

STATE CASE STUDIES¹

We have chosen nursing home closure processes in three states to highlight: Connecticut, Ohio and Wisconsin. Respondents to the first online survey were asked if they thought their state was a candidate for one of the “best practice states.” If they said yes, they were asked to explain why they believed that. These states were researched to see what might make them a best practice state. Public information on all other states were also researched for possible inclusion. While a number of states² may have been excellent choices for a best practice state, the three selected highlighted different best practices. In addition, after the detailed case studies, you will find a list of other states with good practices as well.

All three have a number of “best practices,” some of which seem to respond to the obstacles to a successful transition for nursing home residents identified by the survey respondents. In order to develop these case studies, interviews were held with all stakeholders, including state and local ombudsmen, consumer advocates, residents when possible, state regulatory authorities, Medicaid agencies, union representatives, and representatives of provider associations. Contact information for all individuals interviewed follows each case study.

Wisconsin’s and Connecticut’s case studies focus on their process with voluntary closures, while Ohio’s involves involuntary closures.

All three states developed and continue to improve their systems by bringing together several state agencies to focus on nursing home closures. Thus, Wisconsin brought together a workgroup consisting of the State Ombudsman, the Division of Long Term Care, the Department of Mental Health and Disability Rights to find ways to improve the system. The Connecticut Long Term Care Ombudsman Program, after a particularly complex closure, convened a Nursing Facility Closure Response Coalition. Various state agencies/programs were involved: Mental Health and Addiction Services, Developmental Disabilities, CT Legal Services, and the State Ombudsman. The Coalition’s mission was to develop a protocol to protect resident rights, provide legal representation and monitor the process as the facility closed. Ohio began an examination of its systems by holding a major retreat with a Kaizen event,³ which brought together all the state agencies together to discuss closure issues.

Ohio’s best practices lie on its creation of a resident relocation team that meets even when there is no home closing to constantly communicate and develop solutions to problems; its

¹ For entire study, see http://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF.

² You will find information on some of these states in the Appendix.

³ Kaizen is Japanese for “improvement.” Kaizen refers to activities that continuously improve all functions and involve all parties within the organization or state. It also applies to processes. It has been applied in healthcare, psychotherapy, life-coaching, government, banking, and other industries.

advance work, long before a nursing home is forced to close, at the time a facility is in danger of being terminated from the Medicare and Medicaid programs; its focus on the least restrictive setting; its help for facility staff; and its significant follow up with all relocated residents. Connecticut's best practices lie in its use of its certificate of need process. It can deny closure to an owner who wants to close if it finds it is not in the best interest of the public need and other state considerations. In addition, the state requires a public hearing before it can make a decision to approve or disapprove a request to close. It also has a new statute that mandates that the state ombudsman send a notice to all residents at the same time the provider applies to the state for approval to close to explain rights that residents have. Thus, they will get this notice at the same time they learn the possibility of closing.⁴ Wisconsin has put all its closure rules in statute which gives residents more protections. It has created, in statute, a "relocation specialist" within the State Ombudsman Office who functions whenever five or more residents are moved and oversees all closures in the state; it has developed a relocation team comprised of state agencies; it has held "lessons learned" meetings to discuss what it has learned from complicated closings; and a major focus is on transfer trauma and staffing issues, with a detailed manual outlining these issues.

The case studies discuss these all in detail. Following the case studies, you will find a list of a number of other states with innovative or interesting systems. The list includes a brief summary of these initiatives with contact information.

CASE STUDIES: BEST PRACTICES

OHIO

Involuntary Closures

Background

Bringing Together All State Entities to Develop New Protocols

Ohio's current process began with an examination of its old systems related to involuntary terminations. In 2013, Ohio decided it needed to improve its nursing home closure process and protocols. The state held a Kaizen Event. A Kaizen event refers to activities that continuously improve all functions and processes and involve all parties within the organization or state.

"The Kaizen event was crucial. It gave us a sense of the mission. You need a major retreat to build a mission." George Pelletier, Community Options Coordinator, PASRR Bureau, Department of Mental Health and Addiction Services

⁴ Public Act No. 16-8: An Act Concerning the Long-Term Care Ombudsman's Notice to Nursing Home Residents.

The event focused on the fact that:

“The current Nursing Home Quick Response Team (Team focusing on closures) process within the State Long-Term Care Ombudsman office at the Department of Aging can be unexpected, lacks coordination between several sister agencies and local partners, and has several layers of assessments. This creates a cumbersome process that can cause unnecessary trauma on nursing home residents during the relocation process.”⁵

According to the Ombudsman Project Coordinator, the system was not integrated with the other appropriate state agencies. The state needed a consistent approach from all agencies. In addition to a lack of integration, there was a concern that there was not enough time before a facility closed to help in the relocation.

Members of the core group attending this event included: the State Long-Term Care Ombudsman, the Ombudsman Project Coordinator, and staff from the Department of Medicaid (the primary liaison to the managed care organizations), the Department of Health, and the Department of Mental Health and Addiction Services. Later in the process, other representatives and agencies were added: a member from the Ohio Department of Aging’s Division of Community Living which hosts the senior Home and Community Based Services and Assisted Living Medicaid waivers; and the Ohio Department of Developmental Disabilities.

As a result of this week-long event a number of initiatives were developed:

- A standard process was created that they believed could be applied to any closure or termination;
- A shared web application was proposed to be used across agencies; and
- Primary decision-making was moved to the front of the process by bringing in Home Choice (Ohio’s Money Follow the Person program) to conduct assessments at the beginning of the process.

Specifically, the process was redesigned to ensure that:

- Different roles are played by different people depending on their expertise;
- Documents are shared throughout the process with all agencies;
- Everyone has access to the same information at the same time; and
- Home Choice (e.g., Money Follows the Person) assessments are conducted at the beginning of the process to ensure that residents will have an opportunity to move to the community.⁶

⁵ Lean Ohio Kaizen Event Fact Sheet, Ohio Department of Aging, November 1, 2013.

⁶ See, “Lean Ohio Kaizen Event Fact Sheet, November 1, 2013,” for details of the event in the Appendix

One of the initial changes the state made was to delegate the coordination of this new process to the State Ombudsman Office (from the Medicaid Office).⁷ This shifted the focus from the payer role to the advocacy role.⁸ Local ombudsmen had long been at the ground level in a facility closure, assisting residents in finding new locations and advocating for their rights. In this role, they worked with the regulatory arm of the Health Department to standardize the Team notification when a facility was facing termination. Now the State Ombudsman Office took the lead.

Current Process

A Resident Relocation Team, chaired by the State Ombudsman Office, includes the regulatory arm of the Department of Health (Bureau of Long Term Care), the Department of Aging, the Department of Mental Health and Addiction, the Department of Developmental Disabilities, and the Office of Medicaid. The Relocation Team coordinates the work of all the individual entities. This Team monitors closings.

The process begins when the Ohio Department of Health's Bureau of Long Term Care (regulatory bureau) sends an alert to the State Ombudsman when a facility reaches sixty days of a possible termination date. The Ombudsman Project Coordinator alerts the full Team. This alert starts a "data mining period." No action is taken at this time since the facility still has time to come back into compliance and remain open. Thus, sixty days prior to possible termination for an involuntary closure, the Team begins looking at data on all the individual residents.

The Department of Medicaid pulls together data on all the Medicaid residents in the home using the MDS (Minimum Data Set). This includes names, Medicaid numbers, diagnoses, etc. The local ombudsman adds data for non-Medicaid residents using the facility's census list and resident interviews. The Team looks at this data as well as PASRR (preadmission and resident review) data prepared by the Department of Mental Health and Addiction Services and the Department of Developmental Disabilities. The local ombudsman begins to visit the nursing home weekly. Still not notifying anyone about the possible closure, s/he begins to get to know the staff and residents better during this time.

All collected data is stored in a master spreadsheet by the Office of the State Long-Term Care Ombudsman and shared confidentially via ShareFile as needed. The spreadsheet uses standard headers so that it can be used as a mail merge source document for resident interview forms, resident notification letters, family/guardian notification letters, and follow up lists for post-transition resident activities.

⁷ This did not include any additional funding.

⁸ Interview with Julie Evers, Medicaid Health Systems Administrator 3, Office of Medicaid, Ohio, January 25, 2016.

The Team has weekly phone calls to discuss the possible closure as well as other issues related to closure. The regulatory division of the Department of Health keeps the Team up to date on the possibility of closure and how the facility is doing.⁹ If a managed long term care company has clients in the home, they are brought in as well. The Team develops letters that will go to residents if the facility, in fact, will close. The Ombudsman Project Coordinator begins to assign tasks to Team members as the closing becomes imminent. The Team notifies entities such as the agencies' communications and legislative staff, local mental health or developmental disabilities boards, the Social Security office, the facility pharmacy, the Mayor, County Commissioners, workforce development people (who will be speaking to staff), etc. Before the actual termination, the Team meets with the facility Administration to find out what their plan for closure is: how they will notify staff; what the contingency plans are for staff reductions; whether they will have meetings with the residents; etc. The facility is told that the relocation team will need a conference room to use during the closure process, as well as information from the facility.¹⁰

On the day of the termination, members of the Team visit the home to notify Medicaid or Medicare residents and families that they have thirty days to leave. Every resident is contacted one-on-one by a member of the Team. The Team member delivers the notification letter to each resident, explains the content of the letter and answers any questions. Then, members of the Team interview the residents using a list of uniform questions.¹¹ If a resident cannot be interviewed, calls are made to the families as quickly as possible. Residents are asked if there is anyone they want to move with and if they have any preference on where they might want to move. They are asked if they have any concerns such as their possessions, medication or special equipment, and whether they are smokers, veterans, etc. Residents who pay privately are given a letter from the State Long-Term Care Ombudsman explaining that the facility is losing their Medicare/Medicaid certification, but that they may be able to stay as long as the facility remains licensed, understanding that the facility will be losing residents and staff quickly.

Relevant findings from these interviews are added to the master spreadsheet for all team members to use in their work.

⁹ Interview with Jill Shonk, Bureau of Long Term Care, January 7, 2016.

¹⁰ Pre-planning takes a lot of time. Many homes come into compliance. We asked if all the work done in the pre-planning phase was worthwhile. According to Julie Evers it is: "More often than not, they do come into compliance, but we may have found other important issues such as related to PASRR or MFP."¹⁰

¹¹ See a copy of the resident form in Appendix

“When I was working on a closure, I got to know the residents as people. I was onsite every day or every other day. I got to know the family. Thus, I was able to help them find a placement that is both appropriate and where they wanted to go, where they would thrive. I was worried about transfer trauma. I was a consistent face and person in their life at a time when things did not seem consistent.” Tessa Burton, Ombudsman Quality Liaison

Residents and their families are given lists and descriptions of facilities that meet their needs based on their physical location, services offered and quality information. The Team refers residents and families to the web-based *Long-Term Care Consumer Guide* which includes inspection results and family and resident satisfaction survey scores for all the facilities they might consider.¹²

Shortly after, two teleconferences (one during the day and one at night) are held for anyone needing help; anyone can call in: residents or families. Members of the Team coordinate with one another to try to be onsite every day during the closure. For example, the Department of Health surveyors might alternate with the local long-term care ombudsman over a weekend. They get an updated census and status for every resident still in the home.

Ideally the closing facility then conducts safe and orderly discharges by:

- Giving the new providers resident records, physician orders, advance directives and family information.
- Making sure that the personal needs allowance accounts travel with the residents.
- Making sure that the personal property is packed in a dignified manner.

The receiving facilities arrange transportation.

The State Ombudsman monitors the discharges to ensure that these actions take place and solicits assistance from the Ohio Department of Health if needed. Sometimes the ombudsmen are called upon to engage with families and the receiving facilities to assist with packing and moving. Civil monetary penalties (CMP) monies have been used to purchase boxes for packing when the closing facility doesn't have any or proposes putting residents' things in plastic bags.

During chaotic transitions, it's an all-hands on deck approach for the Team by going through resident face sheets looking for family contact information and making calls to the families; calling neighboring facilities for capacity information and to find places that accept difficult to place residents, such as sex offenders. The Team has facilitated referrals being made to homes when the closing facility is slow to do so. Ombudsmen have sometimes positioned themselves

¹² See copies in the Appendix

at the door to the facility to direct traffic of moving trucks, families and media. Staff from all the agencies have helped with sorting documents, faxing paperwork, meeting with facility assessors, families, staff, etc. Ombudsmen have sought subpoenas to access residents' personal belongings and medical records after one home abruptly closed without distributing these items to residents upon discharge.¹³

Best Practices

Gathering of All Relevant State Agencies to Develop an Improved Process

As stated above, Ohio's current process began with an examination of its old systems related to involuntary terminations using an intensive Kaizen event with all relevant entities. Interviewees believe that this was necessary to develop a mission for all state agencies related to nursing home closures.

Formation of a Resident Relocation Team That Includes All Entities

The Resident Relocation Team that includes all the relevant state agencies is coordinated by the State Ombudsman Office. All members of the Team assist as needed. Residents with special needs (mental health diagnoses, developmental disabilities, private pay, and interest in living in the community) are assigned to team members based on their background, if needed. This includes the Medicaid Office, which participates actively – brainstorming solutions for an individual or helping make phone calls to other homes if needed at closure. One time the Medicaid staff had to tell a non-cooperative facility that it would not get reimbursement for its last 30 days if it did not cooperate.¹⁴

"There are no hats at that time." Jill Shonk, Bureau of Long Term Care.

"We focus on the residents. It doesn't matter which entity we come from." Jane Black, Project Director for the MFP.

Constant Communication and Team Work¹⁵

A weekly call is held by the Office of the State Long-Term Ombudsman with the entire team even if there is no imminent closure. They discuss issues related to closure. This permits them to come up with new ideas. One example: A facility closed abruptly and residents were asked to leave immediately. One of the team members (the local ombudsman) brought up that

¹³ Email with Erin Pettegrew, May 2, 2016.

¹⁴ Interview with Julie Evers, Medicaid Health System Administrator 3, Office of Medicaid.

¹⁵ Interview with Erin Pettegrew. September 29, 2015.

residents leaving so abruptly might lead to “transfer trauma.” This triggered the decision to develop training for the receiving facility on how to mitigate transfer trauma.¹⁶

“This structure is a forum for ideas.” George Pelletier,
Community Options Coordinator, Bureau of PASSR.

Being Prepared: Work before Any Actual Closing

The Resident Relocation Team is fully prepared for any closing. They begin their work sixty days before a potential closing.

Focus on Finding the Least Restrictive Setting

Before closure, Money Follows the Person (MFP) staff look for anyone who has an application in for community living or who has the potential for community living and flags those residents. They look at PASRR information as well as the referral question on the nursing home assessment (Minimum Data Set – MDS) that asks residents if they want to speak to someone outside the nursing home about receiving care in the community. If the MFP staff find anyone who answered “yes” to the referral question, they make the referral directly. Without mentioning a possible closure, they also look at anyone currently in the process of transitioning or who has started the process and stopped.¹⁷ Mental Health and Developmental Disabilities staff conduct a similar review of residents with mental health needs or developmental disabilities in the home.

During the closure, the PASRR Bureau may need to find a “transitional placement,” in a nursing home for a resident with high acuity mental health needs while the Bureau helps to set up a community placement. In that case, the Bureau follows that resident. The case is not closed until the resident is living in the community for one or two months.¹⁸

Even if a facility comes back into compliance, interviewees do not believe the work is useless or a waste of time. MFP staff will continue to work to see what residents could live in the community.¹⁹ Similarly, the PASRR Bureau will act on the information it receives. If it finds PASRR non-compliance, it will perform assessments and/or notify the local boards of mental health to bring in providers to participate in determining if some residents could live in the community.

¹⁶ Interview with George Pelletier, Community Options Coordinator, PASRR Bureau, Department of Mental Health and Addiction Services, February 18, 2016.

¹⁷ Interview with Jane Black, Project Director for the MFP, January 4, 2016.

¹⁸ Interview with George Pelletier.

¹⁹ Interview with Jane Black.

Help for Nursing Home Staff

The Team works with the Ohio Department of Job and Family Services which houses the Workforce Development functions in Ohio. This Department has a Rapid Response Office/Unit/Division that is notified by employers whenever there is a mass layoff. The Team takes the initiative and notifies them when a provider is closing. The notification is done informally because the closing may not meet Ohio's 'mass' quantities requirement for notification or the facility may not be aware of the requirement.²⁰

Follow Up

State Ombudsman representatives visit all relocated residents in their new homes to ensure they are settled, have all the services and medical care they need and that their personal belongings and Personal Needs Allowance/Social Security and other issues have been addressed. Two visits are the goal. They visit within a week or so of the transfer and again six months post transfer. Any resident still interested in community living who was not able to transition out of a nursing home will continue working with HOME Choice, the program that transitions eligible residents from institutional settings to home and community-based settings.

The state is beginning to apply this entire closure process to voluntary closures.

Future

New Initiative:

The state has decided it needs to focus on transfer trauma for all residents in all closures. After the training for the receiving nursing home staff on mitigating transfer trauma is piloted, the state will hold a debriefing and then work to incorporate and apply what has been learned to residents in voluntary as well as involuntary closures. This initiative is being led by George Pelletier, Community Options Coordinator, Bureau of PASSR, a member of the Relocation Team.

Issues Needing Discussion:

1. Sending a letter to the guardians or families if residents cannot understand the issues may be problematic because the Team may not have their contact information until it has access to the residents' face sheets, and the letters take a couple of days to get to them.²¹
2. Meeting with the facility before a closure to ask them their plans may not be as helpful as it could be because staff continue changing as the facility closes.²²

²⁰ Interview with Julie Evers and email with Erin Pettegrew.

²¹ Interview with Erin Pettegrew.

²² Ibid.

Contacts

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WISCONSIN

Voluntary Closures²³

Background

Bringing Together All State Entities to Develop New Protocols

Prior to the current system, Wisconsin had a method in place for nursing home closures that needed improvement. There seemed to be little protection for residents, and people were being moved hurriedly. The state became concerned about relocation stress, or transfer trauma.²⁴ To find ways to improve the closure process, the Division of Quality Assurance, of its Department of Health Services, convened a work group consisting of Division staff, the State Ombudsman, the Division of Long Term Care, the Division of Mental Health & Substance Abuse Services, and Disability Rights Wisconsin. Relocation teams (of sorts) predated the workgroup (as did the state statute authorizing them in closing facilities). The workgroup focused on

²³ Wisconsin rarely has involuntary closures.

²⁴ Interview with Dinh Tran, Division of Quality Assurance, January 7, 2016.

improving the team's processes by clarifying roles and activities, rewriting the department's manual and creating some resources. It did eventually result in the creation of (eventually two) relocation specialist positions that added considerable stability to the team process.²⁵

The efforts of the workgroup resulted in:

- Shifting responsibility for overseeing a closure from the regulatory agency to the Division of Long Term Care. This Division has a greater focus on community placements and is more directly linked to the funding sources for these less restrictive placements as well as the managed care organizations that are directly involved in the discharges.
- Development of a detailed "resident-centered" relocation manual, based on Wisconsin law.²⁶ Among the items included in the manual are:
 - Detailed responsibilities of a relocation team (see below).
 - Specific responsibilities for the administrator, Director of Nursing, designated resident relocation coordinator, social services, and the financial/business staff.
 - Resource materials to lessen transfer trauma.
 - A number of creative ways to enhance the closure process, such as: holding going away parties; shopping for things needed in the new setting; and with permission, sharing addresses of relocated residents and giving updates of how relocated residents are doing.

An addendum that includes how to conduct an individualized relocation process is being added to the manual.

Current Process

Under Wisconsin law, facilities relocating five or more residents must file a Resident Relocation Plan with the Division of Long Term Care. The state must respond within ten days or the plan is automatically approved (unless the state needs more information or clarification). The Relocation Team is asked to comment on the proposed plan before approval.

A facility cannot begin discharge planning for any of its residents until the Division of Long Term Care has approved the facility's Resident Relocation Plan.²⁷ Facilities are urged to meet with the Division of Long Term Care to discuss the requirements before submitting a plan. "It is crucial for facilities to involve and collaborate with the Department of Health Services, Division of Long Term Care, throughout this process. In addition, facilities contemplating closure or downsizing

²⁵ Email from Tom La Duke, Relocation specialist, May 3, 2016.

²⁶ Interview with Tom LaDuke, Relocation Specialist, December 1, 2015.

²⁷ Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities, November 1, 2010: Department of Health Services, Division of Long Term Care - <https://www.dhs.wisconsin.gov/relocation/index.htm>.

should thoroughly review all state and federal regulatory requirements, including those of the Department of Workforce Development, which may differ significantly from the requirements in other states.”²⁸

The Plan requires facilities to state how they will: mitigate relocation stress syndrome/transfer trauma; address special needs of persons with mental illness, intellectual and physical disabilities; address resident preference/choice for location settings; provide opportunity for the resident to visit potential alternate living arrangements and arrange for transportation; procure any needed medical equipment; involve the physician in the transition plan; work with residents and their families to resolve complaints or concerns; and, provide for all medical records to be transferred .²⁹

When a facility submits a relocation plan to the Division of Long Term Care, it includes a roster of residents and their needs. Once the plan is approved, the Relocation Team (Division of Long Term Care Relocation Specialist, managed care staff, Ombudsman Relocation Specialist for residents over the age of 60, Disability Rights Wisconsin for individuals under the age of 60, and Aging and Disability Resource Center(s) (or in some regions, the county human services system), meet to introduce the members to facility administration and discuss the rights of the residents. The provider is also given a chance to update the Team on the closure status and any potential obstacles.³⁰ The provider then sends a letter to the residents and families inviting them to a meeting. Not until just before the meeting is held, the Ombudsman Office also sends a letter to residents and families that states their rights during a closure.³¹

“The Team is strong. If a plan is not good, it is sent back.” Liz Ford,
Disability Rights Wisconsin.

All members of the Team participate in the initial (announcement/informational) meeting with residents and their families. Others who may be asked to review the plan or conduct onsite visits include the Division of Long Term Care, the Division of Quality Assurance, the Division of Mental Health and Substance Abuse Services, Area Administration, and the Office of Legal Counsel. Liaisons to the Team are IRIS Independent Consultant Agency (helps individuals under the Medicaid self-directed waiver), and any relevant insurance plans.³²

At this meeting, the Team discusses the reason for the closure, the kind of relocation assistance to be provided, options to be made available, and funding. Also discussed are the statutory and regulatory requirements (for safe and orderly transfers that avoid/reduce relocation stress); the

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

³¹ See sample Introductory Letter (Appendix) to residents and family members.

³² Relocation Manual.

state's role in monitoring the closure and each resident's relocation plan; the different roles of each team member and the kind of assistance each member can provide. The Team leaves contact information and literature,³³ and various team members follow up with posting and mailing introductory letters as well. The session ends with an opportunity for participants to ask questions and make appointments for subsequent meetings. Relocation planning meetings conducted by the closing facility and in conjunction with any managed care organization discussing resident condition and needs, options and choices are ongoing.³⁴ The Team meets weekly in person at or by phone with the closing facility and involves other stakeholders to ensure that: options counseling has occurred and that the outcome of that is reported; resident needs and preferences are considered; residents know their rights and those rights are protected throughout the closure. In addition, they seek to follow up on any relocation, particularly those that might have been problematic.

As the closure is implemented, the Team receives weekly reports on all relocations (to monitor for any obstacles and/or changes in condition, planning conferences, notices, referrals and assessments, tours and outcomes, actual transfers and the support given), hospital transfers (that are monitored until a final permanent alternate location is found,) and deaths.³⁵

The Team relies heavily on the providers and supports (sending and receiving facilities, care managers, family) to orchestrate the actual move. The Team's role is to monitor and direct the process rather than to actually carry out the responsibilities for the transfer. The advocates (Relocation Specialist from the Ombudsman Office and Disability Rights) try to (and do in large part) follow up on relocated residents and the Division of Quality Assurance (regulatory agency) has done so as well (in particular situations).

Part of the team's regular process for weekly updates is to obtain post discharge reports from both the closing facility and the care managers (for Medicaid enrollees). The Managed Care Organizations have follow up responsibilities at regular intervals after the move outlined in departmental policy and contracts with the state. The regional (local) ombudsmen may have casework as a result of the move that keeps them involved with certain relocated residents for a period of time as well. Volunteer ombudsmen are routinely informed/notified of and asked to follow up on residents relocating to their assigned (receiving) facilities.³⁶

Best Practices

Gathering of All Relevant State Agencies to Develop an Improved Process

As noted above, a work group consisting of the State Ombudsman, the Division of Long Term Care, the Division of Quality Assurance, the Division of Mental Health & Substance Abuse

³³ *Making the Right Choice, You Have Rights, A Voice for Residents Should Your Facility Close and Relocation Stress Awareness*: State Ombudsman Office.

³⁴ Interview with Kevin Coughlin, Policy Initiative Advisor Executive and Jessica Gross, Relocation Specialist, Division of Long Term Care, Department of Health Services, January 7, 2016.

³⁵ Email from Tom LaDuke, May 3, 2016.

³⁶ Email with Tom LaDuke, May 4, 2016.

Services, and Disability Rights Wisconsin, was convened by the Division of Quality Assurance (which had the role of overseeing closures at that time) to find ways to improve the process.

Creation of a Relocation Specialist within the State Ombudsman Office

The Board on Aging and Long Term Care (State Ombudsman Office) applied to the regulatory agency to use CMP (civil monetary penalty) funds to pay for a new position: a Relocation Specialist, housed in the State Ombudsman Office. This position became permanent with funds from the legislature.

The Relocation Specialist functions whenever five or more residents are moved for any reason such as a closure, closing of a unit, downsizing or renovation. This position lends consistency since it is a statewide position. “We can hit the ground running.”³⁷

As well as overseeing all closures in the state, the Ombudsman Relocation Specialist mentors and trains new local ombudsmen in their duties during a closure. The Relocation Specialist keeps an eye on the overall closure process; coordinates all ombudsman activities; and helps local ombudsmen where needed.

Protections are in Statute

The fact that all of the requirements are in statute is very important. It gives teeth to the rules.

“If a provider says he cannot manage to help residents tour potential new facilities, I can tell them that it is in the law and they have to follow the law.”

Tom LaDuke, Ombudsman Relocation Specialist

“It gives statute protection for residents.” Liz Ford, Disability Rights Wisconsin

Fundamentals of the Chapter-Fifty Relocation Plan Process,³⁸ created by the Ombudsman Relocation Specialist, lists the essentials of the mandates in the statute:

- The process must be person-directed with a focus on relocation stress mitigation (mitigating transfer trauma), and allow for plans that fully prepare the resident and subsequent providers.
- Residents must be provided with enough options that take proximity to friends/family into consideration.
- No resident can be forced to relocate to or remain in any placement without a court order.

³⁷ Interview with Thomas LaDuke, December 1, 2015.

³⁸ See Appendix for copy. This has been used in training with state agencies and will be added to the official manual in the near future.

- Residents must be offered opportunities to tour alternative living arrangements.
- Residents must be provided assistance and support with moving and should not have to bear the cost of relocation.

*Relocation Team*³⁹

The establishment of a Relocation Team is also in Wisconsin statute.⁴⁰ Relocation Team members have divergent roles and responsibilities although all are asked to review the proposed relocation plan.

“I spend quite a lot of time looking at the plan. I create a document with my comments and suggestions and speak to the Relocation Specialist in the Division of Long Term Care. Generally, my comments and suggestions are accepted.”

Tom LaDuke, Ombudsman Relocation Specialist.

The whole Team works together to provide the relocating resident with information on how to access and obtain resources, how to collaborate in the discharge planning process, and how to ensure assistance with the successful implementation of the resident’s discharge plan. Team members focus on diminishing the effects of transfer trauma. They educate the facility on what they have to do to mitigate the stress and regularly monitor for this. They discuss ideas such as: tailoring activities to address the changing environment and focus on move related events; arranging to tour examples of various residential options, holding “going away” parties, or shopping for things needed in a new setting such as household goods or arranging “drive-bys” of new living arrangements to help residents become oriented to new and unfamiliar locations. The manual lists a number of other ideas such as: posting, with permission, addresses of relocated residents, giving updates on how relocated residents are doing in their new homes, and providing training on Resident Relocation Stress Syndrome for residents’ families and other representatives.⁴¹

³⁹ Relocation Manual.

⁴⁰ Chapter 50, Wis. Stats.

⁴¹ Relocation Manual.

“We are all in this together. We want the best outcomes for the resident. Everyone comes to the table with their expertise. It is a group effort.” Otis Woods, Survey Director.

“Lessons Learned” Meetings

The Relocation Team holds “lessons learned meetings” after complicated closures to identify strengths of the process and areas needing further strengthening. At the beginning of the new process, these meetings were held after each closure; now, meetings are held less frequently. To prepare for the lessons learned sessions, the Ombudsman Relocation Specialist uses a worksheet⁴² that includes the sex and age of the resident, payment source, concerns during the relocation process, follow up, and any transfer trauma. After each “lessons learned meeting,” the state produces a report listing the issues and the outcomes of the closure.

“After each of the closures, the state discusses what could have been done better. This has led to changes over time. Collaboration is the key.” Kevin Coughlin, Policy Initiative Advisor Executive Division of Long Term Care, Department of Health Services.

Clear Definition of Roles⁴³

The Relocation Manual clearly details the role of each Team member.⁴⁴

The facility, managed care organizations: Prepare residents for relocation and help find placements that residents want.

Division of Long Term Care Relocation Specialist: Leads the team. Orients team members. Coordinates all activities and monitors the closing. Conducts the “Lessons Learned Meeting” when the closure is completed.

Ombudsman Office Relocation Specialist for residents over 60 years of age: Pulls together resources and keeps an eye on the process from a resident perspective. While the local ombudsman works on a case level, the Ombudsman Relocation Specialist focuses on systems advocacy. Examples of this include: providing communication to all, coordinating with the local

⁴² See Appendix for a copy of this outline.

⁴³ Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities, November 1, 2010: Department of Health Services, Division of Long Term Care.

⁴⁴ Ibid.

ombudsman, and liaising with the Division of Long Term Care's Relocation Specialist almost daily.⁴⁵

Disability Rights Wisconsin for residents under 60 years of age: Advocates for the placement in the least restrictive setting.

Survey Director: Becomes involved only when there are problems with facilities following the rules. When this happens, he or she would clarify the rules for the facilities.⁴⁶ The Survey Director is not a regular member of the Team.

Other members of the Team: Monitor efforts to relocate residents.

Timing: Depends on Number of Residents to be relocated

State law⁴⁷ mandates that the effective date of closing may not be earlier than 90 days from the date a relocation plan is approved if 5 to 50 residents are to be relocated, or 120 days from the date of the relocation plan if more than 50 residents are to be located. The facility must remain open until each resident is properly relocated. If all residents are appropriately relocated before 90 or 120 days, the facility may close.⁴⁸

Unique Inclusions in the Required Relocation Plan:⁴⁹ Focus on Resident Transfer Trauma and Staffing Issues

The "Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities," which includes all nursing home residents, identifies the critical importance of addressing resident transfer trauma and staffing issues.

Transfer trauma

The manual focuses on diminishing the effects of Relocation Stress Syndrome (RSS) or transfer trauma by including resources for staff training on how to identify and address RSS.⁵⁰ It also talks about designating staff to individual residents to monitor any stress during closure.

In addition, the manual discusses facility and state responsibilities during a closure.

Facility responsibilities: As part of its relocation plan, the closing facility must:

- Train staff on transfer trauma

⁴⁵ Tom La Duke, February 15, 2016.

⁴⁶ Interview with Otis Woods, Wisconsin Survey Director, Department of Health Services, February 1, 2016.

⁴⁷ Section 50.03(14)e, Wis.Stats, <http://www.legis.state.wi.us/rsb/stats.html>. For regulations - http://dhs.wisconsin.gov/rl_DSL/index.htm

⁴⁸ Resident Relocation Manual for Nursing Facilities Serving People with Developmental Disabilities Community Based Residential Facilities, November 1, 2010: Department of Health Services, Division of Long Term Care - <https://www.dhs.wisconsin.gov/relocation/index.htm>.

⁴⁹ Ibid.

⁵⁰ Ibid.

- Consider proximity to family in the relocation
- Give residents an opportunity to visit alternative settings, with staff to provide transportation and support them
- Make sure all belongings and clinical information have been transferred to the receiving facility

State responsibilities

- If a discharge far from family cannot be avoided, the state has to consider ways to alleviate any harm to the resident, such as considering options available for providing transportation to a spouse.

Additionally, the manual addresses the responsibilities of the receiving facility: “For receiving facilities/entities, the goal is to focus on the relocated resident and her/his needs and wishes in order to mitigate or minimize transfer trauma/relocation stress syndrome after relocation.”⁵¹ The receiving facility is given suggestions on how to lessen any trauma.

Staffing issues

The manual highlights the need to respond to employee stress and possible staff shortages by requiring the facility to explain how it will inform staff of the plans for facility closure or downsizing and the relocation of residents. The relocation plan must state how the facility will address staff stress at the loss of jobs and relationships and how the facility will act to retain necessary staff to facilitate resident care.⁵²

“We have spoken to staff sometimes before we speak to the residents or families to emphasize their need to help the resident and stay committed to their job.” Kevin Coughlin, Policy Initiative Advisor and Jessica Gross, Relocation Specialist, Division of Long Term Care, Department of Health Services

⁵¹ Relocation Manual.

⁵² Relocation Manual.

Use of CMP funds

If the state takes over a facility through a receivership order (in cases where there is an immediate threat to residents), it might use CMP funds to hire a consulting and management firm to help with the closure.⁵³

FUTURE

The state is working to address the following issues:

- How best to advise residents and families. Since the meeting to announce the closing to residents and families occurs about a week after the plan is approved, many residents and families have already heard the rumors. Many leave or are very upset by the time the meeting is held.
- How best to help a resident with dementia to participate in the discharge planning and how to get providers and families to agree to their participation.

CONTACTS

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⁵³ Interview with Lisa Thomson, Pathway Health, Independent Consulting and Management firm. Such a firm might also be hired by a facility itself to help, using facility funds.

CONNECTICUT

Voluntary Closures

Background

Bringing Together All State Entities to Develop New Protocols

In 1999, during a complicated closing in Bridgeport, Connecticut, the Connecticut Long Term Care Ombudsman Program convened a Nursing Facility Closure Response Coalition. Various state agencies were involved, such as the Department of Mental Health and Addiction Services, the Department of Developmental Disabilities, the Office of the State Long-Term Care Ombudsman, as well as Connecticut Legal Services. The mission of the Coalition was to develop a protocol to protect resident rights, provide legal representation and monitor the process as a facility closed.

A study, conducted by Waldo Klein, Ph.D., MSW, confirmed that the intervention by the Ombudsman Program and the Nursing Facility Closure Response Coalition during this complicated closure that led to convening the Coalition, lessened the difficulties faced by residents. As a result of these findings, the Ombudsman Program developed a Nursing Facility Relocation Plan to act as a guide for future closures. This plan is the foundation of the current process, but will evolve and change as needed.

Current Process⁵⁴

Unlike most states, Connecticut can deny a facility's request to close. The facility must send a letter of intent requesting an Application for Approval to Close to the Certificate of Need and Rate Setting Division of the Department of Social Services (Medicaid Agency), Division of Health Care Services. This division evaluates the request on a number of different criteria: the relationship of the request to the state health plan; the financial feasibility of the request and its impact on the nursing home's financial condition; the impact of the closure on quality, accessibility and cost-effectiveness of health care in the region; utilization statistics; the business interest of the owners and partners; and any other factor the Department believes is important.⁵⁵

At the same time the facility sends its request to the state, Connecticut law requires the facility to notify residents, families and the Ombudsman Program of its intent to seek approval to close.⁵⁶ The notice letter must state that the Department has 90 days to make a decision to

⁵⁴ Interviews with Dawn Lambert, Project Director for Medicaid Rebalancing Initiative and Mairead Painter, Manager, Department of Social Services, February 1, 2016 and Nancy Shaffer, State Ombudsman, November 23, 2015.

⁵⁵ Department of Social Services: Decision in the matter of: Docket Number 10-710, Courtland Gardens Health Center, Inc. July 1, 2010.

⁵⁶ Conn. Gen. Stat. §17b-352.

approve or reject the request, that no resident can be involuntarily transferred during this time, and that all residents have the right to appeal any proposed discharge. A notice also goes up in the nursing home and is sent to newspapers in the area.

Next, the nursing home sets up family and resident meetings within a week or two to discuss the request to close. The purpose of the meeting is to explain the process, to assure residents that they have certain rights during the process and that they have the opportunity to make informed choices if the home is granted closure from the Department of Social Services.

The process of bringing together the various state agencies together is in flux. Historically, the Ombudsman Program initiated bringing the various state agencies together for a meeting with the residents and families. Over the years the process has evolved. A few years ago the head of the Medicaid Rebalancing Initiative (Money Follows the Person - MFP) and the Ombudsman Program conducted joint meetings when they had a group of four homes closing at one time. As the state has moved more and more towards encouraging individuals to receive care in the community, the process is changing and the state will be determining whether there is a need to redesign this part of the process. For now, MFP and the Ombudsman Program are undertaking this task.

A public hearing is then held, usually at the nursing home with a two-week notice (notice of the hearing is also put in newspapers). Once the public hearing is completed, the Department of Social Services reviews the hearing testimony and the certificate of need information. If the Department grants approval, the facility generally will close in 3-5 months.

Every resident is assessed and informed of their rights such as the right to choose, right to a discharge notice, the right to appeal the transfer, etc.⁵⁷ The Medicaid Rebalancing Initiative, (Money Follows the Person) immediately brings in transition coordinators and case managers, making sure that every individual knows their options to receive care in the community. In fact, MFP staff are often in the facility assessing residents for transition to the community as soon as the request for closure is sent by the facility to the state.

A specialized case manager is assigned to every resident; a transition coordinator develops the community plan if warranted. The case manager and transition coordinator talk to everyone. They do not rely on records. The State also pays for transportation to permit residents to visit other homes and alternative placements. This is part of the state's Informed Choice initiative (see below).⁵⁸

The Ombudsman Program monitors the process and focuses on ensuring residents are not encouraged to transition to other nursing homes prematurely. It provides information on

⁵⁷ See, "Nursing Home Closing – Resident Rights and Options," Connecticut Legal Services, Inc., in Appendix.

⁵⁸ Interviews with Dawn Lambert, Project Director for Medicaid Rebalancing Initiative and Mairead Painter, Manager, Department of Social Services, February 1, 2016 and Nancy Shaffer, State Ombudsman, November 23, 2015.

choices to residents and families; assists in their visiting other locations; and monitors the discharge plans, the upkeep of the home and the staffing levels. Ombudsmen make sure that residents understand they have the right to refuse a transfer. If a home the resident prefers has a bed, but doesn't want to take the resident, legal staff from the ombudsman office might call the home and remind them of their responsibility based upon state statutes⁵⁹. In the past, they have also negotiated with a home to take a resident into a short term bed until a long term bed is available; worked with families that might be in disagreement; and monitored discharge plans. The State Ombudsman Office has developed checklists for residents and families on how to compare homes during on-site visits, as well as a Resident Belongings Packing List to help when packing up to leave.

If applicable, the Department of Mental Health and Addiction Services will come in and work with residents to determine their needs and placements.⁶⁰ A face-to-face assessment and interview is conducted with the resident and guardian to: discuss needs, give information about resources, and discuss returning to the community. If the resident is going to another nursing home, "we research the homes that have more experience with the needs of these residents."⁶¹ They often take residents to view other living situations, such as residential care homes.

If the Ombudsman notifies Connecticut Legal Services that they are needed, staff will go in (sometimes with the Ombudsman) to talk to residents on Medicaid about their legal rights.⁶²

Each agency works separately unless there is a need to coordinate.

"If a nursing home refuses to take a resident, we might call the home that is refusing. We might set up an appointment with the resident at that home so the facility can meet the resident (before they reject). This might make a difference." Jennifer Glick, Director of the Department of Mental Health and Addiction Services

Best Practices

State Can Deny a Facility's Request to Close

State law requires that a nursing home facility that wants to close receive CON (certificate of need) approval to terminate services.⁶³ Although it has not been used often, the state can stop a closure. While most states say they cannot stop a provider from closing a home, Connecticut

⁵⁹ Connecticut General Statute 17b-352

⁶⁰ Interview with Jennifer Glick, Director, Department of Mental Health and Addiction Services, February 1, 2016.

⁶¹ Ibid.

⁶² Interview with Kevin Brophy, Director of Elder Law, CT Legal Services, February 2, 2016.

⁶³ Conn. Gen. Stat. §17b-352. Massachusetts has recently passed a similar law.

law gives the state the power to say “no” based upon public need as well as other considerations (see above).

There are two situations where the decision-making by the state is limited.

- 1) If a facility files for bankruptcy. When this occurs, decisions are made in federal court.
- 2) When the state believes there is an immediate jeopardy for residents because the facility has run out of money and cannot and is not paying its bills. In these circumstances, the state, with the understanding that the provider will not object, applies to court to put in a receiver who will decide on the closure.⁶⁴

In the last five years, there have been 13 closures: 3 bankruptcies, 5 receiverships and 5 CON requests.⁶⁵

“We denied one a few years ago; it was determined that it was financially viable and we needed the beds. We forced them to sell.” Chris Lavigne, Director of Reimbursement and Certificate of Need, Department of Social Services, Division of Health Care Services

Mandated Public Hearing⁶⁶

Under Connecticut law, the Department of Social Services must hold a public hearing before making a decision to approve or deny a closure. The hearing is run by a hearing officer and is recorded by a reporter. The application is on the Department’s website for review before the hearing. The provider presents his/her case and can be asked questions by the hearing officer. These questions can range from how the facility tried to become financially viable to how it will conduct discharge planning if it closes. This permits residents and others to speak or submit written information about the closure at the public hearing for consideration by the state. It

⁶⁴ Rich Wysocki, Principal Cost Analyst, Department of Social Services, February 25, 2016.

⁶⁵ Ibid, February 2, 2016.

⁶⁶ While many people believe this is a best practice because it slows down the process and permits residents and others to let the state know how the closure will impact them, the state’s rate setting director believes that it can put stress on residents and it opens the door for out of state providers to come in and look for a “fire sale.” He is concerned about the fact that if these new owners fail, the residents will have to go through another long process. He has begun to analyze the record of success and failure when the nursing homes are sold to out of state providers. In addition, he believes that Connecticut has too many nursing home beds and the state wants to rebalance. Interview with Chris Lavigne, Director of Reimbursement and Certificate of Need, Department of Social Services, Division of Health Care Services, January 26, 2016.

also slows up the process to permit more time for residents to find new placements if the facility does close. There must be at least two weeks' notice before the public hearing.⁶⁷

“The public hearing mandate is very helpful. It gives the people most affected the opportunity to participate.” Deborah Chernoff, Public Policy Director, New England Health Employees Union, District 1199, SEIU.

If the Department denies a request to close, the facility may be forced to sell at a loss or turn the facility over to the state. While the Department rarely denies a request, it can happen. In one instance, a concerted effort by the residents, families, community and union at the public hearing resulted in the Department refusing to grant a facility closure.⁶⁸

As discussed above, there is a limitation of the best practice of holding a hearing. If a facility is facing possible closure due to a filing of bankruptcy or appointment of a receiver, no public hearing is required. The Federal Court in a bankruptcy proceeding might ask residents and families to testify, depending on the case. In a receivership, as noted above, the receiver makes the decision whether to close the facility. There is no requirement to hold a hearing.⁶⁹

“We need to hear from you in order to help us make a decision on this nursing home.”

Hearing officer Rich Wysocki, Principal Cost Analyst, Department of Social Services – Wethersfield Health Center Hearing: November 10, 2011

Here are some selections of testimony by residents at a hearing:⁷⁰

“I'm sure you are aware judge, that if you approve the closure of Wethersfield Health Care Center you are breaking up a family; my family. I don't care where I'm placed, but I want my roommate to come with me. We have a bond. And she has flourished as a result of our being roommates. I worry she will regress once you remove us from our home together.”

⁶⁷ Chapter 368v* Health Care Institutions, Sec. 19a-486.e.

⁶⁸ Interview with Deborah Chernoff, Public Policy Director, New England Employees Union, District 1199, SEIU, February 2, 2016.

⁶⁹ **Conn. General Statutes, Chapter 368v*, Health Care Institutions, 19 a - 545.**

⁷⁰Wethersfield Health Care Center, Date Taken: November 10, 2011

“I don't want to leave because I like the staff. The programs are fun. This is a good place to live. We are going to have to leave our friends. I don't want to leave my home.”

“I am concerned as to where I will be placed. I would like to be placed with my relatives who live in New London. I enjoy my staff and everyone I come in contact with. I would not want to lose that. I don't want my home taken away from me.”

“At this time in our lives we should not have to lose what we have now. We want to stay. This is my home. No one has a right to take it away from me.”

Waiving Wait Lists and Enabling Residents to Move to Their First Choice Facility

Within the last few years, Connecticut has instituted additional measures to enhance resident choice of facility during a closure.⁷¹ For example, residents who wish to be admitted to a nursing home with a waiting list are permitted to bypass the waiting list. Furthermore, residents seeking admission to a facility with no vacancies can move to that facility within 60 days of their transfer if a room becomes available. While residents in that situation must first transfer to another facility, it still gives them a chance to eventually live in the home of their choice.

Informed Choice Process for Nursing Facilities⁷²

The Department of Social Services has initiated an “Informed Choice” process for nursing homes. The goals are to:

- Find out the client’s individual preference for where they wish to receive care.
- Provide access to information about community options.
- Have the Universal Assessment completed and explore an individualized community care plan option for each individual.
- Provide an opportunity for an individual to move to the desired and most integrated setting appropriate to their needs.
- Consistently document the resident’s preferences.

This initiative focuses on residents generally, not just in situations where facilities close. However, according to Mairead Painter, Manager, Department of Social Services, this initiative frames how they work with residents when a facility gets an approval to close.⁷³

⁷¹ Senate Bill No. 1127, Public Act No. 11-233.

⁷² See Appendix for a copy of this initiative.

⁷³ Interview on February 1, 2016.

Letter to Provide Additional Information to Residents on Their Rights and Services Available

The State Ombudsman has been concerned that once the facility notifies her and residents and families that it has applied for approval to close, many residents and families will panic before she can get in to make sure they understand their rights. The facility may be half empty by the time she arrives to give information. In May 2016, she was successful in getting legislation passed requiring that a letter be sent from the Ombudsman Program at the same time (or with) the facility letter. The ombudsman letter will provide further explanation of the closure process, residents' rights, etc. "Often times, many residents have already discharged to other nursing homes by the time this public hearing is held... The facility's letter presents only the facility/business's perspective and usually has strong language that gives the sense there is no alternative but to close. This initial message can be devastating to the resident and family. Therefore, balancing that message with the assurance that the residents have rights and protections needs to be heard at the same time. The addition of this letter from the Office of the State Ombudsman will present a more balanced picture to the residents and their families of what is happening, their rights and protections and advises them that they can take time and not be rushed into any decisions."⁷⁴

FUTURE

1. Connecticut had a statutorily mandated Nursing Home Financial Advisory Council made up of representatives from the licensure and investigation agency, ombudsman program, provider community, Medicaid agency, and Governor's Office of Policy and Management.⁷⁵ This council has been recently convened. Under the statute, the Council will examine the financial solvency of and quality care provided by nursing homes. Committee responsibilities include (1) evaluating any information and data available, including, but not limited to: (A) quality of care, (B) acuity, (C) census, and (D) staffing levels of nursing homes operating in the state, to assess the overall infrastructure and projected needs of such homes, and (2) recommending appropriate action consistent with the goals, strategies, and long-term care needs set forth in the strategic plan developed in statute. This Council has just become active. It meets quarterly. It has begun talking about the climate of homes going into receivership and out-of-state owners coming in. In the future it will examine incentives that can be built into the system related to financial issues, quality and oversight of the industry.
2. New statutory guidelines for Money Follows the Person requires them to get involved early in the Medicaid process. MFP staff have become very adept at nursing home transitions. This has given them an opportunity to regroup and think about a redesign of the closure process and the roles of MFP and the Ombudsman Program. They will be working on this in the future.

⁷⁴ Agency Legislative Proposal – 2016 Session: 11302015_SDA_LTCOP/CON.

⁷⁵ Public Act 14-55, section 2 [1] and section 17-339 of the Connecticut General Statutes.

- Union representatives⁷⁶ are concerned that once a home requests approval to close, the outcome seems inevitable. It believes Connecticut should think about how it let a home get to the stage where it feels it has to close. The state needs a better plan of assessing needs in the different parts of the state and not just focus on shrinking the number of beds in the state.

CONTACTS

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⁷⁶ Interview with Deborah Chernoff, Public Policy Director, New England Employees Union, District 1199, SEIU, February 2, 2016.

Other Innovative Practices in State Nursing Home Closure Protocols

While Connecticut, Ohio, and Wisconsin have a number of “best practices,” that we described in our detailed case studies, other states offer innovative and interesting systems or procedures related to nursing home closures. We have described some of these practices below⁷⁷. These approaches are certainly not inclusive of all innovative practices around the country, but this information can serve as a resource for advocates and states seeking to improve their nursing home closure process. This list includes a brief summary of these state initiatives with contact information.

Iowa

In Iowa, a closure team handles the process of closing a nursing home. The team consists of the Department of Inspections and Appeals (DIA), the Office of the State Long-Term Care Ombudsman (OSLTCO), Iowa Medicaid Enterprise (IME), and Disability Rights Iowa (DRI). DIA leads the team and conducts weekly meetings.

One of the most common challenges that closure teams face in Iowa is dwindling staff and supplies. DIA monitors staffing levels during the closure process. If staff members are quitting, the team requests the facility obtain temporary staffing for the closure. The facility can obtain the temporary staffing through temporary health care professional staffing agencies.

Iowa also has a unique practice of employing a discharge specialist to handle involuntary discharge/transfer notices. In the nursing home closure process, the discharge specialist participates in the following: (1) family and resident meetings when closure is discussed; (2) on-site visits, and (3) scheduled closure calls. In one-on-one meetings, the discharge specialist assists residents and their decision-makers with how the closure will impact them. In addition, the discharge specialist follows up with the residents after the move to determine if the transition was successful and to help the resident with any issues. Throughout the closure, the specialist provides advocacy for residents to maintain their rights and ensure their desires and needs are met.

Iowa has one another unique practice: during Iowa’s nursing home closure process, the closure team may utilize CMP funds to pay for expenses associated with the relocation to other facilities. Transportation expenses are an example of a covered expense.

For more information, contact:

Cynthia Pederson, JD
Discharge Specialist
Office of the Iowa State Long-Term Care Ombudsman

⁷⁷ Most of these states were identified by the respondents to the on-line survey.

515-393-1710

Cynthia.Pederson@iowa.gov

Michigan

A complete guide to Michigan's nursing home closure practices can be found in, "Best Practices for Regulatory Nursing Facility Closure," a manual created by the Michigan Nursing Facility State Closure Team.⁷⁸

In Michigan, special emphasis is placed on finding out and fulfilling the residents' needs and preferences during the closure process. Members of the team, including adult service workers and disability network staff, are assigned residents to work with. After assignment, the team member meets with the resident and family to inform the resident of the relocation options available: (1) relocation to another nursing home, (2) return to the community through a waiver program, or (3) relocation to an adult foster home or home for the elderly. Residents and families are asked to identify their top choices. These choices are then put into a "fax packet" and requests for admission are faxed to the selected places. Residents can choose where they go after being accepted to any of their choices. If none of their choices are able to accept them, team members work with residents to come up with additional choices for relocation. The "fax packet" can be found in the "Best Practices for Regulatory Nursing Facility Closures" manual Michigan created.

The closure team, which sets up a location in the facility to work, ensures that the residents' needs are being met by having the teamwork area be open and accessible to residents. Often times, team meetings are held in an activity room or a dining room. State team members stay into the evening so that they can walk the halls and get to know the residents better. Team meetings are held daily in order to keep the most current log of information (fax packets, responses from facilities, and requests for additional information). With this updated information, every team member is able to help a resident with any question or problem the resident may have.

In addition, near the end of the closure, the team consolidates the remaining residents in the same hall of the facility. The closure team tries to keep roommates and friends together during the consolidation. To help keep the residents' spirits up and keep them engaged, the team requests special meals for the residents, including their favorite foods, and they host special activities. In order to ensure that there are never only two residents remaining in the facility, the team holds the last five residents together until the last one has been placed. This way, they can all leave on the same day and no one is the last to go.

⁷⁸ See Appendix.

Forty-eight hours after the resident has moved, a team member does a follow-up by telephone with the Director of Nursing, unit manager, social worker, or other staff member at the receiving facility to make sure the individual is adjusting well to the new setting. Often, multiple residents will move to a new facility together. If there are any questions or concerns, a team member and familiar face will attempt to resolve the problems in person.

For more information, contact:

Alison Hirschel
Michigan State LTC Ombudsman program
517-827-8023
hirschel@meji.org

Minnesota

Minnesota follows a detailed timeline when a nursing home intends to close. The facility must issue the first notice of closure to the Commissioner of Health, the Commissioner of Human Services, the county social services agency, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and any managed care organizations that contracted with Minnesota health care programs within the county where the nursing facility is located. Within five (5) working days of the first notice, the county must provide the nursing facility with the names, phone numbers, fax numbers, and emails of the persons that will be coordinating the county efforts. Within ten (10) days of the receipt of the first notice, the county must meet with the facility to develop a relocation plan. The Commissioner of Health, Commissioner of Human Services, Ombudsman for Long-Term Care, and Ombudsman for Mental Health and Mental Retardation are all given information about the date, time, and location of the meeting so that they may attend.

Minnesota has a helpful “Closure Planning and Resource Grid”⁷⁹ that delineates this timeline and the specific responsibilities that both the facility and county have during the closure process.

For more information, contact

Cheryl Hennen
State Long-Term Care Ombudsman
Minnesota Office of Ombudsman for Long-Term Care
651-431-2555
Cheryl.hennen@state.mn.us

⁷⁹ see Appendix

Pennsylvania

In Pennsylvania, the team responsible for coordinating the closure process includes but is not limited to:

- Department on Aging Bureau of Facility Licensure and Certification (for personal care homes),
- Mental Health Association,
- Disabilities Rights Network,
- Legal Services, and
- Area Agency on Aging.

Depending on the needs of the residents, the relocation team may include representatives from the Office of Adult Protective Services, Salvation Army, Red Cross, the police, or the District Attorney (if criminal charges are being filed). The Department on Aging Bureau of Facility Licensure and Certification leads the relocation team. The Salvation Army & Red Cross find space, provide clothing, and sometimes house residents if there is a need. All other agencies talk to the residents to determine their needs and choices and deal with other issues.

The relocation team tries to coordinate the effort so there is enough time for a smooth and stress-free closure. However, many times, a nursing home closure is an emergency and is very stressful for the residents. Ombudsmen attempt to mitigate relocation stress by planning and preparing for closures in advance.

For more information, contact:

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Rhode Island

In Rhode Island, ombudsmen focus on transferring each resident's personal property from one nursing home to another during the closure process. In this way, ombudsmen can ensure that all of the residents' personal belongings go with them on discharge day, including their PNA money and clothes. Residents' clothes are placed in grey laundry bags, which dissolve in the washer. Utilizing these grey laundry bags helps prevent the transfer of bed bugs to the new nursing facility during the relocation process.

In addition to personal property, Rhode Island ombudsmen place a special emphasis on accounting for each resident's medications. If there are scheduled drugs for pain, facility nurses

inventory the remaining medications at the closing facility and bring it to the new facility. This additional step is taken so that each resident does not have to wait for a physician to prescribe the medication at the new facility.

Ombudsmen also assist with completing change of address forms so that any benefits from the government are sent to the new facility.

After the discharge, the ombudsman's office monitors the residents for a month to ensure that their needs are being met at the new facility. If the residents are unhappy with their new placement, they are moved again.

For more information, contact:

Kathy Heren

State Long Term Care Ombudsman

Rhode Island Office of the State Long Term Care Ombudsman

The Alliance for Better Long Term Care

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South Carolina

The South Carolina Department of Health and Human Services convenes an interagency Emergency Response Task Force ("task force") when a nursing facility needs to be closed. The state long-term care ombudsman, local long-term care ombudsman, Protection and Advocacy for People with Disabilities, Department of Health and Environmental Control Licensure and Certifications, Adult Protective Services, and Medicaid representatives are frequently on the task force. The task force confirms roles and responsibilities and coordinates development of an action plan for resident relocation.

One of the first steps the task force takes is to compile a list of residents and information. Next, ombudsmen work with Medicaid to develop a letter informing residents, their representatives and family members about the impending closure. Ombudsmen then interview each resident and/or representative in person to find out where they wish to live after the closure, and the task force determines the availability of a bed in the resident's preferred facilities. The task force also considers how to pay for the residents' transportation before relocating residents. Generally, State Long-Term Care Ombudsman or local Long-Term Care Ombudsman Program representative take charge, meet with the team, and keep everyone updated on the status of the residents' placement.

To ensure that residents have at last the basics and their personal items when they move, each resident is given an "emergency relocation bag" that includes toiletries, light clothing, and an extra bag for packing their personal items.

Ombudsmen operating in the receiving region are notified of the transfer and expected to visit with residents within the first thirty (30) days of moving in.

For more information, contact:

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State Long Term Care Ombudsman

South Carolina Lieutenant Governor's Office on Aging

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Washington DC

Washington DC Ombudsman Program has a team including the assigned nursing home ombudsman, the ombudsman program manager, and about nine volunteers monitoring an ongoing closure. The Program has developed:

- a resident closure packet which includes among other things:
 - A Guide for Resident/Family /Guardian during Nursing Home Closure which includes a checklist and describes the major process.
 - A Resident Preferences Sheet that lists wake up times, sleeping aids, bathing preferences, etc. to help the staff at the new location.
- Volunteer Closure Packet which includes among other things:
 - An intake form
 - A Discharge and Transfer Procedures listing exactly what the volunteer is to do.

The Ombudsman Program is also utilizing regular family council meetings to ensure that the facility provides updates to the residents and family members as well as participation of the regulatory agency, the Medicaid agency and the DC office of Aging. Their office advocated for all these groups to attend so all family members and residents could understand their role during this closure.

Staff also invited Ombudsman from Virginia and Maryland to participate in the meeting to provide information about the nursing homes in neighboring jurisdictions. Through their advocacy, residents can now go to these out of state/contracted Medicaid facilities without having to go through a major process.

In addition, Washington DC's Code gives private right of action⁸⁰ to residents, resident's representative and the long term care ombudsman that gives them the right to bring an action in court for a temporary restraining order, preliminary injunction, or permanent injunction to

⁸⁰ Nursing & Community Residence Protection §44-1004.03, Subchapter IV. Private Rights of Action.
<https://beta.code.dccouncil.us/dc/council/code/titles/44/chapters/10/>.

enjoin a facility from violating any provision of the law. It also gives them the right of civil action for damages.

Subchapter II of this Code gives the resident, resident's representative and the long term care ombudsman the right to ask the Attorney General to petition the court for a receiver, or, if denied, to file the request themselves.⁸¹

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⁸¹ <https://beta.code.dccouncil.us/dc/council/code/sections/44-1002.03.html>.