



**State of Tennessee
Department of Finance and Administration
Division of Mental Retardation Services**

Arlington Developmental Center Closure and Community Transition Plan

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EXECUTIVE PREFACE

The State of Tennessee is committed to ensuring that individuals with mental retardation have a healthy, secure, and meaningful life surrounded by family and friends. In concert with this mission, the State has decided to close the Arlington Developmental Center (ADC) and to provide appropriate services and supports to its current residents in alternative community-based settings. The State has also made the decision to sell most of the 535-acre Arlington campus and to place the proceeds from the sale of this valuable property in an endowment fund for the expansion of the West Tennessee community service system for persons with mental retardation.

Several factors have led to these decisions:

- **Deteriorating Conditions of the Physical Buildings and Equipment at ADC**
The State hired an engineering architect to do a thorough review of what could be done to repair the physical plant of ADC and provide safe living conditions for its residents. The findings indicated that extensive repairs to ADC's physical plant were needed to address maintenance issues and to bring the facility up to current codes and regulations. The State concluded that these costs were prohibitive and that closing ADC, building 12 four-bed community-based Intermediate Care Facilities for the Mentally Retarded (ICF/MR) homes, and expanding the number of Arlington Waiver-funded homes was a better alternative.
- **Escalating Operating Costs of ADC**
Per resident costs at ADC are projected to be over \$1,100 per day for the 2007 fiscal year. ADC's per diem rate is the highest among all long-term health care residential facilities in Tennessee and it is one of the highest in the nation. These costs are far higher than the current costs of supporting individuals with mental retardation with similar needs and challenges in community residential settings.

- **The State of Tennessee Division of Mental Retardation Services' (DMRS) Improved Performance in Providing Quality Community Services**

Over the past four years, there have been many improvements in the DMRS community services system. These improvements have been reflected in surveys by the federal Centers for Medicare and Medicaid Services, DMRS' own quality assurance reviews of community provider agencies, and in the Arlington Court Monitor's annual status reviews of community homes serving class members. In May 2006, DMRS' statewide Quality Management System for its community services system was recognized for its design and implementation by the American Association on Mental Retardation, now known as the American Association on Intellectual and Developmental Disabilities.

- **Meeting the Needs of Individuals on the Waiting List for DMRS Services**

As of May 31, 2007, 2,010 individuals are on the waiting list for DMRS services in West Tennessee, including 371 individuals whose need is classified as "crisis." Meeting the needs of these individuals requires the State to ensure the most cost efficient means to increase its service capacity, including greater reliance on the more flexible, individualized, and less costly long term supports in the Home and Community Based Services (HCBS) Waiver Program and less reliance on costly state institutions.

This Tennessee policy direction follows a national trend that has resulted in a dramatic decrease in the census of state developmental centers from over 169,000 in 1974 to less than 40,500 in 2005. Concurrently, nationwide the number of individuals with mental retardation receiving long-term supports through HCBS Waiver Programs has grown from 23,000 in 1987 to over 424,000 in 2004. Overall, since 1987, the increased reliance on the Waiver Programs has fostered a 200%+ increase in the number of individuals who are developmentally disabled receiving long-term health care supports.

In short, there are important reasons for the State of Tennessee to make this decision to close ADC and to re-invest the resources of its large campus in the further expansion of community-based services for persons with mental retardation in West Tennessee. Although some have expressed concern over the State's decisions, almost two-thirds of the original Arlington Class members have already moved from ADC to community homes.

As of June 30, 2007, only 128 individuals receive services at ADC and there have been fewer than ten new admissions to ADC in the past decade. The number of ADC's residents moving to community living arrangements has also accelerated in recent years. In FY 2005-2006, 18 individuals moved from ADC to community homes. During the period of July - December 2006, conservators of an additional 45 individuals indicated that they wished to enter the planning process for their family members to move to community homes. As of June 30, 2007, 30 of these individuals have already moved to their community home, and the remaining individuals are expected to move by December 31, 2007.

Conservators of former ADC residents are also largely very satisfied with their decision to move their family members to community homes. A DMRS statewide satisfaction survey (2005 - 2006) found an 81% satisfaction rate among conservators of individuals receiving community services. The Arlington Court Monitor's 2005 survey of conservators of community class members found a similar overall 90% satisfaction rate, with high satisfaction ratings associated with many specific aspects of community services, including healthcare (87%), home quality (92%), and opportunities for community outings and activities (83%).

Based on these findings, as well as the experience of other states, the State firmly believes that its decision to close ADC is the right one. Yet, it is also a challenging one that requires careful planning to meet not only the needs of current residents of ADC, but also the needs of those who would have relied on ADC's services in the future.

This Closure Plan is the beginning of the State's effort to ensure that successful community transitions will occur for ADC's current residents. The Plan represents a statement of DMRS policy by the Deputy Commissioner and it has been conditionally approved by the Court Monitor. In developing this Closure Plan, the State has made a concerted effort to listen to conservators of ADC's current residents. Several Family Forums, facilitated by Stephen Norris, Deputy Commissioner for DMRS, and Dr. Nancy Ray, Arlington Court Monitor, have been held at ADC. The forums have been well attended and have offered the State opportunities to hear family and conservators' concerns and to report on existing community services, as well as preliminary new service development plans.

Community provider agencies have also been invited to the Family Forums to share their service options with conservators. In the Family Forums, conservators have offered specific recommendations that are reflected in the Closure Plan. The Deputy Commissioner and the Court Monitor will continue holding these forums on a quarterly basis throughout the ADC closure period.

In addition to the Family Forums, the ADC Chief Officer and ADC's Assistant Superintendent for Residential Services have met with conservators of 95 of ADC's residents since mid-2006 regarding transition. Meetings will be held with the conservators of all remaining residents over the next six months. These meetings offer conservators and family members a more personal and private opportunity to raise their questions and concerns and to speak frankly about what they most want in a community service arrangement for their family member. The parents, guardians, and conservators of ADC residents also receive additional closure updates in the ADC monthly newsletter.

The State's decision to close ADC and expand the DMRS community services system in West Tennessee came only after careful thought and consideration of what will be in the best interest for persons with mental retardation in the region. This Closure Plan is the beginning of the State's communication of how it plans to replace and improve upon ADC's services. In regards to ownership of responsibilities of the Plan, DMRS intends to create an

implementation grid of Closure Plan commitments and make clear assignments to help management monitor compliance.

It is inevitable that there will be amendments to the Closure Plan. As substantial changes in the Plan are contemplated, the State will discuss them and solicit input from conservators and other stakeholders. The 2006 Settlement Agreement approved by the Federal District Court in 2007 (the "Settlement Agreement") also requires that any substantial changes to this Closure Plan shall be subject to approval by the Court Monitor.

CHAPTER 1

THE CURRENT RESIDENTS OF ARLINGTON DEVELOPMENTAL CENTER

Profile of the Current ADC Residents

Most (101) of the 128 individuals who reside at ADC live in nine residential units in ADC's main administration building, the Baker Building, and the remaining 27 individuals live in three residential units located on ADC's upper campus. As ADC has downsized in the past five years, some of the residential units on the upper campus have gradually closed; the remaining residential units on the upper campus are expected to close by the end of 2007.

In accordance with federal rules and regulations, as well as Federal Court orders, each resident of ADC receives a number of medical, functional, and habilitation assessments each year. Data from these assessments provide valuable information in formulating the macro planning for ADC's closure, the development plans for the community system, and appropriate individualized transition planning for each of ADC's current residents.

In addition, in accordance with the provisions of the Settlement Agreement, special assessments have been conducted of all ADC residents whose interdisciplinary treatment teams identified them as being medically fragile and/or as having severe behavioral problems. These latter assessments were conducted by qualified expert consultants, Karen Green McGowan, RN, CDDN, and Edward E. Hughes, B.A., M.A.

Relying on data from these various assessments, an informative profile was developed of the ADC residents and the following is a snapshot of those residents still at ADC in March 2007:

- 60% of the Arlington residents are 45 years of age or older, and there remain only seven individuals at ADC who are under the age of 30. Most of ADC's residents, regardless of their age, have lived at ADC for more than 20 years.

- Virtually all (95%) of the residents have been diagnosed as profoundly mentally retarded and 15% have significant behavioral problems.
- The resident population as a whole is also unusually medically challenged. Two-thirds (62%) have seizure disorders; 67% have significant gastrointestinal disorders; 3% have chronic respiratory conditions; and 16% have diabetes and/or thyroid conditions.
- More than one-fourth (27%) of the residents cannot tolerate oral feedings and receive all their nutrition through enteral feeding tubes.
- An estimated 28% of the residents will require 24-hour a day nursing services in their community homes and an additional 30% will require at least several hours of nursing services on a daily basis. The remaining residents are estimated to need at least weekly (43%) or monthly (6%) nursing services.
- Almost two-thirds (62%) of the residents are non-ambulatory, and almost all of these individuals require two or three persons to assist them in transferring (from bed to chair, etc.) and in bathing/showering. These individuals also require specialized vehicles to transport them and their wheelchairs. All of these individuals will also require significant physical accommodations in their community homes.
- Three people (2%) have a diagnosis of cancer.
- There is a high risk for aspiration pneumonia amongst this group at 66%. There are 10 people (7%) who are at risk for pneumonia because of chronic obstructive pulmonary disease and 20 people (15%) who have a history of aspiration pneumonia.
- Due to their various physical challenges, 69% of ADC's residents require specialized equipment (e.g., individualized seating arrangements, sidelyers, Easy-Standers,

various splints, etc.) to maintain proper posture, preclude further contractures, and prevent skin integrity problems.

- Almost all (91%) of ADC's residents require assistance in dressing; 75% are incontinent; and 75% cannot communicate verbally.

ADC Residents Compared to Other Class Members Living in Community Homes

An initial step in planning for the community services development for current residents of ADC was determining how similar or dissimilar they are from the nearly 260 Arlington class members already living in community homes in West Tennessee. Thus, the State determined that it was critical to assess all current ADC residents on the Inventory for Client and Agency Planning (ICAP), which is the standard assessment tool used by DMRS to assess the services and support needs of individuals entering and being served by its community service system. ICAP assessments provide a comprehensive review of an individual's services and support needs in nine areas, including healthcare, adaptive and maladaptive behavior, functional (physical) limitations, communication, and needs for assistance in personal care and daily living. A basic description of the service and support needs of individuals qualifying for each DMRS Residential Need Rate is provided on the following page.

The State arranged for the ICAP assessments of ADC residents to be done by an independent agency, Dual Diagnosis Management, which has been specially certified by the ICAP developers to conduct these assessments. ADC residents will be assessed again in 2008 to ensure a current profile of their service and support needs. Once they are living in the community, they, like all other individuals now in the community services system, will receive repeat ICAP assessments every other year. The State has also agreed to conduct repeat ICAP assessments of ADC residents at the request of their conservators, the Court Monitor, the Regional Director or the ADC Chief Officer. If desired, family members/conservators may also be present when the re-assessments occur.

Individual Qualifications for DMRS Residential Need Rates

LEVEL 1

These individuals are independent in most activities of daily living and they are able to be on their own for some part of the day without staff supervision. None of the current ADC residents and only 1% of Arlington class members in Waiver-funded community homes currently have this DMRS Residential Need Rate.

LEVEL 2

These individuals require a moderate amount of staff support to perform activities of daily living. Most live with one or two other individuals and they are usually supported by one residential staff person. These individuals do not have significant medical needs, behavioral problems, or physical challenges. The person does not routinely require awake overnight staff.

LEVEL 3

These individuals require considerable help with most activities of daily living and they may have moderate health care needs, associated with stable health care conditions. These individuals do not have significant behavioral problems or physical challenges, although some need a modest level of therapy support or the services of a behavior specialist. These individuals usually live with one or two other individuals, and the home is typically supported by one staff person most of day, with two staff persons present during selected times.

LEVEL 4

These individuals have significant physical challenges and/or behavioral needs. They also have medical conditions which require healthcare oversight by a registered nurse, and many also require direct nursing services. Most of these individuals require support from some clinical therapists and/or behavior specialists. These individuals usually live in a community home with one or two other individuals, and the home is usually staffed with two staff persons, except perhaps during the nighttime hours when the individuals are sleeping. Occasionally, Level 4 homes may also be staffed with three staff persons.

LEVEL 5 (Medical Residence Home)

These individuals have very significant medical concerns, and they require on-site nursing services 24-hours a day. These individuals are usually non-ambulatory and they usually have very significant physical challenges. Almost all of these individuals are not able to perform any activities of daily living independently, and most are not able to take oral nutrition and are dependent on enteral tube feedings. These individuals require on-going clinical therapy and registered dietician services, and many also require some behavior specialist services. The medical residence homes usually serve three individuals and in addition to the nursing staff there are usually two or three other direct support professionals in the home at all times.

LEVEL 6 (Intensive Behavioral Support Home)

These individuals have very significant behavioral problems, and they require 2:1 staffing coverage, except perhaps during sleeping hours when they require 1:1 staffing coverage. These individuals typically live alone and require ongoing intensive services of behavior specialists and mental health professionals. Many of these individuals also require significant staff assistance with activities of daily living and have medical conditions, including psychiatric diagnoses.

Initial ICAP assessments completed for ADC residents, in conjunction with other determining factors, have indicated that the majority of these individuals have support needs that equate to the DMRS Residential Need Rate of 4 (67%), with an additional 30% of these individuals being identified as requiring a DMRS Residential Need Rate of 5. The remaining 3% have been identified as needing the intensive behavioral Residential Need Rate of 6.

Percentage of Arlington Class Members by Residential Need Rates at ADC and in Community Residential Settings (March 2007)

DMRS Residential Need Rate	ADC Residents	ADC Class Members in Waiver Community Homes
1	0%	1%
2	0%	2%
3	0%	21%
4	67%	65%
5	30%	4%
6	3%	7%

By comparison, Arlington class members who are already living in Waiver-funded supported living homes are similar in that almost two-thirds of this population (65%) is also evaluated to need the DMRS Residential Need Rate of 4. Yet, almost one-fourth of this population is also evaluated as needing lower DMRS Residential Need Rates of 1 (1%), 2 (2%) and 3 (21%). In addition, far fewer of the Arlington class members who are already living in Waiver-funded supported living homes are evaluated as needing the DMRS Residential Rate of 5, reserved for individuals with very challenging medical conditions (4% versus 30%). A slightly greater percentage of the current Arlington class member population in Waiver-funded homes have been evaluated as needed the DMRS Residential Rate of 6, reserved for individuals with very challenging behavioral needs (7% versus 3%), but this difference is of less consequence.

ICAP assessments are not presently done for Arlington class members living in private ICF/MR homes in West Tennessee, these assessments are planned in the near future. Presently, there are no comparative data of the characteristics of the 192 individuals who live in these facilities. It is estimated, however, based on informal observations by the private

ICF/MR administrators that relatively few of these individuals would be evaluated as needing either the lowest DMRS Residential Need Rates of 1 or 2 or the highest DMRS Residential Need Rates of 5 or 6.

In short, although the current ADC residents are similar in level of need to many class members currently living in the community, a greater percentage of the current ADC residents will require intensive levels of medical supports and services in their community homes. By contrast, there are very few (four) individuals remaining at ADC who will require intensive behavioral supports (i.e., Residential Need Rate 6). Therefore, as DMRS plans for the appropriate transition of the remaining ADC residents to community residential homes, it will be necessary to develop more Waiver funded community homes with higher levels of health care services and supports. Simultaneously, private ICF/MR programs, which may be selected by some conservators, will also need to make certain changes in their services and supports to meet the more intensive residential support, healthcare, and physical accommodation needs of many ADC residents.¹

In particular, it is evident that many community homes for the current ADC residents will require:

- Full physical accommodations and entrance ramps for individuals who rely on wheelchairs;
- Substantial on-site nursing, clinical therapy and nutrition services;
- Support from speech language therapists to ensure safety when eating and prevention of aspiration;

¹ In the fall of 2006, four ADC residents with significant medical and physical challenges successfully transitioned to the SRVS ICF/MR facilities.

- Extra direct support staffing to accommodate individuals who require two and three person transfers;
- Direct support staff persons who have significant healthcare education, as well as special training in meeting the specific physical and meal time challenges of many of the individuals;
- Specialty vans that can accommodate individuals in wheelchairs, including many that can accommodate extra large/high wheelchairs; and
- Extra storage space to accommodate the individuals' special adaptive equipment.

CHAPTER 2

THE CURRENT WEST TENNESSEE COMMUNITY SERVICES SYSTEM

West Tennessee Regional Office

DMRS has divided the administration of its community services system into three regional areas: West Tennessee, Middle Tennessee, and East Tennessee. In West Tennessee, the West Tennessee Regional Office (WTRO) of DMRS is the local point of entry for DMRS Waiver-funded community service system. The WTRO also provides some assistance in transitioning individuals to community-based ICF/MR homes, although these programs are directly regulated and administered by the Tennessee Department of Health. The WTRO has two locations: one in Jackson, Tennessee (731-423-5670) and the second is on the campus at ADC in Arlington, Tennessee (901-745-7200).

The WTRO is responsible for coordinating and overseeing all transitions of ADC residents to community homes. The WTRO Transition Team is comprised of professionals, all of whom have worked for many years in mental retardation services and most of whom have several years of specialized experience in planning transitions of individuals from ADC to community homes. In addition, senior management and healthcare professionals at ADC, including the Chief Officer and the Deputy Superintendent for Residential Services, play an active role in transition planning for all ADC residents moving to community homes.

In 2006, the WTRO, in collaboration with the Court Monitor, community provider agencies, and conservators, developed a new community transition planning process for ADC residents. This new process, described in Chapter 5 of the Closure Plan, has fostered better communication with conservators, a more timely service planning process, and earlier involvement of selected provider agencies in planning and developing community homes.

The WTRO has also improved its monitoring of individuals after their move to community homes. This new process is designed to ensure more cooperative oversight by the WTRO

and the Court Monitor's Office and the more timely response to identified problems and/or concerns raised by conservators, class members, and community providers.

The WTRO Transition Team is committed to assuring safe and healthy transitions to community homes for all ADC residents. Families are encouraged to call the WTRO to learn more about the community services system or to raise issues or concerns. Informational brochures and reports about community services are also available from the WTRO.

Existing Community Residential Options for ADC Residents

There are two community residential options for ADC residents in West Tennessee: (1) HCBS Waiver-funded community homes and (2) private ICF/MR homes. Both types of community homes currently are operated by private residential provider agencies.

As referenced above, Waiver-funded community homes are under the administration of DMRS, whereas private ICF/MR homes are under the administration of the Tennessee Department of Health. However, recently enacted Public Chapter 761 provides that these facilities must comply with DMRS rules and operating guidelines and it directs that DMRS shall have reasonable access to the facilities and records to monitor quality of care. As of June 30, 2007, 225 Arlington class members live in West Tennessee Waiver-funded community homes and 32 Arlington class members live in private ICF/MR homes. In addition, as of June 15, 2007, DMRS has determined that the remaining 160 residents of West TN private ICF/MR homes are members of the Arlington "at-risk" class per the 2007 Court-approved Settlement Agreement regarding the definition of the class.

The most evident difference between these two types of residential programs is their size. Licensure regulations restrict new Waiver funded homes to no more than four individuals, whereas the available private ICF/MR homes serve six to eight individuals. Another evident difference is that whereas there are over one dozen Waiver-funded residential provider

agencies supporting homes in many communities of West Tennessee, presently only two private ICF/MR providers are available in Shelby County.²

In addition, while both Waiver-funded and private ICF/MR homes are capable of meeting the full range of service and support needs of the individuals living at ADC, services are arranged and funded differently in the two models of care. The private ICF/MR homes offer an all-inclusive package of residential supports, nursing services, clinical therapy, dietician, and behavioral services. These homes are funded with an inclusive daily residential rate, determined by TennCare and the Comptroller's Office, based on cost reports submitted by the provider agency. Thus, when choosing a private ICF/MR, conservators choose to receive all residential and ancillary services from the ICF/MR provider agency.

By contrast, Waiver-funded community homes allow conservators to select a residential provider, a day services provider, and nursing, clinical therapy, dietician, and behavioral providers separately. Some conservators prefer this model, as it allows more flexible choices of providers, and it also allows conservators to change provider agencies for the various required services more readily. For example, conservators may choose to change residential providers, but keep the individual's other providers the same.

In both residential models, physician services, including medical and mental health specialists, and dental services are selected separately by conservators and these are funded by Community Services Network, Medicare (for eligible individuals), and/or TennCare.

In addition to the above two residential models, families may also choose to have their family member come home to live with them. If this option is chosen, the State will provide access to personal assistant services to assist families in caring for their family members. Class members living with their families are also eligible to enroll in Community Services Network, a special healthcare network that is described in more detail later in this chapter.

² There is a third community-based ICF-MR in Trenton, Tennessee, but due to its size (80 beds) and its programmatic features, this facility has not been an available option for Arlington class members.

Privately-Sponsored ICF/MR Homes

There are currently two private ICF/MR provider agencies operating homes available for ADC class members. Shelby Residential and Vocational Services (SRVS) operates eight, 6-person ICF/MR homes in the White Haven and Raleigh areas of Memphis. Open Arms Corporation operates eight, 8-person ICF/MR homes in the Raleigh and Frayser areas of Memphis. Together, these providers sponsor 112 private ICF/MR beds, 32 of which are currently occupied by Arlington class members, before the “at-risk” class definition is applied.³

In addition, on May 25, 2006, Governor Bredesen signed legislation which would allow for the new development of up to 40 new community-based ICF/MR placements each year for the coming four years. Although these new placements are not restricted to West Tennessee alone, they are restricted to services for individuals leaving the State developmental centers, and thus it is likely that many of these beds will be available for ADC residents. This new legislation also provides DMRS a collaborative role with the Tennessee Department of Health in overseeing the services and supports to individuals in community-based ICF/MR homes.

DMRS has appointed the task force required by this legislation to review, among other things, oversight of ICF/MR facilities. DMRS received the task force report at the end of June 2007 and is reviewing the recommendations from that group.

As of June 2007, only SRVS’ ICF/MR operation has met the quality standards of the Court Monitor for new admissions of Arlington class members. Open Arms Corporation has submitted a comprehensive quality improvement plan and is working with DMRS and the

³ Both of these providers have also expressed interest in downsizing their existing ICF/MR homes to accommodate individuals with significant physical challenges (and their significant adaptive equipment). If this change is effectuated, SRVS and Open Arms would also anticipate opening some new community ICF/MR homes, which would serve four or five individuals.

Court Monitor's Office to make programmatic improvements in an effort to achieve Quality Tier Status in its scheduled review in the fall of 2007.

As of June 2007, five ADC residents have moved to SRVS' ICF/MR homes, and one additional individual is scheduled to move in the fall of 2007. Meetings with SRVS' officials suggest that additional vacancies in its ICF/MR homes will be available later in 2007, as DMRS has agreed to facilitate transitions of any existing residents, as requested by their conservators, to Waiver-funded supported living homes.

At the request of their conservators, DMRS is committed to facilitating these moves of generally higher functioning individuals with limited medical needs to Waiver funded supported living homes. Both SRVS and the Open Arms Corporation have indicated that as many as one-fourth of their current ICF/MR residents, with lesser medical and physical needs, may be interested in moving to Waiver-funded community homes.

Finally, as discussed in greater detail in Chapter 4 of the Plan, a major provision of the Settlement Agreement is the State's agreement to develop at least 12, four-person, DMRS-operated community-based ICF/MR homes on or near the existing ADC campus to meet the needs of the most medically fragile and physically challenged individuals now living at ADC.

Arlington Waiver-Funded Community Homes

Due to certain protections in federal Court Orders, Tennessee established a special Arlington Home and Community-Based Waiver for Arlington class members (the "Arlington Waiver") in 1994. The Arlington Waiver is monitored by the Federal Centers for Medicaid and Medicare Services (CMS), the Bureau of TennCare, DMRS, and the Federal District Court of West Tennessee and its appointed Court Monitor.

The Arlington Waiver provides funding for residential, day services, and other ancillary services including clinical therapies, nutrition services, behavior supports, specialized equipment, etc. This section of the Closure Plan discusses Arlington Waiver residential services. Later in this chapter, other services not funded by the Arlington Waiver but through State dollars are discussed.

As of June 2007, there are 17 provider agencies authorized by DMRS to provide community supported living homes to one or more Arlington class members. These Arlington Waiver-funded homes, which serve one to three individuals, are located across West Tennessee, but the vast majority are located in the Memphis metropolitan area (including Bartlett and Cordova) and in the greater Jackson area.

As described in Chapter 1, Arlington Waiver-funded residential homes provide six different levels of residential supports and services tailored to meet the individualized needs of Arlington class members. Although all Arlington Waiver-funded homes offer a residential staffing ratio of at least one staff person on duty (24-hours a day), most of these homes provide more intensive staffing ratios, including some that offer 1:1 or 2:1 staffing ratios for individuals with DMRS Residential Need Rates of 4 – 6.

Each year, the Court Monitor reviews the Arlington Waiver-funded residential provider agencies serving Arlington class members, and those meeting certain quality standards are awarded Quality Tier Status. In the 2007 review, 14 of the 17 agencies reviewed achieved Quality Tier Status. Those agencies are: Behavioral Services of Tennessee, Community Developmental Services, Impact Centers, Omni Visions, Madison Haywood Developmental Services, West Tennessee Family Solutions, Cornerstone, St. John's Community Services, Guardian Community Living, Volunteers of America, MOSAIC, Shelby Residential and Vocational Services, Support Solutions of the Mid-South, and Spectrum. In accordance with an agreement between the Court Monitor and DMRS officials, only residential provider agencies awarded Quality Tier Status are eligible to accept new admissions of Arlington class members.

As discussed in the following chapter, DMRS is presently working with all Quality Tier Status residential provider agencies to determine their plans for expanding their residential services. DMRS is also assisting other existing authorized Arlington Waiver residential provider agencies to improve their services in order to make them eligible to serve additional Arlington class members, including those transitioning from ADC. In addition, DMRS is soliciting a small number of new Arlington Waiver-funded residential provider agencies to come to West Tennessee.

State-Funded Residential Supports and Funding

All ADC residents moving to Arlington Waiver-funded community homes are authorized to receive additional residential supports and funding to facilitate their moves from ADC to a community home and to assure long-term financial support for their life in the community. While the DMRS budget is contingent on annual state appropriations and the precise method for calculating the amount for each of the following supports is certain to need review and adjustment over time, DMRS does intend to provide these supports to class members as long as they are needed.

- **Establishment Funds** are authorized to assist these individuals to furnish their homes, purchase needed household supplies and linens, and cover special one-time start-up costs, like rental and security deposits. Establishment Funds are usually limited to \$4,000 per class member; special exceptions may, however, be authorized for individuals with unusual needs, including those individuals who must live alone due to severe behavioral challenges. The State also provides for Re-establishment Funds of up to \$2,500 per class member per year to cover necessary costs for furniture replacement, residential relocation costs, etc.

- **DMRS Housing Costs Subsidies** are available to subsidize rent, utilities and related services costs for individuals receiving supported living services. The amount of the DMRS State-Funded Subsidies for Housing Costs awarded to each individual is based on an assessment of the individual's income and expenses and a determination of the difference between an individual's income (typically SSI/SSA payments) and authorized food stamp allowance and his/her estimated residential costs. DMRS Housing Costs Subsidy awards have usually been limited to \$450 a month, but higher allowances may be authorized for individuals based on exceptional need.
- **Transportation Funding for Class Members** are non-emergency transports for individuals to and from approved activities specified in their plan of care. These services do not replace services available through TennCare. There are 38 providers in West Tennessee approved to provide these services. Currently, nearly 300 individuals are benefiting from this service.

The Community Services Network (CSN)

In accordance with a remedy ordered by the Federal District Court of West Tennessee to overcome acknowledged barriers to needed health care services for Arlington class members under the TennCare Program, all Arlington community class members, regardless of whether they live in a community-based ICF/MR home or an Arlington Waiver-funded community home, have access to Community Services Network (CSN) of West Tennessee, Inc.

CSN is a network of approximately 1,200 health care providers, including primary care physicians, medical specialists, medical equipment suppliers, dentists, mental health and behavioral support professionals, and clinical therapists (physical, speech/language, occupational and nutrition services). The network also includes 45 hospitals as well as 10 inpatient rehabilitation centers whose staff have special experience and training in meeting the short-term rehabilitation needs of persons with mental retardation.

Through the resources of CSN, Arlington class members are exempted from the service and medication limits/caps of the TennCare Program and fees paid for selected services are enhanced to accommodate the extra time/skill sometimes required to provide healthcare services for individuals with mental retardation. The resources of CSN cannot be rescinded from Arlington class members unless approved by the Federal Court.

CSN service coordination differs somewhat for individuals living in community-based ICF/MR homes and those in Arlington Waiver-funded community homes. For both groups of individuals, CSN's network of medical, mental health, and dental providers is available. For individuals in Arlington Waiver-funded community homes, CSN also coordinates and pays for therapeutic services (e.g., clinical therapies, nutrition, and behavior support services), specialized equipment, durable medical supplies, and medications. These latter services are not covered by CSN for class members selecting the community-based ICF/MR residential model as they are provided for in the basic Medicaid ICF/MR residential rate.

Arlington community class members have a CSN-assigned case manager who facilitates their access to CSN's network of medical and therapeutic service providers. For class members who reside in Arlington Waiver-funded community homes, this case manager must be a registered nurse who has special training in meeting the healthcare service coordination and oversight needs of individuals with mental retardation. For class members living in a community-based ICF/MR, for whom a nurse case manager is included in their Medicaid ICF/MR rate, CSN assigns a clinical professional to facilitate the class member's access to CSN services.

Early in the transition planning process for ADC residents moving to community homes, class members' conservators meet with the CSN Transition Coordinator to review the network's services, sign a consent form to have their family member participate in CSN, and begin to make choices of medical and healthcare providers for their family members. Before moving to a community home, individuals and their conservators choose a primary care

physician, a dentist, and other specific medical specialists and therapeutic providers recommended in their Individualized Transition Support Plan. The individual receives a CSN membership card similar to a health insurance card.

After class members move to their community home, they and their conservators rely on their CSN case manager to assist them in accessing needed healthcare providers and services. The CSN case manager may attend Circle of Support planning meetings; and for class members in Arlington Waiver-funded community homes, the case manager also makes regularly scheduled visits to the member's home to review the benefits received through CSN and to collaborate with the individual and residential agency staff to identify additional resources/supports that may be necessary.

As indicated above, CSN opens the door to a large healthcare provider network for class members, and it has allowed Arlington class members to elude most of the barriers to accessing quality community healthcare.

Arlington Waiver Ancillary Services

As noted above, all Arlington class members enrolled in the Arlington waiver also have access to an array of Arlington Waiver-funded ancillary services.⁴ Some of these services, like day program and vocational services, are available to all Arlington class members. Others, like specialized clinical therapy, nursing, and behavior services, are authorized based on an individual's needs, in accordance with plans of care and orders from their primary care physicians. Class members enrolled in the Arlington Waiver who are living at home with family members have the same access to these services as those living in Waiver-funded supported living homes, with the exception of the Special Needs Adjustment which relates to payments to supported living waiver providers.

⁴ For ADC residents moving to private or state-operated ICF/MR model community homes, these services, with a few exceptions, are also available, but they are funded within the ICF/MR rate and/or through Medicare or the Community Services Network.

As referenced below, many of the health related and therapeutic Arlington Waiver ancillary services are coordinated for Arlington class members by their Community Services' Network case manager. In some cases, based on individual need, additional services not funded by the Arlington Waiver (or exceeding Arlington Waiver caps) are covered. In these situations, the individual's Circle of Support, through his/her ISC and/or CSN nurse case manager, alerts the West TN Regional Office of the additional need and provides justification for the exception. If the exception is not initially granted, Circles of Support and/or the individual or his/her conservator may (and have in the past) request that the Court Monitor review the service needs and intervene if appropriate.

- **Day Services** are individualized services and supports, offered to individuals during the day, that enable individuals to acquire, retain, or improve their skills in participating in community activities, including work-related activities. These services are separately funded for all individuals in Arlington Waiver funded community homes, except those who receive the Residential Need Rate 5 (Medical Residence Home), behavioral respite services, and respite services funded on a per diem basis. Conservators are able to choose among 35 authorized providers of day services in West Tennessee. In practice, most conservators have historically chosen their family member's residential provider agency to also provide day services.
- **Dental Services** cover all necessary dental services, including preventive care, fillings, root canals, periodontics, dentures, and other dental treatments that are intended to relieve pain and treat infection. Arlington Waiver recipients may choose among nine authorized providers of dental care. In accordance with existing Court Orders, most dental services for Arlington class members are coordinated and paid for by Community Services Network.
- **Environmental Accessibility Modifications** assure homes are accessible for the individual. Funds are made available for interior or exterior modifications that are

required. Arlington Waiver funding for these modifications is limited to \$15,000 every two years. In exceptional situations, however, DMRS may authorize additional state funding to cover environmental modifications. It is anticipated that such exceptional situations will exist for some ADC residents who have Residential Need Rates of 4 or 5 as they move to community homes.

- **A Special Needs Adjustment** of an additional \$60.00 per day is available to Residential Habilitation and Supported Living homes with 1-4 persons. A special needs adjustment does not change the rate level designated for the individual, but adjusts the rate level as a result of one or more of the following circumstances. Some examples of situations when a special needs adjustment would be considered include:
 - 1) A person who requires special supports that require close supervision because of such things as frequent elopement, requiring 2-3 person lift, or needing tracheotomy care. A Special Adjustment for these circumstances may continue indefinitely, but the Regional Office must review the special adjustment at least annually.
 - 2) Another use would be for an individual in circumstances, such as having experienced a serious illness, injury or surgery, that are time-limited but that require support(s) at a higher level than described by the Rate Level. A special adjustment may be approved for up to 90 days and may be extended for an additional 90 days. During this period, if it appears that the condition will become a long-term issue, an ICAP must be administered to determine whether the Rate Level should be adjusted. If the Rate Level is adjusted, the Special Adjustment would no longer be necessary and would be immediately discontinued.
 - 3) Another situation where the adjustment may be applied is when the person needs a roommate and requires a special adjustment until one moves in. A special adjustment may be approved for up to 90 days and may be extended so long as it is necessary.

- **Nursing Services** are skilled nursing services that fall within the scope of the Tennessee Nurse Practice Act and are directly provided to an individual in accordance with a physician/physician assistant/nurse practitioner-ordered plan of care. The Court Monitor's Quality Tier includes 12 residential provider agencies that are licensed by the Tennessee Department of Health to provide nursing services. Currently, there are also nine licensed home care organizations that provide direct nursing services to Arlington class members.

In addition to these free-standing nursing services, it is important to emphasize that all Arlington class members who live (or will live) in Arlington Waiver-funded community homes with Residential Need Rates of 4, 5, or 6 also receive registered nurse oversight services that are funded within their residential rate. Individuals with the Residential Need Rate of 5 (Medical Residence Homes) also have on-site licensed nurse staffing funding built into their Arlington Waiver-funded residential rates.

- **Personal Assistance** services are provided to assist individuals living at home with family or friends. Personal assistants may assist an individual with household chores, budget management, skill building activities, and other activities of daily living. Currently, four Arlington class members who are living at home supported by family members are receiving this service.
- **Specialized Medical Equipment and Supplies and Assistive Technologies** are specific supports recommended by qualified professionals. These services must have a direct medical or remedial benefit to the individual, and they may include such services as assistive devices, adaptive aids, and training by the appropriately qualified professional on how to utilize such equipment. The maximum allowable Arlington Waiver funding for these services is \$10,000 per individual every two years, although the State will provide additional state dollars to cover equipment costs if special conditions and needs warrant. If an individual needs multiple devices that would

exceed the financial limitation, this would be an example of when an exception may be awarded and the cap exceeded to meet the needs of the individual. These services are usually coordinated by the class member's CSN case manager.

- **Therapeutic Services** are clinical therapy services, including physical, speech, and occupational therapies, nutritional services, and behavioral support services. These services are available to assist individuals in overcoming barriers to accomplishing personal goals and maintaining optimal health and safety relative to daily tasks and activities. Arlington Waiver funding is available for therapy assessments, the direct provision of therapy services, and training direct support professionals to implement therapy plans in community homes. For class members in Arlington Waiver-funded homes, these services are typically coordinated by the class member's CSN case manager. In instances when a Waiver-funded provider of clinical therapy or behavior support services for a class member cannot be located, the State authorizes therapist/behavior analyst members of its West Tennessee DMRS Regional Office to provide these services.
- **Vision services** include routine eye exams, eyeglasses, contact lenses, and dispensing fees. In addition, state funds are provided to support vision mobility services through the Star Center and Helen Keller Center for Arlington class members. These services are usually coordinated by the class member's CSN case manager.

CHAPTER 3 EXPANDING, SUPPORTING, AND STABILIZING THE PRIVATE COMMUNITY SERVICE NETWORK

To achieve the successful closure of ADC and to meet the service and support needs of the many individuals on DMRS' Waiting List, DMRS must expand its community services network and better assure the stability, tenure, and uniform quality of its service provider agencies. These challenges are not new to DMRS; indeed they have been the agency's primary agenda items for at least three years. As reflected in the boxed insert on this page, DMRS' expenditures for waiver and other services have grown from \$324 million in FY 1997 - 98 to over \$775 million in FY 2005 - 06.

In this chapter of the Closure Plan, the most important efforts of DMRS to promote the expansion, stability and quality of its community services system are discussed.

Long-Term Development Planning

In the fall of 2005, DMRS established a Task Force to complete a long-term service development plan for West Tennessee. The Task Force was comprised of many stakeholders, including service recipients, conservators, residential and ancillary service providers, independent support coordinators (ISCs), and community advocates. The Court Monitor also participated in the Task Force. The effort culminated with the report, the "West Tennessee Community Development Plan" in June 2006.

**DMRS Fiscal Year
Expenditures/Budgets and
Total Service Recipients Served**

Fiscal Year	Actual DMRS Expenditures*	Total Service Recipients**
FY1997-98	\$324,433,800	12,000 estimated
FY1998-99	\$379,612,700	12,323
FY1999-00	\$406,815,400	12,814
FY2000-01	\$454,253,500	13,502
FY2001-02	\$512,829,400	13,746
FY2002-03	\$562,489,800	13,741
FY2003-04	\$610,045,700	13,435
FY2004-05	\$694,760,700	13,682
FY2005-06	\$775,153,600	15,165
FY2006-07	\$841,704,900 budgeted	15,287 estimated

*Figures reflect both State and federal service support dollars.

**These figures include family support and early intervention service recipients.

The plan provides data about the current service recipient population, including those individuals residing at ADC; those currently on the DMRS Waiting List; and those who can reasonably be expected to join the Waiting List in the coming years (e.g., children in public school special education programs). It also discusses a number of systemic issues, including provider recruitment, staff training, quality assurance, and reimbursement that currently affect service system growth. The report closes with a number of specific recommendations linked to various aspects of the service delivery system including residential, day, transportation, and dental services.

Perhaps one of the most important outcomes of the taskforce's work was that it developed a list of principles to

guide future service system expansion. These principles, which are listed in the boxed insert, have been endorsed by the Deputy Commissioner of DMRS.

**Guiding Principles for DMRS Service System Expansion
West TN Community Development Plan
June 2006**

- In the expansion of its service system, DMRS should ensure the efficient use of available State and Federal funds to promote service access as promptly as possible to as many individuals as possible.
- Service benefits and resources should be allocated among different groups of service recipients based on objective and fair criteria.
- DMRS should, in concert with various stakeholders, develop explicit priorities for service system development, which recognize the competing needs of different groups of individuals.
- Service system expansion should ensure that new services are made available both for those individuals in need of 24-hour residential supports and those individuals who need (non-residential) support services to remain in their family homes.
- DMRS must ensure that the service system's stability and quality are not compromised as it expands its capacity.
- Improvements in the wages and training programs for direct support professionals must be essential components of DMRS' service system development plan.
- The improved efficiency of DMRS' service planning, service approval, and problem resolution processes, as well as other systemic service system "processes" must be a component of long-term service system development.

Provider Agency Growth Plans

Simultaneous with the long-term planning effort discussed above, the DMRS WTRO Director and the ADC Chief Officer have been working with the management teams and corporate

boards of directors of residential provider agencies now in West Tennessee. In informal meetings with each provider agency, they have worked to help the provider agencies formulate short and long-term agency growth plans.

These discussions have helped the agencies to refine and better articulate their mission and their primary service population. They have also prompted agencies to engage internally in more long-term planning, reflecting on their preferred geographic service areas, their capital and operating financial resources and needs, and the capabilities and limitations of their management teams and local operations.

This effort started with 13 residential provider agencies that had demonstrated a quality performance track record in West Tennessee. Not surprisingly, the 13 residential provider agencies responded differently. Some agencies now have fairly specific growth plans that extend out through the calendar year 2009 (shortly before ADC's expected closure), whereas others have growth plans formalized only for the current fiscal year. These meetings have indicated that these providers plan collectively to expand their residential capacity by over 100 individuals by mid-2008.

This endeavor has been equally important in prompting residential provider agencies and their boards of directors to develop thoughtful and predictable business growth plans. This "managed" growth planning should, along with other DMRS efforts outlined below, help promote both the stability and quality of the service system through this expansion period. DMRS now has a better understanding of what expansion capacity can be reasonably expected from the network of residential provider agencies that already have a tested track record in West Tennessee.

More recently, DMRS has attempted to map service gaps for various services and distribute this information to providers to further assist them in developing their business growth plans. This communication began in March 2007, and the WTRO will continue to provide

agencies with what service needs exist in the different areas of West Tennessee on a quarterly basis.

Supporting Provider Expansion

DMRS has also developed a better understanding of what it must do to encourage its existing provider network to expand and meet the needs of more individuals. A critical factor will be the mutually supportive partnership between DMRS and its provider network to provide quality services. DMRS Deputy Commissioner Stephen Norris appreciates this imperative relationship, and he has made it a priority to meet with and respond to provider agencies' concerns.

Ongoing meetings with providers have clarified that the provider network has some fundamental expectations of DMRS for tangible supports in the form of a fair and timely reimbursement system, a sound program of quality assurance, and high quality technical assistance and staff training programs. In the past two years, progress has been made in the design and operation of DMRS' reimbursement and quality assurance systems and continued improvements are underway. In addition, as detailed in Chapter 8, new initiatives are underway to advance DMRS' staff training programs.

In addition to the above programmatic supports, DMRS also recognizes that fiscal incentives to offset development costs for program expansion will encourage the existing provider agencies' participation. Thus, in FY 2005, the State began offering grants ranging from \$18,900 - \$61,400 to provider agencies that agreed to expand their services to address gaps in the current service network. Since June 2005, a total of \$1,762,032 in developmental grants have been offered to 25 provider agencies, of which \$923,710 were offered to 12 provider agencies in West Tennessee.

Providers who accept persons who transition out of ADC also receive Development Incentive Funds. The funding may be used for recruitment, office equipment, staff salaries, staff training, and short-term retention of homes while an individual is preparing to transition to the provider. The current Development Incentive amount has been increased from \$4,820 to \$6,820 per person to allow funding for providers to actively participate in the transition process. One half of the amount is paid when the transition plan is completed and the remaining portion is paid upon the individual's placement into community services.

New Provider Recruitment

Notwithstanding DMRS' efforts to rely primarily on the expansion of provider agencies already in Tennessee, it is apparent that some new provider recruitment will also be necessary to assist DMRS in meeting the needs of individuals awaiting its services, including the current residents of ADC. In particular, existing residential provider capacity outside of Shelby and Madison Counties is limited. Accessing direct nursing services for Arlington Waiver service recipients is difficult in almost all communities of West Tennessee, and clinical therapy and behavior support providers are difficult to find in some areas of Madison County and other rural communities of West Tennessee. Different approaches are being taken to address each of these service gaps.

Residential Providers

For more than 10 years, DMRS has had an ongoing recruitment program for residential provider agencies. These efforts have brought many quality provider agencies to Tennessee that have become strong partners in DMRS' community services system. Yet, some recruited outside providers have been less successful and have left the State, often due to a combination of operational and fiscal problems.

Thus, DMRS' current efforts to recruit residential providers are more selective and targeted. Better research is done to examine provider agencies' performance records in other states

before encouraging them to come to Tennessee. DMRS is also being more careful in defining the geographic areas/regions where new residential providers are needed, as well as the special expertise of prospective providers in meeting the needs of the most underserved groups, including persons who have mental health concerns and who have very complex medical needs.

DMRS also recognizes that once an agency comes to Tennessee to establish services, DMRS' assistance is necessary to help the new management team get started and succeed. DMRS is currently interviewing candidates for a professional position in its WTRO dedicated to provider network recruitment; and the entire protocol for new provider orientation and support is being revamped and enhanced. The protocol will promote growth and revenue for the new providers by better coordinating service recipient referrals and by ensuring the providers more responsive technical assistance programs.

Finally, DMRS also offers start-up development grants to new providers willing to develop needed services in Tennessee. These grants of up to \$60,000 are offered to help new agencies offset costs for establishing an office headquarters in Tennessee, receiving new provider training, and starting up operations before the agency actually begins to provide services (and receive Arlington Waiver reimbursement).

Through its Quality Management System, discussed in Chapter 7, DMRS has also established more rigorous oversight and monitoring of the performance of newly recruited providers in their first year of operations. In addition, all new providers will be subject to specific targeted assessments at any time that they increase their residential census by five or more individuals in a three-month period. These initiatives were put in place to ensure that problems encountered by newly recruited provider agencies will be promptly identified and addressed.

Nursing Services

DMRS recognizes that the nursing shortage experienced at all levels of medical care has impacted the delivery of nursing services in the Arlington Waiver program as well. In addition, DMRS acknowledges that the Home and Community-Based Waiver reimbursement rate for nursing services statewide has become non-competitive. To that end, the DMRS Deputy Commissioner is looking for funding to increase nursing reimbursement rates, with plans to make the necessary adjustments at the earliest date possible. Higher rates will allow the Arlington Waiver to provide a nursing reimbursement system that is more competitive and cost effective. The State has also recently completed a study of nursing salaries in West Tennessee, which has suggested that direct nursing service reimbursement in the Arlington Waiver should increase by approximately 11 - 13% to be competitive. This rate increase will be requested in the FY '08 - '09 DMRS budget. In the interim, the State has agreed to finance nursing services with State dollars for any Arlington class member receiving Waiver services who is not able to obtain these services under the Waiver, with coordination by CSN.

DMRS is also encouraging its residential provider agencies to become authorized direct nursing providers for the individuals they serve. This option often ensures more stable nursing services than can be purchased from free-standing home health agencies. Residential agency nurses are also usually more familiar with all of the agency's service recipients and they can become valuable health educators for all of the agency's personnel. In addition, by affording nurses a role in the agency's management team, residential agencies can often make the nursing position more attractive and fulfilling.

Individuals with the Residential Need Rate of 5 (Medical Residence Homes) also have on-site nurse staffing funding built into their Arlington Waiver-funded residential rates. DMRS is studying this model in order to make recommendations for this service to be more flexible and accessible to individuals with significant nursing needs. One model being considered will establish several levels of nursing services within the rate for individuals with varying levels of nursing needs. Recommendations, due around August 1, 2007, are expected to

include needed revisions to the Arlington Home and Community Based Waiver, community nursing rates, the DMRS Provider Manual and the Provider Agreement.

Clinical Therapy and Behavior Support Providers

The shortage in clinical therapy and behavior support providers has, in part, been triggered by limitations in DMRS' reimbursement for these services in its Arlington Waiver programs. In July 2006, DMRS took initial steps to rectify these problems with revised reimbursement allowances for evaluations, inclusive of plan development. These changes will help make the Arlington Waivers' reimbursement for these services more competitive.

Notwithstanding these improvements, DMRS anticipates that it may remain challenging to ensure the availability of clinical therapy and behavior support services in rural communities where there are generally too few Arlington Waiver service recipients to encourage therapists to offer home-based services. Thus, CSN has been making efforts to determine whether there may be rehabilitation centers in larger towns near these rural communities that may consider serving some Arlington Waiver recipients, either in the recipients' own homes or in the rehabilitation centers (on an ambulatory basis). The latter arrangements have already been made available for some Arlington class members in rural communities through Community Services Network.

The to-be-developed State-operated Resource Center (discussed in the following chapter) will also provide a safety net for clinical therapy service provision for those individuals who are unable to find willing therapy providers in their community. As discussed in more detail in the next chapter, the Resource Center will also provide special clinics for assistive technology and physical and nutritional management which will be of special assistance to the ADC class members with the complex physical challenges.

CHAPTER 4

NEW STATE OWNED AND OPERATED SERVICE DEVELOPMENT

As noted in the prior chapter, the State plans to accommodate the needs of the 128 individuals currently residing at ADC in part through the planned expansion of the existing private community service delivery system. Yet, the State also will supplement this private provider service delivery system with several new State-sponsored service initiatives. This chapter addresses the new State-sponsored initiatives.

In accordance with the provisions of the Settlement Agreement, the State will develop and operate 12, four-person community-based ICF/MR residential homes in the Arlington area, as well as a multi-purpose State-operated Resource Center (the "Resource Center"), which will have the capacity to provide medical and therapeutic services. The Resource Center will provide space for a community center that will offer social and leisure activities for individuals, as well as educational forums and meeting space for families and advocates. Although not referenced in the Settlement Agreement, the State also plans to build 12 additional fully accessible and sprinkled four-bed community homes and to make these homes available to private community residential provider agencies to operate.

State-Operated Community-Based ICF/MR Homes

The State-operated community-based ICF/MR homes will be newly constructed homes located in the Arlington area within four miles of the Resource Center. These homes will meet all applicable federal and State codes for ICF/MR homes; they will be fully accessible for individuals in wheelchairs; and they will include the added safety measure of fire sprinkler systems.

Clark, Dixon, & Associates have been awarded a \$520,000 contract for the architectural design of the State-operated ICF/MR homes, and the firm has already presented the State

with the preliminary specifications for the homes and sketches have been prepared. The State estimates that the construction of the ICF/MR homes will cost approximately \$760,000 per home. This funding, just over \$9 million, was authorized in the fiscal year 2006-2007 budget.

All of the homes will be located in residential neighborhoods in the Arlington area and the footprint of each house will be approximately 4,000 square feet. The four bedroom, two and a half bath homes will provide each of the four residents a private bedroom and there will be a shared kitchen, great room and sunroom area. All doorways of the homes will accommodate wheelchairs, and necessary ramps and extra storage space for adaptive equipment will be provided. The properties will include eight parking spaces and a loading area at the back of the home.

The State anticipates starting construction of these homes in November 2007, with the first home opening for residents by September 2008.

State-Owned ICF/MR Homes: Development Timelines*

Construction Project	Projected Start Date	Projected Completion Date	Move-ins completed
2 homes	Nov 2007	July 2008	Sept 2008
2 homes	May 2008	Sept 2008	Nov 2008
2 homes	Oct 2008	March 2009	May 2009
2 homes	Feb 2009	June 2009	Aug 2009
2 homes	May 2009	Oct 2009	Dec 2009
2 homes	Sep 2009	Jan 2010	March 2010
12 Arlington ICF/MR Homes	November 2007	January 2010	March 2010

*Timelines are estimated and are subject to conditions beyond DMRS' control.

State-Owned Arlington Waiver Homes

The State has also committed to build 12 additional four-bed community homes. These homes, like the State-operated community ICF/MR homes, will be fully accessible and sprinkled. Although built and owned by the State of Tennessee, these homes will be operated by private provider agencies authorized by the State to sponsor supported living/residential habilitation homes funded by the State's Home and Community Based Waiver programs. Private provider agencies selected to sponsor the State-owned homes will be limited to those which have performed well on the DMRS quality assurance surveys and the Court Monitor's Community Status Reviews.

It is anticipated that the 12 homes will be located in various different communities in the greater Memphis area. Tentative locations include: Whitehaven, Bartlett, Cordova, Germantown, and Oakland. These homes will offer their residents private bedrooms and a fully accessible bathroom. Appropriate ramps, widened doorways, grab bars and other accommodations will also be provided.

The State has initially budgeted \$3 million for the 12 homes; although it is expected that additional allocations will be necessary to fully complete this project. Architectural plans for the homes have already been developed and the State has selected Riverview-Kansas Community Development Corporation to build the first home.

Construction on the first home (which is located in the Whitehaven area of Memphis) began in February 2007. The State anticipates that the occupancy of the new homes will be possible within four - six months of groundbreaking. Although the scheduling of groundbreaking on the remaining 11 homes is still pending, it is anticipated that at least four of these homes will be opened by early to mid-2008, and that the remainder will open later in 2008 through early 2009.

West Tennessee Region Resource Center

As ADC downsizes and closes, it will be important to expand the continuum of services available through the establishment of a Resource Center in West Tennessee. Many of the safety net services are already available within the West Tennessee Regional Office, and others will be transferred over from ADC to the Resource Center at timelines to be determined and included within this Closure Plan as known. In addition to providing safety net services for waiver service recipients residing in West Tennessee, the Resource Center will provide contracted services to West Tennessee ICF/MR residents. One exception however is that medical specialty clinics will only be available for class members. Resource Center capacity and resources will be determined and driven by the need for supplemental and safety net services. The Resource Center will initially be housed within the existing buildings on the ADC campus. The exact site for its permanent location will be determined pending an analysis of existing buildings on the ADC campus. If existing facilities prove to be inadequate, new construction funding will be provided for.

A land use study is currently being conducted of the ADC campus, its existing buildings, and the future needs of the region in order to determine the most efficient and economical method for housing the West Tennessee Regional Office, the Resource Center, and the ICF/MR homes. As the land use study progresses, estimated square footage requirements; types of space; accommodation needs of a fully outfitted dental suite, assistive technology workshop, class rooms, large and small meeting rooms, lending library, and Community Center will be refined with architectural requirements and blueprints developed. The study, being completed by M.M.H. Hall, is expected to result in a report to DMRS in September 2007.

The Resource Center will support Tennesseans with mental retardation in residing in community-based settings of their choice by providing access to needed medical and health related services, while DMRS continues to build community awareness and capacity to meet the population's unique healthcare needs. The Resource Center operational hours will

normally be Monday through Friday from 8:00 a.m. to 4:30 p.m., with exceptions made for specialists or consults requiring alternate hours and special activities at the Community Center.

Ongoing operating costs for the Resource Center are anticipated to be \$5.3 million dollars per year. It is important to reinforce that the Resource Center will not be an alternative service choice to community-based services for individuals enrolled in the Arlington Waiver for whom such community based services are reasonably accessible. Such access would be fiscally irresponsible of the State and would discourage use of the community based service system.

Services, available to both class and non-class members living in West Tennessee waiver or ICF/MR homes, will initially consist of:

- **Assistive Technology Services** - assessment, acquisition of, customization and design of, fitting and delivery of assistive devices based upon individual and environmental needs. Initial set-up training will be provided for all assistive technology provided. These services will primarily be available on site.
- **Durable Medical Equipment Lending Library Resource** - a variety of assistive living devices, mobility devices, positioning devices, environmental controls and augmentative communication devices. This library will become a part of the Assistive Technology Department. Equipment can be checked out on loan to waiver and ICF/MR service recipients in West Tennessee for trial, assessment, or to temporarily meet needs related to failure of equipment owned by the service recipient.
- **Psychiatry** - psychiatric services will be available for diagnosis, consultation and as a safety net for treatment through the Resource Center for individuals with dual diagnoses.

- **Dental Services, inclusive of oral sedation** - waiver and ICF/MR service recipients in West Tennessee unable to be seen in community-based settings, either due to tolerance or community capacity issues, can access this clinic. Oral sedation will be available. Dental service availability will be limited to on-site.
- **Psychology Services** - individual and group counseling sessions, as determined to be clinically indicated. Psychologists are available for individual-specific treatment, consultation and education with ICF/MR or community-based Circles of Support, and families of service recipients transitioning from ADC to the community setting as part of the Family Assistance Program (FAP), both on and off site.
- **Intensive Mental Health Consultation Team Services** - time-limited consultation with community providers to assist in management of impending or actual crises of a behavioral and/or psychiatric nature. Services may include, but are not limited to, education pertaining to particular mental health diagnoses, training on addressing the needs of individuals with combined mental health and mental retardation diagnoses, time-limited consultation and assistance in the community during impending or actual crisis situations, assisting with difficult transitions back to the community following psychiatric hospital discharges, or assisting ISCs with the development of appropriate discharge plans during psychiatric hospitalizations. Intensive Consultation Team Services will be available to waiver and ICF/MR service recipients in West Tennessee both on and off site.
- **Nursing Services** - to support service recipients during their visits to the Resource Center. Nurses will be integral members of the Physical Nutritional Management Teams, Day Program, and Enteral Nutrition Team. Nursing consultation with waiver and ICF/MR providers in West Tennessee will be available on and off site. It is not the intent for the Resource Center to provide direct nursing services.

- **Medical Consultation** - may include, but is not limited to: review and education of recommendations for Do Not Resuscitate (DNR) orders, physical or medical decline, behavioral decline, developmental disability diagnoses such as Downs Syndrome, unusual or genetic concerns, enteral nutrition, review of dementia diagnoses, medication review, tracheostomy or respiratory issues, and/or critical care related treatments. Medical consultation will be accomplished through establishment of relationships between Resource Center medical doctors and nurses and treating primary care physicians, medical specialists, agency nurses and other clinicians as indicated. Medical Consultation will be available to waiver and ICF/MR service recipients in West Tennessee both on and off site.
- **Behavior Analysis** - available to waiver and ICF/MR service recipients in West Tennessee. Behavior service consultation will be available for service recipients already getting behavior services via an Arlington Waiver provider in order to offer assistance in stabilizing a challenging situation. Behavior Analysts and Behavior Specialists will be integral members of the Neuro-Behavioral Team, Intensive Consultation Team, and Physical Nutritional Management Team. Behavior services will be available both on and off site.
- **Occupational Therapy** - available to waiver and ICF/MR service recipients in West Tennessee. Occupational Therapists will be integral members of the Assistive Technology Department and Physical Nutritional Management Teams, with services available both on and off site.
- **Physical Therapy** - available to waiver and ICF/MR service recipients in West Tennessee. Physical Therapists will be integral members of the Assistive Technology Department and Physical Nutritional Management Teams with services available both on and off site.

- **Speech Language Pathology** - available to waiver and ICF/MR service recipients in West Tennessee. Speech-language pathologists will be integral members of the Assistive Technology Department and Physical Nutritional Management Teams with services available both on and off site.
- **Nutrition Services** - available to waiver and ICF/MR service recipients in West Tennessee. Registered Dietitians will be integral members of the Enteral Nutrition Team and Physical Nutritional Management Teams with services available both on and off site.
- **Community Center** – available for a variety of activities, including, but not limited to community social events, educational events, advocacy groups, etc. This Center will be designed to allow flexibility in its use, to accommodate groups both large and small.
- **Neuro-Behavioral Team Services** - will consist of, at a minimum, a medical doctor, psychiatrist, nurse, psychologist, and behavior analyst. Neuro-behavioral team services will be available to waiver and ICF/MR service recipients in West Tennessee. Referrals may be made in relation to medical related issues, new diagnoses, difficult diagnoses, and multiple medications. Interventions and consultations will be provided through a model that includes and supports Circles of Support and clinicians. Services will be available both on and off site.
- **Physical Nutritional Management Team Services** - include, but are not limited to: a registered nurse, a registered dietitian, a physical therapist, an occupational therapist, speech-language pathologist, and a physician and behavior analyst as indicated. Physical Nutritional Management Team services will be available to waiver and ICF/MR service recipients in West Tennessee both on and off site.

- **Enteral Nutrition Team Services** - screening, assessing, evaluating, and monitoring the nutritional status and efficacy of nutritional support therapy provided to waiver and ICF/MR service recipients in West Tennessee. Consultation and guidance will be provided to Circles of Support related to management of nutritional intake, elimination, risk prevention, and tube management protocols. The Enteral Nutrition Team will consist of, at a minimum, a medical doctor experienced in the management and insertion of dislodged tubes, a registered nurse, and a registered dietitian.

In addition to the services above that will be accessible by all West Tennessee DMRS service recipients, the following service will also be provided, but only to Arlington class members:

- **Medical Specialty Clinic Space;** operationally staffed - designed to accommodate medical specialists who desire to see service recipients within the Resource Center during scheduled clinic times. The Medical Specialty Clinic will be staffed adequately to meet the needs for Medical Information Management, scheduling, and support nursing. It is intended that the nurses within the Clinic will become familiar with the class members accessing the Clinic, assist with information gathering in anticipation of the medical specialist's appointment, and support both the medical specialist and class member during the scheduled appointment.

Initially, it is intended that specialists such as Gastroenterology, Internal Medicine, Metabolic Bone/Rheumatology, Neurology, Gynecology, and Physiatry will be approached for provision of services through the Medical Specialty Clinic. Specific specialty types will be pursued based upon current known usage patterns and a survey of the Parent Guardian Association of West TN for their estimation of projected needs.

The availability of these specialties through the Medical Specialty Clinic will be governed by demand/need for the service as well as physician willingness to provide services outside of their typical office setting. Physicians accessing the Medical

Specialty Clinic area will be required to independently bill Medicare, TennCare, and other third party payers.

The services offered at the Resource Center inevitably will change over time. The initial offering will primarily consist of services currently provided by ADC and/or the West Tennessee Regional Office. Through regular assessment of utilization patterns, needs assessment, and provider capacity of the DMRS provider network, additional services may be offered, or services provided by the Resource Center may be transitioned to community based service providers.

Space will be designated within the Resource Center facility to provide day programming services to individuals residing in the state-operated ICF/MR homes. While the day program will not be a Resource Center service, individuals with disabilities accompanying a housemate for a medical appointment in the Specialty Clinic or Assistive Technology may be permitted to participate while they wait on their housemate. Areas to be encompassed include: seniors' day programs, sensory processing, vision training, self care/work readiness training, motor skills training, speech and communication training, music therapy and art therapy.

CHAPTER 5 THE TRANSITION PLANNING PROCESS

For each resident moving out of ADC, the move will be carefully planned in collaboration with the individual, his/her conservator, his/her Circle of Support, some members of ADC management, and the WTRO Transition Team. The Court Monitor's Office also oversees all transitions of ADC residents to community homes, and no individual may move from ADC without the Court Monitor's assurance that the individual's home is appropriate and that all needed services and supports are available. The Court Monitor's Office and DMRS officials also carefully oversee the individual's progress after the move, with special attention to ensure that all recommended services and supports are in place and that all class member and conservator concerns are addressed.

For most individuals leaving ADC, formal transition planning will occur over a period of three to four months. There is no rigid schedule, however. Sometimes arrangements can be made more quickly, especially in situations when an individual is planning to move to an established community home where needed physical accommodations are already in place. Other times, arrangements may take longer. This is often the case when an individual needs such significant physical accommodations that the choice of building a new community home (rather than renting and accommodating an existing home) is considered the most appropriate option.

Regardless of the planning period, however, there are certain steps and activities that are associated with all transitions and they usually occur in fairly regular order. The purpose of this chapter is to outline these steps and activities.

Step 1: Introductory Meetings

In order to ensure that all conservators have a good understanding of the ADC closure process and how it will affect their family member, the ADC Chief Officer and Assistant Superintendent for Residential Services have been holding personal meetings with the conservators of all ADC residents. At this meeting, conservators learn when their family member's residential unit is estimated to close, what residential options are available in the community - both in waiver homes and ICF/MR facilities, how the transition process flows, and the first steps in that process. The personal nature of the meetings allows conservators a comfortable setting in which to raise concerns, fears, and hopes privately.

Since mid-2006, personal meetings have been held with the conservators of 107 of ADC's residents, and additional meetings are scheduled to occur with the conservators of most of the remaining residents by September 30, 2007. During these meetings, conservators are also notified if their family member meets the medical and physical challenges qualifications for placement in the State-operated four-bed ICF/MR facilities to be built in the Arlington area.

Subsequent to these meetings, conservators are offered the option to enroll in the formal community transition planning process for their family member. Thus far this option has been selected by over 61 conservators; 42 of their family members have already moved to a community home and another 19 are scheduled to move by the end of December 2007.

Alternately, conservators are offered the option to delay enrolling in the community transition planning process. As warranted, conservators are informed, if due to the pending closure of their family member's residential unit, that he/she may need to move to another unit on the ADC campus.

Conservators who elect not to enroll in the formal community transition planning process may contact ADC at any time to indicate that they have changed their mind. In addition, ADC officials will keep in regular contact with conservators, providing them with

information about the ongoing closure process and how it is affecting their family member, and inquiring about the conservator's current interest in starting transition planning.

Of course, there will come a point (probably in late 2007 or early 2008) when all conservators (whose family members will not be moving to the new State-operated ICF-MR community homes) will be required to enroll in the formal community transition planning process for their family member. Present indications are, however, that this enrollment will remain largely voluntary, with the timing chosen by the conservators themselves. Indeed, most conservators who have had their introductory meetings with the ADC Chief Officer or Deputy Superintendent have chosen to immediately enroll in the community transition planning process.

Step 2: Choosing a Residential Model, a Provider Agency, Housemates and a Home

Shortly after enrolling in the community transition planning process, conservators receive a telephone call from a member of the WTRO Transition Team and the Court Monitor's Office. Through these contacts, conservators are assisted in choosing a residential provider agency, identifying the geographic areas where they would like their family member to live, and finding prospective housemates for their family member.

It is also in this early stage that conservators make the initial choice of the Arlington Waiver-funded community home or the community-based ICF/MR homes. Conservators also work closely with the WTRO Transition Team and the identified residential provider in reviewing and ultimately choosing a community home for their family member.

Meanwhile, the Court Monitor or one of her associates will visit the class member at ADC, meet with his/her staff members, and review his/her records. During these visits, the class member is also observed in different settings (e.g., on the unit, at the work or program area, outside, etc.) and, as warranted, meetings are held with various clinical therapists,

physicians, nurses etc. who are responsible for the class member's care at ADC. A summary memo is prepared of the review and it is shared with the WTRO Transition Team; ADC officials; Community Services Network; the conservator/guardian upon request; and when decided, the class member's chosen residential provider.

In addition to this general review, which is completed for all ADC residents planning to move to community homes, the Court Monitor's Office has arranged for a specially qualified nurse consultant to complete a comprehensive review of the health care status and recent (past several years) health events for all ADC residents entering transition who have significant medical challenges. These reviews are summarized in memos and shared with the Transition Team, the ADC management team, and the chosen residential provider as well as conservators (upon request). These reports ensure that all involved in the individual's transition are well-versed in the individual's health care status and required medical services and supports.

Step 3: Choosing an Independent Support Coordination Agency

Another early step in the transition planning process is the selection of an independent support coordination (or ISC) agency. ISC agencies are charged with overseeing and coordinating the recommended services and supports for all class members after they move to a community home. These agencies provide this service by assigning a case manager, called an independent support coordinator or ISC, to each class member before he/she moves to a community home.

ISCs have relatively small caseloads of 20 - 25 individuals and they have the specific responsibility of chairing committee meetings of the conservator, the class member, service provider agencies, and other stakeholders on behalf of the individual at regularly scheduled intervals following the transition from ADC. This committee is called the Circle of Support (COS) and may also include people that the individual has chosen to assist him/her in

developing the plan. The COS is convened whenever there is a need to make a significant change in an individual's services and supports or at least annually to formally update the individual's overall service plan, called the Individual Support Plan (ISP).

While the WTRO Transition Team writes the initial ISP to cover the transition period, ISCs are responsible for revising and updating the class member's ISP after they have moved to their community home. As a special safeguard, DMRS requires that ISPs developed for individuals moving from ADC be formally reviewed and updated by the individual's Circle of Support 30 days after the move. This safety check ensures that any needed changes in the services and supports for an individual can be made promptly and efficiently.

ISCs are also charged with visiting class members on his/her case load at least every month and preparing a monthly report summarizing how each class member is progressing and, as applicable, what steps were taken to resolve any problems or concerns.

Currently, there are seven ISC agencies in West Tennessee available to provide services to ADC residents. Members of the WTRO Transition Team will familiarize conservators with each agency and assist conservators in choosing an ISC agency.

Step 4: Enrolling in the Community Services Network (CSN)

Early in the community transition planning process, conservators also meet with representatives of the Community Services Network (CSN). During this meeting, the conservator and the CSN representative discuss the benefits of CSN enrollment. If the conservator chooses to sign consent for CSN services, CSN discusses with the conservator his/her preferences for the family member's primary care physician, dental provider, and other health care providers, and any specific health care concerns.

Prior to a class member's move to his/her community home, a CSN representative will visit the class member at ADC and review his/her complete medical file. Before the move, the class member will also be assigned an official CSN case manager and will receive an official CSN membership card, which facilitates access to all of the health care providers and services in the CSN network, within ten days of transitioning to the community.

Before an individual moves to his/her community home, CSN, together with the residential provider agency, also ensures that a post-move full physical examination is scheduled with the individual's community primary care physician in the first month after his/her move. As warranted, other immediately needed medical appointments are also arranged before an individual's move to ensure that they occur as soon as needed after the community transition.

Step 5: Preparing Individual Support Plans and Health Care Plans

Although there is quite a lot of administrative paperwork that needs to be completed by ADC and WTRO officials to facilitate a resident's move from ADC to a community home, two documents, the Individual Support Plan (ISP) and the Health Care Plan, are the most important. Work on both of these documents usually begins within four to six weeks of a conservator's decision to enroll their family member in the community transition planning process.

The WTRO Transition Team prepares the first draft of an individual's ISP and the ADC Health Care Coordinator prepares the first draft of the individual's Health Care Plan. These documents are shared with the Court Monitor and all members of the individual's Circle of Support, which includes many of the staff members who have cared for the individual at ADC. They are also discussed at the individual's first formal transition meeting, which is called the "Planning Meeting." This initial meeting has fewer participants than later transition meetings in order to avoid overwhelming the individual and family members.

Suggested revisions and additions to the ISP and the Health Care Plan are made, and then they are re-circulated for review by all involved parties, including the Court Monitor. Over the next several weeks, as the individual's community move becomes more imminent, these plans continue to be refined and modified.

Ultimately, the WTRO Transition Team aims to have both an individual's ISP and his/her Health Care Plan formally approved by the Court Monitor about 30 days before the scheduled community move. This allows time for the residential provider agency to "learn" the plans and train all the staff members who will be working with the individual in his/her community home.

Step 6: Home Assessments and Accommodations

As referenced above, the majority of the residents of ADC have significant physical challenges and most will require physical accommodations to be made to their new community homes. The exceptions to this general rule will be those individuals who plan to move to existing community homes, especially existing community-based ICF/MR homes, which are already fully accommodated to meet the needs of individuals who depend upon wheelchairs for mobility.

Once conservators have chosen the type of community residential model (Arlington Waiver versus ICF/MR community home) and the residential provider agency, the choice of the specific home is usually the next decision. For individuals choosing the community-based ICF/MR model, these facilities have already been accommodated to meet most needs of persons with significant physical challenges, so they are generally move-in ready, but sometimes a few, usually modest, additional renovations may be needed.

For individuals choosing the Arlington Waiver-funded community home model, there are more home choices and provider agencies work closely with conservators and individuals in this decision-making process. Once a potential home or homes have been selected, the WTRO Transition Team will arrange for a team of ADC clinicians (who know the individual) to visit the home(s) and complete home assessment(s) with recommendations for needed renovations.

Once home assessments have been reviewed and approved by the WTRO, the residential provider agency is responsible for ensuring that all recommended accommodations are in place before the individual moves. As noted previously, the Arlington Waiver provides up to \$15,000 per person every two years to ensure needed accommodations. In select cases, where accommodations costing more than this amount are needed, State dollars are authorized to cover the additional cost.

Finally, before an individual is permitted to move into his/her community home, the home must pass inspections by DMRS officials and the Court Monitor's Office. These inspections check the appropriateness of the neighborhood, basic maintenance and safety features of the home (e.g., smoke detectors, safe lighting, fire extinguishers, functioning appliances, safe hot water temperatures, etc.), and all of the specific modifications and accommodations recommended in the completed home assessment.

Step 7: Final Move Preparations

In the last six weeks or so before an individual moves to his/her community home, many final move preparations are underway. There are usually at least two formal transition planning meetings where final changes are made to the class member's ISP and Health Care Plan.

During this time, ADC officials and the WTRO Transition Team are also busy with various administrative tasks, including taking steps to ensure that the individual's Social Security benefits and ADC Trust Funds are transferred and that the individual's various identification cards are available and accurate (e.g., birth certificate, Social Security Card, etc.). ADC officials also coordinate and make arrangements for the packing of an individual's belongings and needed special adaptive equipment and their transport to the individual's new home.

Conservators and class members often play an active role in assisting the residential provider agency in furnishing the community home and in buying basic household items, including bed and bath linens, pots and pans, and new clothing and other personal items the individual will need in his/her community home. Some conservators get together with the conservators of their family members' prospective housemates and they collaborate on these home furnishing and decorating decisions. As referenced in Chapter 2, up to \$4,000 per class member is allocated for these expenses. Since most class members will live with one or two other individuals, this allowance results in \$8,000 - \$12,000 being available to fund the establishment of the ADC class member's new community home. In special situations, usually when an individual's needs require that he/she live alone, DMRS has awarded extra state funds to support community home establishment costs.

Meanwhile during this period, conservators are usually in frequent contact with their chosen community residential provider, CSN case manager, independent support coordinator (ISC), and the Court Monitor's Office. There are always questions and lots of things to get done in these final weeks, which are usually very exciting and occasionally a little stressful.

Step 8: Moving Day

ADC officials and the WTRO Transition Team work closely together on moving day. Conservators are also involved and often spend much of moving day with their family

member. Often all of the larger items of furniture and household items have been moved into the homes several days earlier, and this “official” moving day is reserved for the individual to move in a few items and clothing from his/her ADC bedroom, including special adaptive equipment.

On moving day, ADC staff persons who have worked with the class member accompany him/her to his new home. At least one former ADC staff person (per shift) usually stays with the individual in his/her community home for the first two to three days. This additional staffing is designed to ease the individual’s transition from ADC to his/her community home and it also ensures “real life” opportunities for the ADC staff members to help the community home staff persons learn about the individual, his/her likes and dislikes, needs, and special requirements.

Step 9: Post Move Monitoring and Oversight

After an individual moves to his/her community home, DMRS officials and the Court Monitor, as well as the individual’s ISC and CSN case manager stay closely involved in monitoring the delivery of services and supports and the individual’s quality of care and protection from harm. DMRS officials visit the home on the day of the move, and at least once weekly for the next several weeks. ISCs and CSN case managers also visit several times in the first month. ISCs begin issuing a monthly report and CSN issues at least three update reports during that first month which summarize the individual’s progress in settling into his/her new home, as well as any problems that must be addressed.

The Court Monitor’s Office stays abreast with the findings of these early reviews and remains in close contact with the residential provider agency and conservator. Approximately eight weeks after an individual’s move, the Court Monitor’s Office conducts a comprehensive review and submits a formal report to DMRS officials, the residential provider agency, the

individual's ISC, the CSN case manager and the conservator/guardian upon request.

Immediate steps are taken to address any specific concerns.

During this post-move period, each individual is also assigned a community advocate. The DMRS contracts with a private agency (currently Tennessee Disability Advocacy Coalition) for the provision of community advocacy services. Community advocates attend Circle of Support meetings in the community, visit class members at their homes, and they are often a valuable resource to conservators who have specific concerns or requests on behalf of their family members.

Individuals may also reach out to the class representatives, People First of Tennessee, the Parent Guardian Association of West Tennessee, and the U.S. Department of Justice for advocacy services.

CHAPTER 6 THE CLOSING OF ARLINGTON DEVELOPMENTAL CENTER

ADC Census Downsizing Projections

Date	Census
June 30, 2007	128*
December 31, 2007	109
June 30, 2008	91
December 31, 2008	57
June 30, 2009	31**
December 31, 2009	8
March 31, 2010	0

* This figure represents the actual census as of June 30, 2007. The other figures in the chart are projections.

** It is expected that most (24 of 31) of the residents remaining as of June 30, 2009 will be those individuals who will move into the remaining 6 state-operated four-person ICF/MR homes to be built in the Arlington TN area.

Orchestrating the actual closure of an institution like ADC that supports many individuals with complex medical, physical, and cognitive conditions is a difficult task. The gradual downsizing of ADC must be done in a manner that prevents health and safety risks to the residents remaining. This means that attention must be focused on minimizing disruptions in care and services to the greatest extent possible, including the unnecessary moves of individuals among residential units and unnecessary staffing changes. It also means ensuring that essential quality assurance oversight and facility maintenance must continue throughout the closure process.

The State also has obligations to the workforce of ADC. It must ensure that staff members are treated fairly and assured all of their civil services rights to alternative State employment opportunities. The State has further agreed to provide direct assistance to the Arlington workforce through the provision of special training opportunities to prepare them for future jobs and the provision of special job counseling and State-sponsored job fairs on the ADC campus.

As the closure proceeds, the State will also need to take specific steps to retain employees who will be needed through the closure, but who will not be able to transition to new employment opportunities at the Resource Center and/or the small ICF/MR homes located

in the Arlington area. These concerns will become especially significant once ADC's census drops below 100 residents, which is anticipated to occur in early 2008.

This chapter is intended to provide information pertinent to the actual closing of ADC and how the State intends to address all of the above issues.

Gradual Downsizing of the ADC Resident Census

ADC officials and the Transition Team, in concert with the Court Monitor, have agreed that the safest path to ADC's closing would be to first downsize and close the residential units on ADC's upper campus, which have historically served the more physically able and medically stable residents. This process has been underway since 2001, when the first three residential units on the upper campus closed. In 2003, another residential unit on the upper campus closed; in 2004, a unit in the Baker Building closed; and in 2005 and 2006, a total of five residential units on the upper campus closed.⁵

As of June 30, 2007, there were only 27 individuals residing on ADC's upper campus in three Daniel Boone cottages. As the remaining three units of the upper campus close, it will be necessary for individuals living there who have not moved to a community home to change residences to one of the units in ADC's Baker Building on the lower campus. ADC administration believes that these placements in the Baker Building will be readily possible, as there are a number of conservators of current Baker Building residents who have already entered the transition process.

Prior to any individual's actual move to another residential unit during the closure process, the ADC administration will notify his/her conservator and assure them the opportunity (if desired) to visit and comment on the proposed new residence. Whenever possible, ADC

⁵ The one unit in the Baker Building that closed in 2004 was the Holly Unit which was located on the third floor. The location of this unit had long presented evacuation concerns for its very impaired residents.

officials will attempt to accommodate any specific conservator requests in making these residential moves. ADC officials will make all possible efforts to minimize the moves of individuals at the Center throughout the closure process.

The gradual closing of the current Baker Building is projected to occur over the 22-month period from June 2008 through March 2010. As noted in the table below, due to physical plant concerns, the Spruce residential units are scheduled to close during the beginning of this period; whereas the Maple residential units, considered to be in the best physical condition, are scheduled to close at the end of the period. DMRS will determine what additional safeguards are needed to protect Baker Building residents during building renovations and will put them in place.

At some point during early 2008, ADC administration officials also intend to begin some moves within the Baker Building to congregate on the Maple Units the 48 individuals presently scheduled to move to the 12 four-bed State-operated ICF/MR homes located in the Arlington area. This decision is being made to promote the individuals' continuity of care and to provide a good training/transition ground for program and staff development for the new State-operated ICF/MR homes. The moves will also help the individuals develop relationships

ADC Residential Unit Closure Schedule	
Upper Campus	Date Closed/ Scheduled to Close
Mark Twain 2	September 2001
Mark Twain 3	August 2001
Mark Twain 4	January 2003
Daniel Boone 1	April 2005
Davy Crockett 2	February 2006
Davy Crockett 1	December 2006
Davy Crockett 3	December 2006
Davy Crockett 4	December 2006
Mark Twain 5	April 2007
Daniel Boone 3	September 2007 **
Daniel Boone 4	October 2007 **
Daniel Boone 2	November 2007 **
Baker Building	
Holly	June 2004
Willow	June 2008 **
Spruce 4	September 2008 **
Maple 1	November 2008 **
Spruce 2	December 2008 **
Spruce 1	May 2009 **
Spruce 3	June 2009 **
Maple 2	August 2009 **
Maple 3	December 2009 **
Maple 4	March 2010 **

** Dates are based on those entering or projected to enter the community transition process as of June 2007 and state-operated ICF/MR homes' projected opening dates.

with others scheduled to live in the State-operated ICF/MR homes and they will assist ADC officials and conservators in selecting compatible housemates for the individuals in their new small ICF/MR homes.

Assuring Quality of Care

During the closure process, ADC officials will maintain the same level of quality assurance oversight as has been assured historically at ADC, and in some areas, the degree of oversight will be heightened. Specifically, it should be reinforced that all quality assurance activities required by federal and State regulations for State-operated developmental centers will remain in place until all residents have moved to their new community homes. In addition, the State will assure monthly reporting of critical data related to ADC's performance in protection from harm and the implementation of recommended services and supports for its residents to the Parties and the Court Monitor. Staffing data, including workforce transition information, will also be included in these reports.

Ongoing activities will include the reporting, review, and investigations of untoward incidents, including injuries of unknown origin and all allegations of abuse, neglect, and exploitation. ADC's Central Monitoring Unit will also continue its close monitoring of individual support plans (ISPs) for all residents and its completion of comprehensive person-centered reviews of at least 15% of ADC's residents each month. In addition, an enhanced monitoring protocol will be implemented to assure that resident moves and staff transfers do not compromise ADC's assurance that all staff training requirements are fully met.

DMRS will also monitor compliance with the specific provisions related to the safe transition of ADC's residents to community homes through oversight of this process by DMRS' Central Office in Nashville. These commitments will include those specified in the Remedial Order, the Community Plan, the current Settlement Agreement, and the Closure Plan. This monitoring will also encompass the specific protocols for transition planning and post-

community placement monitoring developed by the DMRS West Regional Office Transition Team, in collaboration with the Court Monitor. DMRS Central Office will also be closely involved in monitoring the overall conditions and quality of services at ADC throughout the closure process.

The ADC Workforce

Over the period of the gradual downsizing of the resident census at ADC, there will also be a gradual downsizing of its workforce. This process began in 2005 with a reduction of 238 positions at ADC, which resulted in 60 employees receiving layoff letters; approximately 35 of whom were hired to work in other state agencies or community services.⁶ In early 2006, the second reduction-in-force of 105 positions was implemented. Twelve employees received layoff letters but were saved through attrition during the 90-day notice period. In January 2007, 177 positions were identified to be abolished. This affected 121 employees, who were given a 90-day notice period. In April 2007, another 11 vacant positions were identified to be abolished.

Subsequent to the latter lay off, 723 employees remain at ADC. While 51% of these remaining employees are direct support professionals, the remaining 49% have managerial, administrative, clinical/professional, and assorted maintenance and housekeeping titles.

The State projects that at least one-third of the current remaining workforce will apply for and obtain positions in the State-operated Resource Center and 12 four-person ICF/MR homes to be located in the Arlington area. Current projections indicate that the ICF/MR homes will have approximately 196 direct support professional positions, 103 clinical/professional positions, and 20 managerial and administrative positions, exclusive of maintenance and housekeeping positions. It is also expected that there will be an additional

⁶ The discrepancy between the number of positions cut and the number of employees laid off is due to the fact that many of the positions were vacant at the time of the reduction in force.

37 clinical/professional and administrative positions in the West TN Regional Office for the Resource Center and administrative support. Over the course of the three-year closure period, it is also anticipated that some currently filled positions in the DMRS West Regional Office will be vacated and become available.

**Staffing Projections for ADC and 12 State-operated ICF/MR Homes
2007 - 2010**

Date	ADC Census	State-operated ICF/MR Homes Census	TOTAL CENSUS - ADC & ICF/MR Homes	TOTAL STAFF	Direct Support Professionals	Professional & Clinical Personnel	Management & Administrative Personnel*
6/30/2007	128		128	723	368	164	191
12/31/2007	109		109	630	327	140	163
6/30/2008	91		91	526	273	117	136
9/30/2008	74	8	82	492	246	117	129
11/30/2008	60	16	76	459	228	116	115
12/31/2008	57	16	73	443	219	115	109
5/31/2009	34	24	58	411	217	114	80
6/30/2009	31	24	55	357	215	112	30
8/31/2009	17	32	49	338	204	109	25
12/31/2009	8	40	48	325	200	105	20
3/31/2010	0	48	48	319	196	103	20

*Figures in table are projections that can be affected by variables outside of DMRS' control.

All current ADC employees will have the opportunity to interview for any of these positions for which they qualify. Based on current closure projections, it is estimated that these interviews will begin in early 2008.

For many of the current employees at ADC, however, the closure will mean relocating to another employment option either with the State of Tennessee or a private employer. This will occur in full accordance with State policies for reductions in force and will ensure notification of employees of lay off schedules as soon as possible. Presently, the State anticipates that there will be additional layoffs in August 2007 and January 2008.

Re- Employment Assistance to the ADC Workforce

By March 2010, it is projected that all employees at ADC will have either transitioned to new positions associated with the State-operated Resource Center and/or community-based ICF/MR homes, or moved on to another employer. To assist the ADC employees in making their personal re-employment decisions, the State is offering various re-employment services, including:

- Workshops sponsored by the TN Consolidated Retirement System to assist employees evaluate their State retirement benefits and the relative merits of finding a new State versus private employer;
- On-site job fairs to assist employees meet and become acquainted with the job opportunities available from area employers;
- The Rapid Response Team within the TN Department of Labor and Workforce Development has begun assisting employees in refining and/or developing job seeking skills (i.e. preparing resumes, providing job leads) and will assist displaced employees in other areas such as counseling and assistance with applying for unemployment benefits;
- Individual career counseling sessions for any interested employee; and
- Advertising positions available to employees in the community mental retardation service system in the ADC Tabloid and facilitating employees' access to job applications and interviews with prospective community provider agencies.

All ADC employees will also continue to be eligible for on-going job benefits which promote career development. These include a tuition reimbursement program available for most post-secondary accredited educational programs and education leaves of absence. In

addition to these benefits, the State will offer ADC employees an enhanced schedule of advanced training opportunities designed to assist them in becoming more competitive for new employment opportunities both in the new State-operated services in the Arlington area and in other related private sector positions.

These programs include:

- Home Manager Certification through Southwest Tennessee Community College and Jackson State Community College, which includes 15 transferable college credits. Many of the courses will also be offered on-site at ADC for the employees' convenience.
- Professional Crisis Management (or an equivalent program) Certification, an 18-hour, on campus program, which provides special training in meeting the needs of individuals who have behavioral challenges.
- Medication Administration for Unlicensed Personnel, a 20-hour, on campus program, which allows direct support professional staff members to administer medications in community supported living homes through an exemption of the Tennessee Nurse Practice Act. This training is often required for employment in community residential programs.
- Physical and Mealtime Challenges Training, two on-campus, two-day courses which offer specialized staff training in assisting individuals with very serious physical challenges with the activities of daily living, e.g. eating, positioning, transferring, oral hygiene, etc.).
- Nurse Aide Training Program, a 75-hour program. After passing a competency based exam, an individual is qualified for certified nurse aide positions in assisted living and skilled nursing facilities.

Retaining the Necessary Workforce

At the same time that the State is obligated during the ADC closure process to assist ADC's employees to find satisfying and fulfilling new employment, it also has the paradoxical obligation to encourage those employees whose services will be needed through the closure period to stay on at ADC. These employees include those, who due to their years of experience at ADC caring for its residents, are most ably qualified to staff the new State-operated Resource Center and ICF/MR homes to be located in Arlington area.

There are several factors that will assist the State in meeting this challenge. Considerable pre-planning has already been done to project both the staffing needs of ADC during the closure process and the staffing needs of the State-operated Resource Center and ICF/MR homes. These projections will be reviewed and updated throughout this process and they will provide important parameters for State officials as further resident census and staff downsizing is necessary. These projections will also be available to ADC staff, so that they can make the informed personal decisions. As necessary, the State will also offer additional overtime hour opportunities to encourage employees to continue their employment at ADC.

The second factor that will be important in retaining the necessary workforce will be the reasonable trust of the employees that they will be treated fairly and honestly by management. To promote this trust, ADC officials have taken steps to ensure all of ADC's employees are well aware of planned closure activities. For almost a year, the monthly Arlington Tabloid has included a lead article on the status of closure activities and will continue to do so. In March 2007, ADC's Chief Officer began holding quarterly open forums for staff on all three shifts to share information about closure activities and related initiatives.

A third important factor will be specific incentive programs to encourage the continued employment by certain needed employees. ADC plans to do this in several ways. It plans a much more aggressive program to offer flexible job hours. Employees will be offered opportunities to work part-time schedules, to work compressed job weeks, and to participate

in job-sharing programs with colleagues. Depending on an employee's circumstances, each of these opportunities can be helpful in furthering his/her education and/or transitioning to another position.

CHAPTER 7 QUALITY MANAGEMENT

Several years ago, DMRS recognized the need to upgrade the quality oversight of its community services system. Since that time, DMRS has made many changes to address quality concerns raised by consumers, conservators, providers, and federal government overseers. These changes, and the Quality Management System that resulted, have been acknowledged by health care and developmental disabilities experts as being exemplary and of national significance.

Quality management is not a static process; there is no beginning or end point. Rather, it is structured around an ongoing circle of oversight, data collection and analysis by a variety of internal and external groups that focus on outcomes that are important to and affect the lives of service recipients. The information gathered through this process is used to guide DMRS in taking proactive steps to improve the performance of its community service delivery system.

Quality Assurance Surveys

DMRS Quality Assurance Surveys are conducted annually (or every other year for high performing provider agencies). Residential service providers, day service providers, independent support coordination agencies, home health and other clinical services agencies, personal assistance providers and early intervention providers are all subject to DMRS' Quality Assurance Surveys.

The purpose of the survey is to evaluate provider performance in meeting service delivery requirements in the following important areas:

- Protection from harm, safety, and security;

- Medical, nursing and therapeutic services;
- Human rights protections;
- Service planning and implementation;
- Community integration opportunities;
- Access to services;
- Opportunities for choice and decision-making;
- Day services;
- Staff qualifications, training and competence; and
- Financial well-being and accountability.

DMRS Quality Assurance Surveys also review each provider's documentation to support billing and personal funds management practices. If audit problems are found in personal funds management or billing areas, the Quality Assurance Survey team refers the provider to the DMRS Internal Audit Unit for further review.

Survey results highlight exemplary performance as well as identify areas where the provider must make improvements. Each provider receives a performance report card and a total performance rating. All providers who receive low performance ratings in critical areas are subject to specific follow-up activities by DMRS as discussed later in this chapter. Poor performance on consecutive DMRS Quality Assurance Surveys can result in the provider agency losing its contract to provide DMRS Arlington Waiver services and/or receiving specific financial sanctions.

Beginning in 2006, DMRS established a program of recognition for providers that exhibit a high level of performance in their operation. Criteria were established that include exceptional or proficient performance on quality assurance surveys, including substantial compliance with the "individual planning and implementation" and "safety and security" domains; absence of egregious events and a low rate of substantiated investigations; and Quality Tier designation by the Court Monitor. Providers that attain this status receive recognition from DMRS as well as exemption from the quality assurance survey for one year.

Technical Assistance for Provider Agencies

DMRS has stepped up its technical assistance program for provider agencies experiencing difficulties or to enhance internal provider quality improvement activities. DMRS' technical assistance program recognizes that with a community service system consisting of hundreds of provider agencies, it is likely that one or more providers will not perform up to standards at one time or another. The goal of DMRS' technical assistance program is to ensure timely assistance to these provider agencies, as well as assurance that they make the necessary quality improvements or lose their authorization as DMRS Waiver providers.

The program is prescribed for all agencies that perform poorly on DMRS' quality assurance reviews, and it is tailored individually to address each agency's specific performance problems. Depending on the level of difficulties the provider agency is having, the technical assistance program may be voluntary or a mandatory requirement for the agency's continued operation in Tennessee.

While enrolled in DMRS' technical assistance program, provider agencies are carefully monitored by the Regional Quality Management Committee and their programs are checked for needed quality improvements at least quarterly. This oversight guarantees that poor performing providers rectify cited deficiencies in a timely manner. If such improvement is not forthcoming, despite the offered technical assistance, DMRS may take a number of other steps, including financial sanctions, prohibiting new admissions to the agency, and/or downsizing of the agency's scope of service provision.

If substandard performance persists, DMRS alerts the provider agency that it is in jeopardy of having its contract to provide waiver services in Tennessee rescinded. In accordance with contract provisions, DMRS has the authority to take this action with 30 days notice.

Technical assistance is also available to agencies upon request to help them understand DMRS expectations and receive support to improve their systems.

Independent Support Coordination

Each DMRS service recipient is assigned an independent support coordinator (ISC) to help them and their family plan and access needed services. The ISC serves as a case manager for the individual and monitors the delivery of services to ensure they meet the needs and expectations of the person. ISCs must document monthly how the individual's plan of care is being implemented. If there are any problems, the ISC assists the person in resolving the issues of concern, including filing appeals, accessing the complaint resolution process, etc.

If any staff member of DMRS or an ISC agency discovers a situation that presents an immediate risk of harm to an individual, they will stay with the service recipient until the individual is safe and appropriate services are being delivered. All serious concerns of ISCs are also routinely forwarded to DMRS so that their full and timely resolution can be monitored and assured.

Advocates

Pursuant to the Arlington Remedial Order and the West Tennessee Community Plan, each person transitioning from ADC to a community-based program is assigned a paid advocate. During transition, the advocate's role is to:

- assist the person in learning to practice self advocacy to the extent desired;

- encourage and support the person in expressing and asserting his or her interests in making the life choices associated with transition to the community service system; and
- attend the person's transition planning closure meeting.

Following the person's transition, the paid advocate maintains contact as often as necessary to help the individual adjust to his/her new home and neighborhood and to assist the individual and his/her conservator in participation of on-going service planning meetings.

DMRS Internal Audit Unit

When necessary, the DMRS Internal Audit Unit conducts investigations of questionable financial practices by providers. Since January 2005, the Internal Audit Unit has performed 20 provider audits of this nature in West Tennessee. As a result of the audits, reimbursements were recouped from 10 providers, and 7 providers were required to reimburse service recipients for inappropriate charges to their personal funds.

Consumer Satisfaction Surveys

DMRS was awarded a grant through the Center for Medicare and Medicaid Services to create a Satisfaction Survey for service recipients throughout the State. DMRS contracted this project, which started in late 2004, to the ARC of TN. Since then, annual surveys have also occurred in 2005 and 2006. These surveys have consistently shown satisfaction ratings in the 80% range. The State has committed to surveying the satisfaction of Arlington Waiver service recipients annually and to producing public reports of the surveys' findings.

The Protection from Harm Unit

The Protection from Harm Unit operates on both the regional and state level at DMRS and it oversees incident management, investigations, and complaint resolution. In this area, several processes have been refined to assure the protection and safety of individuals who receive services. In addition to collecting crucial data, the Protection from Harm Unit also performs focused trend analyses, generates provider-specific reports for more detailed scrutiny, and participates with the state and regional Quality Management Committees in recommending and providing needed assistance to provider agencies.

Incident Management and Investigations

Provider agencies continue to utilize the incident reporting and investigations system to assure that all critical incidents involving individuals are reported and that necessary interventions to protect individuals from further harm are put in place in a timely manner. Every provider agency is required to have an Incident Management Coordinator and an Incident Review Committee that must meet at least weekly. Provider agencies must ensure that all incidents are reviewed by the Committee and that appropriate corrective actions are identified, documented, and implemented.

DMRS carefully reviews all provider agencies' incident management procedures and activities at the time of their Quality Assurance Survey. The Central Office of DMRS also maintains a statewide data base of all filed incidents, and it ensures that all incidents of alleged or suspected-abuse and neglect are referred for full investigation by DMRS investigators. DMRS also relies on its incident data base to identify significant trends or patterns in incidents for vulnerable persons, individual provider agencies, specific types of provider agencies, and the entire service system.

Preventing Harmful Incidents and Abuse and Neglect

DMRS has several additional requirements aimed at proactive incident and abuse and neglect prevention:

- All provider agencies are required to design prevention plans that will assist them in identifying and correcting potentially dangerous conditions before they result in harm.
- Providers are required to submit a report of planned corrective or preventative actions called a Plan of Correction for all DMRS investigations to address the recommendations and incidental findings stated within the report. Designated DMRS Regional Office personnel have the responsibility of ensuring that the provider identified in a DMRS Final Investigation Report is responding to the report with corrective and preventative measures.
- The DMRS Protection from Harm system utilizes the Tennessee Abuse Registry which includes names of persons involved in substantiated abusive or neglectful acts towards vulnerable persons. Provider agencies must check the registry before hiring an employee or volunteer. If the person is placed on the registry, that person can not be hired or permitted to provide care. This ensures that the persons supported by DMRS are not subjected to repeat offenders. The Abuse Registry is maintained by the Tennessee Department of Health.
- Abuse and Neglect Prevention Committees (ANPC) exist in each region of the state and were created to be independent entities that offer recommendations to DMRS management intended to promote better care and protections for service recipients. ANPCs review the results of investigations of abuse and neglect and identify trends regarding these and other issues related to protection from harm. ADC is unique in that it has its own ANPC that solely looks at issues relating to ADC residents. Currently, DMRS is working with the ANPCs statewide to evaluate their processes and to determine their future direction and function. It is anticipated that as the population of ADC declines, the ADC ANPC will need to merge with the West Tennessee ANPC.

Addressing Complaints

Notwithstanding all of its quality assurance efforts, DMRS is aware that its service recipients and their conservators need an open door for registering their concerns and complaints and a speedy government response.

Service recipients and conservators can file their complaints directly with DMRS or if they prefer, they can file complaints through their ISC, advocate, or service provider. Every Arlington Waiver service provider is required to have an internal complaint resolution system. DMRS has also established a toll-free hotline (1-866-215-3743) to receive complaint reports directly from service recipients and their conservators.

Once a complaint is filed, DMRS begins to address the issues reported immediately and the agency has a performance target to ensure resolution of all complaints within 30 days. Since June of 2004, DMRS has met or exceeded this target timeframe for an average of 93% of the complaints filed.

Mortality Review System

DMRS has in place a comprehensive mortality review policy, the purpose of which is to provide information that could be used to reduce the mortality rate. All deaths that are unexpected or unexplained are reviewed by a regional mortality review committee. While health care information is critical to death reviews, efforts are made to consider the totality of services and to include quality of life issues in the discussions. The preventative intent of the DMRS mortality review process is underscored by the review minutes containing recommendations for systems improvements. Independent oversight of the DMRS mortality review system is provided through an annual review by the Columbus Organization.

Regional and Statewide Quality Management Committees

The real value of a quality management system is its ability to take action in response to its observations and data findings. In Tennessee, this action arm of the quality management system is comprised of a Statewide and the three Regional (West, Middle, and East Tennessee) Quality Management Committees (RQMC). The Regional Committees, which meet at least monthly, are chaired by the deputy regional directors of Tennessee's three regional offices, and the Statewide Quality Management Committee is chaired by the state Director of Compliance and meets monthly.

The RQMC relies heavily on Provider Compliance Reports to assess provider performance. These reports are updated on a monthly basis and families are encouraged to ask the West TN Regional Office for the report(s) on any provider(s) they may be interested in to serve their family member.

When data and other oversight activities suggest that a provider agency's performance is not satisfactory, the Regional Quality Management Committee sends an Agency Team to the agency to monitor services. The Team looks at the key health and safety issues by using a smaller version of the Quality Assurance Survey instrument known as the Targeted Elements Assessment. The Agency Teams report their findings to the Regional Quality Management Committee, which considers whether technical assistance or sanctions are warranted. Throughout this process, the Agency Team works closely with the provider to make sure the provider understands the issues and analyzes its own data in order to modify its Quality Improvement Plan to effect a positive change within its service delivery system.

The ongoing, predictable intervention and actions of the Statewide and Regional Office Quality Management Committees have had a profound impact on the overall culture of expectations within DMRS' community services system.

Data is analyzed on both regional and statewide levels to look for systemic trends so that the State can be proactive in finding solutions for issues impeding quality services. All of this scrutiny is in addition to oversight by other state agencies, such as the Departments of Health and Mental Health & Developmental Disabilities for licensure purposes, TennCare, and other outside sources, such as the Court Monitor.

CHAPTER 8

STRENGTHENING THE COMMUNITY SERVICE SYSTEM WORKFORCE

The heart of DMRS' community services network is its workforce, and especially the many direct support professionals who provide most of the direct services and supports to service recipients. As DMRS continues to expand its community services system, this workforce will need to grow, both in numbers and in skills and knowledge.

Direct support professionals come to the services network with interest and motivation, but often with little prior experience or education in meeting the service and support needs of individuals with mental retardation. Thus, effective and cost-efficient training programs to prepare them for their jobs are critical.

New On-Line Entry Level Training Program

Historically, DMRS has relied largely on an in-house, train-the-trainer model. This program relied upon DMRS curricula and trainers to provide training sessions for direct support professionals and their supervisors, as well as offering credentialing for provider agency personnel to become certified trainers of their own employees.

In recent years, the limitations of this program, especially in its core training offerings for new employees, have been recognized. Providers have found the program costly to deliver and they report that it presents barriers in bringing new employees into their workforce in a timely manner. There has also been criticism of the curricula, which many perceive as not sufficiently updated to meet the more comprehensive requirements of the DMRS Provider Manual. Finally, an essential flaw of the program has been its limitation in allowing employees to take their training certifications with them when they move from one provider agency to another. This limitation often resulted in costly re-training of already experienced employees.

For all of these reasons, in 2005 DMRS became determined to explore other options for its core training program for direct support professionals, and in July 2006 it decided to move to an on-line training program. In January 2007, DMRS awarded MC Strategies, Inc./College of Direct Support, a Knoxville-based staff development firm, the contract to develop and implement this program.

This learner-paced web-based training program will include nine courses which employees take on-line and it will assure competency certification by trained supervisors. The program started enrolling providers for orientation and training in May 2007 and more than 30 have completed these initial steps of the process.

The program relies on a curricula developed in conjunction with some of the most well-known experts in the mental retardation field, and its instructional design is tailored for adult learners. In particular, its on-line delivery approach will allow prospective employees to study at their own pace and to take courses at flexible times convenient to their schedules. The program will also assure a permanent database that will track employees' completed coursework and ensure that training credentials can be readily transferred with employees if they change employers.

This program will not, however, replace all of DMRS' existing training programs. Certification training for employees to administer medications in community supported living homes and special training programs designed to assist employees in meeting the needs of individuals with behavioral problems and physical and mealtime challenges will continue to be provided by DMRS.

The Home Manager Certification Program

DMRS is also committed to continue funding the Home Manager Certification Program, which is administered directly by Southwest Tennessee Community College and Jackson State Community College. This program, which has already graduated more than 100 certified home managers in West Tennessee, is widely recognized for its content, instructors, and the interaction it offers among employees of different residential provider agencies. The program offers graduates 15 college credits transferable to the community colleges' associate degree programs. Perhaps most important, this program has offered a predictable career ladder, with increased wages and benefits, to direct support professionals, encouraging them to stay in the field and become a part of mid-level management.

Participants in the Home Manager Certification Program are selected by their provider agency based on their performance and interest in advanced education. ADC has also nominated some of its direct support professionals to participate in the program. DMRS fully funds the costs for the community college tuition and books for all participants, and it provides an advisor who assists students in maneuvering in the community college environment. This package of assistance has helped the Home Manager Certification Program achieve one of the highest graduation rates of both community colleges' programs.

Attracting and Keeping the Best Direct Support Professionals

Together with the above initiatives, DMRS realizes that it must take direct steps to make jobs in its community services systems more attractive and beneficial to direct support professionals. Research clarifies that many factors influence the desirability of particular career paths and employment, but that certainly one is its monetary rewards. In the FY 2006, \$4.0 million in extra funds were allocated statewide for wage/benefit increases for direct support professionals.

Additional wage/benefit improvements may be within the reach of provider agencies if they are able to reduce turnover of direct support professionals in their community homes, and therefore reduce the additional costs for staff recruitment, training, and overtime due to turnover. In an effort to promote reduced turnover, DMRS is working with Tennessee's Direct Support Professional Association to research the incentives which tend to encourage employee tenure with provider agencies. This research is viewed as especially valuable since most employees who leave jobs with one community residential agency often take a position with another agency despite little or no difference in pay or benefits.

It is apparent that more viable career ladders for direct support professionals will be important to encourage employees to stay in the field and assure a more experienced and skilled workforce. The Home Manager Certification Program has already provided this opportunity for many direct support professionals in West Tennessee. Presently, DMRS is working collaboratively with the University of Memphis' Institute on Disabilities to develop additional similar career advancement programs.

DMRS Safe Workforce Initiatives

Other DMRS initiatives promote better assurances that only qualified workers are able to work in its community services system. Background check requirements are more comprehensive and DMRS is enforcing the use of the State Abuse Registry to ensure that workers who have been found guilty of serious acts of abuse or neglect in children, senior or mental retardation service systems are excluded from future employment with DMRS or any of its contracted provider agencies. These essential protection from harm safeguards help keep "bad apples" out of the workplace and they contribute to overall employee satisfaction.

CONCLUSION

As was stated in the Executive Preface, this closure plan is designed to be a “living” document, recognizing the possibility of changes, most notably in a service recipient’s needs and situation, and should allow for adjustments. Substantial alterations to this plan are subject to approval by the Court Monitor.

The commitments by the state will remain unchanged. These include, but are not limited to:

- Closing ADC;
- Developing and operating 12, four-bed community-based ICF/MR homes;
- Developing and operating a resource center;
- Ensuring a safe transition for all from ADC to the community, and;
- Establishing an endowment fund following the sale of the ADC property for the State to use, at its sole discretion, to benefit persons with developmental disabilities residing in West Tennessee.

This plan addresses priority issues in the closing of an ICF/MR facility and transition of service recipients into a community setting. Through stakeholder cooperation and commitment, successful implementation of this plan is assured. The result will be healthy, safe, and fulfilling lives for service recipients living in the community.