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Transitions from Institutions for Individuals with Intellectual and Developmental Disabilities in Oklahoma, Georgia, Tennessee and Alabama (8/15/16)

Oklahoma – Hissom 1994

Reason Closed	Timeline and Process	Outcomes and Follow-up	Important Lesson
• Lawsuit brought by parent group to improve conditions • Closure ordered by court in 1987, confirmed by federal appeals court in 1992	4-year timeline, last resident left 1994	Court-ordered independent monitoring of outcomes showed that all transitions were successful and many families initially opposed became advocates for community services and resulting quality of life. (See below)	Key to success was to work with each individual one at a time to determine needs will be met before discharge – Debbie Pumphrey, OKDHS

- Institutional vs. Community Services, 2012, by OKDHS in preparation for SORC/NORCE closures: https://www.ok.gov/governor/documents/FAQ%20Community%20Services%20-%20NORCE-SORC.pdf
- Tulsa World, April 2015: "30 Years Later" http://www.tulsaworld.com/news/local/years-later-after-the-lawsuit-that-shut-down-hissom-families/article_dafe58fb-7262-5a7f-a33f-3627fb16104.html

Oklahoma – SORC, NORCE 2015/2016

Reason Closed	Timeline and Process	Outcomes and Follow-up	Important Lesson
• Human Services Commission Resolution, Nov. 2012 • Expected overall cost savings • $35 million needed for capital repairs to be spent instead on community services for residents and waitlist	• Original timeline contingent on transition rate of residents, with projected end dates of 2014 (SORC) and 2015 (NORCE); will be completed July 2016 Process • Area Office Staff and Case Managers meet with each resident/family to determine needs and identify service options. • Case Managers assist family with choices and coordinate service providers. • Resource Center Staff familiar with resident, OCA Advocate, and the selected Community Providers become part of planning team. • Plan is approved by Transition Manager to ensure all services are in place and providers trained before leaving the facility.	• In 2014 OKDHS asked Oklahoma State University's Dr. Jones and Dr. Gallus to conduct 160 follow-up calls with families to determine supports and services needed by families during transition. • In 2015, OKDHS requested a follow up study: Dr. Jones and Dr. Gallus mailed 153 quantitative surveys to family guardians, and followed up with 19 qualitative interviews • Report published May 2016 – 14 moved from opposition to satisfaction; 5 did not have positive experience – Indentified 6 themes: 1. Respect our relative's history. 2. Collaborate: make us feel like	• "Remember, we're family, not professionals" – allow family, who are not immersed in current research, to emotionally process the transition – see link below for TASH Amplified interview with Dr. Gallus • Key to success was to work with each individual one at a time to determine needs will be met before discharge – Debbie Pumphrey

	• Weekly visits by case manager and plan reviewed and updated as necessary during 30 days of placement. • (See full Phase Down Plan, below)	we're part of the process. 3. Provide consistent care. 4. Provide quality care. 5. Include my family member in the community. 6. And then remember: we're family. We're not professionals. (See links for report, "Understanding Deinstitutionalization," below)	

- HSC November 2012 Resolution: http://www.okdhs.org/library/news/rel/Pages/comm11012012b.aspx
- Phase Down Plans for State Administered Resource Centers, January 2013: http://www.okdhs.org/okdhs%20pdf%20library/PhaseDownPlansStateAdminResCntr_ddsd_01102013.pdf
- "Understanding Deinstitutionalization: What Families Value and Desire in the Transition to Community Living" in Research and Practice for Persons with Severe Disabilities, Dr. Jennifer Jones and Dr. Kami Gallus, Oklahoma State University, April 8, 2016
- TASH Amplified interview transcript with Dr. Jones and Dr. Gallus at http://tash.org/blog/2016/05/13/matters-family-members-relative-transitions-community-living/
- Article discussed on Disability Scoop: https://www.disabilityscoop.com/2016/05/17/community-living-skeptics-change/22323
- Article available at: http://rps.sagepub.com/content/41/2/116.full.pdf+html

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Alabama

Reason Closed	Timeline and Process	Outcomes and Follow-up	Important Lesson/Keys to Success
• Initial voluntary closure of small facility in 1996 because of agency belief in HCBS • 2000 Wyatt Lawsuit settlement required downsizing of 3 facilities, 2003 voluntary decision by Commissioner/Asst Commissioners to consolidate to one center (Partlow) when no longer financially sustainable • 2011: Last facility, Partlow, closed for budgetary reasons when dropped to about 70 residents	• 1996 – handled by Regional Director and Regional Community Service Director; attrition and no admissions • 2003 closure timeline appr 9 months – Families given 3 options for residents: go home, community placement, or transfer to Partlow – Worked with families to determine needs and to place residents in home county and/or maintain connections from facility – Developed Personal Profile,	• Initial anger: families had always been told that residents needed specialized care provided in facility – facilities were safe; now being told residents can do anything and get jobs • No complaints from families that things turned out horrible • Most vocally critical family member now exceptionally pleased and offering assistance to other families • 2005 closures did NCI pre- and post-	• Involve residents in process earlier – 2005 closures put families in driver's seat • 2005 closures had support of Commissioner, Assistant Commissioners and Governor • 2005 closures simplified because Facility Directors all left at closure announcement, closure implemented under Acting Director • Advice: start early planning for court committed residents and residents

• Budgetary reasons for closure supported internal agency move to preference for community services	forwarded with ISP and records to Partlow or Regional Comm Svc Ofc to identify/develop providers/ placements – Move to 3-bed homes; a few 6 bed homes for special medical needs • 2011 Partlow closure: more people with complex needs: completed Health Risk Screening Tool (link below) • (see attached Transition Plan)	satisfaction surveys of residents and families (see attached Surveys) which provided feedback and data • New Commissioner in 2011 did not support full process/satisfaction survey • Political resistance to 2011 closure in Tuscaloosa from local city council/ commissioners: wanted to keep facilities to provide jobs/econ stability; most staff were eventually needed/accommodated in other Mental Illness facilities or with community providers	with complex medical/behavioral support needs allow agency/ providers time to develop supports • Had good relationship with and participation in process by National P&A Disability Rights advocacy group • Consider some way to examine/ support employee benefits packages of community providers absorbing displaced state facility staff – often much less than what state job provides

- Karen Green McGowan Health Risk Screening Tool: http://hrstonline.com/product/plan-development/

Source: Jeff Williams, Alabama Department of Health, Office of Quality Enhancement, 334-242-3454, jeff.williams@mh.alabama.gov, started career at Partlow facility, at state agency during closures of facilities, acting director of Partlow during closure

Tennessee – Nat T Winston DC, Arlington DC, Clover Bottom DC, Greene Valley DC

Reason Closed	Timeline and Process	Outcomes and Follow-up	Important Lesson/Key considerations for success
• Initial closures of Winston in 1998 and Arlington in 2010 were court ordered as a result of lawsuits • Closure of Clover Bottom in 2015 was voluntary as agency moved to HCBS • Scheduled closure of Green Valley in 2016 to end litigation as the agency moves to HCBS	• Timelines of 4 years for Arlington and 6 years for Clover Bottom included time to build 4-person homes in the community and address injunction to block voluntary closure of Clover Bottom • 2 years expected for Greene Valley • Steps included (see link below) – Developing provider community for additional service need – Family meetings, provider fairs, and opportunities for families to visit provider locations to help in	• Incredibly successful due to diligent transition planning and monitoring • Satisfactions surveys of former residents were required by lawsuit • Demonstrated success resulted in support from former critics	• Allowing time to dogmatically follow transition plan for each individual • Long term monitoring of placement • Cross-training of new staff

	decision making – Detailed Individual Support Transition Plan (ISTP) for each resident developed with resident, family, center management and transition team – Personal meetings to discuss residential options, transition process and steps – Assistance in choosing residential service model, provider agency and home – Assistance in choosing an independent support coordination agency (ISC) to monitor transition and the chosen supports and services – Enrollment in Select Community of Tennessee if eligible, transfer of SSI benefits and other funds – Set up of new home, cross-training of staff, final approval of ISTP, schedule closure meeting – Current staff care-giver accompanies resident to new home for a transition period and additional cross training • Post placement monitoring visits by Transition Team using ISTP monitoring tool and by ISC • Counseling and job training for affected staff at closing facility		

- Steps to closure process of Greene Valley Developmental Center: http://tn.gov/assets/entities/didd/attachments/GVDC_Closure_Plan_FINAL.pdf
- Success Story: http://tndidd.tumblr.com/post/99059888015/clark-blackwell-recently-had-a-successful
- Also see separate attached documents: Internal Operating Guidelines for Post Placement Monitoring, Master PPM (Post Placement Monitoring Tool), and Transition Checklist

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Georgia

Reason Closed	Timeline and Process	Outcomes and Follow-up	Important Lesson
• 2010 Settlement Agreement with Dept. of Justice required moving 150 persons/year from state institutions to more inclusive setting at a reasonable pace. • 2 hospitals were closed under this process, with DBHDD Commissioner halting transitions twice to address poor outcomes. • 2014 - began voluntary transitions from last ICF and one SNF into one targeted geographic area of the state (NE/Augusta) with no mention of closure – "it's the right thing to do"	• Transition process halted twice until internal assurances from Division of IDD to Executive Leadership could be made that process had been changed, and necessary Technical Assistance for support infrastructure and provider capacity were in place. • Developed Manual and 54-Step Process for transition (see attached) • Worked closely with family members and individuals who wanted to move • Used outside consultant: St. Louis-based Community Resource Alliance (CRA) to assist with revamping process and protocols	• Seen as key success in last 2.5 years • 30 transitions since December 2014, with all believed to be successful o No returns to state facility o Number of acute care hospital bed days remained normal for population o No actual outcomes reports • Deaths – difficult to quantify if they would have died in state facility, but were not unexpected based on age/ medical fragility • State Mortality Reports show no statistical increase in deaths	• Created dedicated Office of Transitions/Director of Transitions – single person accountable for outcomes, reports directly to/weekly meetings with Director of Division of Developmental Disabilities, intimately familiar with each individual being moved – level of vigilance is critical • Focus on transitions within/into one geographic area (NE/Augusta) • Engaged Case Management system much earlier: 60 days before transition • 54-Step Process Map with specific go/no-go decision points

Transition Manual – to be forwarded separately

54-Step Process Map for Transitions – to be forwarded separately

Georgia DBHDD 2015 Interim Quality Management Report: https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/DBHDD%202015%20Interim%20QM%20Report%20Final.pdf

ASO Behavioral Health Provider Update and Review: http://www.georgiacollaborative.com/providers/files/ASO-Behavioral-Health-Provider-Update-and-Review.pdf

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