

ATTACHMENT: ICF-MR COMMITTEE: RECORD OF VOTING AND COMMENTS ON PROPOSED RECOMMENDATIONS

12/16/2009

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
1) Ensure that institutional and community settings meet the safety, medical, personal, social, and spiritual needs of an individual in an environment that fosters a sense of belonging, meaningful interaction and continued growth.	15		0		0	
2) Expand specialized services, including short term medical and behavioral services, dental services, crisis services, and respite services, to ensure these services are accessible statewide for individuals with developmental disabilities living in the community.	15	Borreson - I support the recommendation as I believe the recommendation was put forward to include ICF-MRs as a service provider in community settings throughout the State. Egan - Look into developing regional centers for this. Ondrejka - Combine this with #4. DHS will have to develop a marketing plan so people in the community are aware of these resources. Sterling - This was a key recommendation of the DD Coordinators in the southeast region years ago when the state first discussed closing SWC. The lack of these specialized services has contributed to many individuals returning to ICF-MR. over the years. In addition, it may be beneficial within this proposal to allow center staff to follow people in the community for a more extended period of time than they have the ability to do now as part of the relocation process, particularly if a person has been a long term resident of the institution or has very specialized behavioral or medical needs.	0		0	
3) Leverage existing ICF-MR staff expertise to expand expertise and capacity in the community; for example, by training providers in the community.	15	Borreson - Supports the premise that regional ICF-MR's would be of value throughout the State. Bunck - This is very important because there is a definite risk for losing considerable advanced expertise found in the ICFs. Hart - Provided that the cost of the service is reimbursed by the providers that are being trained. Ondrejka - This could include a train the trainer model.	0		0	
4) Use staff and specialized services at the ICFs-MR, such as dental services, to serve individuals with developmental disabilities living in the community.	14	Borreson - Yes, as geographically appropriate. Bunck Yes, however, this would be a capacity issue for the current number of Center dental staff. Hart - The cost of providing this service should be reimbursed to the ICF-MR. Ondrejka - Combine with #2.	0		1	Breedlove - Need to know more specifics.
5) Ensure a capacity within the state for specialized long-term care for a period of time for people with developmental disabilities with complex medical acuity and behavioral and psychiatric needs.	13	Bunck - With the understanding that this should not be taken as a life-long commitment if new community capacity were to be developed. In the future long-term care should be thought of as changing to meet peoples needs as they mature, have changing health care needs, and changing interests in life based on developmental level, age, and life experiences. In other words, a continuum of choices over a lifetime. Vinehout - Please see the answer in #21 to see ideas on how to do this.	1	Bentley - We shouldn't plan for people to be in institutions for many months or years. People should return to the community within 4 months. That should be enough time to develop the right supports. If there isn't a place that can meet the person's needs after 4 months, the person could continue to stay for 90 days at a time—until there is a place in the community to meet all the person's needs.	1	Ondrejka - Depends - I would support developing the "capacity" for highly skilled, specialized supports in the community, but I think the recommendation referred to the State Centers.

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6) Consider modernization of state DD Centers to reflect best practices and contemporary standards that are community-oriented.	10	Bentley - But, we have to build real homes with nice yards in communities around the state. I disagree with any housing built on the state institution grounds. I also disagree with building smaller institutions and calling them homes. Borreson - The DD State Centers need to be down sized with savings utilized to equalize ICF-MRs rates statewide. Right now State DD Centers are archaic and a "state of the art" modernization program would improve efficiencies and services. "Right sizing" of the State Centers is integral to preservation of the States remaining ICFs-MR and rate equalization based on acuity measures statewide. Ondrejka - Yes, but with the caveat that modernization of the Centers does not include "sprucing up" any existing buildings. It would be better to have homes around the state that could offer the same level of supports people receive at the Centers. Underwood - The highly specialized services for medically complex and medically fragile individuals, as currently exist at CWC, are not available in other facilities. The proximity to UW Hospitals is critical for some of our folks. These services are also a resource for community providers. To allow the dismantling of these services due to aging buildings would be a disservice to current and future generations. Vinehout - We can save money and keep people in the least restrictive environment by carefully analyzing the needs of the population at the state centers and creating a state-run facility that focuses on the needs of the most frail and complex patients and moving those who can thrive in a different type of facility. Of course we may need to create community resources that are not now available.	3	Hart - This statement appears to indicate that the state DD centers are not using best practices and contemporary standards. Loeber - These are ICF-MR facilities that already modernized their facilities. Other states have gotten out of the state-run facility business. State-run facilities are not considered best practice.	2	Breedlove - Need to know cost information to decide. Groskopf - Undecided without knowing cost impacts.
7) Expand community opportunities for residents at state DD Centers on weekends and holidays.	7	Anderson -A new culture of thinking for all DD facilities that weekends and holidays are vital for community integration as are the weekdays. The Southern Wisconsin Center (SWC) does an excellent job with weekday community integration experiences. Let's see this carry over to the weekends and holidays within reason. A funding request (not at all) but a call for more enlightened thinking. A sincere initiative to further the quality of life of residents. Bentley - This doesn't have to be paid staff. Consider using more foster grandparents, Best Buddies, Americorps, and volunteers from churches. Borreson - This should be for all residential DD opportunities statewide. Bunck - This will require additional resources. Sterling - Will this be funded within the rate or how will these opportunities be funded?	4	Hart - This statement gives the impressions that residents at state DD centers have nothing to do on weekends and holidays. I recommend that parents and guardians work with local parent groups and DD staff to voice their concerns. Loeber - This is an internal issue at the Centers. I feel this should not be part of the ICF committee recommendations. Shilling - This recommendation is too narrowly crafted and may result in unintended micromanaging of the state operated DD centers. Community activities must be looked at more closely based on resident needs, staff and budgetary restrictions, etc.	4	Groskopf - Undecided without knowing cost impacts. (Agree with concept.) Ondrejka - Depends - I agree that people who live in ICF-MRs should have at least as many opportunities on weekends as they do during the week. I'm just not sure that this is in the purview of our committee. Underwood - Not within scope of Preservation Study. I suspect that community day service providers also operate on an M-F schedule, no weekends, no holidays so I don't feel this would be an issue encountered only at the State DD Centers. Vinehout - This is a matter of local management and one I would expect would be best left to the local administrators and their staff. If it is a resource issue the matter should be addresses through the budget process by the agency requesting additional staff.
8) Ensure information on short-term ICF-MR programs is known as an option for people on waitlists.	14	Loeber - This is an issue for ADRC & Family Care. This should easily be resolved. Ondrejka - Combine with #9. Stress that the resources are available short-term, until community-based services are available. It is unconscionable that families in crisis aren't given any options. Even a 30-day respite could be a tremendous help.	0		1	Groskopf - Unsure of funding source & would recommend technical assistance from DHS re: entire process.

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9) Provide short-term support for individuals and families on waitlists.	14	Ondrejka - Combine with #8.	0		1	Groskopf - Unsure of funding source & would recommend technical assistance from DHS re: entire process.
10) Develop strategies for improving retention of community-based caregivers.	8	Bentley - This starts with increased wages and health care. Groskopf - Agree, as long as other programs/initiatives are collaborated with (workforce development grants, etc.). Sterling - Perhaps the state could provide a training program for community caregivers where specialized services are required. Now it falls on the community providers to develop and fund their own training programs. This can be costly. It also results in many agencies duplicating programs that may be better provided from a centralized entity. In addition, with the MA budget woes, providers in the Family Care system are being asked to do more with less as rates get adjusted statewide. With this comes their inability to pay a living wage to people who may otherwise want to make caregiving a real career choice. If there is any way the state could assist in the critical and often costly area of staff training, this would be a good thing for our most vulnerable people. There is historically a large amount of turnover of staff in these settings which is incredibly detrimental to residents. Perhaps with a more structured training system and support, this too could be reduced.	2	Borreson - Not part of this task force's focus. Hart - This statement appears to be directed to community based caregivers and is not connected to ICF-MRs. It would appear to be more of a comparison of benefits for employees at ICF-MR as compared to community based employee benefits.	5	Loeber - Does not know for a fact that their retention levels vary from the ICF's. Underwood - If retention is an issue, which it must be if it was mentioned, there must be another avenue for that to be addressed. Vinehout - This is a management issue for community facilities and is not related to the question of the future of ICF-MRs and the directions given the Task Force.
11) Establish a parent forum, composed of parents of individuals living in both institutional and community-based settings, as a way of sharing information about the service array available for people with developmental disabilities.	12	Loeber - Said 'yes' but is unclear as to with whom they would be sharing information.	1	Hart - This appears to be very broad based as services vary depending on the level of an individual's disability. The statement must include guardian's as many residents are not represented by a parent.	2	Underwood - Not within scope of Preservation Study but do see it as a good idea. Vinehout - This recommendation addresses problems that are beyond the scope of the Task Force and unrelated to the question of the future of ICF-MRs.
12) Undertake a rigorous study of mortality rates in Wisconsin for people with developmental disabilities in both institutional and community settings to understand the relative mortality and safety risks in both settings.	11		3	Borreson - Too many variables and scarce dollars in these times need to be directed to 'services'. Groskopf - Unsure of cost benefit ratio. Shilling - While this information might be helpful in better understanding the level of care for the developmentally disabled, it would seem extremely difficult to extract relevant data to accurately compare these settings side by side.	1	Vinehout - This recommendation may be needed but it is beyond the scope of the ICF-MR Preservation Task Force.

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<p>13) Place a moratorium on ICF-MR restructuring.</p>	<p>7</p>	<p>Anderson - The voluntary placement initiative called for by Secretary Timberlake has been nothing short of debacle in reference to the SWC. The overwhelming majority of families and guardians at SWC have said the residents have a safe and secure campus at SWC. Both the health and quality of life of our loved ones takes priority over trends. Borreson - I believe we need to stop talking about restructuring, modernize State DD Centers (right size them) and use operational funds saved to fund existing ICF-MRs. We need a structure that will preserve regional ICF-MRs rather than following a policy of inadequate funding that assures the demise of Community ICF-MRs. Loeber - The state has achieved its desire to decrease ICF beds. Stop the process of the courts determining the most integrated setting to meet a persons needs. This has not proven to be effective and wastes the time of the courts. There would also be a savings of time and resources by not having to update the community plans every year. Most families/guardians are not choosing the ICF. The ICF-MR restructuring is not needed. Leave the process to the ADRC's and the Managed Care organizations. Underwood - Goal of restructuring (downsizing number of beds) must surely have happened by now. Time to re-evaluate goals of restructuring – unless restructuring actually meant elimination. A moratorium would also provide time to examine as to whether or not what consumers need actually exists outside of an institutional setting. Please see comments to #21. Vinehout - This statement cuts to the heart of why the task force was created. It is the first step to resolving the issues raised in the Legislature that led to the creation of the Task Force. The answer is an unequivocal YES. We must accept as policy that there are individuals that – some time in their lives – will need the services of ICF-MRs. Wisconsin must assure ICF-MRs are part of the spectrum of services available for DD clients.</p>	<p>5</p>	<p>Bove - The ICF-MR initiative ensures that individuals with developmental disabilities have the choice to voluntarily relocate from ICFs-MR; and provides sufficient funding to support their community costs if they choose to do so. Bunck - I am not directly involved in county ICF-MR restructuring but I am involved with the Centers. I do believe that for economic, legal, and most importantly, consumer-choice reasons, this is the right time to rethink and re-engineer how Wisconsin views and supports the long-term care needs of people with intellectual disabilities.</p>	<p>3</p>	<p>Groskopf - Cannot provide informed opinion. Shilling Without a time frame for the moratorium or benchmarks for when it would be lifted, this recommendation is too broad. The ICF-MR restructuring process should continue to be closely examined and I agree that a long term vision for our care system should be clarified before major changes are made going forward. Sterling - Need more information before deciding.</p>

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14) Increase Medicaid reimbursement rate at non-state ICFs-MR (for example, by reallocating funding that had previously been used for residents who die to increase the Medicaid ICF-MR reimbursement rate).	11	Groskopf - Agree, as long as impact to the overall Medicaid budget is cost neutral. Loeber - This is critical. ICF-MRs will continue to disappear. Underwood - Under the ICF-MR Restructuring global pot of money, according to the Relocation Reports for the past 3 years, funds that become available when an ICF-MR resident dies can be and are being used to support the higher cost of individuals being relocated to non-institutional settings. My understanding of the global ICF-MR Restructuring budget is that the set amount of money designated by the Legislature must be used for the cost of new community relocations AND to manage the cost of serving individuals remaining in the institutions. There appears to be no prohibition on increasing reimbursement at non-state facilities – as long as the total spent stays within the global budget. Vinehout - We also discussed considering alternative funding methods to assure adequate funding for ICF-MRs. We discussed an ‘adequacy model’ of funding that would address the high fixed costs of institutional facilities.	1	Breedlove - There would have to be a simultaneous increase in the CIP 1B rate. CIP 1B is more underfunded than ICF-MRs.	3	Bove - The Department must follow the direction in the 09-11 biennial budget bill regarding the level of Medicaid reimbursement for ICFs-MR. The Department can not make funding commitments for future biennia (i.e., the 11-13 biennium and beyond); these decisions will need to be made in the context of the development of the overall state 11-13 biennial budget and the fiscal constraints facing the state. Ondrejka - Depends - I agree with increasing MA reimbursement and equalizing rates for state and private ICFs (#18), but I think that parenthetical comment should be eliminated. Shilling - Would need more detailed information on the impact this might have on department wide Medicaid funding.
15) Ensure that institutional funds that are reallocated to the community remain sufficient to support fully individuals’ needs.	14	Borreson - Dollars need to follow the person. Loeber - This is critical. Community placement will not provide the most integrated settings. Ondrejka - Yes, but I believe this can be done within the existing structure of full funding for two years, with the funds rolled into the overall MCO rate after that. Sterling - As it stands now, MCOs get the actual cost of the community plan for members for a limited period of time. Is the intent of this to require the State to fully fund indefinitely?	0		1	Groskopf - Need further definition.
16) Advocate for federal changes to allow self-directed waiver funds be used for ICFs-MR.	3	Bunck - Especially if the ICF-MR services are specialized and tailored to specific individual needs and can change as a person's need and interests change over time.	8	Bove - The principle of self-direction is inconsistent with residing in an ICF-MR. Breedlove - CMS won't allow it, and the IRIS implementation committee hasn't concluded that the IRIS model could work in an ICF-MR. Loeber - Anyone who can self-direct their funds should not be living in an ICF-MR. If guardians want to do this, there are settings where this can work. Shilling - This issue should be looked into at greater length to determine the impact it may have before pursuing federal changes.	4	Underwood - If someone has the ability to self-direct then I am unclear as to why they would use ICF-MRs.
17) Refine the ICF-MR reimbursement method to more accurately reflect the level of acuity of individuals with developmental disabilities.	12	Borreson - DD1a and DD1b have long been the most acute care provided in an ICF-MR's. There are tremendous acuity differences within each level and dollars need to be direct to where they are most needed. Vinehout - It is a serious mistake to use only a functional or ADL assessment for ICF-MR clients. Adequate measures of acuity exist and they should be used.	0		3	Ondrejka - Maybe - I agree with the principle, but I'm not sure that acuity level is the best method for calculating rates.

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18) Explore the possibility of using the same Medicaid reimbursement formula for state and non-state ICFs-MR.	12	Egan - This is an absolute necessity. Underwood - Facility A should receive the same level of reimbursement as Facility B for identical services. The formula should have nothing to do with union or non-union employees or state or non-state facilities. The service provided and acuity level (#17) should be determining factors of reimbursement.	1	Breedlove - Their cost structure & the impact of the unions is very different.	2	Bove - Applying the same Medicaid reimbursement formula for state and non-state ICFs-MR will increase costs to the Medicaid program. The Department must follow the direction in the 09-11 biennial budget bill regarding the level of Medicaid reimbursement for ICFs MR. The Department can not make funding commitments for future biennia (i.e., the 11-13 biennium and beyond); these decisions will need to be made in the context of the development of the overall state 11-13 biennial budget and the fiscal constraints facing the state.
19) Instruct DHS to conduct an internal review of its current oversight methods designed to ensure that people with developmental disabilities are living in the "most integrated settings," as required by state and federal law.	11	Sterling - I know there have been efforts over the years to improve the utilization review process.	1		3	Groskopf - Unsure of cost benefit ratio. Underwood - Only because any review of DHS oversight methods should be done by an independent, unbiased source - not DHS. Vinehout - The recommendation appears to be beyond the scope of the task force. It may be a useful and needed exercise.
20) Instruct DHS to create a task force composed of state center staff, ICF-MR staff, and other knowledgeable people as appropriate to develop a plan to adapt programs and environments within state centers and ICFs-MR to best meet the needs of an aging population.	14	Bentley - We need experts in aging to come up with a plan to support aging consumers in ICF-MRs and in the community. Bunck - People with intellectual disabilities are, in many instances, now living as long as everyone else. Hart - Every resident of a state center completes an annual WATTS review. During this review the court determines that an individual is living in the "most integrated" setting. Are people living in the community required to have an annual review to determine if placement in the community is the "most integrated". Would the option of being placed at a state DD center be available? Ondrejka - This effort should be expanded to other settings. All providers have to learn how to support people with DD as they age. Sterling - Please address the issue of active treatment. I have felt for years that elderly people that have a developmental disability have been treated unfairly in their golden years. When in their lives can they just be elders and not placed in programs where everything has to be measured? Vinehout - Although the best venue may be an effort organized by industry groups and DHS, not spearheaded by DHS alone.	0		1	Underwood - Only because DHS should not be in charge of this, not because it is not needed. The needs of the aging DD population should absolutely be addressed.

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21) Establish a Legislative Council Study committee to review the recommendations of this workgroup and investigate whether the long-term care system for individuals with developmental disabilities is adequate to meet the spectrum of needs.	5	Egan - This might ensure that all of the Committee's work will be taken under consideration. Loeber - This is necessary to make sure these recommendations are moved forward.	6	Anderson - Let us move forward with many of the excellent recommendations made here. Borreson - I suggest that for now a Legislative Council Committee not be requested and only if DHS does not follow on this committee's recommendations should a study be requested. I would rather ask the DHS Secretary to name this Committee or like Committee to prepare implementation plans for this Committees recommendations. Bove - A Legislative Council Study is not needed to review the recommendations of this workgroup. A Leg. Council Study of the adequacy of the long-term care system for individuals with developmental disabilities would be duplicative of the work completed by this workgroup. Shilling - This may be duplicative of the work that has already been done and would delay the implementation of this committee's recommendations. Vinehout - The recommendations I have agreed to above can be implemented by DHS without a Legislative Council study. A study will only slow the process. There was a much larger question raised by the Task Force that would be of interest to the Legislature and should be recommended to Legislative Council for a study. That question was addressed in #6 above. The role of the state centers in serving the ICF-MR population should be addressed. Can we provide care to some individuals in the state centers in a least restrictive environment? Can we create a "right size" state facilities in Wisconsin that address the needs of individuals that are the most frail and have the most complex medical conditions while providing care for others in a different type of facility? Perhaps we need a long range plan for the State Commission. A way to address several of the budget and policy problems the state now faces – high mandatory overtime at the state facilities; evidence of chronic understaffing; high turnover; aging, high maintenance, high cost facilities that are now inadequate to address the changing needs of the population. Can we create two smaller, state of the art facilities that address the needs of the population the state really has a mission to serve – the most complex, frail individuals in our state?	4	Bunck - It would seem that if the previous 20 items move forward, this would not be necessary. If not, my vote would be 'yes'. Underwood - Yes and No – a legislative council study may only delay the process and not address critical funding issues as rapidly as needed. However, a council study would provide an expanded opportunity, not provided for in our short timeframe, to examine what other states are doing. Example: CA has created by legislative act, a pilot project for Adult Residential Facilities for Persons with Special Health Care Needs. This pilot project was developed to address the special health care needs of individuals impacted by the closure of a state DD facility. The requirements for operation of these facilities and who can utilize these services is all spelled out in law. They are not ICFs/MR. They are far superior to the adult family home that our medically fragile folks have as an option. Maximum number of residents per facility is 5. Law is very specific as to who can administer these facilities and training requirements. Notable requirements LPN, or licensed psychiatric technician is awake and on duty 24/7. As Senator Vinehout commented, what is needed may not currently exist. A Leg Council Study could examine in more detail a variety of options and service models.

<u>Committee Members Voting:</u>		
Steven Anderson	Ted Bunck	Jennifer Ondrejka
Cindy Bentley	Cathy Egan	Jennifer Shilling
Phil Borreson	Gina Groskopf	Kim Sterling
Fredi-Ellen Bove	Harold Hart	Rebecca Underwood
Lynn Breedlove	Ardis Loeber	Kathleen Vinehout