

Wisconsin's ADA Title II Plan

Phase 1

January, 2002

**Wisconsin Council on Long Term Care
ADA Title II Advisory Committee**

Wisconsin's ADA Title II Plan

Phase I

December, 2001

- *“...Americans with disabilities should have every freedom to pursue careers, integrate into the workforce, and participate as full members in the economic marketplace. The New Freedom Initiative will help tear down barriers to the workplace, and help promote full access and integration.....”* George W. Bush, President
- *“...President Bush's Executive Order calls for the swift implementation of the Supreme Court's Olmstead decision that holds that unjustified isolation or segregation of qualified individuals through institutionalization is a form of disability-based discrimination prohibited by Title II of the ADA...”* Tommy G. Thompson, Secretary, Department of Health and Human Services
- *“...We strongly urge States to increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA. In developing their plans, States must include the involvement of people with disabilities throughout the planning and implementation process...”* federal Office of Civil Rights
- *“...The challenge for the Wisconsin Long Term Care Council is to provide me with advice on how we can accomplish the goal of turning our current long term care system into one that focuses on community living whenever possible within the resources available. One of the top priorities is to address the waiting lists for long term care programs. We must continue our progress in a consistent and steady manner.....”* Phyllis Dubé, Secretary, Wisconsin Department of Health and Family Services
- *“...The Olmstead plan shall take into account the preferences of a person with disabilities with regard to preferred residential setting...and shall ensure the provision of needed services to prevent unnecessary institutionalization....”* Senator Judy Robson, and Representative Steven Foti, Co-chairs, Wisconsin Joint Legislative Council Special Committee on Developmental Disabilities
- *“...Wisconsin's Plan to meet the requirements of the Olmstead decision is one the citizens of the state can take pride in. It reflects the best thinking of consumers and their representatives, policy-makers and academics. The plan is a blueprint for legislative action molded in Wisconsin's finest progressive tradition. It demonstrates that the state is prepared to meet this important challenge of serving all of its citizens.”* George F. Potaracke, Chair, ADA Title II Committee

Table of Contents

I. Wisconsin’s ADA Title II Plan.....	1
A. Overview	1
B. Introduction.....	1
C. Phase 1 Target Population: Consumers Currently Living in Institutions	2
D. ADA Title II Plan Objectives with Strategies.....	3
Objective 1: Informed Choice - Ensure that long term care (LTC) consumers, as well as their families and guardians, are informed of their rights under Title II of the ADA, and are empowered to make informed choices of whether to live in the community or in an institution. In Phase 1, the term consumer refers primarily to people currently in institutions.	3
Objective 2: Assessment and Decision Making - Develop, systematically apply, and periodically evaluate consistent criteria as well as assessment and decision-making processes (with clear delineation of the role of consumers, families, guardians, case managers, and other professionals) for: institutional admissions; discharges from institutions and acute settings; reviews of “appropriateness” of existing institutional placements; and evaluations of consumers in the individual planning process.	5
Objective 3: Range of Services - Develop and implement strategies to achieve a full range of LTC services, balancing consumer choice for independent living, in-home support services, and new community-based facilities. There must be adequate housing capacity and workforce to serve diverse consumer choices including all persons with LTC needs throughout Wisconsin.....	9
Objective 4: Funding - Provide sufficient funding: to relocate appropriate individuals in institutions by transitioning institutional capacity and resources to community care; to expand capacity to eliminate waiting lists for community service; and to strengthen existing community care capacity for current consumers. This should be accomplished no later than 7/1/07 for all institutionalized persons who: a) have not made an informed choice to stay in the institutions, and b) could be served appropriately and cost effectively in the community. Incremental progress will be made in each year of the biennium to achieve these goals. Priority will be given to relocating those individuals who are in institutions or are at clear risk of institutionalization, and are interested in and determined appropriate for community living.....	11
Objective 5: Safeguards - Develop more effective safeguards to ensure that the ADA Title II rights, wishes, and preferences of consumers are taken into account as much as possible in every phase of service delivery, regardless of whether or not the person has a guardian or other legally designated decision-maker in his or her life	16
Objective 6: Oversight - Wisconsin will incorporate criteria derived from the Supreme Court’s <i>Olmstead</i> Decision and President George Bush’s Executive Order on the <i>Olmstead</i> Decision in carrying out its oversight, monitoring, plan review mandates related to the effectiveness and coordination of long term care to meet the individual outcomes of persons with disabilities.	17
Chart 1 -- Resource Estimates to Carry Out Strategies for the Next Two Years	18

II.	Supporting Information.....	21
A.	ADA Title II Background.....	21
B.	The <i>Olmstead</i> vs. L.C. Decision – ADA Title II as Interpreted by the U.S. Supreme Court.....	21
C.	Wisconsin’s Stakeholder Input Process.....	21
	Council on Long Term Care.....	22
	ADA Title II Advisory Committee.....	22
	Phase 1.....	22
	Phase 2.....	22
III.	Workgroups – ADA Title II Phase 1	23
A.	Legislation and Budget.....	23
B.	Systems Design.....	25
C.	Data and Research.....	26
D.	Client Evaluation.....	27
IV.	Appendices	29
A.	Current Long Term Care System.....	29
B.	Wisconsin Council on Long Term Care Members	40
C.	ADA Title II Advisory Committee Members by Workgroup and Other Members	41
D.	Program Profiles – Systems Design Workgroup.....	44
E.	Statutory References – Systems Design Workgroup	75
F.	Detailed Report of Research and Data Workgroup.....	85
	Proposed Nursing Home Relocation Survey, Instructions, Sampling Size Estimate – Research and Data Workgroup.....	90
G.	Assessment Processes – Client Evaluation and Assessment Workgroup.....	93
H.	Summary of Complaints for Office of Civil Rights from Wisconsin Consumers	95
V.	Glossary	96

I. Wisconsin's ADA Title II Plan

A. Overview

The Wisconsin Department of Health and Family Services, in conjunction with the Governor, the Legislature, the Counties, Advocacy Organizations, Consumers and in cooperation with other appropriate federal, state and local entities—including, but not limited to— the Departments of Administration, Transportation, Public Instruction, Commerce, Veterans Affairs, and Workforce Development including the Division of Vocational Rehabilitation; Wisconsin Housing and Economic Development Authority; the Judicial System; the University of Wisconsin System; and the Wisconsin Technical College System — will coordinate and take the lead in carrying out Wisconsin's responsibilities related to the Americans With Disabilities Act (ADA) Title II as interpreted by the Supreme Court in the *Olmstead vs. L.C. (Olmstead)* decision.

Wisconsin wants it noted prominently that additional funding is needed from the federal and state governments to assist in accomplishing the Objectives, Strategies, and policy changes set forth in this ADA Title II Plan.

B. Introduction

The Department of Health and Family Services (DHFS), in conjunction with the Wisconsin Council on Long Term Care, created the ADA Title II Advisory Committee as a subcommittee of the Council, to review the federal requirements of the ADA Title II, as interpreted by the Supreme Court in the *Olmstead* decision (for more detail see Section II). The charge to the Committee was to report to the Council on changes the state could make to assure that Wisconsin's long term care system complied with ADA Title II. This document provides the recommendations of the Committee and the Council on the specific ways Wisconsin can improve its long term care system. The Plan can also be seen as a blueprint for legislative action. (For detail on the long term care (LTC) system and systems redesign in Wisconsin see Appendix A.)

Wisconsin's ADA Title II Plan is divided into two phases: Phase 1 and Phase 2. This report represents the work of Phase 1. ***During Phase 1, that occurred in 2001, the ADA Committee focused on consumers of all ages currently living in institutions.*** Additionally, Phase 1 also responds to the recommendations from a recent special legislative study committee that looked at the *Olmstead* decision, in their *Report of the Wisconsin Joint Legislative Council's Special Committee on Developmental Disabilities*, (May 1, 2001).

Phase 2 begins in 2002 and focuses on consumers at-risk of institutionalization, those on waiting lists, repeat admissions (revolving door), and prevention strategies that allow consumers to live in their own homes or in other community settings.

The authority and oversight of the Council on Long Term Care will continue during the review and implementation of the final development of ADA Title II recommendations as contained in this Plan and in Phase 2 of the Plan development.

NOTE: In developing the Phase 1 Objectives and Strategies in this Plan, it was recognized that many of the recommendations contained herein are intertwined. It is useful, therefore, to review the Plan in its entirety in order to understand the scope and complexity of the issues. Additionally, in developing the Phase 1 Plan and anticipating the Phase 2 focus, it was recognized that it is impossible to separate the issues and concerns that face consumers living in institutions from the needs and problems of those on waiting lists or living in the community, but at-risk of institutionalization. It is acknowledged that, in this Phase 1 Plan, some of these distinctions are not clear-cut.

C. Phase 1 Target Population: Consumers Currently Living in Institutions

- | | |
|--------------------------------------|---|
| What disability groups? | <ul style="list-style-type: none">- Frail elderly- Physical disabilities- Developmental disabilities- Mental illness- Substance abuse with dual diagnosis |
| What facilities are included? | <ul style="list-style-type: none">- State Centers for the Developmentally Disabled- State Mental Health Institutions- Nursing Homes- Institutions for Mental Disease (IMDs)- Intermediate Care Facilities for Mental Retardation- Residential Care Centers for Youth (formerly CCIs) |
| What facilities are excluded? | <ul style="list-style-type: none">- Community Based Residential Facilities (CBRFs)- Group homes- Residential Care Apartment Complexes (RCACs)- Adult Family Homes- Foster homes (children)- Hospitals (except IMDs) |
| Other criteria | <ul style="list-style-type: none">- Length of stay greater than 100 days |

D. ADA Title II Plan Objectives With Strategies

Objective 1 – Informed Choice

Ensure that long term care (LTC) consumers, as well as their families and guardians, are informed of their rights under Title II of the ADA, and are empowered to make informed choices of whether to live in the community or in an institution. In Phase 1, the term “consumer” refers primarily to people currently in institutions.

Objective 1 Strategies

- A)** The Department of Health and Family Services (DHFS), the Board on Aging and Long Term Care, and other advocacy organizations will jointly develop a variety of educational and outreach materials in various languages and alternative formats (examples: videotapes, audiotapes, large print, Braille, etc.) that are directed primarily to institutionalized consumers and their family members and secondarily to state and county staff, health providers, and others. These modalities will provide information on community living options, consumer and family empowerment, and will define consumers’ rights under ADA Title II. Dissemination methods and best-practice uses of these various informational and educational materials will be developed, with particular focus on consumers, families, staff, and others who may not be knowledgeable.
- B)** DHFS will define its statutory responsibility (re.s.46.03(4), Wis Stats) regarding "developing and maintaining education and prevention programs" to include information regarding the *Olmstead* Supreme Court decision.
- C)** DHFS will conduct a survey of a statistically significant sample of nursing home residents to learn how many are interested in living someplace other than the nursing home. The survey will be conducted by individuals who do not have a stake in the survey responses and who have been instructed in the administration of the survey to get the most accurate results. A recommended survey instrument and instructions for this purpose has been developed as a part of the ADA Title II process and are found in Appendix F. The purpose of the sample nursing home survey is to acquire a reliable percentage of institutionalized consumers who might live in the community. DHFS will use the experience of the sample survey to determine if the instrument and process are viable, and if they are found to be, will use or adapt them for other institutional settings, e.g., Intermediate Care Facilities for Mentally Retarded (ICF-MR).
- D)** Restore the Family Care Independent Advocacy Program. Family Care is the state’s long term care redesign pilot project. Further information is in Appendix A. The Family Care Program is a promising approach to addressing the issues in the ADA Title II and the *Olmstead* decision. It eliminates the institutional bias in long term care services for Family Care target groups, provides pre-admission consultation to individuals considering an institutional living arrangement, and provides an entitlement to services for all individuals at the institutional level of care —regardless of their choice of living

situations. However, Family Care uses a managed care approach to provide these services. It is imperative that consumers and their families have an independent and informed advocate to assure that they receive services that meet their needs. Some people fear that in managed care, the organizations authorizing services have a financial incentive to not provide services that may be needed. The resources needed to carryout this strategy are noted in Resource Estimates to Carry Out Strategies for the Next Two Years on p. 18--21.

Objective 2 – Assessment and Decision Making

Develop, systematically apply, and periodically evaluate consistent criteria as well as assessment and decision-making processes (with clear delineation of the role of consumers, families, guardians, case managers, and other professionals) for: institutional admissions; discharges from institutions and acute settings; reviews of “appropriateness” of existing institutional placements; and evaluations of consumers in the individual planning process.

Objective 2 Strategies:

- A)** DHFS and counties will review systematically the status of each consumer in the ADA Title II target population who currently lives in an institutional setting to determine his or her interest in living in a community setting. The consumer’s and family’s awareness of community living as an option will be a central part of the review. Determining their residential preference should be a priority. The issues of consumers who seem to be “stuck” in institutions will be particularly investigated and the factors surrounding their inability to leave delineated. (This strategy responds to the 5/01 recommendation of the Wisconsin Joint Legislative Council’s Special Committee on Developmental Disabilities to evaluate institutionalized clients’ interest in living in a community setting.)
- B)** The Legislature will amend state statutes (Chapters 46, 49, 51 and 55 as needed) in order to assure that Wisconsin law is inclusive of the federal ADA Title II and *Olmstead* requirements. These changes will include a requirement that persons will receive services in the most integrated setting. This revision will also include a listing of the criteria that must be considered and balanced by courts and by professionals in making placement and service decisions. These criteria will include those rights related to ADA Title II and *Olmstead* as well as those already provided to Wisconsin residents under a variety of court cases (i.e. State ex rel Watts v. Combined Community Services Board, Re Protective Placement of D.E.R.) and administrative rules (i.e. HFS 94.02(17) on least restrictive placement), as well as additional wording as needed to reflect the intent of current state policies.
- C)** All consumer evaluation criteria and decision-making processes at all levels of care for both pre-admissions and post-admissions will include the following elements:
- the assessor will learn the consumers preferences and will have extensive knowledge of the resources and services available for individuals who want to live in a community living location;
 - the assessment will include consumer treatment needs, least restrictive environment, informed choice, discharge potential, and community-living preference;
 - there will be follow up assessments, at least annually; and
 - information will be collected centrally to develop data bases.

- D)** DHFS, counties (defined as all county-based entities that operate or govern long term care and mental health programs and activities), and advocacy organizations will explore diverse methods for assessing consumer appropriateness for community-living that are tailored to the unique needs of each of the ADA Title II target groups. Each target group must be assessed based on its unique needs, which vary considerably among populations. The assessments should be conducted by unbiased, professional assessors who focus on the desires of the consumer and the family as a priority in the decision-making. “Unbiased assessment” of a consumer’s living needs and appropriateness means that the assessment is conducted by an individual or organization that maintains no financial or personal interests in the client’s living situation. Optimally, a team of assessors is a demonstrated way to balance assessment interests and perspectives. The team should include the consumer and professionals who are familiar with the particular consumer population such as a nurse, a social worker, a psychologist, an independent living specialist, etc.
- E)** DHFS will evaluate whether the Medicaid Utilization Review Process can be made more valuable for consumers in ICFs-MR and psychiatric hospitals and is consistent with ADA Title II particularly in relation to informed choice. If so, the process will be used as a mechanism for monitoring inappropriate institutional placements and identifying the number of people inappropriately placed in each institution. If not, DHFS will approach the federal government to amend the process or work to phase out the role of Utilization Reviews.
- F)** DHFS will develop a model and a fiscal estimate, by 3/2002, for a program that provides assessments and arranges for community services for people in hospitals who may be in need of LTC services before they are discharged. This model program and fiscal estimate will become part of the next DHFS biennial budget proposal. The model will be based on the Hospital Link concept, that, in the past, has been an effective and efficient program that arranges for community placement after hospital discharge rather than trying to help someone relocate back to the community after placement in a nursing home.
- G)** DHFS and the Legislature will ensure statewide mandatory pre-admission screening consultation by counties or entities without a conflict of interest for all persons being admitted to institutions. “Without a conflict of interest” means that the professional or organization that is helping the consumer make plans has no financial or other personal interest in the outcome. DHFS is monitoring the effectiveness of the Family Care pre-admission consultation process (PAC) in Family Care pilot counties. If found effective, this feature of Family Care would become a safeguard in every county. Without this there will continue to be widespread instances of individuals being directly and inappropriately admitted to institutions without county involvement.
- H)** DHFS will evaluate the potential of the federally required Pre-admission Screen and Resident Review (PASARR) process to become a more useful client assessment process for consumers with serious mental illnesses and developmental disabilities. The

PASARR processes are required by the federal government for all facilities that receive Medicare and Medicaid reimbursement, yet many involved in the process question the efficacy of PASARR, as it is currently used. There should be follow up assessments as there have been in the past when there was a federal requirement for annual reviews. Potential areas for improvement include those previously mentioned: the assessor knowing the consumer well; considering informed choice and least restrictive environment; and developing a data base regarding consumers with mental health or developmental problems. Future consideration will be given to expansion of the PASARR processes for consumers admitted to ICFs-MR, institutions for mental disease, and the state's Centers for the Developmentally Disabled. DHFS will develop options for improvement by 6/30/02, including possible Legislative budgetary and policy recommendations.

- I) DHFS, the Judicial System, and counties will undertake a statewide quality improvement and monitoring role regarding "Watts" reviews and county protective services. A "Watts" hearing (based on a Wisconsin Supreme Court case) is an annual judicial determination regarding all consumers in protective placement. Its purpose is to review if the person's condition or needs may have changed over the year because of positive medical or social efforts. Ideally, the judge, guardian ad litem, guardian, and consumer evaluate if the consumer is in the least restrictive placement possible and, if not, consider a change in living arrangement if the consumer so desires. A part of ensuring quality improvement and monitoring will require that DHFS specify which of its Bureaus are responsible for this role. The outcome will be more consistent application of the "Watts" decision and thus a reduction in the number of people who are deemed "appropriately placed" in an institution when in fact they are not.
- J) DHFS will expand use of Family Care's Long Term Care Functional Screen to additional areas of the state as an innovative process for eligibility evaluation for the populations for whom it was created: persons who are elderly, and those with physical disabilities and developmental disabilities. The Functional Screen does not presuppose eligibility based on whether the consumer lives in an institutional or home environment. The federal Center for Medicare and Medicaid Services has approved this screen as a valid and reliable tool for determining institutional level of care for the aging and for persons with physical disabilities and developmental disabilities.
- K) DHFS will evaluate its Mental Health/AODA demonstration projects to ascertain if the project's client assessment tool is useful in evaluating community-living options. Evaluation criteria noted in Strategy C of this Objective will be adhered to.
- L) DHFS, counties, and advocacy organizations will review the "comprehensive evaluation" process in the context of protective placements, to make sure that these evaluations reflect ADA Title II criteria such as consideration of consumer choice and provision of services in the most integrated setting. At present, these evaluations vary widely in their validity and in some instances involve minimal direct contact with the consumer. Evaluation criteria noted in Strategy C of this Objective will be adhered to.

- M)** DHFS and advocacy organizations will periodically review and conduct an evaluation of all client assessment tools and processes for determining the needs of persons with disabilities and frail elders. Quality assurance is an important part of the long-term care system. Evaluation criteria noted in Strategy C of this Objective will be adhered to.
- N)** DHFS and counties will use a common instrument for evaluating least restrictive environment, a significant piece of the assessment and care planning process. The “La Crosse County Human Services Tool for Evaluating Least Restrictive Environment” was a precursor to Family Care planning and was intended to guide the assessor in her/his professional judgement related to least restrictive environment for the consumer being evaluated. Consideration should be given to statewide use of the La Crosse Tool, or other comparable documents, that evaluate least restrictive environment.

Objective 3 – Range of Services

Develop and implement strategies to achieve a full range of LTC services, balancing consumer choice for independent living, in-home support services, and new community-based facilities. There must be adequate housing capacity and workforce to serve diverse consumer choices including all persons with LTC needs throughout Wisconsin.

Objective 3 Strategies:

- A)** DHFS, the Departments of Administration and Commerce (safety and buildings) and the Wisconsin Housing and Economic Development Authority will coordinate, encourage, and assist individuals and groups that are interested in developing new accessible housing, particularly independent apartments, as well as community-based facilities to meet the needs of consumers leaving institutions. Although many people will choose to live independently, some people will prefer to live in a facility that provides assistance to residents. The distribution of Residential Care Apartment Complexes (RCACs) is not equitable around the state; yet, they are of critical importance to the future of long term care services.
- B)** DHFS will work with the nursing home industry, consumer advocacy groups, and other key stakeholders to re-define the role of nursing homes as the market for LTC services changes. It is important to maintain a reasonable distribution of nursing homes throughout the state. A reasonable distribution of nursing homes will ensure that when an individual needs or prefers nursing home care, he or she can still live in proximity to family and friends.
- C)** DHFS, the Department of Workforce Development, the Wisconsin Technical College System, the University of Wisconsin System, as well as advocacy organizations will coordinate and develop strategies to ensure that an adequate workforce is available to meet the needs of consumers who move from institutions as well as those who choose to remain. Institutional and structural barriers to entering the field of employment in LTC will be identified and addressed. The placement of individuals in settings that are less restrictive and more integrated than are institutions will likely require a greater direct care workforce than is currently available in the long term care system. Economies of scale created by group settings will be lost as people are more dispersed. It is imperative to attract and retain a qualified workforce.
- D)** DHFS will be more proactive in ensuring that counties assess all eligible consumers for community living. All community-based long term care programs will operate in such a way that these programs consistently help currently institutionalized persons to move into the community.
- E)** DHFS; the Departments of Administration, Transportation, Workforce Development, and Corrections; WHEDA; and the counties will coordinate in the development of options for an appropriate and affordable array of services for people desiring to live in the community, including but not limited to:

- housing, including home ownership and accessible, affordable independent apartments;
- home-based living situations;
- workforce to provide daytime, evening, and weekend in-home attendant care;
- specialized transportation;
- assistive technology;
- psychiatric services; and
- crisis and respite services.

- F)** DHFS will implement the Children’s Long-Term Support Redesign initiative as one way to streamline services available to families who have a child with a disability. The family-centered focus is crucial, with parents receiving appropriate support, assistance, and respite. DHFS will evaluate if an adaptation of the assessment tools mentioned in this Plan might be useful in evaluating the needs of children and families.
- G)** DHFS will explore federal and state statutory changes needed to assure that all long term care services support children in their homes as a first priority as opposed to out of home placements. The goal is to increase home-based programming options for families who have a child with a disability. (This ADA Plan does not address the needs of children who are involved in the correctional system.)
- H)** DHFS will develop the capacity in all counties for community-based services for children with emotional disabilities, such as the Integrated Services Projects (e.g., Children Come First). In many instances, integrated services have enabled children to leave institutions and live in the community.
- I)** DHFS, the Department of Public Instruction, and the Division of Vocational Rehabilitation will address the issues associated with children with disabilities as they become young adults and transition to adult programs, funding sources, and, sometimes, wait-lists. Families must be assisted to make future plans so that, where possible, their adolescent children will be supported to work and live in a community setting as they transition to adulthood. The phenomenon of young adults with disabilities going into institutions or other more restrictive settings solely to have a funding source must be avoided.

Objective 4 - Funding

Provide sufficient funding: to relocate appropriate individuals in institutions by transitioning institutional capacity and resources to community care; to expand capacity to eliminate waiting lists for community service; and to strengthen existing community care capacity for current consumers. This should be accomplished no later than 7/1/07 for all institutionalized persons who: a) have not made an informed choice to stay in the institutions, and b) could be served appropriately and cost effectively in the community. Incremental progress will be made in each year of the biennium to achieve these goals. Priority will be given to relocating those individuals who are in institutions or are at clear risk of institutionalization, and are interested in and determined appropriate for community living.

Objective 4 Strategies:

(Note: The Chart on pp. 18-21, "Resource Estimates to Carry Out Strategies for the Next Two Years," includes the estimate of the funding needed to carry out these strategies in the next two years.)

Transition Institutional Capacity to Community Care and Focus on Relocations

- A)** Develop ways to assure that the money follows people from institutions into the community. DHFS will develop a protocol so that anyone receiving institutional care in Wisconsin, who qualifies under *Olmstead* guidelines, will be entitled to have the money for institutional care "follow them" to pay for home and community care. DHFS will maximize all current options that provide adequate funding (including CIP II, CIP 1A, CIP 1B programs) as consumers move to more integrated settings. DHFS will develop additional or new options no later than 6/30/02 for consideration by the Governor and Legislature in the next biennial budget process.
- B)** The Governor, Legislature, and DHFS will transition institutional capacity to community care through programmatic and budgetary changes. In the last few years there has been an increasing number of nursing home closures. Develop state policies in consultation with key stakeholders, including the Council on Long Term Care, that will provide fiscal incentives, including voluntary closure of nursing home beds in areas where there is excess capacity. The incentives developed will work towards maintaining capacity where it is needed. The state will proactively budget for these closures and provide the CIP II resources needed to relocate individuals into the community as appropriate. Provide funding for the following:
- Relocation of individuals from institutions using the CIP II program.
 - Unbiased counseling and assessment of the individuals who desire to transition to a community placement when nursing homes close. A quick response is needed to assess the needs of residents and develop a care plan for those appropriate for relocation into the community. When an entire nursing home closes, counties are not funded to and are often not able to process that volume of referrals in a short period of time. The state needs to recognize these costs as a part of the nursing home phase down agreements. Funding will be provided that will give DHFS flexibility to pay for either additional county care

manager time or to enter into contracts with independent organizations to complete these assessments and care plans in a timely way to avoid having consumers make unnecessary multiple moves.

- C) DHFS and counties will ensure smooth and timely transitions for consumers moving from institutional to community-settings. DHFS will modify community based long term care programs to ensure that there is adequate funding to cover staff time for transition planning as well as transitional expenses for consumers (e.g., security deposits, furniture, structural modifications to assure accessible living arrangements) as institutionalized persons move into the community. For this transition to be effective, it is imperative that the appropriate support and services be available to people, including individuals with multiple conditions that may pose a special challenge for relocations. The State will develop, fund, and contract for specialized consultation services to work with nursing facilities, community based residential facilities, counties and other local services agencies to develop creative service plans to relocate individuals with multiple conditions.
- D) DHFS will develop financing mechanisms by 6/30/02 to relocate youth at the state Mental Health Institutes into community services. DHFS will explore options, including: moving the state GPR dollars from the hospital to the community for youth at the state Mental Health Institutes, use of Medicaid Health Check, and the proposed Children's Waiver.

Expand Community Care Capacity

- E) The Governor, Legislature, and DHFS will develop a new long term care budget methodology. With the future growth in people needing long term care, the Legislature, Governor and DHFS, need to adopt a new budgeting system for long term care that supports a consistent policy and vision across the entire system, including the county system. The current system of budgeting program by program or service by service does not show the overall impact of these discreet budget decisions and how they impact on the entire system. Policy and budgeting need to be aligned towards a vision of cost-effective long term care options, which promote consumer choice of care setting.
- F) DHFS and the Legislature will fund at adequate levels all client assessment processes that are proposed in this plan. It is impossible to isolate assessment procedures and processes from sources of funding.
- G) The Governor and Legislature will expand community care capacity, as the population in need of long term care continues to increase. Expand the capacity of the various community programs that serve the ADA Title II populations in non-Family Care counties through increased resources in the next two years. Provide additional resources in subsequent years as the need is determined to eliminate waiting lists for home and community services that serve these populations by 7/1/07. Provide funding for the following:
- Demographic growth in the Community Options Program and waiver Programs in non-Family Care counties/target groups; eliminate waiting lists in the Community Options

and waiver programs for older persons, persons with physical disabilities and persons with developmental disabilities;

- Relocations and diversions of persons with developmental disabilities and persons with brain injuries using the existing home and community based Waivers: CIP 1B, and the Brain Injury Waiver.
- Family Support Program and the proposed Children's Redesign Waiver;
- Expansion of the Family Care pilot sites to include a Kenosha County Care Management Organization. Provide resources to fund the next round of planning for new sites up to the level authorized in the Family Care statute;
- Review the status of the current Mental Health and AODA System Redesign Pilots, and as needed, retool the service delivery model, in line with the vision of the Blue Ribbon Commission. Keep the momentum for the redesign and develop a new cost proposal for the retooled service delivery model and include in the next legislative budget process.

- H)** DHFS will explore, no later than 6/30/02, how individuals with mental health needs, at the institutional level of care, can be served through a new "CIP II-like" Waiver.
- I)** The state will assume the responsibility for the state share of the Medicaid funding for Community Support Program services. Currently counties provide the state match for this Medicaid State Plan Benefit. The state is required by the federal government to assure that this benefit is available statewide. DHFS and counties will work towards a mutually agreed upon method for transitioning this fiscal responsibility to the state, including the most equitable way to allocate these funds and serve all people waiting for, or in need of services.
- J)** DHFS will develop and submit to the federal government a new Children's Redesign Waiver to expand federal resources by 9/30/02. This new home and community based Waiver will include services appropriate for children and families, including children with developmental, physical and emotional disabilities. This will include full funding of the Integrated Service Projects for children with emotional disturbance for those children eligible for and enrolled in the Children's Waiver. The additional state resources will be included in the next legislative budget session.
- K)** The Governor and Legislature will authorize additional Medicaid funding to expand the Medicaid personal care program to the extent allowed by federal law. This expansion will enable people with disabilities to more fully participate in community life, including taking fuller advantage of employment opportunities. The Medicaid personal care benefit is an entitlement, therefore, unlike waiver services, all recipients who need the service will have access to it. These changes will include:
- Allowing coverage of personal care services to the entire community outside the home. By providing activities of daily living cares in the workplace, people can come out of institutions and live a normal life.
 - Expanding the components of the personal care benefit to include instrumental activities of daily living (IADLs), such as: cueing, financial assistance, housekeeping assistance not related to personal care, telephone assistance and possibly to transportation to

appointments that are not medical (if it is determined feasible and does not duplicate other services). These services could be both in the home and community.

- L)** Maintain the capacity of the Family Care program to serve consumers who are not eligible for Medicaid but are at the institutional level of need. DHFS will review current eligibility to determine if modifications are needed to assure the state maximizes its ability to capture federal funding and serve those most in need.
- M)** DHFS will secure the maximum number of community-based long term care program slots under Wisconsin's agreements with the federal government for consumers who meet ADA Title II criteria. Wisconsin statute 46.80(3) requires the state to use all available funds from federal and state sources; however, this is in contrast to the current practice of not using all available Medicaid Waiver slots, e.g., in the Brain Injury program.
- N)** DHFS will maximize federal revenue sources and develop and maintain new options to expand additional federal revenue to pay for the expansion of community programs no later than 6/30/02. DHFS will generate federal revenue by capturing additional Medicaid funding for expanded home and community based care, without displacing current funding. Options will include: investigating a new "Intergovernmental Transfer Program (IGT)" for community care and/or the use of the county Community Aids overmatch as leverage.

Enhance the Strength of the Existing Community Care Capacity for Current Consumers

- O)** The Governor and Legislature will strengthen the existing community care capacity for current consumers by increasing reimbursement rates for all community based long term care programs so that they realistically correspond to the actual costs of community services for participants. In future budgets, annual cost-of-living increases for home and community care (e.g., COP and CIP) should be included that are tied to an agreed upon measure of inflation such as the consumer price index. Long term care services cost more each year. To ignore inflation results in the erosion of the capacity of the existing programs. Counties now have to choose between allocating additional county tax levy or serving fewer people. These additional resources will provide support so that:
 - CIP II rate increases to \$45 dollars a day to provide a rate that will pay for the increased costs associated with the relocation of nursing home residents who may have more significant needs. Experience has shown that to be successful at making new placements for those with higher needs, the average cost of CIP II would need to increase.
 - The CIP 1A rate is increased to \$300 a day and separated from the State Center for Developmental Disabilities' current "drop rate" or reduction in the State Center budget as currently mandated by the legislature. As the population of the Centers decrease, it is still necessary to maintain a level of staffing at the State Centers to preserve the quality of care for those individuals who remain in the Centers and to maintain adequate staffing to meet Medicaid certification standards. The decoupling of the drop rate adds increased costs reflected in the cost estimates in the Chart on pp. 18-21.

- CIP 1B rate increases to \$74.70 a day to pay for the actual cost of serving one individual or “slot”. Although the budgeted rate for a slot in FY ’00 was \$49.38 a day, the actual average cost of serving an individual was \$74.70 a day.

Address Issues Related to Counties

- P)** DHFS, the Long Term Care Council, and the ADA Title II Committee will track and review the outcome of the current Wisconsin court cases regarding the County Shield Law. They will revisit this issue and propose a modification of the “County Shield Law” (s. 51.61(1)(f), Wis. Stats.) if needed, to assure that this language is not used as a justification for violating the *Olmstead* rights of consumers. Specifically, the “limits of available funding” provision should not relieve the state and counties of their responsibility to provide services in the community to institutionalized persons who meet the *Olmstead* criteria. At the present time, the combined effect of the County Shield law and the lack of county control over institutional spending results in situations where the “available funds” are not accessible by county decision-makers in placement decisions. This may result in violations of the ADA Title II.
- Q)** The Legislature will create and fund a method, or clarify existing protocols, to assist counties in covering the costs of individuals who are at risk of having their *Olmstead* rights violated because of exceptionally high costs. DHFS and counties will work together to develop appropriate allocation methodology.
- R)** DHFS and the federal Office of Civil Rights (OCR) will clarify and communicate the roles of the state and federal governments in regard to assuring county services and programs’ compliance with ADA Title II and the *Olmstead* decision. This will include those conditions under which the state or federal governments may impose a variety of sanctions on counties re. s. 46.031 (2r) (a)(2) Wis. Statutes, as a result of ADA Title II violations. Depending on the infraction or situation, the state will assure appropriate services or that an alternative contractor is in place to carry out county responsibilities. An example would be a county’s refusal to use COP or COP-waiver funds to serve nursing home residents who meet ADA Title II criteria.

Objective 5 - Safeguards

Develop more effective safeguards to ensure that the ADA Title II rights, wishes, and preferences of consumers are taken into account as much as possible in every phase of service delivery, regardless of whether or not the person has a guardian or other legally designated decision-maker in his or her life.

Objective 5 Strategies:

- A)** DHFS will provide leadership and coordination in developing comprehensive training strategies for the diverse professionals and others in all settings who make client placement decisions or who conduct or participate in client assessments. Partners in promoting the trainings will include representatives from counties, the judicial system, advocacy organizations, and others. The training programs should focus on judges, guardians ad litem, guardians, social workers, hospital and other discharge planners, case-managers, care-coordinators, health providers, regulators/quality assessors, ombudsmen, etc. The trainings should include as teaching guides the assessment tools discussed in this Plan. The trainings should utilize as trainers consumers as well as key professionals in the state (e.g., rural judges, central city social workers) who have taken bold steps to successfully de-institutionalize consumers for whom they have decision-making authority.
- B)** DHFS and the counties will develop methods for counties and providers to document the direct participation of consumers in the development of their individual service plans.
- C)** DHFS and advocacy organizations will work with counties in educating those guardians who are resistant to a community placement for their ward when such placement has been deemed appropriate. Additionally, legal remedies available to wards will be clarified and strengthened.
- D)** DHFS, the counties, and advocacy organizations will develop and implement new county oversight mechanisms for guardianships, representative payees, and protective payees to improve quality and reduce abuse of these roles.
- E)** DHFS and the Legislature will improve legal protections related to guardian and provider conflict of interest issues, e.g., in situations when there is a fiscal benefit for a guardian or a provider to keep a consumer in a more restrictive setting.
- F)** DHFS; the Departments of Workforce Development, Administration, and Commerce; and WHEDA will address policies related to and intensify development of dispersed, affordable, accessible housing programs and community-based employment programs. It is imperative to ensure that consumers' choices for where to live and work are not limited to congregate residential and employment models.

Objective 6 - Oversight

Wisconsin will incorporate criteria derived from the Supreme Court's *Olmstead* Decision and President George Bush's Executive Order on the *Olmstead* Decision in carrying out its oversight, monitoring, plan review mandates related to the effectiveness and coordination of long term care to meet the individual outcomes of persons with disabilities.

Objective 6 Strategies:

- A)** DHFS, the counties, and advocacy organizations will ensure that all institutional settings develop timely and viable discharge plans for all residents and make referrals to appropriate community services unless there is an explicit rationale (which is consistent with the *Olmstead* decision) for why the person cannot or does not want to move out.
- B)** DHFS will improve the data collection in institutional settings, especially for individuals with mental health and behavioral health needs. This includes exploring modifications to the state module for the Minimum Data Set. DHFS will develop options no later than 6/30/02.
- C)** DHFS will incorporate ADA Title II-related factors in the many program reviews it conducts. One example of a review that DHFS undergoes is in s.46.278 (3) (A) which states that the Department shall evaluate the effect of the home and community based waivers for persons with developmental disabilities on Medicaid costs and on the program's ability to provide community care alternatives to institutional care in facilities certified as Medicaid providers.
- D)** DHFS and all other agencies and organizations discussed herein will integrate the strategies presented in this Plan in further implementing Wisconsin's long term care redesign activities: Family Care, Mental Health/AODA Managed Care, Children's Redesign. The framework reflected in Family Care - an entitlement that has as its basis, consumer choice - provides the state with an effective response to *Olmstead*. The activities Wisconsin undertakes now to respond to *Olmstead* will be consistent with the overall direction of long term care reform as it is occurring in Family Care and other redesign projects.
- E)** DHFS will continue to provide staff support for both the Council on Long Term Care and the ADA Title II Advisory Committee for their continued work and oversight of the ADA Title II Plan. The Council and Committee activities will be funded by DHFS.

Chart 1

Resource Estimates to Carry out Selected Strategies for the Next Two Years

Objective & Strategy	Recommendation Assumptions	Resources Provided in 01-03 Biennial Budget	Additional Resources Needed & Cost Estimate
Objective 1(d) Family Care Advocacy			
Restore Family Care Independent Advocacy	Fully fund at \$1.1 Million all funds for two years.	Funding vetoed.	Provide \$525,000 in new GPR and \$525,000 in new FED for the next two years, as follows: Year 1: \$250,000 GPR and \$250,000 FED. Year 2: \$275,000 GPR and \$275,000 FED.
Objective 4 (b) Transition Institutional Capacity to Community Care			
Relocate People from institutions through CIP II Waiver.	Provide 1,600 new slots over the next two years at the rate of \$45/day.	686 slots at \$40.78/ day in FY 02 with at an initial cost of: FY 02: \$2,104,500 GPR and \$2,997,300 FED, and cost to continue in FY 03: \$4,227,300 GPR and \$5,976,200 FED.	Provide an additional \$4.6 Million GPR for the next two years to fund 114 more new CIP II Slots in Year One and an additional 800 slots in Year Two and to move the 686 FY 02 slots from \$40.78 to \$45 per day.
Assessments and Care Plans when Nursing Homes close.	Develop capacity to contract for or to provide additional resources to counties/ other entity to perform timely assessments of NH residents when NH's close. The cost would assume the cost of one full time contracted nurse consultant.	None.	Provide \$66,000 a year for the next two years to fund community assessments. (\$33,000 GPR and \$33,000 FED).
Objective 4 (c) Specialized Consultation to Help Relocate Persons with Multiple Conditions			
Develop contract for specialized consultation to help relocate persons with multiple conditions	Provide the cost of a FTE psychiatric nurse or psychiatric social worker per year.		Provide \$75,800 a year for the next two years to fund a psychiatric social worker to contract for specialized consultation services. (\$37,900 GPR and \$37,900 FED)

Objective & Strategy	Recommendation Assumptions	Resources Provided in 01-03 Biennial Budget	Additional Resources Needed & Cost Estimate
<i>Objective 4 (g) Expand Community Care Capacity</i>			
Demographic growth in the COP and Waiver Programs.	Fund 700 new COP slots each year, using 30% COP-Regular slots and 70% COP-Waiver slots	None.	Provide \$8.7 Million new GPR in the next two years for COP and COP Waiver. Year 1: \$2,443,800 GPR and \$1,343,600 FED; Year 2: \$6,367,300 GPR and \$3,890,500 FED.
Eliminate Wait Lists for COP and Waiver Programs.	Fund an additional 1,200 slots over the next two years, assuming services for 18 months starting January 2002, using a split of 30% COP and 70% Waiver funding in non-FC counties & populations.	FY 02: 1,000 new COP Waiver slots, at a cost of \$2,851,300 GPR and \$3,003,600 FED. FY 03: Cost to continue FY 02 new slots \$4,452,700 GPR and \$4,947,000 FED.	Provide \$5.9 Million GPR for the next two years to fund a reduction in the COP waiting list. This would provide the remaining 360 COP-R slots, since the '02-'03 budget included only Waiver slots.
Relocations and Diversions of Persons with Developmental Disabilities through CIP 1B Waiver	Provide 500 new CIP 1B slots, with 250 slots each year for next two years at a new rate of \$74.70/day.	FY 02: 310 new CIP 1B slots at \$49.67/day, with 60 specifically for relocations, at a cost of: FY 02: \$1,168,100 GPR and \$1,663,600 FED and cost to continue in FY 03: \$2,400,000 GPR and \$3,385,600 FED.	Provide \$2.9 Million GPR for the next two years to fund an additional 250 CIP 1B slots at the current actual cost, \$74.70/day, and to fund the additional costs for increased rate for the 310 slots provided in FY 02 at a rate of \$49.67/day. This would bring the total slots to 500 new slots at \$74.70/day.
Relocations & Diversions for Persons with Brain Injuries through BIW	Provide 100 new Brain Injury Waiver (BIW) slots (50 a year) over the next two years at the rate of \$184/day.	Statutory change allows counties to create locally matched BIW slots.	Provide \$2.8 Million GPR for the next two years to provide 100 new Brain Injury Waiver (BIW) Slots (50 per year), funded at the existing rate of \$184/day.
Funding for Families with Children in Need of Long Term Support	Provide funding for 778 children in the Family Support Program over the next two years.	FY 02 \$250,000 GPR and FY 03 \$750,000 GPR to provide services to 226 more children.	Provide \$2.5 million new GPR for the next two years to provide services to an additional 553 children in the Family Support Program.
Expand Family Care Care	Add Kenosha CMO by July 1, 2002 and provide resources to fund planning for additional pilot sites up to the maximum allowable in statute.	None.	Provide \$3.7 Million GPR for Kenosha CMO expansion and for additional planning funds in the next two years.

Objective & Strategy	Recommendation Assumptions	Resources Provided in 01-03 Biennial Budget	Additional Resources Needed & Cost Estimate
<i>Objective 4 (i) MA Community Support Benefit</i>			
State funding for Medicaid match for Community Support Programs for persons with severe and persistent mental illness.	State picks up the entire cost of all persons currently served by MA funded CSP services, applying the \$1 Million in CSP grant funds towards this cost.	Total for biennium of \$1.5 Million GPR to address the waiting lists for the CSP programs as follows: FY 02: \$500,000 GPR, and FY 03: \$1 Million GPR.	Provide \$12.6 Million GPR for the next two years to pay for the state assuming the responsibility for the state share of MA funding for CSP programs without transferring any Community Aids funds to offset these costs. This includes applying the \$1 Million in CSP grant funds that counties receive.
<i>Objective 4(l) Family Care Non MA Eligible People</i>			
Maintain the capacity of Family Care to serve Non-MA's	Expand GPR resources to serve all the Non MA comprehensive Level eligibles by 7/03.		Cost estimate cannot be completed until Family Care pilots provide data needed.
<i>Objective 4 (o) Enhance the Strength of Existing System for Current Consumers</i>			
Increase CIP II rate	Increase rate to \$45/day for the existing CIP II slots.	FY 03: Rate increase from \$40.78 to \$41.86/day at a cost of \$558,700 GPR and \$787,600 FED	Provide an additional \$2.9 Million new GPR for the next two years to increase the rate to \$45/day beginning 1/1/02.
Increase CIP 1A rate	Increase rate to \$300/day and decouple from Center "drop rate"	FY 02: Rate increase for new placements increase from \$184/ day to \$200/ day. FY 03: Rate increase from \$200/day to \$225/ day. Costs are covered by an offset in the reduction in budgets at the State Centers.	Provide \$1.5 million in new GPR if the rate is increased from those approved in the FY 02-03 budget to \$300/day and if the rate is "decoupled" from the Center's Budgeted drop rate.
Increase CIP IB rate	Increase rate to \$74.70/day	FY 03: Rate is increased from \$48.33/day to \$44.67/day for a cost of: \$499,700 GPR and \$711,600 FED.	Provide an additional \$19.3 Million GPR for the next two years to fund an additional increase to \$74.70/day beginning in FY '02.

II. Supporting Information

A. ADA Title II Background

The Americans with Disabilities Act (ADA) was enacted by Congress in 1990 and contains several “titles,” the purposes of which are the integration of individuals with disabilities into the mainstream of society. ADA Title II addresses nondiscrimination on the basis of disability in the services provided by public entities such as state and local governments and their contractors. Consumers with disabilities must be provided with an equally effective opportunity to participate in or benefit from the public entity’s services or must be “reasonably accommodated” in an integrated setting.

B. The *Olmstead* vs. L.C. Decision – ADA Title II As Interpreted by the U.S. Supreme Court

The U.S. Supreme Court in 1999 ruled on a suit that had evolved through the State of Georgia court system. The suit alleged that the state failed to place two consumers with mental illness in community-based programs after treatment staff determined that it was appropriate for them to be discharged from treatment in state facilities. The Supreme Court determined, in a decision entitled “*Olmstead v. L.C.*” that a violation of ADA Title II had occurred. The Court further ruled that states could demonstrate compliance with ADA Title II if they have a comprehensive plan for placing persons with disabilities in less restrictive settings and a waiting list that moves at a reasonable pace. Furthermore, the affected persons must desire community placement and the placement must take into account available resources, including the needs of others with disabilities.

The federal Department of Health and Human Services’ Office for Civil Rights and the Centers for Medicare and Medicaid Services have directed the states to develop plans for providing community-based services for people with disabilities.

C. Wisconsin’s Stakeholder Input Process

Wisconsin began the process of redesigning its various long term care systems in 1995 with broad stakeholder involvement. The goal was to move toward community-based services and away from institutional care. To design new systems for persons with mental illness, the Governor’s Blue Ribbon Commission on Mental Health took the lead. For frail elders and adults with physical or developmental disabilities, the Family Care Resource Centers and Care Management Organizations were developed in pilot counties. For children with long term care needs, the Children’s Long Term Support Redesign is being developed. While DHFS has taken the lead in these efforts, each has been informed, monitored, and supported by broad stakeholder input. Further detail about Wisconsin’s long term care system and systems redesign is in Appendix A of this Plan.

Council on Long Term Care

In 2000, then Governor Tommy Thompson created the 15-member Wisconsin Council on Long Term Care to oversee the development of Family Care. The Council has evolved from reporting to the Governor to reporting to the DHFS Secretary. The Secretary's challenge to the Council is to provide her with advice on how to accomplish the goal of turning the current long term care system into one that focuses on community living, whenever possible, within the resources available. The Council, which meets monthly has expanded its number to 17, adding members representing children's long term support issues and issues specific to persons with mental illness. Members of the Council are listed in Appendix B.

ADA Title II Advisory Committee

In 2001, the Council on Long Term Care created the ADA Title II Advisory Committee to review the federal requirements of ADA Title II, as interpreted by the Supreme Court in the *Olmstead* decision. The charge to the Committee was to report to the Council on changes the state could make to assure that Wisconsin's long term care system complied with ADA Title II. There were multiple sources of input to membership on the ADA Committee – DHFS and other state agencies, as well as advocacy and consumer-based organizations in the areas of frail elderly; children with disabilities; adults with physical and developmental disabilities; and individuals with serious mental illness. The result is a very broad-based group of 45 persons, chaired by the state's Long Term Care Ombudsman and Executive Director of the Wisconsin Board on Aging and Long Term Care. The full Committee has met six times and there were multiple meetings of the Committee's four Workgroups. A list of the Committee members, with Workgroup designation, as appropriate, is in Appendix C.

Phase 1

At the ADA Title II Advisory Committee's second meeting in February 2001, the Chair proposed that the Committee focus its current work on those individuals living in institutions who can and want to live in a less institutional, or community-based, setting. The Committee agreed to focus its "Phase 1" activities on system changes that would make it more likely for consumers desiring to move from an institution to a community setting to be successful. The Committee also agreed to study the issues and develop recommendations through its Workgroups, detailed below in Section III.

Phase 2

The ADA Title II Advisory Committee's Phase 2 activities begin in 2002 and will focus on those individuals at-risk of institutionalization, waiting lists, and issues related to the "revolving door" phenomenon. It is anticipated that the Committee will work in Workgroups again and conclude its work late in the year 2002.

NOTE: In developing the Phase 1 Plan and anticipating the Phase 2 focus, it was recognized that it is impossible to separate the issues and concerns that face consumers living in institutions from the needs and problems of those on waiting lists or living in the community but at-risk of institutionalization. It is acknowledged that, in this Phase 1 Plan, some of these distinctions are not clear-cut.

III. Workgroups – ADA Title II Phase 1

The ADA Title II Committee accomplished much of its work via four Workgroups: **Legislation and Budget, Systems Design, Data and Research, and Client Evaluation and Assessment.** The following is a summary of each Workgroup's focus, activities and findings. Workgroup membership is found in Appendix C and products developed by the Workgroups are in Appendices D, E, F and G.

A) Legislation and Budget Workgroup:

Overview: The Legislation and Budget Workgroup, focused their recommendations on what changes were needed in the state budget and statutes to improve Wisconsin's compliance with Title II of the ADA and the *Olmstead* decision. The Workgroup met six times to review information, discuss alternatives with various experts and finalize their recommendations.

Process: In order to have the greatest impact and optimal timing of their budgetary recommendations for this year's biennial budget process, it was decided that initial recommendations would be needed in the spring, and could not wait until the fall when the ADA Committee report was due. For that reason, the group split its work into two parts. First, they reviewed the status of the existing long term care programs, waiting lists, the demographic trends and other key fiscal barriers to community living. In addition, they reviewed the budget requests of DHFS and the Governor. Then they identified specific recommendations on funding levels for these programs for the next two years to be forwarded immediately to the Council on Long Term Care. Next, they moved on to review the recommendations from the various other workgroups to determine the budgetary or statutory implications of those recommendations.

Initial Recommendations: The Workgroup's initial recommendations were forwarded to the full ADA Title II Advisory Committee on March 14, 2001. The full committee approved those recommendations and they were forwarded to the Council on Long Term Care. The Council reviewed, revised and adopted the budget recommendations on March 30th and April 20th. The Council forwarded those recommendations to the Governor, key legislators and to DHFS Secretary Phyllis Dubé in their report, "*Annual Report of the Wisconsin Council on Long Term Care: May 2001.*" This report can be found at the Council's website: www.wcltc.state.wi.us.

Final Recommendations: In the second stage of the Workgroup's work, they discussed the overall process of how the state budgets for long term care. They interviewed DHFS staff who put budgets together for these program areas to find the best way to allow institutional resources to move with individuals into the community. After the legislature and Governor completed work on the '02-'03 Budget, they reviewed the implication of those final decisions and compared them to the May 2001 recommendations of the Council. The Workgroup updated their budgetary recommendations for the ADA Plan report to reflect the resources provided in the last budget period. They also determined what additional resources would be needed in the next two years to continue progress on their recommendations. Those final

recommendations are included in Objective 4 of this Plan. The Workgroup recommendations are generally grouped in the following categories: transitioning resources from institutional to home and community care, expanding community care capacity, maintaining existing community care capacity for current consumers, and issues regarding counties.

The Workgroup then reviewed the recommendations of the other workgroup for legislative or budget implications. Finally, the group tackled complex statutory language change issues, including: Community Based Residential Facilities bed size restrictions in the Community Options Program, Wisconsin's statutes regarding "least restrictive environment" and the new federal language of "most integrated setting", and the "County Shield Law," (s.51.61(l)(f) Wis. Stats.). Based on those discussions, strategies were developed and included in the objectives.

Key Finding: A key finding from the Workgroup (Objective 4, Strategy E) sums up a primary focus of the Workgroup. The Governor, Legislature and DHFS need to rethink how the state budgets for long term care. Budgeting for discreet long term care services independent of each other results in a fragmented and confusing system. The state needs to adopt and support a consistent vision, policy, and budget across long term care programs that assures there will be cost-effective long term care options, which promote consumer choice of care setting, now and into the future.

B) Systems Design Workgroup:

Overview and Process: The Systems Design Workgroup had as its tasks: 1) to review the existing state programs that serve persons covered under ADA Title II/*Olmstead*, and 2) to review state statutes, regulations and processes that affect programs and persons covered under ADA Title II/*Olmstead*. The Workgroup reviewed existing state programs by comparing programs against the criteria that were specified within the *Olmstead* Supreme Court ruling. See Appendix D for these Program Profiles. The Workgroup reviewed state regulations and processes by reviewing the Wisconsin Statutes. See Appendix E for Statutory References. The group then recommended a series of changes in existing programs and processes to better comply with the ADA in Wisconsin's long term care system.

Key Findings: In reviewing programs, statutes, and regulations, the Workgroup identified some prominent patterns:

- Many Wisconsin statutes and regulations which relate to long term care do not adequately reflect the requirements of the ADA Title II.
- There is great inconsistency among the various assessment and decision-making mechanisms that determine whether a person will move into, or out of, an institution – and most of these mechanisms do not adequately take into account the considerations deriving from the *Olmstead* decision.
- Most community-based programs which consumers rely on to ensure that their *Olmstead* rights under the ADA are not violated are under-funded. This takes two forms: inadequate reimbursement rates and/or inadequate number of “slots” funded.
- Wisconsin has several monitoring processes which purport to ascertain the “appropriateness” of a person's placement in an institution – by and large, these processes do not reflect “appropriateness” as it is defined in the “integration mandate” of the ADA Title II.
- Wisconsin has learned (through various pilot programs) how to do a number of things well which could prove to be invaluable in achieving ADA Title II compliance. The application of these ideas should be broadened to other parts of the state.

C) Research and Data Workgroup:

Process: The Research and Data Workgroup focused its efforts on trying to answer the central data question, “How many people currently in institutions are likely to be able to be served in the community?” A first step to answering this question was to develop a definition of the target group with which the ADA Committee and the Workgroup were concerned in Phase 1. The definition the Workgroup developed is on page 2 of this Plan.

At its early meetings, the Workgroup discussed several sources of data and had presentations on those that appeared most relevant. Data sources considered are listed and described in the Workgroup’s complete report in Appendix F.

The Workgroup determined that the Minimum Data Set (MDS) provided the greatest promise for its purposes because of the level of pertinent detail that it contains about individuals. Another attraction is that the MDS includes information on over 90 percent of the institutionalized population in Wisconsin (all residents of skilled nursing facilities and institution for mental disease nursing facilities).

The Workgroup came to the conclusion that the available data did not satisfactorily answer its original question. Reasons for this include:

- Concerns about the objectivity of the questioner;
- Lack of consensus on the criteria that would make a person suitable for community placement;
- The number of permutations available within so many data elements; and
- The belief that analysis of data elements cannot be substituted for the determination made by a “professional” based on a face to face assessment with the individual.

The Workgroup turned its attention to a second factor key cited in the *Olmstead* decision. This is the issue of consumer preference for placement in a less restrictive environment. Although the MDS contains data elements pertinent to this issue, it appears to be the consensus of many informed individuals that these data elements may not be reliable.

Key Finding: The Research and Data Workgroup’s main recommendation is that the Department of Health and Family Services conduct a survey of a scientifically significant sample of nursing home residents to learn how many are interested in living someplace other than the nursing home. The survey should be conducted by individuals who do not have a stake in the survey responses and who have been instructed in the administration of the survey to get the most accurate results. The Workgroup has developed a recommended survey instrument, survey instructions, and information on sample size. These are contained in Appendix F.

D) Client Evaluation and Assessment Workgroup:

Overview: The charge of the Client Evaluation and Assessment Workgroup was to address the assessment and evaluation of all target population clients currently residing in institutions who desire to live in and who could be cared for in a community setting. The Workgroup's purpose was to advise the ADA Title II Committee on meeting the needs and desires of consumers in relation to evaluation and assessment.

Process: The Workgroup invited experts in the area of client assessment to make informal presentations and reviewed a variety of assessment practices, protocols, and procedures already in place. These included: Annual Report on Nursing Homes and Facilities for the Developmentally Disabled; Nursing Home Minimum Data Set; Pre-Admission Screening and Resident Review; Community Options Program; Family Care; Quality Assurance Survey Protocol for LTC Facilities; county nursing home assessment procedures; evaluation practices at Institutions for Mental Disease, Intermediate Care Facilities for Mentally Retarded, State Centers for the Developmentally Disabled, and State Mental Health Institutes; evaluation dilemmas from the legal, county, judicial, and advocacy perspectives; and the unique long term support issues of children, their families, and their transition to adult systems.

Issues: The Workgroup looked at many methods, processes, and tools for assessing institutionalized clients' needs and was unable to identify one ideal assessment process. A chart entitled Assessment Processes is in Appendix G. Furthermore, while most assessments are designed to look at some aspect of client need, many do not focus on appropriateness for community-living. Some assessments emphasize measurement of client functional capacity, others focus on availability/non-availability of supports and services. No one tool appears to combine all appropriate assessment dimensions for ADA Title II decision-making. Other assessment concerns include: data availability; unique needs of specific client groups; the assessment skill and potential bias of the assessor; the assessment intent, results and outcome. Furthermore, the Workgroup attempted to isolate assessment procedures and results from funding-stream flow and community resource availability and concluded that this was not possible. Therefore, in order to continue its work, the Workgroup **assumed** resource and service availability and formulated the strategies recommended to the ADA Committee based on this assumption.

Key Findings:

- Diverse methodologies for conducting unbiased or team-based assessments is critical to addressing conflict of interest in evaluating consumer need and desire
- Comprehensive training for everyone who conducts or participates in client assessments in all settings is necessary.
- Information on community living options must be provided to consumers and families in diverse educational, media, and outreach modalities.
- Family Care's Long Term Care Functional Eligibility Screen and its Resource Allocation Decision-making Methodology should be evaluated in pilot sites and replicated in

additional geographic locations for frail elders and those with physical and developmental disabilities.

- The Preadmission Screen and Resident Review (PASARR) processes should be evaluated and developed to become viable client assessment protocols for consumers with mental health, behavioral, and developmental disabilities.
- All client assessment processes must be funded at adequate levels with appropriate workforce to conduct evaluations and all tools must be reviewed periodically.
- The Children's Long Term Support Redesign initiative must flourish to ensure that children are able to live in their own homes, whenever possible, with parents receiving support, assistance and respite.
- Clients who seem "stuck" in institutions may require unique assessment methods to address their inability to leave the institution.
- The problem of waiting lists that occur after a consumer has expressed desire for community-living and been assessed as appropriate must be addressed, with services and workforce available and funding following the client.

IV. Appendices

Appendix A. Current Long Term Care System

Over the past twenty years, Wisconsin has developed a long term care system composed of an array of programs and funding sources to support individuals with disabilities in nursing homes and other institutions, small and large group settings and at home. Historically, Wisconsin has invested significantly in nursing homes and other institutional care, as well as community long term care. Although the state expanded community-based services, nursing homes and other institutions still constitute a significant part of the current system.

Wisconsin's Medicaid State Plan covers all mandated and optional services permitted under Title 19. Wisconsin also provides broad eligibility, including a comparatively high medically needy limit, a Medicaid Purchase Plan for individuals with disabilities, and through the "Katie Beckett" program extends eligibility to 4,000 disabled children at the institutional level of care need. Medicaid provides many services that help support individuals with disabilities in the community. In addition, Wisconsin Medicaid has a prescription drug benefit that provides necessary medications to enable many people to remain in the community. State Plan services, however are not as flexible as home and community based waivers.

This Appendix contains information on the following: Community Based Service System, Institutional Services, Long Term Care Redesign in Wisconsin, System Strengths, and System Challenges.

Community Based Service System

- **Frail Older People, People with Physical or Developmental Disabilities.** The Community Options Program (COP) is a state-funded, county-administered home care program for frail elders and persons with disabilities to reduce the use of nursing homes. Wisconsin has expanded its community support resources using four Medicaid s. 1915(c) waivers serving persons who are frail elderly or have a physical disability or a developmental disability.

Wisconsin provides a wide range of services under COP and the Home and Community Based Waiver (HCBW) programs: COP Waiver (nursing home diversion program for elderly and physically disabled persons), Community Integration Program II or CIP II (nursing home relocation program for elderly and physically disabled persons), Community Integration Program 1A or CIP 1A (relocation program for persons with developmental disabilities from the State Centers for Developmental Disabilities), Community Integration Program 1B or CIP 1B (institutional diversion program for persons with developmental disabilities), the Community Supported Living Arrangements (CSLA for people with mental illness) and the Brain Injury Waiver (BIW). The Medicaid waivers can pay for most social and environmental supports (as noted in the chart below) not covered by the Medicaid program or the family.

Community-Based Services Under COP and Waivers

Adult Day Care	Respite Care	Supportive HomeCare
Chore Service	Homemaker	Housing/Energy Assistance
Specialized Transportation/Escort	Prevocational Services	Daily Living Skills Training
Personal Emergency Response Systems	Communication Aids	Specialized Medical Supplies
Home Modifications	Adaptive Aids – Vehicle	Adaptive Aids – Other
Adult Family Home (Foster Home)	Group Home	Shelter Care
Court Intake/Studies	Congregate Meals	Home Delivered Meals
Recreation/Alternative Activities	Protective Payment/Guardianship	Supported Employment
Community-Based Residential Facilities	Advocacy and Defense Resources	Day Treatment
Residential Care Apartment Complexes	Home Accessibility Screening	Day Center Service Treatment
Counseling and Therapeutic Resources	Skilled Nursing	

Community-Based Long Term Care Services Under Medicaid State Plan

Case Management	Home Health Aide	Personal Care
Therapies (Speech, Occupational, Physical)	Transportation for Medical Care	Medical Supplies
Skilled Nursing	Orthotics	Durable Medical Equipment
Mental Health Crisis Stabilization	Community Support Program	In-home psychotherapy
Mental Health Outpatient Services	Mental Health Day Treatment	

COP funds are even more flexible and can be used for expenditures not covered by the waivers, such as room and board, community services for persons still in a nursing home, or relative caregiver services. All COP and/or Waiver participants receive assessment, care planning and care management. The essential services such as durable medical equipment, mental health services, home health and personal care are provided under Wisconsin's Medicaid State Plan and authorized through a separate process.

The Waivers are administered through 67 county governments and one tribe. A total of 26,044 people were served under Wisconsin's COP and Waiver programs in 1999, distributed as shown in the Table below.

COP/Waiver Participants and Expenditures by Target Group

	Percent of People Served*	Percent of Expenditures*
Elderly	47.7	28.9
Physically Disabled	14.6	10.5
Developmentally Disabled	33.4	57.4
Seriously Mentally Ill	4.2	3.1
AODA /Other	1.1	0.15

* May not total to 100% due to rounding.

In CY 1999, Wisconsin's home and community based waivers accounted for \$385,417,641 in expenditures (state and federal funds). The state-funded COP program had expenditures of \$34,859,378 for the same year. In addition, counties use other state and federal funding

sources and county tax levy to support individuals in their homes. DHFS annually reports comparative costs to the legislature for elders and people with physical disabilities between the COP-Waivers and nursing homes. For 1999, taking into account all Medicaid and other public funds (includes all Title 19 benefits, state and county funds, and SSI), participants in the COP-Waiver had total public long term care costs of \$196.3 million a year while the same group in a nursing home would be estimated at \$335.5 million. Average daily costs were \$59.09 for waiver participants compared to an estimated daily cost of \$85.84 for nursing home care for the same group of people, adjusting for level of care.

Wisconsin also has four managed care projects that combine Medicaid and Medicare primary and acute care with long term care services. The PACE program serves elderly individuals and the similar Wisconsin Partnership Program serves elderly people and people with physical disabilities. In 1999-2000, over 1,200 were enrolled in PACE and Partnership. PACE and the Wisconsin Partnership Program provide Medicare and Medicaid acute and long term managed care at a cost of roughly \$37 million.

Family Care is Wisconsin's long term care redesign pilot program. The Family Care pilot managed long term care program had an annual budget of \$26,676,200 all funds in state FY '99 (with \$120,468,300 all funds budgeted in FY '00). A total of 3,786 adults were enrolled in Family Care as of August 31, 2001 in the five pilot counties. Further information on Family Care follows in the LTC Redesign section.

- **Persons with Serious and Persistent Mental Illness.** Wisconsin provides services to persons with serious and persistent mental illness in the community through Medicaid fee-for-service benefits, and through state and county-funded services. Counties in Wisconsin are responsible for adult mental health services within the limits of available funds (called the County Shield Law, s. 55.06(9)(a)). State, county and Mental Health Block Grant funds (known collectively as Community Aids) support a variety of flexible long term services for persons with serious mental illness and substance abuse. Medicaid pays for targeted case management, day treatment, in-home treatment, crisis stabilization, and Community Support Program (CSP) services (also sometimes called program of assertive community treatment). About 90 CSPs serve 6,000 individuals annually. Community Support Programs provide intensive care management, coordination and support services to prevent institutionalization. Community crisis stabilization services are successful in preventing out of home placements. In addition, there are two successful, flexible county managed care programs for children with severe emotional disturbances and their families which build off the county comprehensive Integrated Services Projects for children.
- **Children with Disabilities.** An estimated 20,000 Wisconsin children have disabilities and about half of them need long-term support to remain at home. The 4,000 disabled children in the Katie Beckett program received the wide range of Medicaid LTC services available through Medicaid fee-for-service. Over 2,500 children received services last year through the highly flexible, state-funded Family Support Program (FSP), allowing families to direct their own services and supports. The state provides COP and HCB waiver services to about 1,000 children (included in the previous COP and Waiver program totals). The Birth to 3 Program, part C of the Individuals with Disabilities Education Act (IDEA), serves 7,000

infants and toddlers. The Title V Children with Special Health Care Needs Program provides service coordination, referral and information at five regional locations to families whose children have a special need. Children also receive services under IDEA, Title I.

- **Medicaid.** Wisconsin spends roughly \$187,800,000 a year on an array of Medicaid State Plan services to support long term care needs in the community. The Personal Care services covered under the Medicaid fee-for-service card benefit include the full range of support for activities of daily living. The personal care benefit is “prior-authorized” by the state Medicaid agency. The services provided by personal care workers are under the supervision of a registered nurse, ordered by a physician and delivered according to a written plan of care. The Personal Care benefit is one of the faster growing components of the state Medicaid budget. In the last year, the state spent \$96 million, a 9.9 percent increase over the previous year. The Medicaid reimbursement rate for Personal Care rose to \$15.50/hour last year. Medicaid covered skilled nursing services in the home enables consumers with extensive nursing needs to live in community settings. Private duty nursing is covered in the community and other settings.
- **Housing.** According to a state survey, about 79 percent of people age 60 and over who live in the community own their own homes. As age increases, the likelihood of home ownership decreases. Home ownership is much more limited among people with disabilities.

Wisconsin has 82,632 federally assisted rental housing units. Of those, 42,272 or 51 percent are elderly units, while 3,466 (4 percent) are units for people with disabilities. In addition, the Wisconsin Housing and Economic Development Authority (WHEDA) subsidizes rental housing construction to provide reduced rents for low income tenants.

Wisconsin has several options for assisted living for persons with disabilities in which Medicaid waiver funds can pay for services. These include Adult Family Homes (AFHs – 1 to 4 residents), mid-sized Community-Based Residential Facilities (CBRFs – 5 or more residents) and Residential Care Apartment Complexes (RCACs). The current supply includes: 2,218 adult family homes with 4,000 beds; 637 CBRFs with 4,976 beds; and 55 RCACs with 2,134 units.

- **Waiting Lists.** As of 12/31/00, counties reported that 9,202 people are waiting for COP and home and community based waiver services, with 638 of those residing in nursing homes or other institutions. Counties reported that approximately 3,196 children were waiting for Family Support Services on December 31, 1999. Although the state does not collect wait list information from counties for Community Support Program services, through information provided by county programs it has been estimated that there are 272 people waiting for services. Counties report that there are a number of children waiting for the Integrated Services Project services. In the five Family Care pilot counties, waiting lists for community based care are being eliminated. The waiting lists in these counties have dropped from 3,129 people in December of 1998 to 2,798 as of December 31, 2000. As of September 30, 2001, it has been reported that four of the five Family Care pilot counties no longer have waiting lists. The only remaining county, Milwaukee, has estimated that their older adult COP and Waiver wait list is now down to roughly 1,000 people.

Institutional Services

- **Nursing Homes.** According to a December 1999 survey conducted by DHFS, Wisconsin had 424 nursing facilities, with 47,296 licensed beds. Wisconsin nursing homes had 39,719 residents on December 31, 1999 (84 percent occupancy rate). For 66.8 percent of these residents, Medicaid was the primary pay source with an average per diem cost of \$98 for Medicaid recipients.

Most people (>84 percent) residing in nursing homes are at the Skilled Nursing level of care and 93 percent are age 65 or older. Over one-fourth of nursing home residents had been in the same nursing facility for four or more years. Almost 80 percent of admissions to nursing facilities were from acute care hospitals. About 46 percent of discharges were to a less restrictive community setting, while 31 percent of the discharges were due to the death of the resident.

- **Institutes for Mental Disease.** Institutes for Mental Disease (IMDs) are a very small subset of the nursing homes in Wisconsin. Altogether there are four licensed IMDs with a total capacity of 337 beds. On December 31, 1999 286 people resided in IMDs. Most admissions are from acute care or psychiatric hospitals and another 5% were admitted from other nursing homes. Twenty-one percent of residents in IMDs were protectively placed under Chapter 51, 69% were protectively placed under Chapter 55 and 62% had a court appointed guardian.
- **State Mental Health Institutes.** The state operates two state Mental Health Institutes that provide acute psychiatric hospital services, with a total population of 553, as of April 2001. This includes both civil and forensic patients. The Institutes perform short-term “competency” assessments. For forensic patients they are used to advise a court as to whether a defendant is competent to stand trial. They also provide treatment for individuals who cannot be successfully treated elsewhere. About 42% of the beds are for civil commitments and 57% are for forensic patients. Length of stay varies from 2 weeks to 6 months for most civil admissions, and the length of the commitment for forensic patients averages several years.
- **Intermediate Care Facilities for the Mentally Retarded.** Wisconsin had 37 intermediate care facilities for the mentally retarded (ICFs-MR). These facilities had a total licensed capacity of 2,119 and 1,951 residents (92 percent occupancy rate). Over 99 percent of residents had Medicaid as the primary pay source and an average daily cost of \$138. More than 78 percent of residents of ICFs-MR were under age 65. Over 75 percent of residents of ICFs-MR have been in the facility for five years or more. Most (57 percent) admissions were from a community setting. Forty-nine percent of discharges were to the community.
- **Developmentally Disabled Centers.** DHFS also operates three State Centers for persons with developmental disabilities with a census of 875 individuals.

- **Expenditures.** The Medicaid budget for nursing homes is over \$1 billion annually. The State allocates \$3.6 million in state funds annually for persons in IMDs with counties matching at least the same amount from locally administered funds. In addition, the State spends roughly \$118,600,000 on residents in the three State Centers for Developmental Disabilities. The total budget for fiscal year 2001 for the two Mental Health Institutes was \$82.3 Million.

Long Term Care Redesign in Wisconsin

In 1995, Wisconsin began an extensive strategic planning process to redesign the long term care system, long before the *Olmstead* Supreme Court decision. This was a very extensive process involving hundreds of consumers, consumer advocates, providers and state staff. Together they drafted a set of guiding principles for redesigning the system as well as key strategies. Three parallel planning efforts evolved to implement this new vision, including Family Care for adults with developmental disabilities, physical disabilities and frailties of aging; a redesign of the public mental health and substance abuse system; and a redesign of the system for children with severe disabilities. All three efforts share the values of consumer choice: flexible and comprehensive services, improved access, cost-effectiveness, and consumer outcome focused quality.

- **Family Care.** Family Care is the most evolved of the redesign processes. Wisconsin began piloting its new model of long term care delivery for adults with physical and developmental disabilities and frail elders in 1999. Family Care is a managed long term care program that combines the state, federal and local funding for community and institutional long term care into a single capitated benefit.

Family Care provides a one-stop shop for general information and assistance, institutional and residential services pre-admission counseling, prevention, and intake for long term care programs through an Aging and Disability Resource Center in each Family Care county. A Care Management Organization is responsible for enrolling interested individuals and providing assessment, care planning and services through a network of providers created to provide quality, cost-effective services and to offer maximum consumer choice.

Family Care addresses key issues in the ADA Title II and *Olmstead* through its pre-admission consultation process prior to institutional placement to assure all individuals will have access to someone who can help them make informed choices. In addition, all eligible and entitled individuals must have access to services, including community-based care, as appropriate. Decisions regarding a care plan are to be done in a structured process that begins with identifying the consumer's key outcomes and building a care plan with the consumer to achieve those goals.

Five counties are piloting the full Family Care benefit and the Resource Center: Fond du Lac, Portage, La Crosse, Milwaukee and Richland Counties. In addition, four counties are providing just Resource Center services: Kenosha, Trempealeau, Marathon and

Jackson. As of July 31, 2001, of the 3,607 people were enrolled in Family Care in those five counties, 1,964 were elderly and 1,135 were disabled.

Wisconsin is proceeding carefully with the implementation of Family Care, allowing time to evaluate before expanding to additional sites. While it is hoped that Family Care implementation will expand incrementally beyond the five pilots over the next decade, the rest of the system in 67 counties can be improved in the short term by adopting some of the same strategies which are incorporated in this ADA Plan.

- **Mental Health and Alcohol and Other Drug Abuse (AODA) System Redesign.** The Mental Health/AODA redesign has many similarities to Family Care. Initially, four sites were intended to operate as county managed care organizations to deliver mental health, substance abuse, psychosocial rehabilitation services and alternative supports to people with severe mental illness, many who also have substance abuse service needs. The initial design included a single funding stream to counties that combined prepaid Medicaid capitated dollars with Community Aids. The feasibility of this model is currently under review. The goal of the pilots is to assure consumers have a comprehensive array of options and choices to meet an individual's identified strengths, needs and outcomes, with a focus on prevention, early intervention and recovery.
- **Children's Long Term Support Redesign.** The redesign of the long term care system for children has also developed on a parallel track. The special circumstances of children and families and the interactions with the education and child welfare systems led to a distinct planning process. A Children's Long Term Support Redesign committee, with a parent majority, has been working to develop changes including planning a Medicaid children's home and community based waiver that would provide flexible and family centered long term support services that are appropriate for children across the spectrum of disabilities.

System Strengths

- **National Reputation.** In the past, Wisconsin has had a strong reputation in the field of community-based long term care and mental health. The COP program and CSPs are often cited as models for community-based services and have been nationally recognized for their innovation. County care managers implement programs locally and many are tremendously creative. The programs are designed in such a way as to have the care managers work with consumers to build individualized plans of support around community resources. The care managers authorize payment for services. Wisconsin's Medicaid program is recognized as one of the most comprehensive in the country, covering all Medicaid's mandatory and optional services. Financial resources have been added in each biennium for community based long term care programs, such as COP and the Waivers. Overall, the state provides a significant amount of financial support for a variety of long term care services. Wisconsin reported a high per capita Medicaid expenditures for home care in 1999 at \$77 per capita, compared to the national average of \$58 per capita.

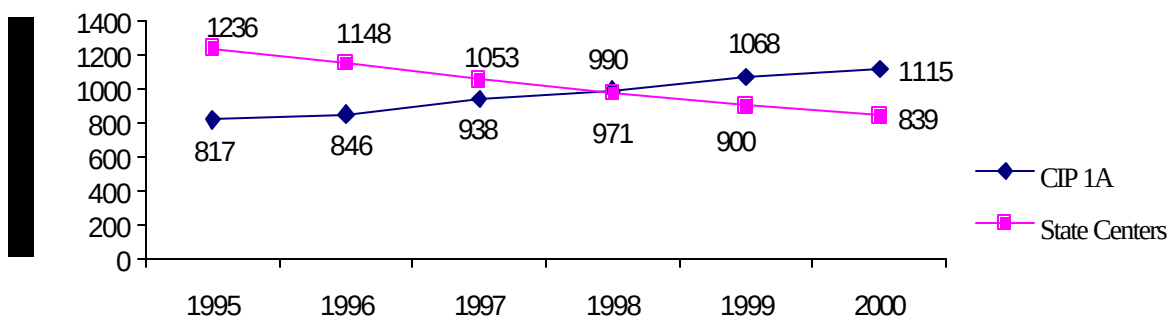
- **Relocation Efforts.** In 1999, Wisconsin developed a project known as Homecoming with the assistance of a federal Centers for Medicaid and Medicare Services nursing home transition grant and will continue these efforts with a second grant. The project was initially targeted, but not limited, to non-elderly persons with physical disabilities. During the 15 months of the first Homecoming grant, more than 80 individuals were placed in the community through the efforts of the project partners. These people are being supported in the community through a combination of COP/Waiver, Medicaid fee-for-service, and local funds.

In June of this year, DHFS announced the availability of an additional \$1 million for relocations from nursing homes. By early October, 87 people who were on waiting lists have moved out of nursing homes. A second \$1 million will be set aside in January for additional relocations.

In addition, through the CIP II program, as nursing homes close, the Department has developed a process to work with counties to relocate as many individuals as possible in the time available before closure.

DHFS has developed strategies to identify and relocate persons with developmental disabilities from the State Centers for Persons with Developmental Disabilities. A special waiver program (CIP 1A) was developed to fund community services for persons relocated from State Centers. By the year 1999, the number of persons served in the community in CIP 1A (1,068) exceeded the number of residents in the State Centers (900). The trend of relocation and community development continues as community providers become increasingly skilled at developing services in the community for persons with significant disabilities. The census at the three Centers stands at 875. Below is a chart that shows these trends over time.

Number of People in the State Centers vs. Number of CIP 1A Participants



System Challenges

Wisconsin's current long term care system has a number of issues that need to be addressed to assure that people are served in the most integrated setting.

- **Reliance on Institutional Capacity.** In spite of Wisconsin's efforts to expand the availability of community-based long term care, Wisconsin still relies on the extensive capacity of its nursing homes. In 1998, Wisconsin had 557 nursing home beds per 1,000 population age 85 and above, compared to a national average rate of 451 per 1,000.

A nursing home is still the first—and often the only—option that many people consider when addressing the care needs associated with aging and disabilities. Families seek a safe, predictable setting for aging parents. Elders, people with disabilities and families are often not familiar with the available community options and turn to nursing homes and institutions for help. Physicians and hospital discharge planners often rely on nursing homes for post-hospital recuperative care. In addition, Medicaid provides a powerful fiscal incentive by providing entitlement to nursing home care for eligible individuals.

Medicaid fee-for-service community-based supports are entitlements, but many people need assistance beyond what these services can provide. Many community-based services are provided under waivers and are only available within proscribed budget authority. Wisconsin has a unique Community Integration Program that can shift some funding to community care when a person relocates and a nursing home bed closes. However, these funds are not available for a relocation when a bed is not closed.

- **Limited resources for home and community based care.** The current home and community based waiver services can be provided up to the maximum set by the state legislature. Although the resources for some of the home and community based services have increased over the past decade, they have not kept up with the number of people requesting services, and continue to increase in non-Family Care counties. As of 12/31/00, counties reported 9,202 people waiting for COP and home and community based waiver services, 638 of those were residing in nursing homes or other institutions.
- **Limited screening or outreach to nursing home and other institutional residents.** The limited state funding has reduced the ability of counties to do outreach to persons in nursing homes. As a result outreach to identify people in institutions who want to return to the community is not consistent across the state. The current Pre-Admission Screening and Resident Review Process required by the federal government before individuals with mental illnesses or a developmental disability can be admitted to a nursing home, has been questioned as efficacious in assuring individuals are appropriately placed.
- **Few incentives for counties or nursing homes to encourage relocations.** Since the state and federal government pay for nursing homes under Medicaid, but do not pay for some community-based services, there are disincentives to relocate people. The philosophy of some counties is that people in nursing homes are safe, and so, scarce

resources should be focused on people in the community who may face greater risk to health and safety.

- **Nursing home staffing difficulties and increasing closures.** With current shortages in staffing, it is difficult for nursing homes to identify persons appropriate for relocation and to develop transition plans and community services. Even though such relocations are difficult, they do happen as nursing homes close. However, the state has not been realistic in budgeting for nursing home bed closures and continues to underestimate the actual closure rates in the state budget for the CIP II program. Over the past two years, an estimated 1,400 nursing home beds have closed.
- **Variation among county practices because of local control.** “Home rule” is highly valued. At the same time, counties struggle with extensive needs among older people and people with disabilities who wish to remain in the community and avoid or postpone nursing home admission. Thus few incentives exist for counties or nursing homes to identify and relocate nursing home residents to the community. Consequently, there is variation across the state in the provision of opportunities for greater community integration for nursing home residents.
- **Initial cost of relocation.** Even if funds are available for on-going costs in the community through waivers and/or Medicaid card services, initial costs for relocating residents of nursing homes are higher than starting services for community-dwelling applicants for COP or the Waivers. Since some of these costs can only be funded from scarce state COP resources, counties are reluctant to develop expensive plans. Developing these more complex plans also takes a great deal of care manager time and effort.
- **Insufficient peer support for people needing informal support to make a transition.** People who have lived for a long time in an institution may have few connections to the community. They and/or their guardians may be fearful of relocation and need support both in the decision-making process to relocate and after relocation. People doing outreach in the *Homecoming* project found that even when people had asked to be on a waiting list, when confronted with the imminent possibility of relocation, they were apprehensive. Guardians of persons with developmental disabilities and mental illness often lack knowledge of the community supports available and have significant concerns about relocations to the community. Peer support strategies can be very effective in providing people with useful information and a sense of security.
- **No Medicaid Waivers for persons with mental illness.** Under federal requirements, persons with only a mental illness diagnosis do not qualify for Medicaid home and community based care waivers. Their community service costs are covered only by fee-for-service Medicaid benefits, Community Aids and county funds. Relocations for these individuals can be very difficult and expensive for counties. Counties have been responsible for costs to serve adults with mental illness in the state Mental Health Institutes or other inpatient settings. However, Medicaid does pay for children in those

facilities, which many claim has led to incentives for counties to use those facilities for in-patient psychiatric care for children.

- **Serving persons with severe mental illness and challenging behavioral problems.** County COP and Waiver program staff often report needing assistance when making successful placements for persons with complex needs. For persons with mental illness who reside in nursing homes or in IMDs, relocation is often difficult due to their extensive and complicated needs. These persons may have significant and multiple diagnoses (mental retardation, severe mental illness, history of physical or sexual abuse, substance abuse, brain trauma, etc.). They often experience difficulties in community living, and may have poor housing/rental histories that make finding housing in the community extremely difficult. Care managers in small counties may not have sufficient experience with dually-diagnosed or otherwise complex individuals to be able to develop a successful care plan. Many local provider agencies are not prepared to provide services to consumers with dementia or severe mental illness who require more intensive care management and advocacy by counties. Behavioral problems can pose a real barrier to nursing home discharge.
- **Personal Care and Home Health Services have limitations.** Wisconsin's Medicaid home care benefits have limitations. Personal care benefits are not covered outside the home in natural settings and cover only activities of daily living, but not many instrumental activities of daily living. DHFS has increased flexibility in these benefits, such as decreasing the frequency of nurse supervisory visits, when appropriate. DHFS is exploring offering a choice of consumer-directed care for those recipients who are interested and able to take a larger role in directing their care. Although some states use their Home and Community Based Waiver case managers to authorize Medicaid State Plan personal care services for people (which make up the bulk of personal care recipients), Wisconsin has not done so.
- **Shortage of accessible, affordable housing.** Some consumers who were identified for community placement under the *Homecoming* grant either were not relocated, or had their relocation delayed, because suitable housing was not available. Many areas have waiting lists for Section 8 vouchers or have little accessible and affordable housing available. Housing delays make it difficult to develop a plan for individuals and create frustration for community agencies working on relocations.
- **Lack of adequately trained workforce.** Successful community placements are dependent in large part on the existence of a trained and dedicated direct care workforce. Prolonged high employment rates in the state have contributed to a serious shortage of direct care workers in all long-term care services and settings. Turnover in many facilities is as high as 100 percent, and turnover among home care workers is often at least 50 percent annually. Without an adequately trained workforce, home and community based services are difficult to put in place even when adequate resources are available. DHFS has identified a position to serve as a point person to provide leadership on this issue.

Appendix B: LTC Council Members

Tom Rand, Council Chair
Bethany St. Josephs Care Center
La Crosse, WI

Carol Eschner, Vice Chair
Interfaith
Milwaukee, WI

Chuck Wilhelm, Council Secretary
Director, Office of Strategic Finance
DHFS
Madison, WI

Dale Block, Consumer Member
Independent Living Council
Black River Falls, WI

Lynn Breedlove
Wisconsin Coalition for Advocacy
Madison, WI

Beth Christie
Laureate Group
Waukesha, WI

Tom Frazier
Coalition of Wisconsin Aging Groups
Madison, WI

Diane Hausinger
Director of Administration
Fond du Lac, WI

Julie Litza
Director of Medicaid Services
United Health Care of WI, Inc.
Milwaukee, WI

Rita Maher, Consumer Member
Brown Deer, WI

Ella Pious, Consumer Member
Burlington, WI

George Potaracke
Board on Aging and Long Term Care
Madison, WI

David Slautterback, AARP
Madison, WI

Melvin Steinke, Consumer Member
Wisconsin Rapids, WI

Alice Westermeier, Consumer Members
Campbellsport, WI

Appendix C: ADA Committee Members by Workgroup and Other Members

Program Design Workgroup Members

Lynn Breedlove, Workgroup Chair Wisconsin Coalition for Advocacy Madison WI	Steve Stowell Wisconsin Department of Workforce Development Madison, WI
Julie Button Ombudsman Green Bay, WI	Jennifer Ondrejka Wisconsin Council on Developmental Disabilities Madison, WI
Shirin Cabraal Legal Action of Wisconsin Milwaukee, WI	Ruth Roschke Mental Health/AODA Pilots Implementation Madison, WI
Scott Durren State Independent Living Council Madison, WI	Lisa Mills People First of Wisconsin Milwaukee, WI

Research and Data Workgroup Members

David Slautterback, Chair AARP Liaison Madison, WI	Rita Odegard AAA of Dane County Madison, WI
Barry Blackwell Wisconsin Council on Mental Health Milwaukee, WI	John Olson Governor's Committee on People with Disabilities Mineral Point, WI
Molly Cisco Grass Roots Empowerment Project Milwaukee, WI	George Potaracke Board on Aging and Long Term Care Madison, WI
Marjorie Kozich Wisconsin Housing & Economic Development Authority Madison, WI	Chuck Wilhelm Wisconsin Department of Health and Family Services Madison, WI

Legislation and Budget Workgroup Members

Thomas Frazier, Chair
Coalition of Wisconsin Aging Groups
Madison, WI

Phillip Borreson
Trempealeau County Health Care Center
Whitehall, WI

Shel Gross
Mental Health Association
Madison, WI

Liz Hecht
Family Voices
Madison, WI

Steve Jones
Bethesda Lutheran Homes & Services
Watertown, WI

Larry Kleinsteinber
Wisconsin Department of Veterans Affairs
Madison, WI

Rachel Letzing
Legislative Council
Madison, WI

Maggie Merdler
Wisconsin State Employees Union
Madison, WI

Byron Olson, Consumer Member
Wild Rose, WI

Laura Rose
Legislative Council
Madison, WI

Maureen Ryan
Wisconsin Coalition of Independent Living
Centers
Madison, WI

Craig Thompson
Wisconsin Counties Association
Monona, WI

Sinikka McCabe, Administrator, DSL
Wisconsin Department of Health & Family
Services
Madison, WI

Client Evaluation and Assessment Workgroup Members

Dale Block, Chair,
Consumer Member & Independent Living
Council
Black River Falls, WI

Claire Ryan
National Alliance for the Mentally Ill
Middleton, WI

Laura Flood
Wisconsin Department of Health & Family
Services
Madison, WI

John Schad
Kewaunee County Human Services
Algoma, WI

Earl Hawley
Trans Corp
Kenosha, WI

Steve Verriden
Access to Independence
Madison, WI

Steve Mercaitis
Wisconsin Personal Services Association
Prairie du Chien, WI

Deb DeRoos
Former Ombudsman
Madison, WI

Marge Pifer
Wisconsin Department of Health & Family
Services
Madison, WI

ADA Advisory Committee Other Members

Charlene Dwyer, Administrator
DWD Division of Vocational Rehabilitation
Madison, WI

Peggy Handrich, Administrator
DHFS Division of Health Care Financing
Madison, WI

Tim Hartin
Wisconsin Health & Hospitals Association
Madison, WI

Brian Purtell
Wisconsin Health Care Association
Madison, WI

Appendix D: Program Profiles – Systems Design Workgroup

ADA Title II Analysis of Wisconsin LTC Programs-7/9/01

Does this program meet the *Olmstead* criteria?

Program: Brain Injury Waiver	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	- No outreach officially done by the State; some counties tell people about the program. It appears <i>Olmstead</i>/ADA rights are not routinely communicated to current/potential clients. - Currently under-spending due to promised slots that are still open (client not ready) and eligibility requirements (see #2 below).
2. Full access to community services / funding for institution residents.	- Very limited access to this waiver: Based on administrative decision, the only consumers who are eligible are those who have spent a cumulative 60 days at one of four state-selected subacute rehab centers, and who obtain Prior Authorization from MA (Prior Authorization is for paying the nursing home subacute at a higher rate--\$500-600 per day--than the typical MA rate of less than \$100 per day). - The other crucial factor is whether the county is willing to apply for a slot (some counties have opted out). 208 slots funded (as of 4/01), of these 205 are actually used. The remaining 3 are assigned but vacant (one of these will soon be used). Assigned slots can be held/promised for one year with no expenditures. There is a wait list of 12 people. - Written policy indicates applications for the BIW should not be made until the individual is within 90 days of being discharged from the subacute. This is enforced more now than in the past. Average length of stay among the four acceptable centers is 135 days. The largest center has the longest average days of stay at 279. - Can only do relocations (no diversions). Prior to 1/99, diversions were allowed. - No age requirement for BIW, <u>but</u> the four state-selected subacute rehab centers only accept people who are 15 years or older. - There are rights to appeal through the Dept. of Hearings and Appeals.
3. Community services funding adequate to provide quality services.	Once eligible, funding is very good. Average per diem is \$180 per day. Formal rate = \$167 / day. The range of daily costs in the program is \$25 - \$500 per day. (The extra money to fund the higher average cost comes from unused dollars in the BIW budget. The entire budget is not expended because of the slots that are assigned but vacant, and from slots that are used for low cost clients who could be adequately served by other programs such as CIP IB or CIP II, but aren't on those programs due to wait lists. If these low cost clients were served by other programs, the BIW slots could be used

Program: Brain Injury Waiver	
Criteria	Analysis
	to serve individuals who have greater needs, more in line with the \$167 per day allocation). • Cost averaging allows for high-cost cases. (One case is currently at \$500 per day.)
4. Funding for up front costs to relocate people from institutions.	• Comprehensive, flexible. • Will fund home modifications and equipment not covered by MA card.
5. Consumer choice in decision-making.	• State encourages counties to honor consumer choice; level of choice depends on counties. • Client often under guardianship.
6. Adequately comprehensive package of community services.	• Generally comprehensive, but availability of specialized services may be an issue in some communities.
7. Which “state professionals” determine who can live in the community?	• Clients are dependent on a referral from one of the four sub-acute rehab centers to the county; then the county makes the application to the state. • Willingness of the counties to apply varies greatly. Some refuse due to possible liability (could incur part of the cost).
8. Safeguards around guardian decision-making.	• County case managers are expected (by the state) to address guardianship issues. • Occasionally the state Community Integration Specialists (in BDDS) will help mediate disputes.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	• Administrative eligibility criteria is more of an issue / barrier to community placement than the needs of the client.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

Children Come First (CCF) serves ages 0 to 18. It is an 18 month intensive family-centered and individualized program. Normal caseload is 125 cases but can serve up to 145 cases at any time. Serves Dane County.

Wraparound Milwaukee (WM) generally works with adolescents aged 13 to 17 and will take younger children. Cut-off age is 18. WA won't work with really young children. WM's normal caseload is 550 to 600 adolescents per year.

Both CCF and WM are Medicaid managed care programs. The goals of the programs are to provide wraparound services to the community to prevent and shorten institutional placements for children with serious emotional disturbance (SED).

Program: Children Come First and Wraparound Milwaukee	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	• By WI Code, children are required to be kept in the “least restrictive setting.” • One of the main goals of both CCF and WM is to keep the child out of residential child caring facilities (RCC) or other institutions. Adolescents used to be kept in RCCs for years. • Disenrollment planning starts as soon as the child is accepted into CCF or court-ordered into WM. • For both WA and CCF, treatment is family-centered and family-directed. A treatment team is made up of those individuals the child and family wants, especially natural supports such as extended family, members of their church, neighbors-individuals who will be there when the children and family leave CCF or the court order to WM ends. With WM, a care coordinator puts together the family's treatment team which also includes the welfare worker or probation officer. With CCF, a care coordinator coordinates the team. • For those children in CCF who do go into RCCs while in CCF, the average length of stay is 4 ½ to 6 months. See answer to question #7. • For those children in WM who do go into an RCC while in WM, the stay in the RCC is only for a few days and only when they are a danger to themselves or others. See also answer to question #4.
2. Full access to community services / funding for institution residents.	• CCF gets \$8 million per year or \$3,500 per month per child/family regardless of actual cost. • WM costs per child vary with the child's and family's needs. The range is \$1,000 to \$10,000 per month per family (\$3600 average cost). • With CCF, there is an ARFT unit that coordinates CCF cases. The county contracts with Community Partnerships for up to a caseload of 145 families. CCFP is a private managed care entity that must provide case management, treatment and out-of-home placement at a cost of \$6,000 per month, if needed.

Program: Children Come First and Wraparound Milwaukee	
Criteria	Analysis
	50% of the funding comes from Medicaid for CCF and if Medicaid is unavailable the county pays. - WM pays all costs associated with stays in RCCs.
3. Community services funding adequate to provide quality services.	- The vision of CCF and WA is to coordinate everything that is available to support the child's treatment needs in the community. However, Lynn Green notes that often the less spent, the better because if too much is spent, the family often becomes too dependent and can't disengage and the child feels yet another loss. - CCF and WM treat the whole family – this may include such things as AODA treatment for a parent, housekeeping, etc. - When the court order includes meeting certain conditions and/or goals, these become a part of the process.
4. Funding for up front costs to relocate people from institutions.	- Upfront costs to locate children from RCCs or other institutions are covered by CCF and WM capitated funds. - With WM, if a child in WM requires a stay longer than several days in an RCC, several safeguards are put in place by WM: (a) WM must give its authorization before the child can be placed in an RCC; (b) a care coordinator from WM oversees the child's care while in the RCC; (c) WM requires a monthly report on the child's treatment, therapy and the family's therapy. - If a child comes to WM from an RCC by court order, his/her therapist must work with the WM team.
5. Consumer choice in decision-making.	For both CCF and WM, the family and the child are the center of the whole decision-making process. Diane Thompson says that adolescents know their strengths and weaknesses and they know what they need. But for both CCF and WM, final decisions are team decisions.
6. Adequately comprehensive package of community services.	The most intensive care for children and their families in Dane and Milwaukee County is in CCF and WM respectively.
7. Which "state professionals" determine who can live in the community?	- All child institutionalizations are court ordered and the child cannot leave without the court's order to do so. The court may order the child to a group home, home, or if treatment failed, to corrections. - Screening for who is eligible for CCF is done by the Administrative Review Board (ARB). ARB is made up of family members, professionals, and county staff. The ARB is mandated to review all social worker recommendations that a child be institutionalized before the social worker can present the case to a court. The ARB must either approve taking the case to a court or come up with an alternative plan. - With WM, the court's order into WM can be extended if the criteria in answer to question #9 are not yet met when the original order ends.
8. Safeguards around guardian decision-making.	For both CCF and WM, the guardian simply "replaces" the family and its decision-making authority in the team process.

Program: Children Come First and Wraparound Milwaukee	
Criteria	Analysis
	WM notes that the main problem with guardians is when WM can't find them. They have to search and if they cannot find the guardian, they go to court and have WM appointed as temporary guardian. If the child has no real family, upon discharge from the court's order the child is placed in a foster home or group home – WM "builds" a new family for the child.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	1) <u>Criteria for getting into CCF and WM:</u> For CCF, the criteria used to determine whether a child should be accepted into CCF are (a) an SED diagnosis by a psychologist or psychiatrist, (b) the child is at risk of being institutionalized (documented by a social worker), (c) the child is actively on the case load of a social worker working under the director, (d) all traditional serves have failed. <u>For WM,</u> a court must order the child into WM. The child is referred to the court by a child welfare worker or a probation officer. The court declares the child a child in need of protective services and orders the child into WM, sometimes with specific conditions and goals. The child must also have an SED diagnosis that is determined by a psychologist or psychiatrist. 2) <u>Criteria for getting out of WM or CCF:</u> The criteria the court and WM look at before discharge from WM are: (a) if the adolescent is old enough, is there adequate planning for school or vocational training; (b) the family has the ability to access resources if needed; (c) all members of the team are together on the plan for the child and family; (d) child has met program goals or has voluntarily disenrolled. .

ADA Title II Analysis of Wisconsin LTC Programs- 6/27/01

Does this program meet the *Olmstead* criteria?

Summary: CIP 1A is the Medicaid Waiver program which provides community services for children and adults with DDs who have moved out of the “State Centers for the Developmentally Disabled.” People already in the CIP 1A Program are receiving various levels of funding, partly because the CIP 1A rates were at different levels at the points in time when individuals moved out of the Centers. At present, the rate for “new placements” out of the Centers is \$190/day. The governor’s budget proposed changing that to \$200/day in Year One, and \$225 in Year Two – with no proposed rate increase for people already in CIP 1A.

Program: CIP 1A	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	- Some DD Center residents could understand the essence of <i>Olmstead</i>; some can’t. <i>Does anyone explain it to residents? To families?</i> Probably not. <i>Is information given to people when institution placement is imminent, re: available program, ADA rights?</i> Probably varies by county.
2. Full access to community services / funding for institution residents.	- Varies by county. CIP 1A is a “voluntary program,” the county doesn’t have to be proactive. - It takes time (sometimes a lot) before placement is made. - CIP 1A does not cover the county’s costs incurred during the pre-placement planning process for each individual. - The Governor’s proposed rate increase will increase the number of people who could move to the community and received quality supports, but perhaps only by a modest amount.
3. Community services funding adequate to provide quality services.	- DHFS has documented that there are some DD center residents who could move into the community if the CIP 1A rate were raised. - Some Center residents will require a higher rate than \$225/day.
4. Funding for up front costs to relocate people from institutions.	No up-front costs covered.
5. Consumer choice in decision-making.	<i>How does discharge planning take place? Do consumers have any say?</i> Not clear.
6. Adequately comprehensive package of community services.	- CIP 1A and Medicaid card services – pretty flexible and broad. <i>Is supported employment allowable?</i> <i>Does it link / coordinate with other programs?</i> <i>Are any services excluded?</i> <i>What about paying families for direct care?</i>
7. Which “state professionals” determine who can live in the community?	<i>Do Center staff express opinions?</i> <i>Are outside professionals involved? Until review?</i>
8. Safeguards around	<i>Do guardians have too much veto power?</i>

Program: CIP 1A	
Criteria	Analysis
guardian decision-making.	• <i>Do courts / counties shy away from overriding guardians?</i>
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	• Eligibility = ok • <i>Who is considered “appropriate to leave?”</i>

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

Program: CIP 1B	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	- Some DD residents could understand the essence of <i>Olmstead</i>; some can't. <i>Does anyone explain it to residents? To families?</i> <i>Is information given to people when institution placement is imminent, re: available program, ADA rights?</i>
2. Full access to community services / funding for institution residents.	- Varies by county. CIP 1B is a "voluntary program," the county doesn't have to be proactive. - It takes time (sometimes a lot) before placement is made. - CIP 1B does not cover the county's costs incurred during the pre-placement planning process for each individual.
3. Community services funding adequate to provide quality services.	- There are some ICF-MR residents who could move into the community if the CIP 1B rate were raised. - Most ICF-MR residents will require a higher rate than \$48.33/day.
4. Funding for up front costs to relocate people from institutions.	No up-front costs covered.
5. Consumer choice in decision-making.	<i>How does discharge planning take place? Do consumers have any say?</i> Varies by county.
6. Adequately comprehensive package of community services.	- CIP 1B and Medicaid card services – pretty flexible and broad. - Supported employment is allowable. - Does it link / coordinate with other programs? (<i>Examples??</i>) <i>Are any services excluded?</i> <i>What about paying families for direct care?</i> Yes, for adults, except can't pay the participant or spouse.
7. Which "state professionals" determine who can live in the community?	<i>Do Center staff express opinions?</i> <i>Are outside professionals involved? Until review?</i>
8. Safeguards around guardian decision-making.	<i>Do guardians have too much veto power?</i> <i>Do courts / counties shy away from overriding guardians?</i>
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	- Eligibility = ok <i>Who is considered "appropriate to leave?"</i>

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

Program: CIP II	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	• Very little information about CIP II or ADA given to institution residents or others. • Dependent on county. • Strong presumption (by many counties and families) that people in NH's could not make it in the community.
2. Full access to community services / funding for institution residents.	• In most counties, with the exception of a few counties and/or a few people in some counties. • Most institution residents are not listed on CIP II waiting lists.
3. Community services funding adequate to provide quality services.	• Dependent on county (i.e. some counties supplement the rate. • State rate = \$40.78 / day.
4. Funding for up front costs to relocate people from institutions.	• No up-front costs covered.
5. Consumer choice in decision-making.	• Dependent on county, and even on specific case manager. • People who are strong self-advocates or have advocates often get more choice.
6. Adequately comprehensive package of community services.	• Dependent on county
7. Which "state professionals" determine who can live in the community?	• No state staff involved
8. Safeguards around guardian decision-making.	• Dependent on county
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	• No state staff involved.

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

Program: Community Aids	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	Generally not as an outgrowth of Community Aids; dependent on county. All federal and state regulations must be met.
2. Full access to community services / funding for institution residents.	Dependent on county.
3. Community services funding adequate to provide quality services.	Dependent on county.
4. Funding for up front costs to relocate people from institutions.	Dependent on county. It's allowable.
5. Consumer choice in decision-making.	Dependent on county.
6. Adequately comprehensive package of community services.	Dependent on county. The funding is flexible.
7. Which "state professionals" determine who can live in the community?	No state staff involved.
8. Safeguards around guardian decision-making.	Dependent on county.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	No state staff involved.

ADA Title II Analysis of Wisconsin LTC Programs:

Does this program meet the *Olmstead* criteria?-6/27/01

Note of information by work group: Of those receiving services under COP and COP Waivers, approximately 50% are elderly; the other 50% are roughly evenly divided among DD, physical disabilities, and mental health.

Program: COP and COP Waivers	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	• Most people in NHs don't know they are COP-eligible. • Minimal county outreach re: COP (less than there was some years ago) – partly because of COP waiting lists. • Some counties are relatively inactive re: helping people move out of institutions. • Strong presumption (by many counties and many families) that people in NHs and ICF/MRs could not make it in the community. • County staff do not have enough time to do outreach.
2. Full access to community services / funding for institution residents.	• Re: NH closings, there is often uncertainty about availability of a COP / CIP II slot. • COP / COP W wait lists • Counties are not inclined to process if it looks like community services will exceed NH costs. Prevailing attitude that cost should be the deciding factor. • Most institution residents are not even listed on COP / COP – W waiting lists. • There is a shortage of workers to provide services. • Issue: accountability. Counties need to know their <i>Olmstead</i> liabilities (they are not immune from suit). • In COP (not COP – W) people's right to continued service is not guaranteed to be "portable" (when the person moves to a new county).
3. Community services funding adequate to provide quality services.	• Current COP rates: \$40.78 / day.
4. Funding for up front costs to relocate people from institutions.	• COP funds can be flexibly used, for household needs, furniture, other transitional expenses. • COP-W funds are more limited.
5. Consumer choice in decision-making.	• Flexible re: in-home options. • Hospital discharge planners have limited time to make arrangements and move people out. It is easier to discharge someone to a NH than to a community setting; this may mean that planners sometimes avoid suggesting community placements. • Institution residents who are COP eligible do not have much choice about whether to use COP. In some cases no one is offering it to them.

Program: COP and COP Waivers	
Criteria	Analysis
	It's hard to do outreach when there is no funding available. • Once a person is in COP, the level of choice (package of services, workers, etc.) varies from county to county. • When there is choice, there is usually a limited array of options. • People who are strong self-advocates or have advocates often get more choice. Family support affects level of choice.
6. Adequately comprehensive package of community services.	• Case manager caseloads are too high in many counties. • Often necessary to supplement COP with MA and other services. • Some COP workers aren't aware of, or can't access, the services some people need. This is partly due to high turnover, and needs for training. • COP is one of the more flexible programs we have.
7. Which "state professionals" determine who can live in the community?	• No state staff are involved unless the NH, social worker, family or resident makes a referral to COP. • If referral is made, county social worker or county team will determine if the person can get into COP (considering likely cost, whether person appears to be "appropriate to the community"). • Counties need to balance high and low cost placements. Some counties manage funds better than others. • Level of care review does not look at COP possibilities or <i>Olmstead</i> criteria (paper compliance). • Generally "state professionals" do not look at <i>Olmstead</i> criteria for residents. • Key question: Do we view the county as an arm of the state?
8. Safeguards around guardian decision-making.	• Court review of protective placement (via WATTS review or as requested) can be a protection. But guardians often influence the judge. • If periodic assessment is offered, it's offered to the guardian. Guardians can waive the right to a COP assessment and opt not to put the person's name on the COP waiting list.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	• Not clear. • No "state professionals" routinely do this. • COP assessment is one mechanism for doing this. But this does not systematically ensure that NH and ICF/MR residents who meet <i>Olmstead</i> criteria will be able to move to the community.

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

Program: Community Support Programs (CSPs) (certified only – those that qualify for MA)	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	• ADA/<i>Olmstead</i> rights generally not communicated to current/potential participants. • CSPs are not residential programs, rather the staff go to wherever the consumer lives, socializes, etc. The CSP programs are individualized to the wants and needs, the hopes and dreams of each consumer. • There are 80 certified CSPs in the state. Not every county has a CSP; several counties have multiple CSPs, some have only one. • The waiting list problem is serious – those on waiting lists may not be getting any services, or may be getting insufficient services. At best, they are maintaining, not recovering. This group is at risk for homelessness, imprisonment, etc. The length of stay on a waiting list varies from program to program, county to county, ranging from months to years. • Both Winnebago and Mendota say that when a consumer comes from a CSP, his/her stay is shorter because he/she will return to the CSP. • The individual in the CSP receives services as long as the need exists. The problem with discharge is that if the individual becomes ill, there is no safety net. • There is a strong need to make room for more consumers in new or existing CSPs; the problem is insufficient funds. • When a consumer in a CSP is institutionalized, the CSP professionals generally follow the consumer to the institution. They are in on discharge planning, treatment, plan of care and collaboration with the consumer. The consumer's stay in the institution is shorter because the needed supports and services are already in place in the CSP.
2. Full access to community services / funding for institution residents.	• All CSPs are supposed to offer full access. In practice, this varies from county to county. Some CSPs are not able to offer vocational training or independent living. Variations may depend on the political climate of a county and/or on the personal attitudes of county personnel.
3. Community services funding adequate to provide quality services.	• No. Program people often have insufficient funding to provide quality services. • Staff turnover can be a problem. This also varies from county to county.
4. Funding for up front costs to relocate people from	• When a CSP consumer returns to home and CSP, the consumer may need initial intensive care, including shift staff, to help with

Program: Community Support Programs (CSPs) (certified only – those that qualify for MA)	
Criteria	Analysis
institutions.	food, activities of daily living (ADLs), emotional support. This is covered under the transitional funding that is part of the CSP support.
5. Consumer choice in decision-making.	• In terms of moving from one CSP to another (in those counties with more than one) they first work with the consumer to identify problems and potential solutions. CSPs strive for continuity of care and building of long-term relationships with CSP professional. In those counties with only one CSP, there is little or no choice. Again the problem here is lack of resources. • In terms of institutionalization, optimally, yes. If a trusting relationship exists, often the consumer can be reasoned into voluntary admission. If not functioning well enough to do so, there may be an involuntary commitment. Even with ED, the CSP consumer may consent to admission. • The only real problem occurs when the consumer feels ready to leave the institution but the Treatment Team and CSP professionals disagree. • Also, sometime the treatment system in the community is not yet in place, which may cause some delay.
6. Adequately comprehensive package of community services.	• See answers to #2 and #3, above.
7. Which “state professionals” determine who can live in the community?	• When an individual comes into an institution from a CSP, the state professional would include the institution’s Treatment Team working collaboratively with the CSP’s Clinical Coordinator and Case Manager, and in consultation with the CSP’s psychiatrist.
8. Safeguards around guardian decision-making.	• Willingness to work collaboratively with the CSP and the institution varies with the quality of the guardian; Some have corporate guardians. Overall, we need goo and more training for guardians.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	• N/A.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

Program: Family Care	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	- In the initial stages, this is not done systematically. But eventually the state expects counties to do extensive outreach, including institutionalized persons. - Resources Centers will likely be a positive force in this process. - Advocates may need to supplement this activity however.
2. Full access to community services / funding for institution residents.	- Eventually, this is essentially guaranteed by statute. - As a practical matter, however, it is possible (probably even likely) that many institution residents will not know about Family Care or know that they are eligible for it. - Family Care Independent Advocacy can help safeguard around this.
3. Community services funding adequate to provide quality services.	- There appears to be a good faith effort by DHFS to work with counties to ensure that the Family Care reimbursement rates are adequate to provide quality services. - It is too soon to ascertain whether that effect has been successful, or if counties have to sometimes resort to rationing services (a frequently voiced concern regarding managed care)
4. Funding for up front costs to relocate people from institutions.	- Family funding is relatively flexible. - Once a person enrolls in Family Care, they have access to Family Care funding, which could be used for upfront costs regarding institutional relocation.
5. Consumer choice in decision-making.	Consumer choice is prominently featured in Family Care Guiding Principles, statutory language, and rule. This includes access to a consumer-managed approach. It is too early in the development of Family Care to ascertain whether consumers generally perceive that they have an adequate array of choices.
6. Adequately comprehensive package of community services.	Family Care is certainly intended to provide a comprehensive package of services. If the array were limited it would probably be a result of arbitrary restriction of a county, or a county's inability to stimulate the development of certain long term care resources in their area.
7. Which "state professionals" determine who can live in the community?	Care plans for individuals enrolled in FC CMOS, including residential settings, are developed by the CMO interdisciplinary teams and the consumer. The goal is to meet the consumer's preferences for living situation in a cost-effective way. The Resource Allocation Decision method is used by CMOs to achieve this goal. State staff are not directly involved in the care planning process. The state and Center for Excellence can provide technical assistance and consultation in the care planning process, and in development of cost-effective residential options.

Program: Family Care	
Criteria	Analysis
8. Safeguards around guardian decision-making.	There is nothing specific about Family Care that would not also be true of other programs in the current long term care system. The availability of the Family Care Independent Advocacy program can be helpful if there is concern about guardian's decision-making.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	There are no specific criteria for whether someone can live in the community. At this point, all CMOs are using the RAD method in care planning and service authorization, and have not developed any other criteria for determining whether to authorize community residential placements.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

Program: Family Support Program	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	There is not much focus on ADA/<i>Olmstead</i> issues in FSP circles. Consequently most families are not aware of their <i>Olmstead</i>-related rights.
2. Full access to community services / funding for institution residents.	The family support program is very flexible - - a wide variety of services can be accessed.
3. Community services funding adequate to provide quality services.	Family support program funding is limited to \$3,000 per year per child. Many counties actively limit the expenditure to less than \$3,000 in order to spread the funding across more families and keep waiting lists down. The result of that is an inadequate level of funding for many children who are at risk of out-of-home placement.
4. Funding for up front costs to relocate people from institutions.	Family support program funds can be used for this purpose.
5. Consumer choice in decision-making.	Family support program has a positive reputation in most counties for including parents in the decision-making regarding which services their family receives. The limits to choice that surface in some counties are generally a result of the county's own arbitrary limits on service array, or the unavailability of a particular service in the county.
6. Adequately comprehensive package of community services.	Probably not for most children with severe disabilities (due to funding limitations).
7. Which "state professionals" determine who can live in the community?	County case managers and staff of local agencies providing family support program services have some say in who gets family support program services and which services and which services they received, but they do not directly determine admission to institutions or decide who can move out.
8. Safeguards around guardian decision-making.	Parents have far-reaching decision-making powers for minors living in the family home. The main checks and balances are those found in statutes regarding child abuse and neglect.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	N/A

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

Medicaid – Home Care Services

Program: Home Health Care (Personal Care, HH, Respiratory Care, Skilled Nursing)	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	• Program administered by provider – so this depends a lot on providers. • Results – some people know, some don't. • Do discharge planners let people know of available programs and rights? • Some PC agencies require you to recruit your worker.
2. Full access to community services / funding for institution residents.	• Some PC programs have enrollment frozen. • The labor market affects PC, HH and skilled nursing services. • Nursing shortage everywhere, but worst in isolated rural areas. • Increasing the PC reimbursement rate will hopefully help. • DHFS efforts to open the door for new PC programs have been stopped. • Federal Medicare rules have hurt HH agencies. Some have closed their doors or closed branches.
3. Community services funding adequate to provide quality services.	• The PC rate increase helped. • Not a lot of dissatisfaction about rates is being expressed at the moment.
4. Funding for up front costs to relocate people from institutions.	• If a person leaves an institution and only has access to home care services via MA card, that person may have no way to cover up-front costs, such as furniture and household items.
5. Consumer choice in decision-making.	• The law says “choice of any qualified provider” but in reality there may be one or no providers available at the present time, in some locales. • Some agencies say you must recruit your own workers. • The worker shortage makes “choice” unlikely. • Consumers recruit their own independent nurses.
6. Adequately comprehensive package of community services.	• PC services are limited to the home. Many would like services expanded to the community, but the expansion is costly. PC services are limited to assistance with ADLs. Many would like the scope of services expanded to include IADLs (Instrumental Activities of Daily Living) – also costly. • ADA violation? State determined rule, not the feds. • LTC to ADL – debate regarding definition.

Program: Home Health Care (Personal Care, HH, Respiratory Care, Skilled Nursing)	
Criteria	Analysis
7. Which “state professionals” determine who can live in the community?	MA Prior authorization – complex issue – various points of view on appropriateness of the process – OCR complaints pending.
8. Safeguards around guardian decision-making.	Guardian – provider relationship is key (variable).
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	MA prior authorization functional/final criteria. (final is different than for nursing homes.)

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

The one year \$500,000 HCFA Grant ended 12/31/2000. It involved giving \$10,000 to each of the eight ILC's to do peer support, outreach and identification of individual supports needed to live outside the nursing homes.

\$300k went to fund high cost plans such as ramps, furniture, security deposits, etc.

The rest went to administration at the state and ILC level.

137 people were served. Not all were relocated.

The major determinant of success was having access to a LTC slot in the community.

It did improve the relationship between the ILC and the County.

It may be possible to secure federal funds for a similar project in the future.

Program: Homecoming	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	The peer relationship was established and the individuals were notified of their <i>Olmstead</i>/ADA rights.
2. Full access to community services / funding for institution residents.	Full access depends on availability of critical COP/ CIP funds and access to relocation slot, and/or access to MA card services..
3. Community services funding adequate to provide quality services.	Needed more CIP and COP funds. Some were successful with MA card, but only if sufficient with relative support, etc. Some needed more.
4. Funding for up front costs to relocate people from institutions.	\$300k + COP high cost funds for up front costs.
5. Consumer choice in decision-making.	Consumers had choice. In some cases choice limited due to available resources and finances.
6. Adequately comprehensive package of community services.	Counties that are family care pilots were good. At first Homecoming was not working with those counties, but they like the others needed their pumps primed to achieve relocation results.
7. Which "state professionals" determine who can live in the community?	None. The professionals were the County Long Term Support Case managers.
8. Safeguards around guardian decision-making.	Because Homecoming worked with persons with physical disabilities, they did not encounter guardian issues.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	The Long Term Support Assessment Tool was used to plan for services needed; and to determine if adequate resources are available.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

Program: I-Care	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	- Standard managed care contract language. - Dependent on the case manager. - Not sure.
2. Full access to community services / funding for institution residents.	- Only pays for Medicaid covered services. Refer people to other programs. - Doesn't serve people in institutions. If a person is placed in an institution, they are disenrolled and are fee-for-service Medicaid.
3. Community services funding adequate to provide quality services.	No.
4. Funding for up front costs to relocate people from institutions.	Doesn't serve people in institution.
5. Consumer choice in decision-making.	Individualized care plan is developed with care coordinator. Consumers can choose outside of the network to some degree if the provider is willing to join I-Care (e.g., for physicians and dentists). Consumer can only choose among Medicaid-covered services. All negotiated on an individual basis.
6. Adequately comprehensive package of community services.	Only Medicaid services, which is not comprehensive.
7. Which "state professionals" determine who can live in the community?	- None. - I-Care is a voluntary program.
8. Safeguards around guardian decision-making.	- None. - Would get a person a guardian if they felt they needed one.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	None.

ADA Title II Analysis of Wisconsin LTC Programs-6/27/01

Does this program meet the *Olmstead* criteria?

Program: Community Based Medicaid Card Services	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	Dependent on Medicaid provider. All Medicaid state and federal requirements must be met (which requires telling consumers about their 504 and Medicaid rights, but no ADA / <i>Olmstead</i> rights).
2. Full access to community services / funding for institution residents.	Dependent on Medicaid provider scope and right to deny services. Most providers provide a specific service. MA state plan covers all mandated and optional services provided under federal regulations. In some locales, there are limited or no MA providers in certain service categories.
3. Community services funding adequate to provide quality services.	Medicaid is required to provide adequate reimbursement rates to ensure access to services. In some service categories (e.g. dental care) there is a general perception that the rates are too low. In some provider situations, the provider is “subsidizing” the rate.
4. Funding for up front costs to relocate people from institutions.	Not available through MA card services.
5. Consumer choice in decision-making.	Dependent on Medicaid provider. (e.g. choice of worker and availability of providers in each locale.)
6. Adequately comprehensive package of community services.	MA state plan covers all mandated and optional services provided under federal regulations. There are other services that some people need that cannot be obtained via the MA card under the current MA plan in Wisconsin.
7. Which “state professionals” determine who can live in the community?	No state staff involved, except Staff involved in MA Prior Authorization.
8. Safeguards around guardian decision-making.	Dependent on Medicaid provider.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	No state staff involved, except in Prior Authorization.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

Program: County Nursing Homes (NHs), Institutes for Mental Diseases (IMDs), Residential child Caring Facilities (RCCs)	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / Olmstead rights.	- For County Nursing Homes, IMDS and RCCS, no specific <u>Olmstead</u> rights are given. The standard rights and grievance procedures are given and, in some cases, posted. - For County Nursing Homes, under the annual <u>Watts</u> review, the consumer is only casually asked if they want to return to the community without any real informed consent. - Average length of stay – 3 months to 10 years for IMDS, 3 to 10 months at RCCs
2. Full access to community services / funding for institution residents.	- In all cases, whether or not there is full access to community services, varies widely from county to county. - With NHs, the problem is insufficient funds to provide enough community placements. This cost depends on the person's needs, but can be as high as \$10,000.00 per month. And, this placement can go on for many, many years. The issue becomes, who pays, MA, the county, a third-party? Whenever possible, COP waivers, CIP IA, CIP IB, and CIP II are used for community placement. - With IMDs, MA funds cannot be used for institutionalized persons who are under age 65, unless they are under age 22 and are receiving inpatient psychiatric services. The cost of adults in IMDs is borne by the county; however, the county can recover the costs from the person, including insurance and SS funds. - Funds for RCCs come from the state, County Human Services Department, the Department of Corrections, and, in some cases, funds raised by the RCCs students or funds from out-of-state school districts for youths from out-of-state placed in WI RCCs. With two interviewed RCCs, the cost per day/per child varied from \$176.08 to \$219.81. Some RCCS do extensive follow-up with community placements, so do none.
3. Community services funding adequate to provide quality services.	For all institutions above, this varies widely from county to county and community to community. Some of the variables include the creativity of the county/community staff, whether the county/community has sufficient time to prepare, whether the county/staff knows who to contact to get the necessary supports, whether or not the county/community has sufficient funding and other resources (e.g., county staff, workforce), the political will of the particular county/ community, whether or not the consumer being returned to the community has good and sufficient natural supports.

Program: County Nursing Homes (NHs), Institutes for Mental Diseases (IMDs), Residential child Caring Facilities (RCCs)	
Criteria	Analysis
4. Funding for up front costs to relocate people from institutions.	• For NHs, Homecoming funds are used for these costs. • For IMDs, the county and consumer usually have to absorb all transition costs. • For RCCs, the RCC pays transition costs and such costs are included within the per diem rate.
5. Consumer choice in decision-making.	• For NHs, under the <u>Watts</u> and MA review the consumer is casually asked whether or not he/she wants to return to the community, but the choice is not a true informed choice. Under PASARR, the consumer has no choice. • For IMDs, the consumer has some choice (unless civilly committed); however, the issue again is whether or not the choice is an informed choice. • For RCCs, most youths have been civilly committed by the Juvenile Court after referral by a social worker or probation officer. The ultimate decision as to whether the child will return to his/her community rests with the social worker or probation officer who referred the youth to the Juvenile Court in the first place. However, most referring agents work with the youth's RCC Treatment Team in making this decision.
6. Adequately comprehensive package of community services.	• See answer to Question 3.
7. Which "state professionals" determine who can live in the community?	• For NHs, it depends on which one of five means is being used; (1) PASARR, (2) Court's <u>Watts</u> review, (3) an MA review, (4) a county review, or (5) an ICFME review. • For IMDs, the IMD's staff decides. This is reviewed annually. • For RCCs, the group decision is made by the referring social worker or probation officer in conjunction with the youth's Treatment Team (made up of the social worker in charge of the youth's case, the living unit staff, transition staff, or other like multidisciplinary body).
8. Safeguards around guardian decision-making.	• For NHs and IMDs, there are not a lot of safeguards. If a court has placed the consumer in the NH, there is an annual <u>Watts</u> review. The court must place the consumer in the least restrictive environment. However, that review is countered by the county shield law. If the county has insufficient funds, the court may keep the consumer in the NH. Occasionally, a court will order the county to find the funds. • For RCCs, the Department of Juvenile Corrections oversees guardianships. An agent of the court will look at the guardianship home to see if it is appropriate. Also, the court can tell the guardian, "hands-off."
9. Criteria state professionals use to	• For NHs, this again depends on which of the five means (see answer to Question 7) is being used. Each has a different set of

Program: County Nursing Homes (NHs), Institutes for Mental Diseases (IMDs), Residential child Caring Facilities (RCCs)	
Criteria	Analysis
determine if someone is appropriate for living in the community.	criteria. • For IMDs, it is the same as for hospitals and NHs. • For RCCs, it varies from institution to institution. For some it depends on the goals of the agency (court, school, etc.) sending the youth to the RCC in the first place. For others, they will start with week-end tests and see how the youth and his/her family actually do. The youth's actions are the true criteria.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

Pace/Partnership Programs	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / <i>Olmstead</i> rights.	• ADA/<i>Olmstead</i> is not an explicit focus in Partnership. But after a person is enrolled in Partnership, s/he has rights (which are spelled out to people) for continuity of service during a nursing home or hospital stay, and for resuming in-home service after such stays.
2. Full access to community services / funding for institution residents.	• Not everyone can enroll in Partnership (the agency can deny enrollment under certain circumstances). But once a person is enrolled, there is access to a wide variety of LTC and health care services.
3. Community services funding adequate to provide quality services.	• Generally yes.
4. Funding for up front costs to relocate people from institutions.	• Yes, if the person is already enrolled in Partnership.
5. Consumer choice in decision-making.	• Choice (along with responsibility) is featured as a key aspect of Partnership. Practices vary from one Partnership program to the next, but there is some evidence to support the view that this is one of the strengths of this model.
6. Adequately comprehensive package of community services.	• Generally yes.
7. Which “state professionals” determine who can live in the community?	• Movements of Partnership enrollees into and out of nursing homes and hospitals are a result of joint decision-making including the consumer, the family, the guardian (if applicable), and the nursing home or hospital. “State professionals” are not usually involved.
8. Safeguards around guardian decision-making.	• Nothing in particular developed to address this issue.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	• State professionals are not involved.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

- *Mendota has six units, plus outpatient services. It serves children, adolescents, and adults, including geriatric services. Patients enter both voluntarily and by civil commitment; most by civil commitment.*
- *Winnebago's average population is 290; 130 to 150 are male and female forensic patients; the remaining are children, adolescents, adults.*

Program: Mendota, Winnebago	
Criteria	Analysis
10. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / Olmstead rights.	• Mendota and Winnebago – Upon admission, the patient is told of rights and grievance procedure along with a brochure of both. Neither gives the patient and his/her family/guardian their <u>Olmstead</u> rights. • Mendota – The above rights and grievance procedures are again given when the patient becomes coherent. Mendota also has two patient rights counselors to assist patients/families/guardians with their questions. • Mendota and Winnebago – HCFA and JCHO both require that discharge planning is addressed upon admission. Both institutions comply, including projected date of discharge, what are the patient's plans, and what is the case plan. Winnebago notes that about 2/3 have some idea of where they will be going and about ¼ do not know. • Average stay in Mendota is 3 to 6 months. Children usually have a 30-day evaluation, then leave. • Average stay in Winnebago is 93 days. Within this average, some patients stay only a few days and others may stay several years.
11. Full access to community services / funding for institution residents.	• Mendota notes that costs for community placement vary from individual to individual – anywhere from \$30 to \$900 per day. • Winnebago – Community placement also varies from \$30-\$900 per day. Whether or not there is full access to community services varies tremendously from county to county and individual to individual. Often depends on waiting lists, timing, slots, creativity. • Mendota charges a flat rate of \$568 per day. An additional \$100 per day is added for the first three days of Emergency Detention. • MA fee-for-service or the county (in cases when the child is in a Medicaid HMO since Medicaid HMOs will not pay except if it is an emergency detention) pays for children. If a child is in a program like WA or CCF, the program pays. Sometimes private insurance pays.

Program: Mendota, Winnebago	
Criteria	Analysis
12. Community services funding adequate to provide quality services.	Varies by county and by individual. For those counties with many resources, the individual's stay in Mendota or Winnebago will be shorter. In relatively poorer communities, the stay is longer.
13. Funding for up front costs to relocate people from institutions.	Not from either Mendota or Winnebago. Transition costs come from the individual, the family, the guardian, the county, or COP funds.
14. Consumer choice in decision-making.	- Depends on legal status – voluntary or court-ordered commitment. - At Mendota, the adults sit in on the initial staffing and, as they “clear,” they become more and more involved in their own planning. - With a civil commitment, the consumer has little choice in when to go back into the community, unless his/her time has run out on the Commitment Order, then he/she is free to go whenever he/she wants. - At Mendota, the parents or guardian and the Residential Treatment Centers are involved. Without the parents, it is hard to motivate the child to get out.
15. Adequately comprehensive package of community services.	- Varies greatly by county, community, and individual. Some programs are “fixed” or inflexible. Others will put together a package on an individual case-by-case basis. - Mendota notes they are not often able to place adults in CSPs, because the community supports are already in place.
16. Which “state professionals” determine who can live in the community?	- At Mendota, the Treatment Team (psychiatrist, psychologist, social worker, appropriate therapist, RN Unit Manager, and Patient Advocate) work collaboratively with the patient, family member, or guardian. The Treatment Team also works closely with the counties to mesh timelines, education on aggression, etc. - If the commitment is civil, the county decides. Sometimes the court releases the individual before he/she is ready and vise-versa. However, most counties work collaboratively with the Treatment Team (Mendota-Winnebago). - At Winnebago, the Treatment Team is made up of a psychiatrist, social worker, primary nurse, therapists, and, if the patient is a child, a teacher. The Team decides when the individual is stable enough to go back into the community. For children, funding can be a factor—Medicaid pays for treatment while the child is in Winnebago (if the child is not in a Medicaid HMO).. If released, the county pays. So, the county may keep the child in Winnebago longer because of fiscal reasons.

Program: Mendota, Winnebago	
Criteria	Analysis
17. Safeguards around guardian decision-making.	• At both Mendota and Winnebago, the institution can do a “Director’s hold” on the consumer’s release and then take the dispute to court. • In order to protect children and adolescents, a guardian-ad-litem is appointed.
18. Criteria state professionals use to determine if someone is appropriate for living in the community.	• Decreased danger to self or others; stable on medications, if applicable; where is the individual in his/her mental illness and how stable is he/she; will there be appropriate aftercare in the community; will the individual be safe in the community/ what are the other risk factors. • The thing that will slow down the process is when the county plan is found not to be adequate for the patient’s needs.

ADA Title II Analysis of Wisconsin LTC Programs

Does this program meet the *Olmstead* criteria?

- An IMD is a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.
- Wisconsin has 13 hospitals designated as IMDs, with an average total census of around 480. In addition, WI has three nursing homes designated as IMDs, with a total of 172 beds (census unknown). The three nursing home IMDs plan on closing 30 beds in 2001, which follows the trend of declining beds in these institutions.

Program: Institutions for Mental Diseases (IMDs)	
Criteria	Analysis
1. Letting institution residents, other people with LTC needs, and families / caregivers know their ADA / Olmstead rights.	• No specific Olmstead rights are given. The standard rights given at hospitals and nursing homes are given. • The average length of stay in IMDs is going down. In the three IMD nursing homes, most individuals are there three months or less. However, there is a substantial segment of the population that remains for up to ten years. • Need to distinguish between dementia and mental illness. • Persons who are involuntarily committed cannot refuse treatment.
2. Full access to community services / funding for institution residents.	• The cost of care and treatment of persons in IMDs is borne by the county, however, the county may recover the cost from the person, which may include insurance payments for mental health treatment. In addition, a county that places a person in one of the three IMD nursing facilities may receive special state funding that covers a portion of the person's care and treatment. • MA funds cannot be used to pay for any IMD placed individuals who are under age 65 <u>unless</u> they are under age 22 and are receiving inpatient psychiatric services. • The funding of persons in IMDs is challenging – generally all the institution gets is county funds, plus the person's SS.
3. Community services funding adequate to provide quality services.	• Varies county-to-county and individual-to-individual, e.g., whether or not the individual has good natural supports, whether the individual needs a CSP (some of which are marginal). • Depends on creativity, funding, workforce, political atmosphere, time of year (whether the county's calendar budget is getting tight), etc.
4. Funding for up front costs to relocate people from institutions.	• Usually the county and the individual have to absorb these funds.
5. Consumer choice in decision-making.	• Yes, however, no different than any other institution. • The bigger problem is when the person has significant behavioral difficulties – the community does not want the person back (rare, but creates a significant obstacle when it occurs).
6. Adequately comprehensive package	• Varies county-to-county and individual-to-individual, e.g., whether or not the individual has good natural supports, whether

Program: Institutions for Mental Diseases (IMDs)	
Criteria	Analysis
of community services.	the individual needs a CSP (some of which are marginal). Depends on creativity, funding, workforce, political atmosphere, time of year (whether the county's calendar budget is getting tight), etc.
7. Which "state professionals" determine who can live in the community?	The IMD staff says when the person is ready to return to the community. This is reviewed annually.
8. Safeguards around guardian decision-making.	Not a lot. There is the annual <u>Watts</u> review, plus the ch. 55 "least restrictive environment." However, the county child law allows the county to make decision by saying it cannot afford what is often in the best interest of the consumer. And, sometime a court will step in and tell the county to find the money.
9. Criteria state professionals use to determine if someone is appropriate for living in the community.	Same as for hospitals and nursing homes.

Appendix E: Statutory References – Systems Design Workgroup

Review of Wisconsin Statutes Statutory References Related to *Olmstead*

State Powers

Evaluation and Review

1. HFS secretary shall establish a program of research to determine the effectiveness of the treatment, curative and rehabilitative programs of the institutions and divisions [46.014].
2. HFS secretary may inquire into any matter affecting social welfare and hold hearings, subpoena witnesses and make recommendations to appropriate agencies, public or private [46.014]
3. The Department shall:
 - Examine all institutions, public and private, authorized to care for persons with mental illness or substance abuse problems.
 - Inquire into the method of government and management and examine the condition of buildings, grounds, other property and into matters relating to its management. [46.03 (5)].

Withholding Appropriations

1. The Department may withhold a portion of a county's appropriation (to county departments created under 46.215, 46.22, 46.23, 51.42, or 51.437) if the department determines that that portion is inconsistent with state or federal statutes, rules or regulations. The department may also arrange for provision of services by an alternate agency after joint committee on finance approves [46.031 (2r) (a) (2.)].
2. The Department may withhold a portion of a county's appropriation if it determines that that portion is for inpatient treatment in excess of an average of 21 days, excluding care for patients at the DD centers [46.031 (2r) (a) 4.].
3. The Department may require the county to reserve a portion of funds allocated to high-cost clients if it finds that the county has demonstrated a pattern of failure to serve clients whose cost of care significantly exceeds the average cost of care for long-term community support services [46.27 (7) (f)].
4. The Department may not provide state aid to any county department under s. 51.42 or 51.437 for excessive inpatient treatment. For each county department in each calendar year, sums expended for the 22nd and all subsequent average days of care shall be deemed excessive inpatient treatment. No inpatient treatment provided to children, adolescents, chronically mentally ill patients, patients requiring specialized care at a mental health institute, or patients at the DD centers may be deemed excessive [51.423 (12)].

Maximizing Resources for Alternatives to Institutionalization

1. The Department shall use, to the fullest extent legally possible, all available grants from federal, state and other public or private sources to fund community home care services or programs which offer alternatives to institutionalization and which provide comprehensive services at the community level [46.80 (3)].

State Responsibilities

Evaluation and Review

1. The department shall evaluate the effect of the home and community based waivers for the developmentally disabled on: 1) Medicaid costs, and 2) the program's ability to provide community care alternatives to institutional care [46.278 (3) (a)].
2. The Department shall:
 - Conduct a continuous review of the scope and degree of coordination of all state programs and activities on older adults.
 - Make recommendations to the appropriate agencies regarding the expansion, coordination, consolidation and reorganization of particular activities as a means of developing a more effective and efficient total program for older adults [46.80 (1)].
3. The Department shall examine the need for future activities, programs, services and facilities for older adults on the state, local and voluntary levels [46.80 (1)].
4. The Mental Health Council shall:
 - Review all departmental plans for services affecting persons with mental illness.
 - Monitor the implementation of the plans [51.02 (1) (c)].
5. The Secretary shall submit all departmental plans affecting persons with mental illness to the Mental Health Council for its review. The Council shall provide its recommendations to the secretary [51.02 (2)].
6. The Department shall review requests and certify county department to assure that they are in compliance with this section. The Department shall periodically review and evaluate the program of each county department. [51.437 (14)].
7. The Council on Developmental Disabilities shall monitor and evaluate the implementation of the statewide plan [51.437 (14r), 2.b.]
8. The Department, after consulting with counties, independent living centers, consumer organizations and home health agencies, shall do the following tasks regarding personal care:
 - Periodically identify those barriers that lead to a failure to respond to the needs and preferences of individuals who are eligible for these persons.
 - Act to remove the barriers to the extent possible [49.45 (2) (22)].

Planning

1. The department shall submit a state developmental disabilities services plan every five years. The plan shall be developed to:
 - Preserve, protect and affirm the legal and human rights, dignity, privacy and freedom of choice of individuals with developmental disabilities.
 - Promote access to a comprehensive arrange of support and treatment services appropriate to meet the needs and to enhance the abilities of individuals.
 - Encourage and promote the development of innovative cost-effective services which are responsive to the needs of individuals with all types of developmental disabilities, and which use methods of care and treatment which are as flexible, nonintrusive and supportive of individual dignity and choice possible [51.437 (14p, 1., 2., 3)].

Policy Development

1. The state Council on Long Term Care shall assist the department in developing broad policy issues related to long-term care services [46.282 (1) (a)].
2. The state Council on Long Term Care shall assist the department in developing, implementing, coordinating and guiding long-term care services and systems. This shall include reviewing and making recommendations to the Department on monitoring the numbers of persons on waiting lists [47.282 (1) (b) (d)].

Program Development and Implementation

1. The Department shall develop and maintain education and prevention programs that it considers to be proper [46.03 (4)]
2. The Department, in home and community based waivers for developmentally disabled, shall, to the maximum extent possible, authorize the provision of services to serve persons in noninstitutional settings (except for those individuals in DD centers [46.27 (2) (c)]).
3. The Department shall conduct outreach for the early and periodic screening, diagnosis and treatment program (known as HealthCheck in Wisconsin) as required under 42 CFR 44 [49.45 (a) 18.].
4. The Department shall develop a statewide system of adult protective services. The protective service system shall be designed to encourage independent living and avoid protective placement whenever possible. The Department and these county departments shall cooperate in developing a coordinated system of services [55.02].

Least Restrictive Policy

1. The Department has a primary responsibility to elderly persons to assure that all elderly and disabled persons have available and accessible a continuum of care or a wide range of community and supportive services so that they may remain their homes and neighborhoods

for as long as it is possible. The Department shall be the mechanism by which governmental and nongovernmental agencies may coordinate their policies, plans and activities with regard to older adults [46.80 (1)].

2. It is state policy to assure the provision of a full range of treatment that assures all people in need of care access to the least restrictive treatment alternative appropriate to their needs. This is within the limits of available state and federal funds and county funds required to match state funds [51.001 (1)].
3. It is state policy that, in order to protect personal liberties, no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility [51.001 (2)].
4. Application for short-term admissions must be reviewed by the treatment director of the inpatient treatment facility, or in the case of a DD center, by the director. The application shall be accepted only if the director determines that the admission constitutes the least restrictive means of obtaining adequate diagnosis and evaluation of the minor or adequate provision of medical, dental or psychiatric services [51.13 (6) (13)].
5. Community support programs should be available in all parts of the state in order to provide the least restrictive and most appropriate care and treatment [51.421 (1)].
6. Patients have the right to the least restrictive conditions necessary to achieve the purposes of admission, commitment, or protective placement. The county board of supervisors must provide programs, services and resources, within the limits of available state and federal funds and of county funds required to match state funds [51.61 (1) (e)].
7. The Wisconsin adult protective services system has as its declaration of policy that:
 - The services should, to the maximum degree of feasibility, allow the individual the same rights as other citizens, and at the same time protect the individual from exploitation, abuse, and degrading treatment.
 - The county board of supervisors must provide programs, services and resources within the limits of federal, state, and county dollars required for matching.
 - Chapter 55 is designed to establish those services and assure their availability to all persons when in need of them, and to place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, exploitation and neglect [55.001].

Comprehensive Range of Services

1. The purpose and intent of community mental health, developmental disability, and substance abuse services is to enable and encourage counties to develop a comprehensive range of services offering continuity of care [51.42 (1)].
2. The state plan shall have as one of its objectives to minimize the number of developmentally disabled individuals living in institutions by maximizing the development of alternative, noninstitutional community programs [51.437 (14p.), 6.].
3. Patients have a right to receive prompt and adequate treatment, rehabilitation and educational services appropriate for his or her condition, under programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to match state funds [51.61 (1) (f)].
4. Patients have the right be informed of his or her treatment and care and to participate in the planning of his or her treatment and care [51.61 (1) (fm.)]

Capability for Independent or Self-Care Policy

1. The purpose of Medicaid is to provide appropriate health care for eligible persons and obtain the most benefits available under the federal Social Security Act. The Department shall administer medical assistance, rehabilitative and other services to help individuals and families attain or retain capability for independent or self-care [49.45 (1)].

Reviewing Individuals

1. The Department shall screen every person who applies for admission to a facility or an Institute of Mental Disease to determine if the person has a development disability or mental illness. This screening will determine if the individual needs facility care. If it is determined that the person needs facility care, the department (or entity to which the department has delegated authority) shall assess the individual to determine if he or she requires active treatment [49.45 (6c) (b)].
2. Of the persons that the Department has determined that they have a developmental disability or mental illness, the Department shall review every person who has experienced a significant change in his or her physical or mental condition to determine if any of the following applies: 1) the person needs facility care, and 2) the person requires active treatment [49.45 (6c) (c)].
3. The Department shall terminate payment to a facility for a patient unless a utilization review team determines: 1) the patient's need for care and services can only be provided in a facility and 2) the appropriate level of care after reviewing the patient's needs and a rehabilitation plan has been implemented (49.45 (6m) (d) 2.)

Admissions to Facilities

1. For a person who is incapacitated and does not have a guardian or health care power of attorney, the person who is consenting to an admission for that individual may request that a Community Options assessment or a functional and financial screen be done if the person is in a Family Care county [50.06 (7)].
2. For Family Care counties, a nursing home shall inform the prospective resident of the services of a resource center, the family care benefit, and the availability of a functional and financial screen to determine the resident's eligibility for Family Care. This shall be done within a prescribed time period after inquiry by a prospective resident [50.04 (2g)].
3. When Family Care is operating in a specific county, a nursing home shall refer all persons who are seeking admission, and meet one of the target groups of Family Care in that county, to that county's resource center. Exceptions: persons who already had a function eligibility screen within the previous six months, person is seeking respite care only, the person is an enrollee of a care management organization, or a person who is private pay and waives the requirements [50.04 (2h)].

Developing Plans for Individuals

1. As a condition of Medicaid payment, a facility shall provide at the time of a patient's admission to a home, for the development and implementation of a rehabilitation plan including the development of an alternate plan for the patient [49.45 (6m) (c) 2.].
2. The Department may seek a federal waiver of the requirement under 42 USC 1396n (c) (1) that the Department review and approve every written plan of care developed for each person who receives services under a home and community-based waiver. If the federal government approves the waiver, the Department shall, in evaluating a quality assurance system for certification, consider all of the following: 1) the adequacy, safety and comprehensiveness of plans of care developed for individuals and the services provided to them, 2) opportunities for individuals to exercise choice and be involved in provision of services, 3) overall conformance to required state and federal quality assurance standards, and 4) other factors that are required by the federal government [49.45 (37)].

Relocating Individuals

1. Under the resident removal authority in ch. 50.03, Wis. Stats., the Department shall offer removal and relocation assistance to residents removed under this provision. This shall include information on available alternative placements. The Department must involve the residents in planning the removal and the resident shall make the choice among the available alternative placements, except where an emergency situation makes resident involvement impossible. Residents may choose their final alternative placement and shall be given assistance in transferring to such a place. Where the Department makes or participates in making the relocation decision, consideration shall be given to proximity to residents' relatives and friends [50.03, (5m) (c)].

2. The Department shall prepare resident removal plans and transfer trauma mitigation care plans to assure safe and orderly removals and protect residents' health, safety, welfare and rights. The resident shall be provided with opportunity for 3 visits to potential alternative placements prior to removal. [50.03 (5m) (d)].
3. The Department may place relocation teams in any facility from which residents are being removed, discharge or transferred for any reason, for the purpose of implementing removal plans and training the staffs of transferring in transfer trauma mitigation [50.03 (5m) (e)].
4. In any removal, the Department shall provide written notice to the resident, resident's guardian, if any, and a member of the resident's family. The notice shall state the basis for the order of removal and of the right to a hearing before removal [50.03 (5m) (e)].
5. The Department may provide, direct, or arrange for relocation planning, placement and implementation services in order to minimize trauma. The county department in which the facility is located shall participate in the development and implementation of individual relocation plans [50.03 (14) (a), (b)].
6. Upon a closing, a facility must develop individual relocation plans and a preliminary plan that includes a proposed timetable, a list of residents, in addition to other items. The Department shall approve or disapprove the plan. No residents may be relocated until the department approves the preliminary plan or a modified plan is agreed upon [50.03 (14) (c)].

Notices Posted in Facilities

1. Nursing home shall post in a conspicuous location in the nursing home the following: a notice, provided by the board on aging and long term care, of the name, address and telephone number of the long-term care ombudsman program [50.04 (sv)].

County Responsibilities

Planning

1. The county department shall prepare a local plan for delivery of human services. The plan shall be based on an annual need survey of the prevalence and incidence of the various disabilities with the geographic boundaries of the county. The plan shall also include the establishment and estimated costs of providing for coordination of local services and continuity of care [46.23 (3) (am)].
2. The county planning committee shall develop recommend a community options plan for participation in the program. The plan shall include a description of the services available and the services to be developed or expanded as alternatives to institutional care under this program [46.27 (4) (2.)].

3. The county local long term-care council shall identify gaps in services, living arrangements and community resources and develop strategies to build local capacity to serve older persons and persons with physical or developmental disabilities, especially those with long-term care needs [46.282 (3) 9].
4. A county department of community programs shall prepare a local plan that includes an inventory of all existing resources, identifies needed new resources and services, and contains a plan for meeting the needs. The plan shall also include the establishment of long-range plan goals and intermediate-range plans, detailing priorities and established costs and providing for coordination of local services and continuity of care [51.42 (1) (ar) 5].
5. County developmental disabilities services board shall prepare a local plan which includes an inventory of all existing resources, identifies needed new resources and services and contains a plan for meeting the needs of developmentally disabled individuals based upon the services designated under sub. 1. The plan shall also include the establishment of long-range goals and intermediate-range plans, detailing priorities and estimated costs and providing for coordination of local services and continuity of care. [1.437 (9) (am)].

Relocating Individuals

1. If a county department seeks to relocate a person from an IMD to the community using funds provided under sub. (1), the county department shall first obtain approval of the IMD to terminate use of the bed occupied by the individual as part of a plan submitted by the IMD and approved by the Department [46.266 (8)].
2. The county department selected to administer COP shall see to it that its assessment staff shall work with the hospital discharge planner for any hospital patient being referred to a nursing home for admission. They shall provide an assessment [46.27 (5) (am)].

Planning for Individuals Needing Community Services

1. Within limits of state and federal funding, a community services case plan shall be developed for any person with chronic disabilities who is assessed, and for whom noninstitutional community services are feasible, financially viable and preferred by the person or the person's guardian [46.27 (5) (b)].
2. If the county, through an assessment, determines that a community arrangement is not feasible, the county shall explain the reasons to the person and his family or guardian. The county shall maintain records to provide the county long term support planning committee and department with a periodic review of the reasons community arrangements were not feasible in order to assist future program planning [46.27 (5) (d)].
3. The county is fiscally responsible for a COP assessment, case plan or services, for persons located in nursing homes located in its county, unless legal residence was established elsewhere [46.27 (6g)].
4. A person is entitled to Family Care if he or she meets the functional requirements, financing requirements, fulfills any applicable cost-sharing requirements [46.282 (3) (a)].

Providing Information about Community Services

1. A county resource center shall provide information about the center (including services, reassessment, and care plans and family care benefit) to all older persons and persons with a physical disabilities who are residents of nursing homes, CBRFs, adult family homes and residential care apartment complexes [46.283 (4) (e)].

Provider Expertise

1. A care management organization for Family Care must demonstrate that they have adequate availability of providers with necessary expertise and ability, adequate availability of providers that can meet preferences and needs of consumers, etc. [46.282 (3) (b)].

Least Restrictive Setting

1. In civil commitments, the county shall arrange for treatment in the least restrictive manner consistent with the requirements of the individual in accordance with a court order designating the maximum level of inpatient facility, if any, which may be used for treatment [51.20 (13) 5. (c) 2.] .
2. With the exception of alcoholic commitments, every patient committed involuntarily to a board shall be reevaluated by the treatment staff or visiting physician within 30 days and within 3 months of initial reevaluation, and every six months. The purpose is to determine whether such patient has made sufficient progress to transfer to a less restrictive facility or discharge. The findings shall be written, place in person's file, and copy sent to the board which has responsibility for patient and to committing court. [51.20 (17)].

3. The board to which a patient is committed shall provide the least restrictive treatment alternative appropriate to the patient's needs and movement through all appropriate and necessary treatment components to assure continuity of care [51.22 (5)].
4. The county department may transfer any patient. Terms and conditions which will benefit the patient may be imposed as part of a transfer to a less restrictive treatment alternative [51.35 (1)].
5. The county adult protective services agency shall take appropriate emergency action if the emergency action is in the vulnerable adult's best interests and the emergency action is the least restrictive appropriate intervention [55.043 (4) (b)].
6. The court may order protective services as an alternative to placement. The court shall order the appropriate board or agency to protectively place the individual. Placements shall be made in the least restrictive environment consistent with the needs of the person and with the placement resources of the appropriate agency [55.06 (9) (a)].
7. The agency shall review the status of each person placed at least once every 12 months from the date of admission. The review shall include in writing and include recommendations for discharge or placement in services that place less restrictions on personal freedom, where appropriate. The results of the review shall be furnished to the department in such form as the department may require and shall be furnished to the court and to the persons' guardian [55.06 (10)(a)].

Admissions to Facilities

1. A county department of community programs shall review and approve or disapprove all admissions to nursing homes of mentally ill persons under age 65 who are residents of the county, except in an emergency [51.42 (ar) 13.].
2. A county department of development disabilities services shall review and approve or disapprove all admissions to nursing homes of persons with a developmental disability who are residents of the county, except in an emergency [51.437 (4m) (l)].
3. No guardian or temporary guardian may make a permanent protective placement of his or her ward unless ordered by a court but may admit a ward to certain residential facilities or make an emergency protective placement [55.05 (1) (d)].
4. Before ordering any protective placement, a comprehensive evaluation shall be done. The evaluation must include any recommendations for or against maintenance of partial legal rights and recommendations for placement consistent with the least restrictive environment required [55.06 (8) (c)].

Appendix F: Detailed Report of the Research and Data Workgroup

The Workgroup Charge

In February of 2001, the Chair of the full ADA Title II Advisory Committee gave each workgroup a charge. The charge to the Research and Data Workgroup was as follows:

- Identify the information needs of the ADA Title II Advisory Committee. This includes identifying the questions that need to be answered through data and other information in order to inform the work of the Committee and identifying the data and other information needed to answer these questions.
- Identify sources of needed data and information.
- Compile available information in such a way that it can be used to answer identified questions.
- Provide information to the other workgroups and present information to the full committee.

In actual operation, it became apparent that the Research and Data Workgroup (the Workgroup) could not provide the programmatic and policy information needed by each of the different workgroups on a timely basis. Each workgroup developed its own mechanism for seeking the information needed in the course of its discussions. The Workgroup focused its efforts on trying to answer what it believed to be the central data question, “How many people currently in institutions are likely to be able to be served in the community?”

The Workgroup also developed a definition of the target group for its efforts (not the State’s *Olmstead* target group). The definition is as follows:

The Target Group is persons of all ages in institutions, as described below:		
What disability groups?	- Frail elderly - Physical disabilities - Substance abuse with dual diagnosis	- Developmental disabilities - Mental illness
What facilities are included?	- State Centers for the Developmentally Disabled - Nursing Homes - Intermediate Care Facilities for Mental Retardation - Residential Care Centers for Youth (formerly CCIs)	- State Mental Health Institutions - Institutions for Mental Disease
What facilities are excluded?	- Community Based Residential Facilities (CBRFs) - Residential Care Apartment Complexes (RCACs) - Foster homes (children)	- Group homes - Adult Family Homes - Hospitals (except IMDs)
Other criteria	- Length of stay greater than 100 days - Not gathering data specifically on repeat admissions (revolving door)	

At a point in time, roughly 43,000 people with disabilities are in an institutional setting as described in the target population definition above. Almost 40,000 of these individuals are in skilled nursing facilities (includes institutions for mental disease-IMDs), roughly 2,000 are in Intermediate Care Facilities for Mental Retardation (ICFs-MR), another 1,200 are in State Centers or Mental Health Institutes and an estimated 50 children are in Residential Care Centers.

Data Sources Considered

At its early meetings, the Workgroup discussed several sources of data and had presentations on those that appeared most relevant. Data sources considered included:

- **Nursing Home Annual Report** – good descriptive aggregate information giving a snapshot of nursing homes on December 31 of each year. The survey does not include individual data.
- **County Waiting Lists** – aggregate information provided once a year. This year the Department asked for the number of people waiting who are in institutions, but not all counties were able to break this out
- **The Nursing Home Minimum Data Set (MDS)** – extensive information on each nursing home resident, collected by nursing home staff and stored on a data base in the Department.
- **Medicaid Databases** – extensive information on level of care and on the services provided to individuals on Medicaid.
- **The Human Services Reporting System (HSRS)** – individualized information on people receiving community-based long term care services. HSRS has information on children in certain types of institutions, but it is difficult to sort out those who are in an institution primarily due to a disability.
- **Pre-admission Screening and Resident Review (PASARR)** – screens people entering nursing homes to determine if they have mental illness or are developmentally disabled and if they need active treatment. The information is only available in paper records, is collected at admission, and is not regularly updated.
- **Division of Care and Treatment Facilities data systems** – good data on individuals in State-run institutions, but only covers a small percentage of all people in institutions.

The Workgroup determined that the MDS provided the greatest promise for its purposes because of the level of pertinent detail that it contains about individuals. Another attraction is that it includes information on over 90 percent of the institutionalized population in Wisconsin (all residents of skilled nursing facilities and institution for mental disease nursing facilities).

MDS Data Analysis

The Minimum Data Set (MDS) includes many of data elements about each person in a nursing home in Wisconsin. Most are related to the person's medical condition and care needs. The information is used for determining level of care, Medicare reimbursement, care planning and quality assurance monitoring. Although there are some concerns about the quality and reliability of the data, it is still a rich source information on people in nursing homes.

The Workgroup originally focused on a set of data elements that specifically address a person interest in leaving the nursing home, the existence of a supportive person and the nursing home

staff person's assessment of ability to be discharged. After considerable discussion of these items, the Workgroup concluded that this information would not be reliable for a variety of reasons. The group decided to focus its efforts on what the other data elements of the MDS could tell them about a person's likelihood of having his or her needs met in the community.

Criteria

At this point, the Workgroup had to decide on the criteria to be used to answer the question, "Who is likely to be able to be served in the community?" Depending on who is consulted, the response to this question ranges from "anyone can be successfully served in the community" to "only those with minimal limitations and barriers can live in the community." By definition, participants in Medicaid home and community based waiver programs must meet the nursing home level of care. States may not set a higher threshold for nursing homes, so there is no official criteria for who can be served in the community.

The Workgroup reviewed criteria used by national and international researchers to attempt to answer related questions regarding level of care. In addition, the group consulted with the Department COP manager, a residential facility operator, and a Family Care program manager. The people who were consulted all emphasized that each person and his or her circumstances are unique and that decisions to relocate must be based on personal interviews and assessments.

Recognizing the controversy and the many qualifiers, the workgroup settled on an initial set of criteria. The criteria chosen looked at level of physical functioning, presence of cognitive impairment, ability to communicate, existence of mood or behavior problems, continence, diseases and other health conditions, oral/nutritional status, activity patterns, use of medications and need for special treatments. An analyst from the Bureau of Quality Assurance applied these criteria to a set of MDS data. The criteria were modified based on preliminary results. The BQA analyst also analyzed the data using three sets of criteria from one of the research articles reviewed by the Data Workgroup.

The results of these analyses made it clear that adding or excluding even a single criterion could have a significant impact on the results. Since few people could be found to agree on any specific set of criteria, this is problematic to the usefulness of the MDS data for the purposes of the Workgroup.

Results of Analyses

The first data run found that only eight people met the criteria for relocation to the community; that is, they did not have any of the negative criteria that would make them an unlikely candidate for community placement. This surprisingly low number was primarily the result of the use of a data item that is not collected on all residents, but the BQA analyst also noted that several individual criteria eliminated a high number of people from the "could be relocated" pool.

Almost 37,000 people were eliminated by the criterion specified for the number of medications taken (more than 9). Special treatments or procedures, skin condition, oral/nutritional status and

health conditions appear to be other factors that exclude many people from the group likely to be placed in the community.

As members of the workgroup considered these criteria, it became less clear that people with one of the indicators identified should be excluded for the group that could be served in the community. For example, a 1999 study by the Strategic Planning and Evaluation Section found that participants in PACE and the Wisconsin Partnership Program (two community-based long term care pilots operated in Wisconsin) took more medications on average than did nursing home residents. This brings into question whether reliance on multiple medications is in and of itself a valid reason to keep a person in a nursing home.

Age and Limiting Factors

BQA conducted a brief analysis to discover if the existence of negative factors was correlated with age. The analysis found that a resident 65 or under was not significantly more or less likely to be a candidate for relocation than would a resident over 65. The analysis did reveal that the existence of some specific limiting factors or diagnoses were age sensitive. Not surprisingly, older residents were significantly more likely to have Alzheimer's disease or other dementias. Younger residents were significantly more likely to be diagnosed with multiple sclerosis, alcohol related dementia, non-specified mental illness and schizophrenia. Older residents were significantly more likely to be incontinent and to have losses in the ability to perform activities of daily living (ADLs).

Workgroup Recommendations

The Workgroup believes that existing data, even at the level of detail found in the MDS, cannot provide an answer to the question, "How many people currently in institutions are likely to be able to be served in the community?" Given the countless number of permutations possible with so many factors to consider and the importance of subjective factors (motivation, informal supports, etc.) in placement decisions, it may be that this question could never be answered based on quantifiable data. Analysis of data elements cannot be substituted for the determination made by a "professional" based on a face to face assessment with the individual.

The Workgroup turned its attention to a second factor key cited in the *Olmstead* decision. This is the issue of consumer preference for placement in a less restrictive environment. Although the MDS contains data elements pertinent to this issue, it appears to be the consensus of many informed individuals that these data elements may not be reliable.

The Research and Data Workgroup's main recommendation is that the Department of Health and Family Services conduct a survey of a scientifically significant sample of nursing home residents to learn how many are interested in living someplace other than the nursing home. The survey should be conducted by individuals who do not have a stake in the survey responses and who have been instructed in the administration of the survey to get the most accurate results. The Workgroup has developed a recommended survey instrument and instructions for this purpose.

The Workgroup consulted the Department's Strategic Planning and Evaluation Section for assistance with determining a sample size that would provide statistically reliable information. The Department would need to draw a sample of 500 nursing home residents from the Minimum Data Set. This allows for some non- responses as the result of death, discharge or refusal/inability to participate. A sample of this size would provide data that could be generalized to the entire nursing home population. (For more detail of the sampling methodology see the attached memo from Nina Troia.)

The Workgroup designed the survey specifically for persons in nursing homes (generally frail elderly individuals and persons with physical disabilities). It may be that individuals with cognitive or mental impairments will not be able to respond to the survey as recommended. the Workgroup recommends that the Department develop an alternative instrument that can be used with individuals with limited capacity that can collect an individual preference as well as information from a legal guardian or surrogate decision-maker.

Other Workgroup Concerns

While the Research and Data Workgroup believes that people should be provided with the services they need in the least restrictive environment feasible, several issues are of concern and are noted here. These are:

- **Workforce** – The placement of individuals in settings that are less restrictive and more integrated than are institutions will likely require a greater direct care workforce that is currently available in the long term care system. Economies of scale created by group settings will be lost as people are more dispersed. The State must work to develop a workforce to meet the need.
- **Community-based Facilities** – As people are transferred from nursing homes to less restrictive settings, not only will available personnel and services be severely strained, but appropriate facilities will be inadequate in supply and unevenly distributed throughout the State, especially in rural areas. Even now there is a shortage of affordable Residential Care Apartment Complexes in the State and their distribution is not always where they are needed most. To successfully address this problem will require encouragement and assistance from the State.
- **Future of Nursing Homes** – As individuals opt to live in the community, already financially strapped nursing homes may be forced to close. Although some loss of nursing home beds is expected as people move to home and community based settings, the Workgroup is concerned that nursing homes fill a niche in the continuum of long term care resources. It is preferable that a person lives in a nursing home near his or her family and friends than in an institution that isolates by distance. The State needs to consider how it will work with the nursing home industry to maintain a reasonable distribution of nursing homes throughout the State and help nursing homes to retool and diversify.
- **Transition to Family Care** – As the State takes action to comply with *Olmstead* over the short term, we should ensure that those actions will integrate into the full implementation of Wisconsin's long term care redesign activities (Family Care, Mental Health/AODA Managed Care, Children's Redesign).

The Research and Data Workgroup's recommended survey instrument, instructions, and sample size estimate follow.

Proposed Nursing Home Relocation Survey, Instructions, Sample Size Estimate – Research and Data Workgroup

Nursing Home Resident Relocation Survey

1. Are you interested in learning about how your care needs could possibly be met in a place other than a nursing home?

☐ Yes ☐ No

2. I will read a list of supports and services that are often needed by people who are in nursing homes in order to live in the community. As I read them, please let me know if you think you would need that service or support to live in a place other than a nursing home.

- ☐ Locating housing
- ☐ Help with furnishing a home (furniture, kitchen equipment, linens, etc.)
- ☐ Transportation (to appointments, shopping church, bank, etc.)
- ☐ Assistance with bathing, dressing, etc.
- ☐ Assistance with homemaking, such as grocery shopping, cleaning, laundry and home repair
- ☐ Companionship
- ☐ Leisure/recreation activities
- ☐ Medical and/or nursing services
- ☐ Mental health/psychiatric services
- ☐ Assistance from family or friends
- ☐ Financial help for any of these

Are there any other services or supports you think you would need that I have not mentioned? If so what are they?

3. Have you ever looked into getting any of the above services or supports? ☐ Yes ☐ No
If yes, what do you think of the services and supports you were able to find?
-

Would you like someone to help you look for supports and services so that you might be able to live in a place other than the nursing home?

- ☐ Interested at the present time
 - ☐ Interested at some time in the future
 - ☐ Not interested – resident chooses to stay in the nursing home (Please record any consumer comments regarding why, if volunteered without prompting)
-

If you are interested in living in a place other than the nursing home, I will notify the nursing home social worker if you would like me to do so. However, it is important that you understand that it is not always possible to find supports and services that effectively meet your needs in your home community or county.

Referral Requested: ☐ Yes ☐ No

Instructions - Nursing Home Resident Relocation Survey

Read the following:

My name is _____. I am collecting information on behalf of the Wisconsin Department of Health and Social Services, to help them to better plan for the types of services to enable people who need assistance to live in the community. I am asking these questions so that they will know how many people in nursing homes are interested in moving back to the community. I am not able to offer you services and your community may not be able provide all of the services that I will mention. Your answers, however, may help the State to better provide the resources communities need to provide these services.

Ask Question 1.

If the answer is yes, read the following:

Many people move through different living arrangements during their lifetime. Most people prefer living independently in their own home or apartment. When a health problem or disability makes this impossible, people often move to nursing homes. Most communities have other alternatives to nursing home living for people who need assistance with life activities or who need care for health conditions.

Communities have programs that can bring the help a person needs into his or her own home. They also have group settings in which a person can live that provide services and supports, but are more like one's own home than is a nursing home. If your community has funding available for these services and living settings, you may qualify to receive assistance.

Ask Question 2. Read the opening paragraph and then read each item, allowing the resident to respond to each item.

Ask Question 3.

Ask Question 4. If the consumer offers a reason for not having an interest in leaving the nursing home, please record it on the survey form.

If the person responds positively to question 4, offer to make a referral to the nursing home social worker and indicate the response on survey form.

PO Box 7850
Madison WI 53707-7850

Date: August 16, 2001

To: Gail Propsom
David Slautterback

From: Nina Troia, Evaluation Analyst

Subject: Sample for Nursing Home Relocation Survey

You asked me to provide you with an estimate as to the sample size that would be required to conduct a representative survey of a statewide sample of nursing home residents. This survey would collect data regarding their desire to be discharged to the community. I have worked with Tony Reeves to analyze MDS data on the current Wisconsin nursing home census and short-term discharge patterns of a fairly recent population of nursing home residents. I used this data to calculate a sample size for your study. I would recommend that you derive a sample of 500 nursing home residents for this study.

I propose that you over-sample somewhat. I have inflated your sample by about 26% to account for the possibility of people from the 6/30/01 census leaving the nursing home prior to their interview. An analysis of discharge patterns among a recent nursing home census indicated that 26% died or were discharged from the nursing home within a year of the start of follow-up¹.

Per your request, only longer-term residents would be included in the sample, i.e., people who have resided in a skilled nursing home for at least 100 days². A random sample would be drawn from the statewide nursing home population on 6/30/01 and could potentially include someone from every county and nursing home. At one point, you indicated that you were considering drawing the sample from a selected list of nursing homes. While this might expedite data collection, I believe that there could be problems insuring and defending the representativeness of this sampling approach and also inhibit your ability to make generalizations to the entire population of nursing home residents.

The approach that I have recommended will allow you to draw conclusions that can be generalized to the total population of nursing home residents regarding their desire to be discharged to the community. I am recommending a sample size that uses a 5% margin of sampling error. This will allow you to draw fairly precise inferences to the population.

As we have discussed, the desire to be discharged is really only part of the overall assessment of the resident's dischargability. Each individual's care needs would need to be assessed relative to available community resources and informal support systems to thoroughly evaluate the feasibility of a discharge back to the community.

¹ The total 7/1/99 nursing home census was followed for one year and it was found that 20% had died and an additional 6% were discharged from the nursing home for other reasons.

² The 6/30/01 total nursing home census is estimated to be 39,270. 9% of this population lacked an admission date on MDS, and consequently, their length of stay could not be calculated. 5,937 from the total census had admission date data that showed that they had resided in the nursing home for less than 100 days. Neither the people missing length of stay data or the people who had been in the nursing home for less than 100 days will be included in the sample. The nursing home population that is used for the selection of the sample is 29,242.

Appendix G: Assessment Processes – Client Evaluation and Assessment Workgroup

Long Term Care Client Processes: Evaluations, Assessments, Reviews & Data Collection Systems

Process	Primary Purpose (s)						Characteristics of Process		
	Data Collection	Functional Eligibility	Rate Setting/ Authorize Program/ Service Payment	Decision-making- Impacts on Care Plan Development	QA	Other Screening	Client Specific	How/ Where Used	Who Conducts
MDS	x	x (BQA uses in part, feds use)	x	x – NF are to use for that purpose	x		x	NH	NH Staff
PASARR --Level One --Level Two			-- x	x x		x – Active Treatment Needs Evaluation	x x	At admission into NFs for those who facility believes may have active treatment needs (MH or DD).	Level 1 -- NH Level II- Independent Provider
LTC Functional Screen	x	x	x	x	x	x (Identify other needs—i.e. AODA/ MH, Protec-tive Services)	x	Computerized tool with logic pre-programmed eligibility	County RC staff.
FC RAD Method			x	x	x		x	In IDT (Interdisciplinary Team which includes consumer)	CMO IDT
WATTS Reviews				x		x Required	x	Used by Courts to determine	Guardian Ad Litem

Primary Purpose (s)							Characteristics of Process		
Process	Data Collection	Functional Eligibility	Rate Setting/ Authorize Program/ Service Payment	Decision-making- Impacts on Care Plan Development	QA	Other Screening	Client Specific	How/ Where Used	Who Conducts
						Court Review of Protective Placements		individual need for continued protective placement.	
AODA/MH Pilot Screens		x		x			x		
Center Support Needs Evaluation				x			x	Used at to determine match between indiv. Needs and comm. resources	State Center Staff
FC Comprehensive Assessment	x--Not standardized			x	x		x	IDT	CMO CM and Nurses
COP/Waiver Assessments & Care Plans	x--Not Standardized		x	x			x		County CM
La Crosse HSD Evaluation for Least Restrictiveness				x			x	Helps professionals determine appropriate level of care need for indiv. with complex needs.	County Care Manager/HS Professional
NH Annual Surveys	x				x				State BQA Staff

Appendix H: Complaints to Federal Office for Civil Rights (OCR) from Wisconsin Consumers

Overview: As of the publication of this Plan, the Office for Civil Rights—Region V (OCR) in Chicago had received 28 ADA Title II/*Olmstead* complaints from Wisconsin consumers who are institutionalized and would like to live in the community or individuals at risk of institutionalization. The Wisconsin counties involved are Brown, Dane, Dunn, Grant, La Crosse, Milwaukee, Racine, Sauk and Sheboygan. The primary cause of the complaints revolved around waiting lists.

Resolution Process: DHFS Regional Area Administration staff are the direct contacts with the counties in terms of investigating and recommending resolutions to complainants' concerns. Additionally, OCR staff is able to talk directly to Area Administrators for detailed information regarding the consumer's wishes and those of his or her family.

To date (December 2001), OCR has closed 9 complaints with satisfactory resolution. In some instances, the resolution entailed utilizing the Medicaid waivers or the Community Options Program. In other instances, the Medicaid card was used to fund medical needs while the individuals were on the county's waiting list for community care placement.

DHFS tracks complaints by keeping a log that is shared with all appropriate parties, including OCR. DHFS and OCR update the status of all complaints every three to four weeks.

V. Glossary

Children’s Long Term Support Redesign and related waiver – the redesign focuses on providing family-centered care for children with disabilities, with parents receiving appropriate assistance and respite. A proposed Medicaid home and community based waiver will provide flexible support to children with physical, developmental, and emotional disabilities in their homes.

Community Aids – combined state and federal funds distributed to counties to provide a wide range of human services to consumers with disabilities, mental illness, and substance abuse problems.

Community Integration Programs – funded by Medicaid home and community based waivers, CIP II is the nursing home relocation or diversion program for frail elders and persons with physical disabilities, CIP IA is for consumers with developmental disabilities relocated from the state DD Centers, and CIP IB is for consumers with developmental disabilities relocated, or diverted from ICFs-MR.

Community Options Program – COP is the innovative state-funded, county-administered home care program for persons with disabilities from all target groups to reduce institutional placements.

Community Support Programs – provide intensive care management and support services in the community to adults with serious mental illness to prevent institutionalization.

County Shield Law – state statute that permits counties to provide funding for consumers of human services to the “limit of available funds”.

Family Care – the state’s LTC redesign model that emphasizes consumer-driven outcomes and has operated in pilot counties since 1999 for frail elders and adults with physical and developmental disabilities. Resource Centers provide information and pre-admission counseling and Care Management Organizations provide managed care for consumers in community and institutional settings.

Family Support Program – a state-funded, flexible program to support families caring for a severely handicapped child at home.

Home and Community Based Waivers – waivers under s.1915(c) of the Social Security Act that allows states to provide a wide array of services to consumers with disabilities. Examples are the COP-waiver, CIP waivers, and the Brain Injury waiver. Additional waivers for services for children and those with mental illness are being considered.

Hospital Link – a pilot program that, in the past, has provided assessments and post-discharge planning for consumers as they are leaving a hospital.

Institutes for Mental Disease – four specialty institutions for those with serious mental illness and a bed capacity of approximately 340 in the state.

Integrated Service Projects – coordinated, community-based services for children with serious emotional disturbance. One example is “Children Come First.”

Intergovernmental Transfer Program – IGT is an accounting strategy between governments to maximize revenue sources.

Intermediate Care Facility for the Mentally Retarded – ICFs-MR provide specialized care and treatment for those with developmental disabilities. There are 37 in the state that provide care to about 2000 residents.

La Crosse County Tool for Evaluating Least Restrictive Environment – a precursor to Family Care developed to guide an assessor in his/her professional judgment related to the best plan for the consumer being evaluated.

Least Restrictive Environment – wording from state statute that emphasizes the need of consumers with disabilities to live in as non-institutional a setting as feasible.

Long Term Care Functional Screen – an eligibility determination tool developed for Family Care consumers that determines functional level of care for Family Care.

Medicaid personal care benefit – currently covers state “prior authorized” services in the home to assist consumers with activities of daily living.

Medicaid State Plan – spells out what the state, which shares Title 19 costs with the federal government, covers in terms of health care services for low income consumers. In Wisconsin, all mandated and optional services are covered.

Mental Health/AODA Demonstration Projects – grew out of the Blue Ribbon Commission on Mental Health redesign process to emphasize consumer outcomes and recovery. The initial managed care concept is currently under re-evaluation.

Minimum Data Set – federally prescribed data collection system that requires institutions to collect information on consumers in skilled nursing facilities in the state. Although useful for client care-planning, it is judged not to assist in determining consumer preference for living arrangement.

Most Integrated Setting – federal *Olmstead* decision language that emphasizes the desirability for consumers with disabilities to interact with non-disabled persons.

Pre-admission Screen and Resident Review – PASAAR reviews are required by the federal government for consumers prior to admission to institutions to screen for mental health and developmental disability treatment needs.

Residential Care Apartment Complexes – a place where 5 or more adults reside in independent apartments and are provided with up to 28 hours of supportive, personal and nursing services per week.

State Centers for Developmentally Disabled – the three DD Centers provide inpatient care for approximately 875 consumers with developmental disabilities.

State Mental Health Institutes – two inpatient facilities serving approximately 550 consumers with mental illness that provide acute psychiatric care for adults and children, often short-term assessments, as well as for forensic patients.

Watts Review – an annual judicial re-determination regarding consumers in protective placement to evaluate if their needs have changed.