STATE OF WISCONSIN
Department of Health Services
Division of Mental Health and Substance Abuse Services
Division of Long Term Care

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Index Title: Diversion Services for People with Intellectual/ Developmental disabilities and Admission/Discharge Processes through Intensive Treatment Programs (ITP) and Mental Health Institutes

To: Listserv

For: Area Administrators / Human Services Area Coordinators
Bureau Directors/ Program Office Directors / Section Chiefs
County Departments of Community Programs Directors
County Departments of Developmental Disabilities Services Directors
County Departments of Human Services Directors
County Departments of Social Services Directors
Tribal Chairpersons / Human Services Facilitators

From: Brian Shoup, DLTC Administrator

Linda Harris, DMHSAS Administrator

Subject: **Information Memo on Diversion Services for People with Intellectual/Developmental Disabilities and Admission/Discharge Processes through Intensive Treatment Programs (ITP) and Mental Health Institutes.**

Introduction

The Department of Health Services is committed to ongoing improvement of treatment services for all people, including those with intellectual/developmental disabilities (ID/DD). Quality care for people with ID/DD and others involves treatment that is appropriate to individual needs, short-term, and coordinated with local resources to promote successful return to the community as soon as possible. This memo provides information on processes and expectations for providing high quality care and treatment for individuals with mental illness and ID/DD at the State Centers and at the State Mental Health Institutes.

The Role of the Developmental Disabilities Coordinators

Developmental Disabilities Coordinators are DD/ID professionals trained and experienced in both adult and children's long term care systems, best practices for the provision of services and supports, funding streams and policy contexts related to crisis prevention, crisis diversion and relocation of individuals with DD/ID who experience significant mental health problems. DD Coordinators will act as a communication link between Centers and Institutes and with Counties and/or Managed Care Organizations, along with other state waiver programs including the Office of Family Care Expansion (OFCE) and the Bureau of Long Term Supports (BLTS), to coordinate planning and assure timely discharge planning for persons with DD/ID admitted to the State Institutes.

DD Coordinators are available to county human services agencies and Managed Care Organizations to provide information on the most integrated services/supports to best meet an individual's urgent psychiatric needs and to divert/prevent admissions to the State Institutes when alternative approaches are clinically indicated. DD Coordinators are also available to Institute admissions staff and as a resource to the referring party making contact with the Institute admissions staff. A dedicated toll-free phone line has been established at **855-848-7778** in order to provide an accessible source of information on the most integrated services / supports to best meet an individual's urgent psychiatric needs and to divert /

prevent admissions to the State Institutes when alternative approaches are clinically indicated. The Intellectual / Developmental Disability Mental Health Resource Line is intended to assist in problem-solving and resource identification for those professionals working with individuals who are diagnosed with an intellectual / developmental disability and a co-occurring mental health diagnosis / behavioral disorder.

This resource is intended to be used by Managed Care Organizations, County human services agencies, crisis workers, inpatient hospitals and other professionals who are seeking ways to prevent institutionalization. State Mental Health Institute staff who receive calls of this nature will refer those callers to this line. The DD MH Resource Line is not intended to be utilized as an alternate to 911 for emergency situations nor to provide Emergency Mental Health services as described in DHS 34.

This toll-free number is not designed for direct contact with the DD Coordinators. Instead, this line is attached to a voicemail and text messaging system. Once a caller leaves a detailed message, including their name and number, the DD Coordinators receive a text and an email alert (both on their desktop and work cell) notifying them they have received a message. Monday through Friday (excluding State holidays) between 8:00 am and 4:30 pm, the DD Coordinator on call will call into the system to retrieve the message and will call the person back within 2 business hours. If a message is received after these hours or on a weekend, the DD Coordinator will call the person within 2 hours on the next business day.

The DD Coordinators are:

DD Coordinator, 715-723-5542 ext. 4300
Diane.Dietz@wisconsin.gov

DD Coordinator, 262-878-6622
Jennifer.Nora@wisconsin.gov

State Center Intensive Treatment Program Overview

Intensive Treatment Programs (ITPs) are short-term treatment programs intended to help an individual with ID/DD, whose treatment needs have not been adequately addressed in the community, to receive needed treatment. This is accomplished by a comprehensive interdisciplinary assessment, active treatment plans and the provision of recommendations for supports needed to return to community living. ITPs focus on increasing those skills necessary to achieve functioning with as much self-determination and independence as possible, often by addressing complex behaviors.

ITPs are located at each of the three State Centers for people with ID/DD. These programs are called Northern Wisconsin Center EXCEL, Central Wisconsin Center Short Term Assessment Program (STAP), and the Southern Wisconsin Center Intensive Treatment Program (ITP). All three programs provide psychological and psychiatric supports for individuals with ID/DD diagnoses.

Admission Criteria for State Center Intensive Treatment Programs

People eligible for Intensive Treatment Program (ITP) services are children and adults with ID/DD who meet the diagnostic eligibility criteria for residential treatment services consistent with the requirements of the Community Integration Program (CIP) Medicaid Waiver, the Children's Long Term Support ID/DD Medicaid Waiver, and/or enrollment in Family Care, or IRIS, and:

1. People who have a preadmission assessment that has identified active treatment needs which have not been met elsewhere due to complex behaviors which are due to social, psychological, psychiatric, and medical factors;

2. Have a preadmission assessment that identified active treatment needs that can be met at an ITP;

3. Would benefit from treatment to reduce the frequency of behaviors which are interfering with the person's other community supports and simultaneously support development that is necessary to achieve functioning with as much self-determination and independence as possible, and preventing the loss of functionality;

4. Have needs that are consistent with the Intermediate Care Facility/Intellectual Disabilities (ICF/ID) standards; individuals who need a program of active treatment that includes consistent implementation of a program of specialized and generic training, treatment, and health services;

5. Have needs related to acquiring the skills essential for independence such as: toileting, personal hygiene, dental hygiene, eating, bathing, dressing, grooming, communication, medication management, use of medical devices and money management and;

6. Have a need for services and supports that can be adequately and safely met by the ITP.

7. The person must have a guardian and protective placement order as required at the time of admission.

Active community discharge planning is required to begin prior to admission, given the short-term nature of the ITP Services. ITP services are not designed for people who are able to function with little supervision or in the absence of a program of continuous active treatment, or for persons who are generally able to independently take care of most of their personal care needs, and effectively and appropriately make known to others their basic needs and wants.

ITP services are not to be used for emergency detentions under Chapter 51.

Note: Specific admission decisions take into consideration the availability of necessary programs and services based on the preadmission assessment, as well as a person's needs related to social, behavioral and medical interventions. Compatibility with other people already in ITP treatment must be taken into careful consideration when determining which ITP and where in the ITP the individual would best be served in order to promote appropriate treatment for all participants.

ITP Referral and Admissions Process
Referrals are made by County case managers or Managed Care Organization (MCO) care managers to an Admission Coordinator. Each Center ITP has a dedicated phone line for admissions:

EXCEL - Northern Wisconsin Center - Chippewa Falls
715-723-5542 ext. 5115

STAP (Short Term Assessment Program) - Central Wisconsin Center - Madison
608-301-9294

ITP (Intensive Treatment Program) - Southern Wisconsin Center - Union Grove
262-878-6669

ITP admission staff will respond to referral requests from County / MCO staff no later than the next business day. A preadmission screening will be conducted to determine eligibility, based upon the ITP admission criteria as outlined in this memo, within three (3) business days of receipt of required records. If needed, additional information may be requested prior to a final admission decision. When the individual is determined to be eligible for admission, a determination will be made as to the most appropriate ITP program. This will be communicated to the referring agency as soon as it is possible. It will not be necessary for the referring party to re-refer the individual to another ITP as the information will be forwarded to the most appropriate ITP automatically.

As applicable, referrals are coordinated with and approved/authorized by the person's County, or Managed Care Organization (MCO), as well as the person's parent/guardian.

State Centers will strive for scheduling timely admission as soon as possible after the results of the preadmission assessment determines eligibility for an ITP admission. This admission date is communicated to the person's County or MCO, as well as the parent/guardian, and State Mental Health Institute (if applicable). Whenever possible, the admission is scheduled on a mutually agreeable day.

Priority will be given to eligible persons who would otherwise have a prolonged stay at a State Mental Health Institute or for whom an admission to a State Mental Health Institute can be diverted or avoided.

If the appropriate ITP does not have an immediate admission date, all parties will be notified of acceptance for admission pending scheduling of the actual date. A tentative admission date is set based on the earliest anticipated availability of a bed compatible with the person's needs. The most common reasons for an admission to take longer than expected are: delays in receipt of required records, limitations on the staffed capacity of the ITP programs and unpredictable increases in referrals. The order of future admission dates can change based on the need to serve those with the most acute needs. The order of admissions is not organized on a "first come-first served" basis.

Admissions will occur after a determination is made by a preadmission assessment that the individual meets the criteria for admission and the individual's needs can be met at an ITP. Transition planning to the community starts at the time of admission, and includes MCOs, Counties, guardians, providers and the person. The programmatic, habilitative, and clinical emphasis at the ITP includes consideration of where each individual will live, work, recreate, go to school, and receive health care in the future. Stays beyond 90 days must be mutually agreed to by the applicable Managed Care Organization, county, the parent/guardian, and the Center Director.

Prior to admission, the projected discharge date is mutually agreed upon by the County and/or the MCO and the ITP. Extensions beyond 90 days must be *mutually agreed to* and justified for good cause. When there is not agreement and the professional Interdisciplinary Team has determined that the purpose of the ITP admission has been met, the Center Director or designee will set a discharge date and impose as applicable a 10% surcharge on the first day of the month following that date.

Transfers from a State Mental Health Institute to a Center ITP

If a Mental Health Institute admits an individual who may be eligible for an ITP transfer, the Institute will notify the Bureau of Center Operations designee and Developmental Disabilities Coordinators (DDC) within 72 hours of admission. The Institute will discuss with the county and MCO that a return to the community or referral to a State Center would be appropriate. If the county and MCO support an ITP referral; the Institute will notify the DDC. Upon notification, the DDC will communicate with the county and MCO, as soon as possible and no later than the next business day, to verify the referral and begin the referral process and a transition plan will be prepared with the Institute Team within two (2) weeks. During that communication general eligibility criteria will be reviewed before the remainder of the referral process is transferred to one of the ITP Admission Coordinators for completion.

The ITP staff will begin working with the Institute team, the county and MCO. For individuals enrolled in Family Care, final transfer plans include authorization by the Managed Care Organization. For individuals in Waiver counties, authorization will be given by the appropriate county entity. Center ITP admissions typically require a protective placement order and the county is responsible for notification of the court in the event of a change in placement. Within two weeks, ITP staff will assist the Institute and other stakeholders in the development of an Institute discharge plan. When the discharge plan includes an admission to an ITP, the eligible person will transfer as quickly as possible to a Center ITP on a mutually agreed upon date.

ITP Discharge Process and Expectations

Discharge planning begins at the time an individual has been admitted to an ITP. The transition and relocation planning will include a comprehensive team approach which will include (as applicable) Counties, MCOs, ITP staff, DDCs, guardian/person, providers and others as appropriate. This process will emphasize collaborative person-centered planning, resulting in plans that adequately support the person in the community. ITP staff will work with stakeholders on relocation planning, offering support and ideas for developing those plans. Training can also be provided to assist with transitioning. It is expected that behavioral support plans, crisis plans and restrictive measure plans will be shared with ITP staff for recommendations and review. For adults and children for whom discharge will be 90 days or more, a review of eligibility for Money Follows the Person (MFP) will be made by the county / MCO. MFP specialists are available to assist in discharge planning.
http://www.dhs.wisconsin.gov/ltc_cop/MFP/MFP.HTM

Transfer from a Center ITP to a MH Institute

Transfers from a Center ITP to a MH Institute may occur for two primary reasons. The first may be as part of a crisis plan that was developed as part of the preadmission planning process. This would involve an agreement between the Center ITP Director and the MH Institute Director to allow an individual to be transferred to that setting under specific circumstances. The County of Responsibility will be fully aware of this plan and will be notified immediately. These circumstances would likely include when the individual is a threat to self or others due to extreme violent behavior, which the ITPs are not staffed or physically structured to adequately handle, and is attributed to an acute psychiatric condition. The individual would remain in the MH Institute until the individual is psychiatrically stable and could then be returned to the Center ITP. All agencies involved with this person will be informed of the status of this individual and transfers. The second reason for a transfer from a Center ITP to a MH Institute would be for individuals where a prior agreement was not already in place and due to unforeseeable circumstances the individual's needs have changed and would now be best met at a MH Institute. In these situations such a transfer requires approval of the referring Center Director and/or the Director of the Bureau of Center Operations and the Director of the receiving Mental Health Institution or designee in collaboration with Counties and/or MCOs. After a transfer from a Center to an Institute, the Center ITP interdisciplinary team continues to be available to the Institute treatment team for consultation.

State Mental Health Institute Services Overview

Mendota (MMHI) and Winnebago (WMHI) Mental Health Institutes are licensed and accredited hospitals that provide specialized diagnostic, evaluation, and treatment services for patients with diverse needs, including children and adults with mental illness who have been civilly or voluntarily committed and forensic patients referred to the Institutes through the criminal justice system. The focus of this memo is on individuals diagnosed with DD/ID and mental illness who may undergo a civil commitment.

State Mental Health Institute Eligibility and Admissions Process

Patients are admitted to WMHI or MMHI by request of the Courts or Counties within the State. Patients under a civil commitment are committed to their County of residence and the County requests they be treated at one of the MH Institutes. All inpatient admissions must have the approval of the 51.42 Board for Counties with Department of Community Programs or the 46.23 Board for Counties with Department of Human Services in the County where the patient has legal residence.

Institute Admissions Coordinators are:

Winnebago Mental Health Institute (WMHI)
Admissions Coordinators, 920-235-4910, ext. 2527

Mendota Mental Health Institute (MMHI)
Admission phone, 608-444-6748
Admission office, 608-301-1352 and 608-301-1353

In order to avert an Institute admission and to de-escalate a potential crisis the appropriate designee(s), as applicable, from IRIS, the Children's Waiver, Family Care or a Legacy Waiver will collaborate with the assigned County or crisis worker, the Long Term Support Coordinator (or similar position) and a crisis worker to determine clinical and residential options appropriate to de-escalate the situation and prevent an Institute emergency detention under WSS 51.15.

However, if individuals diagnosed with both mental illness and DD/ID are in an emergency situation (the individual meets the criteria for emergency detention under WSS 51.15) Winnebago Mental Health Institute (WMHI) or Mendota Mental Health Institute (MMHI) will admit the individual for the 72 hour detention period.

For a continued stay beyond the 72 hour detention, the DD Coordinators are contacted to provide consultation and assistance with any patient whose discharge will be challenging. Within two (2) weeks a discharge plan will be developed with appropriate consultation. This timeframe is specific to development of a discharge plan, but additional time may be needed to secure appropriate resources. For minors and individuals who have been adjudicated incompetent, the guardian must be involved early on in the discharge planning process. Appropriate funding source stakeholders must be involved.

At the person's initial staffing, determination will be made regarding the continued need for ongoing treatment at MMHI/WMHI. If the person has a treatable mental illness, has onset of a new mental illness and/or the current admission is related to a worsening of an existing mental illness, then placement at MMHI/WMHI would be considered appropriate until such time as the symptoms of the illness are reduced. Simultaneously, as the mental illness symptoms are stabilized, the interdisciplinary team will begin planning the next residential steps consistent with the concept of a most integrated community plan. For any patient admitted to a State Mental Health Institute, efforts shall be made to return the individual to their existing community placement if appropriate.

It is the intent that all children, adolescents and adults with a DD/ID, mental illness and behavioral challenges receive services in the most appropriate treatment setting that will encourage community integration. Any admission on an involuntary basis will lead to a discharge as soon as possible after appropriate arrangements have been made for the safety and treatment of the individual. It is the goal of the State Mental Health Institutes to provide interventions that improve psychiatric stability and when clinically indicated discharge will occur within two weeks of admission.

State Mental Health Institute Discharge Process and Expectations

For adults and children who will be treated and discharged from a State Mental Health Institute in a brief time or are determined to be appropriate for the Institute, treatment will begin with the goal of discharging the individual in a timely manner to their own home, previous community placement or new residential setting. The DLTC designees will work with Institute staff and county or managed care staff to develop a plan that meets the person's needs, can be financially and programmatically developed in a timely manner and sustained.

Financial / Authorization of Admission & Payment

For adults from Waiver counties, the Waiver Manager in the Bureau of Long Term Support (608- 266-8560) will be contacted to assure coordination between appropriate county officials and the community residential program.

For children, the CLTS Section Chief in the Bureau of Long Term Support (608-266-8402) and/or the

Bureau of Milwaukee County Child Welfare will be contacted.

For adults in the Family Care program, the Office of Family Care Expansion (608-261-8345) will be contacted.

MEMO WEB SITE: http://www.dhs.wisconsin.gov/dsl_info/