Ohio | Department of Developmental Disabilities

Division of Legislative Affairs & Communications

John R. Kasich, Governor
John L. Martin, Director

Keith Faber, President Ohio Senate
Statehouse
1 Capitol Square, 2nd Floor
Columbus, Ohio 43215

Joe Schiavoni, Ohio Senate Minority Leader
Statehouse
1 Capitol Square, 3rd Floor
Columbus, Ohio 43215

Cliff Rosenberger, Speaker of the Ohio House
Riffe Center
77 South High Street
14th Floor
Columbus, Ohio 43215

Fred Strahorn, Ohio House Minority Leader
Riffe Center
77 South High Street
14th Floor
Columbus, Ohio 43215

Susan Ackerman, Executive Director Joint Medicaid Oversight Committee
77 South High Street
Concourse Level
Columbus, OH 43215

Dear President Faber, Speaker Rosenberger, Minority Leaders Schiavoni and Strahorn, and Director Ackerman:

On February 20, 2015, the Ohio Department of Developmental Disabilities (DODD) announced the closure of the Montgomery Developmental Center (MDC) and Youngstown Developmental Center (YDC), with operations scheduled to cease June 30, 2017.

Since February's announcement, DODD has sought to minimize the impact these closures could have on family members, guardians, and individuals by maintaining open lines of communication, including offering meetings to ensure everyone is fully informed about the closure process and available alternative housing options, which include: transfer to any of the eight remaining developmental centers, use of a state-funded waiver, access to a small public or privately-run intermediate care facility (ICF).

During the recent House negotiations for House Bill 483, DODD's Mid-Biennium Review legislation, an amendment was added requiring DODD to provide each of you a report on the status of the Department's efforts to find new homes for the residents of MDC and YDC.

Temporary Law section 751.20(B) states the report shall evaluate each of the following items:

(1) The availability and appropriateness of the care, including health care services, provided to each relocated resident in the resident's current residential setting;

(2) The appropriateness of the current living conditions of each relocated resident;

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(3) The number of times each relocated resident has since been transferred, discharged, or otherwise relocated to a different residential setting and the type of setting to which the resident has been relocated;

(4) Reports of death, significant bodily injury, hospital or nursing home stays, and arrests or detainments by law enforcement involving each relocated resident that occurred on or after the date of the resident's relocation and before the effective date of this section.

The attached report is organized according to the above mentioned items.

I am grateful to those who have already begun working with DODD to make these important housing decisions. While I am proud of the work our staff has done to ease the impact of this transition on residents of MDC and YDC, I am very sensitive to the fact that such changes can be difficult and it's the department's responsibility to ensure every individual we serve and their family member or guardian have the resources needed to make the best decision for their unique situation.

When you read the report, you will note the vast majority of people that have left MDC and YDC are satisfied with their new home. I thought I would take this opportunity to share a story about one individual and his family's move.

After many years at one of our closing centers, Joe[1] is back living in his hometown. His mother told us, he's always got a smile on his face. Joe's brother and sister live nearby, and he enjoys taking long walks (being pushed in his wheelchair) with them and his sister's dog.

It took months of planning, sharing information, and training new staff to ensure that Joe had a smooth transition. Time was needed to work with the local county board and housing authority to ensure Joe's housing needs were addressed. Capital assistance funds and rental assistance funds were utilized.

I'm happy to report this family is reunited and enjoying spending time together.

Stories like these are what we strive to achieve.

Please contact me if there are additional questions about this report or any of our efforts to better serve Ohioans with developmental disabilities.

Sincerely,

John L. Martin, Director

[1] The name has been changed to protect the identity of our former resident.

H.B 483 Status Report Related to the Closure of
Youngstown and Montgomery Developmental Centers

This report updates the progress of the Ohio Department of Developmental Disabilities (DODD) to relocate the residents from Youngstown Developmental Center (YDC) and Montgomery Developmental Center (MDC) whose closures were announced pursuant to section 5123.032 of the Revised Code. The report evaluates the four areas identified in H.B. 483, using data from the date of the announcement on **February 20, 2015 through May 31, 2016**[1].

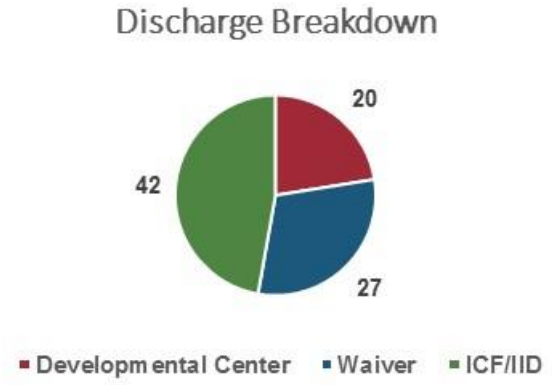
(1) The availability and appropriateness of the care, including health care services, provided to each relocated resident in the resident's current residential setting:

DODD believes that the availability and appropriateness of care related to people leaving centers has been excellent. Both the Dayton and Youngstown areas have long-term, well- established providers of residential and vocational services who have supported people with developmental disabilities for many years. Individuals, guardians, providers, and county boards do thorough discharge and transition planning based on each individual's needs and unique circumstances. These efforts have proven effective in providing smooth transitions to new living arrangements for everyone involved in the process.

Background:

Every resident and guardian of the closing developmental centers was given an option of choosing another developmental center[2], a public or private intermediate care facility for individuals with intellectual disabilities, or an Individual Options (IO) Waiver.

On February 20, 2015, a total of 176 people resided in the Youngstown and Montgomery centers. As of May 31st, 89 (51%) of those residents have transitioned to other living arrangements. The chart below offers a complete breakdown of where those individuals now reside.[3]



[1] Temporary law section 751.20 (HB 483) requires DODD "to prepare a report evaluating the progress of efforts since July 1, 2015…" The Department's report uses the February 20, 2015 announcement date as the starting point, thereby providing over four months of additional data.
[2] No residents were forced to leave state services.
[3] A total of five deaths occurred at Montgomery and Youngtown Developmental Center combined during the reporting period. These residents were **not** discharged and died at the centers.

Since the February 20, 2015 announcement, DODD leadership teams, comprised of staff from central office and Youngstown and Montgomery centers, have continuously met with individuals and small groups of guardians and family members to educate them on available service options. Additionally, provider fairs have been offered and tours of various available settings have been given to families to help them make the most informed decision regarding their loved one's future residence. The leadership teams also have met regularly with the county boards and local providers to ensure needs are being met and necessary services provided.

Measures taken to assure appropriate care:

After the closure announcement, DODD's registered nurse went to each center and every individual's medical and programming needs was reviewed and recommendations for appropriate services and supports were discussed to help the leadership team better understand and build upon available services in the community. Two staff members familiar with the people living at the centers were designated as dedicated transition coordinators to assist with all aspects of transition from the centers.

Ongoing monitoring of each individual to assist with a successful transition of supports and services occurs as follows:

- Face-to-face reviews in the individual's home are scheduled at 30 days, 90 days, 180 days, 1 year, 1 ½ years, 2 years and 3 years from discharge, and as needed or requested. These visits include a review of health care services and vocational, nutritional and environmental conditions. The primary purpose of these reviews is to ensure people are healthy, happy and safe. Guardianship surveys are completed at the same frequency.
- Should a concern arise, special discharge reviews can be requested.
- The guardian, individual, service provider, county board, and department staff develop a plan as a team to address any areas of concern with current services.
- DODD staff helps individuals, families and guardians manage a move to another home or developmental center if they feel there are on-going issues which cannot be overcome, or they are not satisfied or happy with their choice. To date, six people have returned to a non-closing developmental center.

The 2016-2017 Biennium Budget allowed DODD to secure additional funding for systems innovations. As an added incentive for a waiver provider to get additional training to meet the needs of people coming into their care, in September 2015, the department began offering opportunities for waiver providers to be reimbursed up to $500 per individual to allow new staff to participate in individual-specific training prior to the initiation of service delivery. The services include but are not limited to:

- Direct interaction with the individual transitioning to understand the person-centered-plan, wants, desires, expectations;
- Participation of direct service staff (direct care, nursing) in Individual Plan reviews, discharge/planning meetings;
- Identification and understanding of individual needs;
- Promoting the foundation of relationship building with the provider of future services.

Innovation funds are also available (up to $1,000 on top of up to $2,000 available via the HOME Choice program) to assist with startup costs for people moving to waiver services from the centers. Capital Housing funds have also been made available and can be used to purchase, renovate and makes homes accessible for individuals.

(2) The appropriateness of the current living conditions of each relocated resident:

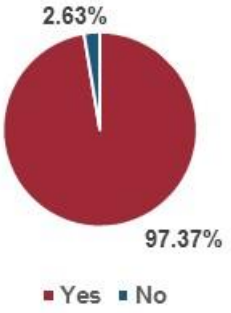
The data represented does not significantly differ from the satisfaction levels of people previously discharged from other development centers over the last six years. The data shows high satisfaction and only minimal dissatisfaction with new services and is consistent with our expectations.

DODD determines appropriateness of the new settings by doing surveys of the individuals/guardians who have left to see if they are satisfied.

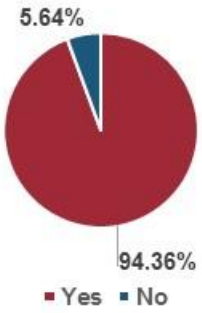
The following data applies to individuals who have moved from the closing centers to non-state operated settings. Community resource coordinators follow up on any issues identified in the surveys or visits until they are resolved.

INDIVIDUAL QUESTIONS FOLLOWING DISCHARGE

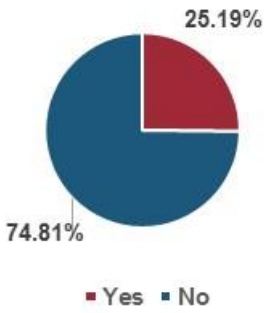
Are you happy living in your home?



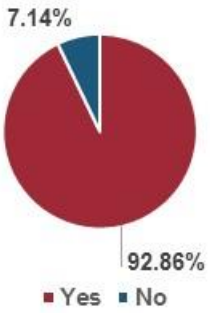
Do you feel safe in your home?



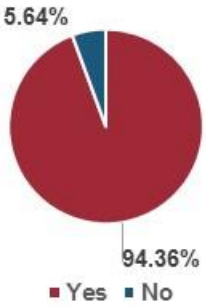
Have there been any behavior support concerns?



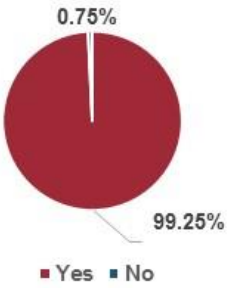
Is the individual currently attending Day Services/Employment?



Is current supervision level being maintained?

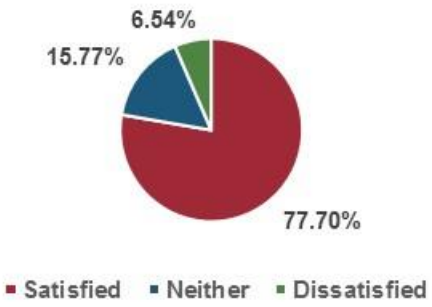


Has person been able to access necessary consultants (medical, dental, psych)?

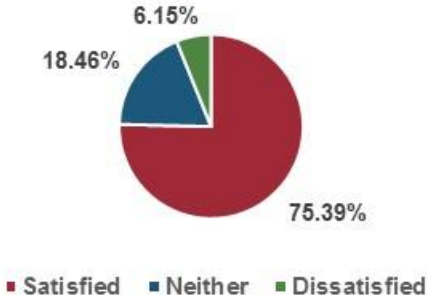


GUARDIAN QUESTIONS FOLLOWING DISCHARGE

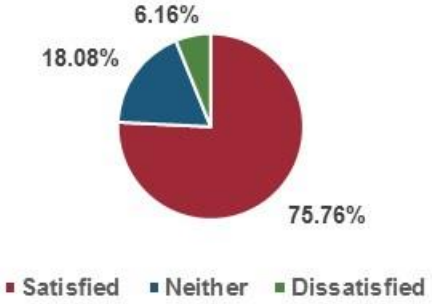
Q: How do you feel about the individual's current home?



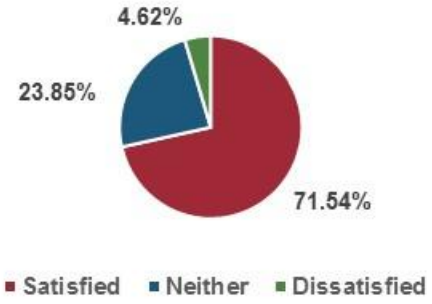
Q: How do you feel about the people who are providing day services, supported employment, or community employment?



Q: How do you feel about the individual's safety at home and/or their day services?



Q: How do you feel about the individual's degree of independence?



(3) The number of times each relocated resident has since been transferred, discharged, or otherwise relocated to a different residential setting and the type of setting to which the resident has been relocated:

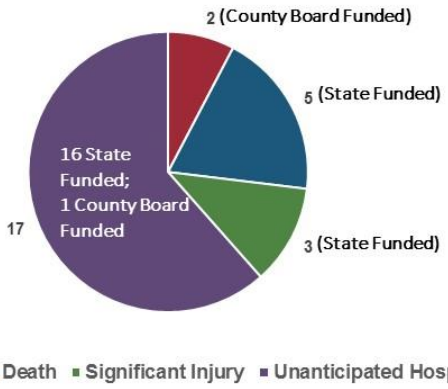
DODD does intensive follow along services for all people leaving developmental centers. Anyone who moves to a community setting and later decides they would prefer to return to a developmental center may do so upon request and approval. We have honored every request for readmission. The number of readmissions mirrors what DODD has observed in the past, unconnected to the closure of Youngstown and Dayton centers. DODD believes that allowing individuals to return to the centers, if needed, is a strength of the system. Doing so, provides a flexible approach that best meets the needs of the individual.

For the reporting period, 69 people have moved from the two closing centers into community settings. Out of the 69, six individuals returned to one of the eight remaining developmental centers following discharge from a closing center. Of those six, two were from homes receiving waiver services and four from an intermediate care facility. Further, four of the six were long-term admissions, while two were short-term/County Board funded admissions.[4] This readmission rate is 9% and consistent with expectations.

(4) Reports of death, significant bodily injury, hospital or nursing home stays, and arrests or detainments by law enforcement involving each relocated resident that occurred on or after the date of the resident's relocation and before the effective date of this section:

While all deaths are met with sadness, we do not believe the transitions contributed to the deaths that occurred. As the data indicates, we had the same number of deaths at the two closing centers, during the same time period, as we did persons who moved into the community. This percentage did not vary significantly from our death rate across our eight non-closing centers (32 deaths over this period). In summary, DODD believes there is a stronger correlation between age/health complications and death than transition. In each of these cases, the physician determined the deaths to be non-suspicious.

DODD's data tracking system monitors what we call major unusual incidents for all individuals served in our system. Of the individuals who left our centers, 27 individuals had incidents reported in four areas. Because of confidentiality issues, the data is provided in summary. Please note: If an individual is county board funded, they would have left the center irrespective of the closure, as these stays are short-term admissions.



[4] Short-term/County Board funded admissions are used for short stabilization to address individuals with challenging behavioral needs.

Law Enforcement: *When an individual served is charged, incarcerated or arrested*. Of the two individuals in this category, one was arrested for assault and the other for an outstanding domestic violence charge that occurred in 2011.

Significant Injury: *Injury of known or unknown origin (**not due to abuse/neglect**) that results in a broken bone, a concussion, five or more stitches or second/third degree burns*. In the three cases noted above, one was a sprained ankle, another was a broken toe and in the third case, a head injury resulted after self-removal of a seat belt.

Unanticipated Hospitalization: *Any unscheduled hospitalization that is not due to a pre-existing condition specified in the individual's service plan.* These include things such as going to an emergency room for congestion and getting admitted for suspected pneumonia. The reason for unanticipated hospitalization for the 17 individuals (23 incidents) noted above were: staff noted the person was not their self and/or was hospitalized for evaluation/observation (10), emesis (1), impaired respiration (1), infection (4), seizure (2), pneumonia/influenza (2), and psychiatric (3).

Every incident, irrespective of the type, is reviewed to assure that appropriate immediate action has been taken to protect the individual's health and welfare and that reports are consistently filed and investigated according to required protocols. Providers of service, in cooperation with county boards, work hard to implement effective prevention plans that result in positive outcomes for individuals.

EXPLANATIONS OF DEATHS THAT OCCURRED (Both Those Who Left the Centers and Those Who Stayed)

To provide context for reviewing the data on deaths, it is important to note that individuals with disabilities die, on average, at an earlier age than the general population because of the complexity of their needs and other health-related issues. In the DODD system, each death is reported, reviewed and investigated in accordance with rule (5123:2-17-02) protocols, which includes notification of the coroner. In addition, DODD Physicians review all deaths for persons receiving waiver services and those who live in an intermediate care facility or developmental center to address any quality of care issues that require additional follow up. Only when all the recommended actions have been addressed will a death case be closed. The Mortality Review Committee comprised of various stakeholders, meets quarterly to review every death ruled accidental/suspicious. The committee reviews these cases along with aggregate data on all types of deaths and makes recommendations for system improvement activities. For all cases with completed investigations, ***no suspicious deaths or deaths resulting from neglect were found.***

The first chart (Chart A) below shows the deaths that occurred at Montgomery Developmental Center and Youngstown Developmental Center during the reporting period. The second chart (Chart B) shows deaths that occurred after discharge from Montgomery Developmental Center and Youngstown Developmental Center. The time period of the deaths was from date of announcement (February 20, 2015) until May 31, 2016.

Chart A

A total of 5 deaths occurred at Montgomery and Youngtown Developmental Centers combined during the reporting period. These residents were **not** discharged and died at the centers	
Average Age of Death	**Causes of Death**
58	Pulmonary edema, seizure, congestive heart failure, interstitial lung disease, aspiration due to vomiting

Chart B

A total of 5 deaths occurred following discharge from Montgomery and Youngtown Developmental Centers combined during the reporting period.	
Average Age of Death	**Causes of Death**
68	Seizure, chronic respiratory failure due to pneumonia, respiratory failure due to pneumonia, sepsis, found unresponsive (had history of seizures)

The process below was followed when reviewing all deaths noted above:

- Each death was initially reviewed by DODD intake upon discovery. This review ensures proper notifications and necessary actions have been taken. If anything seems unusual at this time, intake may ask for more information.
- Each death was referred to the coroner's office. It usually takes three to four months after the referral for the coroner's office to issue a death certificate. At the time of this report, death certificates have been received in three of the five cases, where the resident was discharged. These three were all deemed non-suspicious and the death to be of natural causes.
- Once the coroner's work was completed, a DODD physician reviewed each of the cases "where an investigation was concluded" and the death certificate was available, and deemed the reviewed cases non-suspicious. The physician review includes, at minimum, a review and analysis of the following information:

    1. Copy of DC/Autopsy/Coroner Report/Supplementary Medical Certification
    2. Location of death
    3. Death Expected/Unexpected
    4. What DD services was individual receiving
    5. Detailed description of 72 hours prior to death or hospitalization (72 hour prior to hospitalization if died in hospital)
    6. History/cancer screenings for cancer/hospice death
    7. Law enforcement investigation
    8. Medical and psychiatric diagnosis prior to death
    9. Medications taken prior to death or hospitalization (if death occurred during hospitalization)
    10. Past medical history
    11. Name of Primary Physician
    12. Aspiration/Pneumonia/Respiratory Failure cases:

Conclusions:

The Department appreciates the opportunity to submit this report to the legislative branch for review. DODD believes the availability and appropriateness of care for those residents transferring from Youngstown Developmental Center and Montgomery Developmental Center to a community residential setting has been positive.

The appropriateness of current living conditions of our former residents is overwhelming supported by Department survey results. In addition, the readmission rate of 9% is consistent with expectations and similar to the rate of readmission for prior DC closures. Finally, the department does not believe a transition to the community contributed to the deaths that occurred during this time period.