

Southern Wisconsin Center

Chapter 50 Voluntary Resident Relocation Plan

INTRODUCTION AND OVERVIEW

On February 12, 2009, Department of Health Services (the Department) Secretary Karen Timberlake announced the Department's intent to restructure services at Southern Wisconsin Center (SWC) over the course of the next 28 months. This restructuring initiative reflects current federal and state policies and trends regarding opportunities for individuals with developmental disabilities to live in community settings. The initiative has two key elements: Community relocation of SWC residents will be accelerated with the potential of relocating 100 people on a voluntary basis by June 30, 2011; and, over the same period of time, the SWC short term Intensive Treatment Program (ITP) will be expanded from 10 to 30 beds. The restructuring initiative will be conducted with utmost respect for residents, parents, families, guardians and staff.

This is a unique Ch 50 Resident Relocation Plan submission. It is unique because it was designed, developed and drafted in partnership with the advocacy agencies Disability Rights Wisconsin and the Long Term Care Ombudsman Program. It is also unique because of its initial emphasis on outreach and education to various stakeholder audiences, most importantly parents and guardians. More traditional resident relocation activity is present from the beginning, but this activity is not likely to gain momentum for several weeks or even months.

People with developmental disabilities in Wisconsin and across the nation live full lives in the community. Federal policy, including a US Supreme Court decision, requires that people with disabilities be served in the most integrated setting, least restrictive setting. Wisconsin has a strong commitment since the 1980's to support individuals with developmental disabilities in the community through Medicaid home and community-based programs. Over the years, the knowledge, capacity and technology to support individuals in the community have grown significantly. In Wisconsin, 94% of publicly funded individuals with developmental disabilities already live in the community, enabling them to live with or to be near families and friends and engaged in community activities.

The long-term population at SWC has declined steadily since 1960, as people with developmental disabilities increasingly choose to live in community settings. The number of individuals with developmental disabilities living in community settings has increased significantly. In the past twenty years, the long-term population has declined by two-thirds, falling from 600 to less than 200. Since 2003, more than 800 individuals with developmental disabilities have successfully relocated from institutional to community settings. SWC's role in serving people with developmental disabilities is changing in response to these emerging trends and needs. These individuals may periodically need short-term, intensive and specialized services. To meet this increased need, SWC will expand its short-term Intensive Treatment Program (ITP) from 10 to 30 beds.

The four pillars of the SWC Restructuring Initiative are: Work with SWC residents and their families and guardians to develop an individualized relocation plan that meets each person's unique needs. Provide support and assistance to SWC employees to identify and pursue alternative employment or other options. Maintain a high level of care for SWC residents throughout the transition. Implement an expanded, high quality, state-of-the-art short-term intensive treatment program.

DEPARTMENT ORGANIZATION OF THE SWC RESTRUCTURING INITIATIVE

The Department is establishing a strong project management structure to support the initiative. Teams will be established in each major substantive area, including resident relocation, personnel/human resources, daily operations, facilities, and fiscal. Each team will include members from the Department, as well as other state agencies and stakeholder groups, with the specialized knowledge and experience related to the issue area.

To assure the restructuring of SWC is accomplished successfully, an Oversight Committee has been established by Secretary Timberlake. It is composed of SWC staff, management, and parents/guardians to advise on the initiative, particularly the quality of community placements and the support provided to staff as positions are reduced. In addition, Secretary Timberlake has designated Sandy Paulson as SWC Family Liaison expressly for this initiative. Sandy is the contact person for family and guardians to ensure that questions and concerns are addressed promptly.

As required by Wisconsin law, a Resident Relocation Team comprised of a broad range of stakeholders with developmental disabilities expertise has been formed and will oversee all aspects of resident relocation, including each resident's community placement. Core Relocation Team members include the Department's Division of Long Term Care leadership; SWC leadership and the SWC discharge specialist Todd Redalen; representatives from advocacy agencies Disability Rights Wisconsin and the Long Term Care Ombudsman Program; and the residents' respective county/Aging and Disability Resource Center (ADRC)/Managed Care Organization (MCO). Many other internal and external expert stakeholders will participate as well. Protected Health Information security and resident/parent/guardian confidentiality will be respected at all times.

The well-being of the staff who serve SWC residents contributes to the quality of care and quality of life experienced by the residents. The Department is committed to supporting SWC employees and their needs during the course of the restructuring. An employee Transition Monitoring Team has been established to review the transition from the staff perspective, bring employee concerns to managers, and facilitate effective communication between managers and staff. Staff reductions will take place gradually as resident relocations occur. Every possible effort will be made to achieve the reductions through attrition. The Department will provide support and assistance to SWC employees in identifying and pursuing employment or other options as positions are reduced at SWC.

BRIEF OVERVIEW OF RESIDENT RELOCATION

When a guardian decides to relocate their resident to the community, an individualized relocation plan is developed to meet the resident’s unique needs and interests. The plan will be developed in full collaboration with the resident and his/her family and guardian. SWC staff most knowledgeable about each resident will be involved in the development of the relocation plan. Individuals will be relocated only after their individualized plan, which has been developed to ensure their health and safety and to meet their individual needs, has been approved and signed by the guardian.

The health and safety of residents relocating from SWC is paramount. Safeguards and protections are in place to ensure the health and safety of individuals with developmental disabilities who live in the community. Each individual has a case manager(s) from the county or Family Care staff who is actively engaged with the individual and guardian. Department regulatory staff inspect and monitor community-based providers for compliance with health and safety standards. Each individual’s new placement will be monitored on a regular basis; specifically, at 30 days, between 60 & 90 days, and at 1 year. These reviews include interviews with guardians. The Department, county, Family Care and advocacy staff have the capacity and systems to respond quickly to any concerns that arise.

OFFICIAL NOTICE OF PROPOSED VOLUNTARY RESIDENT RELOCATION AND COMPLETION DATE AS REQUIRED BY CH 50, WIS STATS.

The Division of Long Term Care, licensed operator of Southern Wisconsin Center Intermediate Care Facility for persons with Mental Retardation (ICF-MR), hereby notifies the Division of Quality Assurance, which regulates Southern Wisconsin Center on behalf of federal and state government, of its intent to relocate 100 residents to the community on a voluntary basis by June 30, 2011.

EVENTS TIMELINE TO DATE

February 12, 2009	Public Announcement of Restructuring Initiative
February 12, 2009	Notification of Union Leadership, Employees, Legislators, Advocacy Agencies, High Impact Counties/ADRCs/MCOs, Other State Departments/Agencies
February 12, 2009	Public Announcement of the Restructuring Initiative which includes Voluntary Resident Relocation
February 15, 2009	Family and Guardian Meeting
February 23, 2009	Family and Guardian Meeting (disc recording available)
March 5, 2009	Department Stakeholders Engagement Meeting
March 6, 2009	Core Relocation Team Formed and Began Weekly Meetings to Design Voluntary Resident Relocation Approach and Draft Ch 50 Resident Relocation Team
March 17, 2009	Follow Up Letter to Parents and Guardians
March 22, 2009	Oversight Monitoring Committee Formed
March 22, 2009	Transition Monitoring Team Formed
April 1, 2009	Submit Ch 50 Plan to DQA
April 6, 2009	Family Liaison Announcement (Sandy Paulson)
April 15, 2009	Ch 50 Plan Approval
April 1-15, 2009	Train Staff re Initial Guardian Contact
April 20-May 8, 2009	Conduct Initial Guardian Contact

CONCURRENT KEY ACTIVITIES FOR VOLUNTARY RESIDENT RELOCATION

Outreach and Education: Unique and tailored outreach and educational activities about the voluntary resident relocation initiative designed specifically for parents and guardians will be conducted. Outreach and educational events for various agencies and professionals within the Department of Health Services and other state agency staff will also occur. County/Aging and Disabilities Resource Center (ADRC)/Managed Care Organization (MCO) staff, community residential providers, and community health and social service providers will participate in various events as well.

Resident Relocation: Guardians who wish to proceed with planning for community placement of their resident will engage in the resident relocation process as described later in this document.

OUTREACH AND EDUCATION STRATEGIES

SWC will employ individualized, resident by resident/guardian by guardian approaches in its outreach and education efforts. All residents' guardians will be contacted by SWC staff to be sure the guardian is informed about the voluntary relocation initiative and to inquire whether the guardian is interested in further conversation with SWC relocation staff about it. Guardians who agree to further conversation will then meet individually with the right mix of staff experts to respond to the guardian's questions, needs and interests. These meetings will occur at the time and place most convenient for the guardian. Many other outreach and education strategies tailored for individual families and guardians will occur. Some examples are a guardian-to-guardian mentoring program, access to advocacy, county/ADRC participation in resident annual review meetings, community provider fairs, and informational mailings.

Outreach and education efforts for counties, ADRCs and MCOs will be undertaken county-by-county based on their unique organizational structures; their long term care delivery systems; and the number of guardians wishing to explore community relocation. The Ch 50 Resident Roster is sorted by county given the crucial differences between counties. For example, some counties still operate in the traditional community waiver model while other counties operate Family Care managed long term care programs. In both waiver counties and Family Care counties residents relocating from institutional settings have priority and funding therefore the residents are not subject to wait lists.

Outreach and education for community providers is an important component of this Ch 50 Plan as well. Residential providers as well as health and social services providers make community living possible for persons with developmental disability. Their understanding of the SWC voluntary resident relocation initiative prepares community providers to build needed capacity. When a guardian chooses to explore the opportunities community living offers, community providers will be asked to describe how their care and services would meet the residents individual needs.

The more traditional components of a facility Resident Relocation Plan, as required by Ch 50, Wis. Stats., is the next section of Southern Wisconsin Center's Plan. It is written in Question and Answer format to be reader friendly for all stakeholders and to facilitate Division of Quality Assurance review utilizing the Department's Resident Relocation Manual checklist. The Division of Long Term Care Flowchart describing the Chapter 50 Resident Relocation Process for Intermediate Care Facility for persons with Mental Retardation (ICF-MR) is attached (attachment aa)

1. Q: How will access to advocates including their contact information be made known to guardians?

A: SWC Family Liaison Sandy Paulson will make advocacy contact information known through a letter. Center staff will also share advocacy contact information with interested guardians. Discharge notices required by state and federal law will also list advocacy contact information. (attachment aaa)

2. Q: How will Southern Wisconsin Center engage counties, Aging and Disability Resource Centers (ADRC), and Managed Care Organizations (MCOs)?

A: Southern Wisconsin Center will support and facilitate engagement with counties, Aging and Disability Resource Centers, and Managed Care Organizations. When a guardian has decided to proceed, the Southern Wisconsin Center Qualified Mental Retardation Professional or Administrator will collaborate with SWC Community Integration Staff to schedule an initial planning conversation. It will include the individual, the guardian, and the County Adult Protective Placement designee. They will discuss/identify a plan of action, which could result in referral to the Aging and Disability Resource Center for Options Counseling. Guardians may also choose to visit various community services providers or talk with other guardians at this time. If a thorough investigation of options results in a desire by the guardian, on behalf of their resident, to develop a transition plan, Center staff will work collaboratively with counties, ADRCs and MCOs to ensure a well planned and smooth transition.

3. Q: How will Southern Wisconsin Center engage advocates?

A: Advocacy agencies Disability Rights Wisconsin and the Ombudsman Program are already engaged. Both agencies participate on the Ch 50 Resident Relocation Team that began meeting on March 6, 2009 and both agencies assisted the facility in drafting this Ch 50 Plan. When a guardian voluntarily expresses interest in exploring community living options, SWC Community Integration Staff will once again share advocacy contact information with the guardian. Guardians may choose to seek support and/or formal representation from an advocacy agency at any time.

4. **Q: How will Southern Wisconsin Center engage residents, families and guardians?**

A: Several action steps to engage residents, families and guardians on a voluntary basis have already occurred. Family meetings were held on Feb 15 and 23, 2009; and two letters from Secretary Timberlake have been mailed to all guardians on February 12 and March 17. A third letter will be sent to families and guardians announcing Family Liaison Sandy Paulson on April 6, 2009. As a standing part of the Annual Review process, the guardian, county representative and Interdisciplinary Team discuss interest in transition planning. During April 2009, guardians will be contacted on an individual basis to determine each guardian's interest in the possibility of community living for their resident.

5. **Q: How will Southern Wisconsin Center prevent or minimize relocation stress?**

A: Center staff will receive training in Relocation Stress Syndrome from the Department's expert nurse consultant. This training will also be made available to the community providers that are receiving relocating residents. Transition to community living is a slow, deliberate and carefully planned process, often occurring over several months time. It includes scheduled visits to receiving residential and services providers, and may include overnight stays to gradually orient the resident to their new home. SWC staff who are familiar with the resident will accompany the resident on such trial visits as determined by the discharge plan. Following relocation the community, knowledgeable staff from SWC remain available to receiving providers to answer questions, offer guidance, and train their staff to best implement their new client's residential, treatment and service plans.

6. **Q: How will Southern Wisconsin Center engage physicians?**

A: SWC physicians know SWC residents well. They frequently assess and revise residents' medical care plans and direct their care. Relocating residents' SWC physician will participate in the resident's discharge planning process to assure continuity of care and to address any concerns regarding relocation stress. Physicians from Central Wisconsin Center are also part of the medical team for each relocating resident. Community physicians, who are new to the resident, will be given a comprehensive medical packet of information. The resident's SWC medical team will be available to consult with the resident's new community physician. The Nursing Specialist will make sure that this line of communication is established so that all necessary information is shared effectively. The packet will include a Discharge Medical Summary and Plan of Care, F-22656 (attachment a), given to the community physician at Well Visits that occur in preparation for each resident's transition to community living. Well Visits involve the Nursing Specialist from the Community Relations Team, the client, and care staff from the receiving facility.

7. **Q: What is the resident relocation role of Southern Wisconsin Center licensed or credentialed staff including Registered Nurse, Social Worker, Qualified Mental Retardation Specialist, Physical Therapist, Occupational therapist, Registered Dietician, Activities Director and Chaplain?**

A: Under the guidance of the QMRP, all interdisciplinary team members contribute to the completion of a comprehensive discharge report for each resident before community placement occurs. These reports describe the person's current functioning level and what supports may be needed for living in a community setting. This information is

shared at interdisciplinary meetings convened for community placement purposes such as Transition Planning Meetings, and at formal discharge meetings.

8. Q: How is resident and guardian choice accomplished?

A: Guardians are central to every action step taken in planning for their resident's transition to community living. The assessment and planning process necessary for transition to the community occurs only with the guardian's consent and their active participation. Center staff will partner with the guardian to develop a comprehensive transition plan that supports the outcome priorities of each resident.

9. Q: How does Southern Wisconsin Center make sure Resident Rights are known?

A: Upon admission, client rights are discussed with the guardian and resident as stated in the Admission and Consent to Treatment Agreement- Centers, F-22000 (attachment b). A copy of SWC Administrative Bulletin 6.01, Client's Rights Policy (attachment c), is available to guardians at all times. The Center's Client's Rights Policy complies with rights enumerated in Wisconsin state statutes Chapter 48, 51, 54, 55, 971, 975, and 980. Any questions or issues a guardian may have about resident's rights that cannot be answered by Center's Administrative Staff are referred to a Department Client's Right's Specialist attorney. In addition, guardians may seek support and representation from advocacy agencies such as Disability Rights Wisconsin and the Ombudsman Program.

10. Q: How does Southern Wisconsin Center manage grievances and complaints?

A: Complaints and grievances are managed according to the SWC Administrative Bulletin 6.01/1, Client's Rights Complaints Stages (attachment d), which complies with Division of Long term Care Directive 20.01.01 "Client's Rights Grievance Resolution Process". Copies of these documents are available to guardians at any time. Advocacy agency representatives from Disability Rights Wisconsin and the Ombudsman Program are especially skilled at resolving resident and guardian complaints and grievances. They may be asked by the guardian to assist.

11. Q: What is Southern Wisconsin Center's policy on room transfers?

A: Room transfers at SWC meet HFS 134 requirements at 134.54. Meeting residents' care needs and accommodating their preferences are critical factors to consider when room transfers become necessary. Room transfers are assessed by the Interdisciplinary Team. If a room transfer referral is for the same living area (same cottage), the resident's IDT will make their recommendation to the Unit Director. If a different living area or cottage is recommended, the current QMRP completes a Living Unit Transfer Referral request. The SWC Transfer Committee will meet to discuss options and generate recommendations. These recommendations are evaluated by interdisciplinary teams from proposed living areas. These teams make recommendations back to the Transfer Committee. Guardian participation as IDT members is highly sought and encouraged at this phase. Guardians may appeal room transfer decisions through the SWC grievance procedure.

12. Q: How does Southern Wisconsin Center address residents' special needs such as psychological, behavioral, physical disabilities and durable medical equipment?

A: Interdisciplinary team members with expertise related to any resident's special needs are consulted on an individual, resident by resident basis. Team member experts contribute

to each resident's comprehensive treatment and service plans specific to their area of expertise. For the purpose of relocation to the community and to ensure the special needs of each resident are met in the community, these experts will complete comprehensive assessments, participate in developing the resident's transition plan, attend planning and discharge meetings, and conduct post relocation outcome evaluations. The procurement of Durable Medical Equipment to support the resident's community placement will be discussed at discharge planning meetings. Appropriate staff persons/agencies will be assigned to coordinate procurement. The Division of Long Term Care and the Division of Health Care Access and Accountability (Wisconsin Medicaid Program) will collaborate to assure a smooth procurement process is instituted.

13. Q: How will Southern Wisconsin Center meet federal and state discharge notice requirements (7 day, 30 day and 30 day waiver of notice)?

A: Required discharge letters and notices will be issued timely according to federal and state law. Their content will be reviewed and approved by the Ch 50 Resident Relocation Team. SWC discharge letter templates and the discharge notice requirements and templates contained in the Department's Resident Relocation Manual (attachments e) will be combined and adapted to meet 7 day and 30 day notice and waiver of notice requirements. Each resident's discharge date is determined mutually by the guardian, the Center, receiving providers, and the county/Managed Care Organization. Additional stakeholders such as advocacy representatives and other state agencies may also be involved in determining a resident's discharge date.

14. Q: What are Southern Wisconsin Center's resident discharge protocols?

A: See 14a thru 14j below:

14a. Staff roles

Under the guidance of the QMRP and with the full participation of the guardian, multidisciplinary team members complete a Discharge Report, DCTF-3908 (attachment f), before community placement takes place. These reports describe the resident's current functioning and identify the supports and services that will be needed for living in a community setting. This information is shared at Interdisciplinary Team meetings convened for placement purposes, such as at Transition Planning meetings and at formal discharge meetings. Through collaboration with county case managers (waiver counties) and Managed Care Organization care managers (Family Care counties), SWC discharge planning is implemented and monitored in the community, achieving continuity of care for the relocated resident.

14b. Discharge planning, discharge assessment, discharge plan of care

The discharge process is unique for each resident and occurs with the full participation of the guardian and whenever possible the resident. Assessment Meetings, Transition Planning Meetings and a Discharge Meeting are held to share information about the resident in order to develop a comprehensive Individualized Service Plan. This plan, supported by everyone involved, is based upon what is important to and for the resident to be successful in their new placement. The transition process itself, as it relates to the type and frequency of meetings, is individually tailored for each resident and would typically involve the resident, their guardian, the Interdisciplinary Team, prospective providers, and the County/MCO. Guardians may request an advocate participate as well.

14c. Staffings

The Annual Review staffing and the Model for Achieving my Potential, DCTF-3908 (attachment g); Quarterly Integrated Biobehavior Review, F-24584 (attachment h); and Quarterly Medical/Nursing Review, DDE-4584A (attachment i); along with the Discharge Plan of Care, F-22656 (attachment j); will summarize all services provided to the resident and makes recommendations for services needed going forward.

14d. Touring community provider and service opportunities

When a guardian has decided to explore community residential and service providers, Center staff will collaborate with the county/MCO and the provider agencies to arrange tours and offer transportation as needed.

14e. Preparing receiving providers

When a guardian has selected the community providers that will care for their resident, Southern Wisconsin Center staff will participate in transition activities. These staff persons will meet with the resident's community providers to assure they are familiar with the resident's service and support needs. Center experts will visit the proposed new residence to identify modifications that should be made to best meet the resident's needs and preferences.

14f. Trial visits

Center staff will facilitate and accompany residents on visits to their proposed new residence and assist with the resident's move to their new home as determined through each resident's individual transition and discharge plan.

14g. Records transfer

The resident's Discharge Medical Summary and Plan of Care, F-22656 (attachment a); Clothing List, DDE-3154 (attachment k); Client Financial Information, DDE-4044(attachment l); and their legal documents are given to the guardian upon discharge. With the consent of the guardian these records are also distributed to the county/MCO and to the community based providers and agencies that will be serving the resident.

14h. Physician involvement

SWC Physicians are active and integral members of each resident's multidisciplinary team throughout the discharge process. The resident's physician will complete a Discharge Medical Summary and Plan of Care, F-22656 (attachment a); write discharge orders and prescriptions as needed, and complete the Request for Title 19 Care Level Determination Part A ,OQA-2256a (attachment m). A resident's consulting psychiatrist will write a Discharge Psychiatric Consultation Report, F23155A (attachment n); as well. All staff physicians will be available as needed to consult with community physicians to ensure continuity of care.

14i. Providers' access to Southern Wisconsin Center staff and resources after discharge

The Center's Community Relations Team is the access point for SWC resources, information, and professional expertise for each relocated resident. The Center is

committed to fully supporting every resident during and after their relocation to the community.

14j. Post discharge “follow up” visits

Members of the SWC Community Integration Staff will participate in a 30-day follow up staffing for each relocated resident. Center staff will also participate as needed in additional follow up staffings that may occur.