a statewide self-advocacy program.

Areas of Emphasis:

- [x] **Quality Assurance**
- [ ] Education and Early Intervention
- [ ] Child Care
- [ ] Health
- [ ] Employment
- [ ] Housing
- [ ] Transportation
- [ ] Recreation
- [ ] Formal and Informal Community Supports

Strategies to be used in achieving this goal:

- [x] **Outreach**
- [x] **Training**
- [x] **Technical Assistance**
- [x] **Supporting and Educating Communities**
- [x] **Interagency Collaboration and Coordination**
- [x] **Coordination with related Councils, Committees and Programs**
- [x] **Barrier Elimination**
- [x] **Systems Design and Redesign**
- [x] **Coalition Development and Citizen Participation**
- [x] **Informing Policymakers**
- [x] **Demonstration of New Approaches to Services and Supports**
- [x] **Other Activities**

Objectives/Implementation Activities/Timeline:

| **Objectives** | **Implementation Activites** | **Timeline** |
|---|---|---|
| 4.1 Council will provide opportunities for people with I/DD to provide leadership training to others. | 1) Support statewide self-advocacy efforts.<br>2) Allocate funding to support the development of a stronger state and local infrastructure for the Association of Self Advocates of NC (ASANC);<br>3) Allocate funding to support the development of a stronger state and local leadership;<br>4) Survey ASANC board and membership regarding satisfaction with performance of ASANC. | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - 05/30/2012<br>3) 06/01/2012 - 09/30/2013<br>4) by 11/30/2011 |

| | | |
|---|---|---|
| | 5) Make office space, supplies, and equipment available to support the ASANC. | 5) 10/01/2011 - 09/30/2016 |
| 4.2 Council will provide opportunities for people with I/DD to participate in cross-disability, culturally diverse, leadership coalitions and training opportunities. | 1) Support the development of a cross-disability coalition.<br>2) Assess the viability of the NC Disability Action Network as a foundation for efforts to build and strengthen a cross-disability coalition.<br>3) Allocate funding to build and strengthen a cross-disability coalition.<br>4) Select fund recipient.<br>5) Enter into contract.<br>6) Implement activities.<br>7) Assess effectiveness of efforts to build and strengthen a cross-disability coalition. | 1) 06/01/2013 - 9/30/2016<br>2) by 06/30/2013<br>3) by 02/28.2013<br>4) by 05/30/2013<br>5) by 07/01/2013<br>6) by 07/01/2013<br>7) by 09/30/2016 |
| 4.3 Council will assess the climate of the self-advocacy in NC to determine how best to support people with I/DD to be effective advocates at the local, regional, and state levels. | 1) Release funds to support a state-wide assessment of the goals,of local self-advocacy groups and barriers and opportunities to achieving these.<br>2) Recruit and train 3 Advocacy Ambassadors from among the I/DD community.<br>3) Advocacy Ambassadors will survey self-advocacy groups across NC to determine their goals and barriers and opportunities to achieving these and submit findings to Council.<br>4) Develop a set of recommendations for how the NCCDD can best support statewide self-advocacy based on feedback gathered. | 1) 9/1/2013 – 8/31/2014<br>2) 9/1/2013 – 10/31/2013<br>3) 11/1/2013 – 3/31/2014<br>4) 4/1/2014 – 8/31/2014 |
| 4.4 Council will provide funding/resources to assist siblings of individuals with I/DD in providing informal and natural supports for a brother or sister. | 1) Develop Request for Application for supporting siblings of individuals with I/DD.<br>2) Select recipient(s) of funding and enter into contract(s)contract(s)contract(s).<br>3) Provide technical assistance to enhance the effectiveness of advocacy/systems change efforts.<br>4) Promulgate findings and target selected strategies for advocacy/system change. | 1) 11/2013 – 8/2014<br>2) 3/2014 – 8/2014<br>3) 9/2014 – 8/2015<br>4) 9/2015 – 9/2016 |

Intermediaries/Collaborators Planned for this goal (if known):

**[x] State Protection and Advocacy System**
**[x] University Center(s)**
**[x] State DD Agency**

Association of Self Advocates of North Carolina (ASANC)
State entities that administer funds related to I/DD

GOAL # 5: Council Quality Assurance/Operations

Council Quality Assurance/Operations

Areas of Emphasis:

**[x] Quality Assurance**
[ ] Education and Early Intervention
[ ] Child Care
[ ] Health
[ ] Employment
[ ] Housing
[ ] Transportation
[ ] Recreation
[ ] Formal and Informal Community Supports

Strategies to be used in achieving this goal:

[ ] Outreach
**[x] Training**
**[x] Technical Assistance**
[ ] Supporting and Educating Communities
[ ] Interagency Collaboration and Coordination
[ ] Coordination with related Councils, Committees and Programs
[ ] Barrier Elimination
**[x] Systems Design and Redesign**
[ ] Coalition Development and Citizen Participation
[ ] Informing Policymakers
[ ] Demonstration of New Approaches to Services and Supports
**[x] Other Activities**

Objectives/Implementation Activities/Timeline:

| **Objectives** | **Implementation Activites** | **Timeline** |
|---|---|---|
| 5.1 Council will provide funding/resources that ensure accountability, advocacy, and outreach for its programs. | 1) Allocate funding for the development and monitoring of the NCCDD State Plan to ensure accountability for Goal I programs;<br>2) Coordinate and conduct Program Management activities associated w/ the development and monitoring of the St. Pl. to ensure accountability for programs under this goal;<br>3) Implement the "Route to Success" model as a means of monitoring & ensuring accountability for programs under this goal;<br>4) Conduct evaluation to assess impact of selected State Plan Programs. | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - 09/30/2016<br>3) 10/01/2011 - 09/30/2016<br>4) 10/01/2011 - 09/30/2016 |
| 5.2 Council will provide funding/resources that promote individuals with I/DD and families participating meaningfully in public policy deliberations. | 1) Allocate funding for assistance from a policy analyst to enhance the NCCDD's advocacy for sustainable systems change | 1) 10/01/2011 - 09/30/2016 |
| 5.3<br>Council will provide funding/resources that promotes awareness of its initiatives. | 1) Allocate funding from Communications Initiative to provide marketing and outreach for initiatives.<br>2) Create accessible communication materials.<br>3) Strengthen media relations to further the | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - |

| | | |
|---|---|---|
| | image of the Council and its programs.<br>4) Work with grantees to promote the objectives of the grant and assist in any marketing/recruitment efforts required for the initiative. | 09/30/2016<br>3) 10/01/2011 - 09/30/2016<br>4) 10/01/2011 - 09/30/2016 |
| 5.4 Provide individuals with I/DD and family members/guardians of people with I/DD with opportunities to attend in-state and national events, educating participants with regard to systems change, advocacy and capacity building activities that are consistent with the NCCDD's mission. | 1) Select five advisory committee members for the Rossi Fund from the NCCDD Council. Identify a coordinator and establish a personal service contract.<br>2) Process applications according to Rossi Fund guidelines, including sending letter of receipt to applicant, review of application and event brochure, approval or denial letter created/sent with reimbursement and survey form or copy of guidelines to applicant.<br>3) Ensure that reimbursement is submitted upon applicant's return from event.<br>4) Maintain Rossi Fund demographics and performance data and provide quarterly, usage, status reports to NCCDD. | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - 09/30/2016<br>3) 10/01/2011 - 09/30/2016<br>4) 10/01/2011 - 09/30/2016 |
| 5.5 Enhance NCCDD membership decision-making skills and abilities regarding board participation, and state and national practices and policies affecting people with I/DD and their families. | 1) Coordinate presentations for quarterly Council meetings by local, state, and national experts on topics in, or planned for inclusion in, the NCCDD State Plan.<br>2) Develop contract with presenters approved by Executive Committee.<br>3) Secure Program Report from contractor.<br>4) At least annually, provide board membership training to new and existing members. | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - 09/30/2016<br>3) 10/01/2011 - 09/30/2016<br>4) 10/01/2011 - 09/30/2016 |
| 5.6 Sponsors content expert speakers to present at 10 in-state or national conferences on topics in or planned for inclusion in the NCCDD State Plan. | 1) Market NCCDD Conference Funding initiative on website and in NCCDD newsletter.<br>2) Process conference funding application requests, then provide to Council Executive Committee for review and funding consideration<br>3) Following Executive Committee approval, develop and enter into contract.<br>4) Secure conference funding report from contractor. | 1) 10/01/2011 - 09/30/2016<br>2) 10/01/2011 - 09/30/2016<br>3) 10/01/2011 - 09/30/2016<br>4) 10/01/2011 - 09/30/2016 |

Intermediaries/Collaborators Planned for this goal (if known):

[ ] State Protection and Advocacy System
[ ] University Center(s)
[ ] State DD Agency

## Section V: Evaluation Plan [Section 125(c)(3) and (7)]

○ Outline how the Council will examine the progress made in achieving the goals of the State Plan.
○ Explain the methodology, which may be qualitative or quantitative, thatwill be used to determine if th
met and if the Council results are being achieved.
○ Describe the Council's role in reviewing and commenting on progress towards reaching the goals of tl
○ Describe how the annual review will identify emerging trends and needs as a means for updating the (
PART A: Outline:
The North Carolina Council on Developmental Disabilities (NCCDD) has adopted a logic model that underscores all of its work. Called "Route to Success," this model was developed over five years by the Pennsylvania DD Council and The Human Services Research Institute. The model describes system change as the result of a collection of coordinated activities that have been shown in field tests in Pennsylvania, and through the model's use in other forums, to be necessary for effective systems change to take place. The NCCDD's mission - to ensure that people with DD and their families participate in the design of and have access to culturally competent services and supports, as well as other assistance and opportunities, which promote inclusive communities, encapsulated as "building bridges to community" -- as supported by the DD Act, guides the Council's efforts. These efforts move the state towards building supports, policies and practices that engage people with I/DD and their families in the planning and living of their own lives. Ensuring the existing systems – both funded and informal – respond to and respect people with I/DD and their families requires a migration towards embracing the full participation of people with and without disability in those lives. The Route to Success model reflects the range of activities that system change requires, and describes these activities so that Council members, staff, grantees and other stakeholders can monitor NCCDD's efforts and NCCDD can plan for appropriate next steps.

Goals and Objectives in the Five-Year Plan have been developed using language that references the model and the importance of the five major activities it describes: 1)
expanding the knowledge base; 2) using social strategies – research; 3) creating stakeholder will; 4) supporting policy entrepreneurs – champions; and 5) using unexpected events. Activities arising from these Goals and Objectives use specific language from the model, and the Council will use both qualitative and quantitative measures to examine progress. Over the course of five years, activities of each of these types will combine in a planned way to inspire various systems of services to be more consistent with what the Council goals and the DD Act define. Evaluation of the plan's goals will address both the input/process – are the activities described in the plan being conducted as intended? – and the output/result – did the initiative achieve what NCCDD hoped it would? Using a variety of strategies to monitor will enable Council members and staff to determine both the reliability of the work and its results over time. Goal statements represent the description of the results to be achieved.

PART B: Methodology to determine needs being met and Council results being achieved:
Detailed study, over the course of Route to Success's development, indicates that the model successfully describe the events that lead to accomplishing Council goals. The model has meaning to Council members, staff, and grantees, who understand and appreciate the variety of activities described. The model uses action verbs so activities can be measured, even if the measuring is complex. Measuring the success of activities in "expanding the knowledge base:" this column will include selected AIDD performance measures, along with benchmarks and information from "Residential Services for Persons with DD: Status and Trends;" "State of the States;" the National Core Indicators; NCCDD's "Strategic Analysis for Change" (a gap analysis developed by HSRI); the State Employment Leadership Network (SELN, ICI-Mass.); the data collection instrument in the College of Direct Support; NCCDD's Alliance for Full Participation initiative; and, specific to the self -advocacy goal, NCCDD's self-advocacy benchmark tool known as "Power UP."

The NCCDD inputs are the resources used to support achieving goals; these resources are countable. They may be Council resources (funding, staff or NCCDD member time); or activities conducted outside NCCDD that are consistent with Council goals and objectives, but which the NCCDD does not sponsor. For example, if the NCCDD were conducting a needs assessment, it would count as an input the funding, staff time needed, and the number of survey responses. If, at the same time, a professional association in the state decided to develop an online in the topical area for the needs assessment, the Council could count that effort as an input toward its goal.

Outputs are also counted. Some outputs will be immediate. Others will be longer term and reflect the complex process of achieving Council goals.

Outcomes are harder to measure. In fact, it may be necessary to look at many outputs over several years to see if attitude change, knowledge level, research results, the work of diverse stakeholders and champions, and the many unforeseen happenings along the way have actually achieved Council goals. Has the work of the Council accomplished its goals, embodied its mission and achieved long-term societal benefits that are identified in the DD Act?

Formative strategies are used throughout the Council's work. These are complemented by rigorous data gathering, as well as independent evaluation of funded initiatives. Principal among these is the regular meeting between grantees and Council staff, for review of activity plans, successes and barriers, and adjustments that might be required for the project to move forward as planned.

PART C: Council's role in reviewing and commenting on progress of the Plan Goals:
Grantees report activities throughout the grant cycle, and the staff reports grantee efforts, consistent with the Five-Year Plan. The DD Suite tool enables the Council to track efforts to assure coherence with this plan. In addition to formal reporting to AIDD, grantees' efforts are reviewed regularly by the various Council committees and associated staff, so that members are fully informed about the work of grantees, about the correlative work of staff, and have frequent opportunities to tie their knowledge of efforts outside the Council to the work being supported with Council resources. The NCCDD meets quarterly, along with its committees; its Executive Committee meets on a monthly basis, per need, when the Council is not is session. Regular reports on initiatives are made to the full Council at each quarterly meeting, so that all Council staff and members know how the Plan is being implemented. Of particular importance are those areas where implementation may be going less well. For initiatives that find barriers to implementation and for other efforts that experience less success than expected, reports made to the Council engage the expertise of both its members and staff in collaboration with fund recipients to finding solutions to problems. When substantive changes are required, these are reported in the annual update of and amendment to the Plan.

In this area, "Route to Success" is especially helpful. By using the model in initiative design, grantees are encouraged to focus their efforts on targeted system change activities. There is clarity from the beginning of an initiative about the nature of its work, its intended inputs and outputs, and a clear sense of how the initiative contributes to a greater effort that will result in system change. Committee and Council members know what to expect from each funded endeavor and are prepared for the potential obstacles that may arise. Members bring a wider perspective because of the nature of their own Council activities and life experiences.

This breadth of activity serves the NCCDD in another way. Because of the broad scope of community connectedness of Council members, each is able to make linkages between NCCDD's work and work outside Council resources. A Council member that, e.g., sits on an advisory board for a state organization can facilitate connections between the Council initiative and the relevant organization's efforts, fostering collaboration and maximizing Council resources. Some systems are complex; it may beyond the power of the Council alone to bring about needed system change. By insuring that all NCCDD members and staff have good knowledge about the broad array of the Council's work, the NCCCDD can insure that the members serve as resources to initiatives, as well as encouraging work on activities outside the NCCDD that is related to its goals and objectives.

PART D: How the annual review identify trends and needs and for updating the Comprehensive Review and Analysis section:
Council members are ideally positioned to develop perspectives that range from the very broad, national level to the very detailed – what is happening in one of the North Carolina counties. The NCCDD staff regularly informs Council members about national initiatives, national issues, and provide information about any state policy and practice. There are regular Member Forums at each Council meeting where new information is shared; additionally, interested Council members are encouraged to participate in national and state venues and bring their perspective back to the Council.

The North Carolina Council, with support from the NCCDD's Council Development Fund, the Information and Technical Assistance (TA) Center for Councils on DD, and AIDD itself, periodically hosts and attends national meetings, as well as meetings of neighbor Councils, to discuss issues at the regional and national level. Members and staff take what they learn back to their committees and the Council as a whole. Connections are made at these meetings so that an informal network develops and is able to share information.

Participation on the Council of state and regional agency representatives, along with legislators, further enables NCCDD to access policy and practice decisions that are being made at the agency level. Dialogue with agency staff broadens the forum for discussion. This broader perspective contributes to realizing the Council's mission - to enable inclusive communities, not just for people with I/DD but for all people in North Carolina. By reflecting the issues that face people with I/DD, in the context of their communities, the Council is able to affect the viewpoint of the agencies responsible for the delivery of services and supports.

Added to these broad points of view is the data that emerges from Council initiatives and the personal experiences of Council members. This combination of quantitative and qualitative material provides a powerful and comprehensive "state of the state" in North Carolina and a backdrop against which to review new findings from new Council initiatives. The opportunity to compare and contrast the "big picture" with personal experience, or what's happening in two different parts of the state, or what an initiative planned and what the initiative is finding during implementation, enables NCCDD to explore the reasons for differences, the power of the data, and to share what it learns with those in positions of power across the state. With the constants of the DD Act and the Council mission, members and staff identify what works, what should work, and what doesn't work in North Carolina, and discuss these issues with the national experience as the point of reference.

## Section VI: Projected Council Budget [Section 124(c)(5)(B) and 125(c)(8)]

| Goal | Subtitle B $ | Non-Federal Share $ | Total $ |
|---|---|---|---|
| 1. Supporting/ Strengthening Self Advocacy Organization | 204927.00 | 42182.00 | 247109.00 |
| 2. Supports - Workforce - Leaders/Professionals | 391688.00 | 86729.00 | 478417.00 |
| 3. System Response to People's Needs | 778962.00 | 85277.00 | 864239.00 |
| 4. Transition | 154175.00 | 33859.00 | 188034.00 |
| 5. General Management | 557670.00 | 43779.00 | 601449.00 |
| 6. Functions of the DSA | 31214.00 | 31214.00 | 62428.00 |
| 7. TOTALS | 2118636.00 | 323040.00 | 2441676.00 |

## Section VII: Assurances [Section 124(c)(5)(A)-(N)]

Written and signed assurances have been submitted to the Administration on Intellectual and Developmental Disabilities, Administration for Community Living, United States Department of Health and Human Services, regarding compliance with all requirements specified in Section 124(c)(5)(A-N) in the Developmental Disabilities Assistance and Bill of Rights Act of 2000:

**[x] Assurances submitted**

Approving Officials for Assurances:

**[x] For the Council (Chairperson)**
**[x] For DSA, when not Council**

## Section VIII: Public Input and Review [Section 124(d)(1)]

PART A: How the Council made the plan available for public review and comment and how the Counc
accessible formats of the opportunity for review and comment.
The 2012 Draft Amendments were released in two phases. The first set of amendments were approved at the August 2012 Council meeting. The second set were approved at the November 2012 Council meeting. Both sets of amendments had extensive marketing efforts from the Council's Communications initiative. The full plan, reflecting "track changes", was featured on the NCCDD website in word doc, pdf, and text format. The revised plans was distributed via the NCCDD mailing distribution list as an attachment to an electronic mail announcement. The draft amendments were available in braille and digital format upon request.

PART B: Revisions made to the Plan after taking into account and responding to significant comments.
Public comment on the NCCDD draft goals and objectives were favorable and didn't require revisions to the initial plan. Survey results attached.

The draft amendments released June 2012 included only technical and grammatical revisions. Two public comments were received. One asking if the amendment document was available in Spanish; the other comment suggested that information in Section III, Part B, viii (transportation) be elaborated on with more detail provided on transportation in rural areas.

Comments regarding substantial amendments to the five year plan were collected between August and September 2012; release for public input followed. The Council received public comments encouraging the addition of sexual violence prevention and emergency preparation to the State Plan. Revisions to the State Plan were made based on public comments received. The revisions were approved at the NCCDD quarterly meeting in November 2012.