Washington State
Department of Social
& Health Services

Report to the Legislature

Planning for the Future of DDD Residential Habilitation Centers

Prepared in Response to Recommendation #2 in "Capital Study of the DDD Residential Habilitation Centers" Report by the Joint Legislative Audit and Review Committee, issued December 4, 2002

September 30, 2003

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PLANNING FOR THE FUTURE OF DDD RESIDENTIAL HABILITATION CENTERS

Executive Summary
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September 30, 2003

In December 2002, the Joint Legislative Audit and Review Committee (JLARC) issued its "Capital Study of the DDD Residential Habilitation Centers." This study contained a recommendation that DSHS should use this and other documents to address projected future institutional needs for developmentally disabled individuals in Washington State. The report was to project anticipated changes in the type of care needed by institutional residents, and alternative or combined use scenarios for each Residential Habilitation Center (RHC) campus. DSHS is to present this collection of information and alternatives to the Legislature by September 30, 2003.

This report discusses three options, based upon a needs assessment of the individuals living in RHCs, the expertise the community services system has demonstrated, and current national trends. The three options the department presents information about are: (a) the RHCs could be entirely closed with the establishment of certain kinds of community services, or (b) a small(er) RHC(s) could exist to support some individuals and for the purpose of providing emergency respite care in particularly challenging situations, or (c) the policy direction established in 1988 could continue whereby some RHCs could remain open but with regularly funded downsizing, and with some admission capacity, until attrition and downsizing force additional consolidation and closure in approximately 25 to thirty years.

In their Phase 3 report issued December 1, 2002, the Developmental Disabilities Strategies for the Future Stakeholder Workgroup indicated a preference for letting the marketplace (of potential customers) determine what the capacity of RHCs should be. While a "marketplace" model is not included in this report, one option provides a regular opportunity for limited admissions. The Stakeholder Workgroup supported the concept of choice as being the most critical dimension, weighing more than the opportunity for community integration, and more than the value of non-congregate settings.

The current status of the Fircrest Master Plan, which is not due to have a final product until spring 2004, was reviewed by the department but is not included as a significant consideration for this report.

This report provides the capital costs of various reduction scenarios, as well as the cost of total closure and maintaining the status quo. Costs of various kinds of alternate community programs for people moving from the RHCs are presented and forecasted. Costs of addressing the issue of staff reductions are included. Information presented demonstrates that costs for community settings are somewhat less than for RHCs, and over time, all of the costs increase. The report contains three alternate scenarios. These alternatives are not the only options. With the information provided in the report about costs, other scenarios may be constructed.

The department believes that the needs of people living in RHCs, with a few exceptions, can be met in the community, however, there are impacts upon those clients and their families that must be considered. Twenty-two percent (235) of people living in RHCs are over 55 years of age. Sixty percent (636) of RHC clients have lived in their current facility for thirty years or more. These factors reflect important implications to consider when reducing facilities, because of the importance of ensuring sound transition activities that protect people's health and adjustment.

Ways to mitigate the impacts upon clients, families, and employees are suggested. Clients and families can be assisted by identifying those who want to move, and determine, based upon consistently applied criteria, who will remain in the RHC. The criteria should include factors such as the age of the person, where the person's family lives, how long the person has resided at an RHC, what kind of transition process is needed for any particular individual, and other similar factors. The department can provide people and their guardians with choices about the location of the community service, selection of vendors when possible, and choices about housing, and so forth. A quality assurance service that periodically monitors both quality of life and whether needed services are being received should be implemented for all people who move. Adequate case management support (1:50) must be provided for all RHC clients placed.

Per JLARC direction, this report offers alternative scenarios for policy makers. It also provides an historical context, information about clients, facilities, costs, and other states' experiences. Included are three illustrations about how this information can be applied in Washington State to address the future of the RHCs.

PLANNING FOR THE FUTURE OF THE DDD RESIDENTIAL HABILITATION CENTERS

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CHAPTER ONE

Introduction

During the 2002 legislative session, the Legislature directed the Joint Legislative and Audit Review Committee (JLARC) to conduct a review of the five Residential Habilitation Centers (RHCs) serving individuals with developmental disabilities, operated by the Department of Social and Health Services (DSHS), Division of Developmental Disabilities (DDD). The purpose of the review was to investigate the possible alternative uses of the land and facilities currently used by RHCs. In December 2002, the Joint Legislative Audit and Review Committee (JLARC) issued its "Capital Study of the DDD Residential Habilitation Centers." This study contained the following recommendations.

Recommendation 1:

Department of General Administration, Real Estate Services, should develop options to dispose of excess property identified at Lakeland Village, Rainier School, and Yakima Valley School by JLARC's consultants. Such options should maximize the investment return to the state. This recommendation was implemented and the report was produced on April 11, 2003.

Recommendation 2:

DSHS should synthesize this report and two other documents relating to the future of the RHCs: *The Stakeholder Workgroup Strategies for the Future*, and the *Fircrest Campus Master Plan* [not available until Spring 2004]. The resulting synthesis should address projected future institutional needs for individuals with developmental disabilities in Washington State, anticipated changes in the type of care needed by institutional residents, and alternative or combined use scenarios for each RHCs campus. DSHS should present this collection of information and alternatives to the Legislature by September 2003.[1]

DSHS/DDD/RHC Study JLARC Goal:

JLARC further clarified this recommendation in correspondence, "What we are asking for in recommendation #2 is that DSHS develop a long range strategy for the future of RHC's. While focusing on the future population that will be eligible for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) is a place to start. How the state chooses to serve those individuals - in a large institution, in a small institution, or via the private sector - is a policy decision. It is that policy decision that we are asking the department to focus on."

Options

The options presented in this report are not intended to be limiting. They are more examples than finite solutions of the kinds of services and/or combinations of services that should be developed. The actual possible configurations are infinite. The detail for the options includes cost per client day and capital cost information for each facility. This report analyzes combined scenarios, such as East and/or West side locations, Skilled Nursing Facility (SNF) and/or ICF/MR, facility size, the possibility of increasing choices in community services, and/or closing all RHCs. There are many combinations of choices that will meet the needs of people with developmental disabilities, who are or would be in the future eligible for ICF/MR services. It is also important that the state of Washington continue to develop a strong community based services system that can serve all of its citizens with developmental disabilities.

[11] "Capital Study of the DDD Residential Habilitation Centers," State of Washington Joint Legislative Audit and Review Committee (JLARC), issued December 4, 2002.

Based upon a needs assessment of the individuals living in RHCs, the expertise the community services system has demonstrated, and current national trends, it appears that: (a) the RHCs could be closed with the establishment of certain kinds of community services, or (b) a small RHC(s) could exist to support some individuals and for the purpose of providing emergency respite care in particularly challenging situations, or (c) the policy direction established in 1988 could continue whereby some RHCs could remain open until attrition and regularly funded diversion and downsizing options offered opportunities for additional consolidation and closure.

CHAPTER TWO
Overview of the History and Current Trends of Developmental Disabilities Services

DDD provides a broad range of services and support to over 32,000 eligible clients. Of these enrolled clients, about 31,703 are served in the community. The remaining 1,059 clients (July 2003) live in one of the five Residential Habilitation Centers (RHCs). Approximately 19,000 people who are living in the community receive a paid service, in addition to case management services.

The RHCs have been providing services to developmentally disabled individuals for the last 98 years. In 1892, the state opened the first school for individuals who were then described as "defective youth" (i.e., deaf or blind children) in Vancouver. A separate school was subsequently opened for children with mild mental retardation. This school quickly became overcrowded, and a long waiting list developed. In 1905 the Legislature enacted a basic law stating that the mentally deficient were not capable of developing or learning skills, and therefore they must be segregated from other children, with expert medical services provided for them. This legislation established the custodial asylum care system for people with developmental disabilities. A second school for children with more severe mental retardation was opened in 1905 in Medical Lake, adjacent to Eastern State Hospital. Eventually six RHCs, Lakeland Village, Rainier School, Fircrest School, Yakima Valley School, Interlake School, and the Frances Haddon Morgan Center, were established which by 1970 served approximately 4,000 people and had large waiting lists.[2] Data for numbers of people served in community settings for the early 1970s are not accessible.

During the 1950s and 60s, families advocated for community services for their sons and daughters with developmental disabilities. Through work with Senator Kaye Epton, they were able to get legislation that made it possible for counties to develop day program services for children who were prohibited from attending public school and adults who lived at home. These centers were called Developmental Centers and provided educational, social, and pre-vocational services.

In 1969, the Legislature authorized the state to develop group homes specifically for people with developmental disabilities. By the early 1970s, many hundreds of children and adults were served in their local communities.

The Office of Case Services was initiated in October 1974 under the Bureau of Developmental Disabilities (BDD). Case Services focused on eligibility determination, individual service planning, service linkage, and monitoring for persons with developmental disabilities and their families.

In 1971, Washington passed the first Education For All legislation, which was followed in 1974 by the passage of Public Law 94-142 by the U.S. Congress. These laws mandated a public school education for all children. Prior to passage, children with the most significant disabilities were prohibited from attending public school. Also, in the mid 70's, the Washington State Legislature initiated respite care services to families. Respite care was designed to give families a break in care, and to prevent out of home placement. All of these efforts, that were mostly sponsored by families, were dedicated to making education and services available and closer to home for children and adults. They resulted in significantly reduced demand for institutional care.

In the 1970's the concept of "normalization," was sweeping the country. The Developmental Disabilities Planning Council (now the DDC) and DDD made a major investment in providing intensive training to the developmental disabilities community, including self-advocates, parents, counties, providers, educators, professionals, and DDD state and regional staff. This training significantly changed how Washington State approached community services to people with developmental disabilities. The goal became to determine how people with developmental disabilities can be present and participate in their home communities in ways that are typical to all

[2] Baumgart, Howard, Over Fifty Years of Caring a History of Rainier School and Mental Retardation, 1997.

community members. It replaced the continuum of services concept that required a client to succeed at successive learning steps in order to have a job or a home.

Many of the developmental disabilities community stakeholders, reflective of the national response, embraced this concept. One of the consequences was that institutions were viewed as not community based, not integrated, and were considered the most restrictive setting. The Legislature regularly provided funding for "downsizing" institutions. Families who believed that the RHC was the best possible setting for their son or daughter went on the defensive, and as community services have expanded, and RHC census decreased, have felt themselves to be in a struggle to protect services for their family member.

Meanwhile the RHCs were evolving from large custodial care entities into settings where habilitation and training was expected to occur. In the late 1970s the state decided to participate in the Title XIX Intermediate Care Facility for the Mentally Retarded (ICF/MR) program, in order to increase the funding to serve people more appropriately. The ICF/MR program is a developmental model that is training intensive. The RHCs became certified as ICF/MRs. There were also some privately owned community based ICF/MR facilities. Entering this program meant training and habilitation programs were required for RHC residents. In the late 1980's, however, the RHCs were at risk of decertification. Major financial investments were made by the Legislature to move people out of RHCs back to communities, leaving RHC staffing in place for a much richer staff to resident ratio and increased ability to meet residents' training and habilitation needs.

The combination of improved staff to resident ratios, increased tightening of regulatory expectations and higher staff wages has resulted in increased daily rates in the RHCs. Over the last 10 to 15 years, costs at the RHCs have continued to rise. The population has continued to decrease. This caused the Legislature serious concern since they were seeing a continuous need to increase funding for the foreseeable future.

In 1988, Washington completed a comprehensive review of the state's participation in the ICF/MR program. Washington subsequently implemented the report's recommendation that continued participation in the ICF/MR program be phased down and community services be improved and made more available through home and community based services (HCBS) waiver(s).[3] The Title XIX waiver program enabled states to earn a federal match for community services that were provided to individuals eligible for ICF/MR care in lieu of ICF/MR institutional care.

In 1994, Interlake School, which served 150 people who were considered medically fragile, closed due to the cost of the program and the barriers the building presented to providing program services required under Title XIX regulations. Individuals were placed into community-based services, and at Lakeland Village, Fircrest, Rainier School, and Yakima Valley School.

ICF/MR and community-based services have evolved similarly in all states across the nation. ICF/MR services in large institutions have decreased and Home and Community Based Services have increased. Washington has increased its capacity and ability to develop family supports, residential, and vocational programs in the community to meet the needs of both very fragile people, as well as people with extremely challenging behaviors. Each year, the expertise in the community increases. At this point it is generally accepted that with very few exceptions, any person who lives in an RHC can live safely and well in the community, given the funding necessary to provide the supports needed.

While for a couple of decades the premise was accepted that community care was less expensive than institutional care, that is no longer considered strictly true. Community care can

[3] "Report to the Governor from the Interagency Task Force on Intermediate Care Facilities for the Mentally Retarded," Washington Department of Social and Health Services, December 1988.

be less expensive, and is in most cases; but in fact there are individuals whose support needs are such that their community programs are or would be more expensive.

Division of Developmental Disabilities and Current Trends

DDD is currently charged with the responsibility to provide needed support within available funds to people with developmental disabilities and their families. These services and supports include assistance in education, life skills, physical accommodation, employment, and living arrangements. The mission of the division is to make a positive difference in the lives of the people eligible for services through offering quality supports and services that are individual and family driven; stable and flexible; satisfying to the person and their family; and able to meet individual needs. Support and services shall be offered in a way that ensures people have the necessary information to make decisions about their options and provide optimum opportunities for success.

A person is eligible for services if he or she has a disability that originated before the age of eighteen (18) years. The disability must be expected to continue indefinitely, constitute a significant handicap, and be attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation.

After initial acceptance in the field of developmental disabilities nationally, normalization has evolved to entirely new approaches to serving people with developmental disabilities in ways which support empowerment. Trends include ways to provide individuals with self-determination and choices, and an affirmation of the philosophy that people should be able to find the supports they need in their own communities in typical settings. This trend has led both nationally and in this state to more families and individuals with developmental disabilities directing their own family support budgets, employment programs and early childhood programs. People with developmental disabilities and their families and advocates expect DDD to consider their desires and change the system to meet their perceived needs. There is a growing expectation that the client is a meaningful part of the decision-making process and as such directs the outcome of expenditures made on his or her own behalf. Younger people with developmental disabilities and their families are experiencing much more integration and control over the services they receive, both from birth-to-three programs and schools, than that which was possible for older people. The expectations of these individuals are for such autonomy and choice-making to continue and be the normal flow of life. These expectations and the change in service philosophy have made impacts on policy and financial demands on the state budget, and have made placement in RHCs less relevant to many families.

Crossroads

The evolution in the field of developmental disabilities brings Washington State to a crossroads. The state must make choices about the direction services to people with developmental disabilities will take for the foreseeable future. There are now approximately 7,800 people, including people with seriously disabling conditions and/or significant behavioral challenges, who are being served out of their family homes in community settings.[4] There are 1,059 persons being served in RHCs. We know that these residents, with few exceptions, can be served in the community. We also know that that there is a small group of individuals in the RHCs for whom the RHC is currently the only treatment option that can support the person safely.

The Centers for Medicare and Medicaid (CMS), U.S. Department of Health and Human Services, conducted an audit of Washington State's DDD waiver. One finding in the July 2002 report was that the state limited access to ICF/MR services [in the RHCs] for eligible individuals. ICF/MR

[4] DSHS Research & Data Analysis, Executive Management Information System, Aging and Disability Services Administration – Developmental Disabilities, "Total Clients Enrolled," Report dated 7-23-03. Data indicated for April 2003: 4008 people in DDD contracted residential; 114 SOLA; 3680 non-DD Facilities.

services are part of the Washington State Medicaid Plan and are listed as a covered service without limitations. This means that a person who meets the medical necessity criteria [ICF/MR eligibility] is entitled to receive the service in the amount required by the person's assessed needs in an ICF/MR, or s/he may choose to receive services in the community through Washington's HCBS waiver.[5] This creates a policy challenge for Washington State. It speaks to the possibility of needing to either change (limit) access and risk reductions in federal funding, or to create additional ICF/MR community beds or HCBS resources, or to permit unrestricted admissions to RHCs.

The department will continue its efforts to build the kind of community service options that offer satisfactory alternatives to ICF/MR care and can support individuals in their home communities with their families or as close to families and friends as possible.

[5] "Washington Medicaid Assessment Report, Community Alternatives Program Waiver," Control # 0050.90.R2, Centers for Medicare and Medicaid Services, issued July 25, 2002, p.22.

CHAPTER THREE
Lessons Learned From Experience

Experience of the 1994 Closure of Interlake School

Similar to other states' experience, the Interlake closure taught Washington that planning at the client and at the system level is essential to success. Clients and families need to participate in future moves planning. At Interlake, allowing parents and guardians to express their dissatisfaction through a formal process with the closure and required moves seemed to assuage some of their negative feelings and dissatisfaction with the planned closure. Employees' reactions to the closure need to be taken into consideration and planned for. The Reduction In Force (RIF) process needs to be considered early on and enough human resources' staff hired to make the process smooth and quick so anticipated savings can be gained. By planning ahead to create community capacity, renovate other state facilities, and offer options to permanent employees, the schedule to move people can be met.

The closure of Interlake School took about a year and a half from March 1993 through June 1994. Client placement and transfers, however, occurred beginning in the 1989-91 Biennium.

It was very important to keep staff aware of plans and events regarding the closure. The goal was to keep staff informed and to help keep them focused on their jobs of providing good care to the residents. To accomplish this, three actions were initiated:

(1) in order to keep staff informed, a weekly newspaper was published with the front page having a column of "news and views" that gave both facts and rumors that were around campus regarding the closure,
(2) the superintendent made it a practice to be out on campus daily visiting with staff providing support and information to them,
(3) the superintendent kept raising the issue to staff to keep them focused "how are we going to do this in an orderly way and continue to provide good service?"

The superintendent indicated that he wanted to (1) keep staff morale high while providing quality services, (2) keep the residents healthy as they lived at Interlake and as they moved to other residences, and (3) keep the facility certified.

The RIF process was problematic because facility human resources staff could not process the RIF'ed employees quickly enough. Savings that could have been generated were lost. In any future closures, it would be cost effective to assign one additional Human Resources FTE to each facility to assist with the RIF processing so delays do not occur. While almost no one from Interlake lost their job because of the closure, other state employees did because of the 'bumping' process.[6] It is important to keep the other facilities aware of how the RIFs at one facility might affect other facilities as more senior staff 'bump' less senior employees. In Medical Lake, the Department of Corrections accepted a number of employees into vacant positions. The superintendent made it a point to sit with every individual and talk to them when the person received their RIF notice.

A transition person was hired to help people apply for different jobs, and to find where to apply. This person worked with other organizations to accept RIF'ed persons and where possible, to modify requirements so that displaced persons could qualify for open competitive positions.

[6] 'Bumping' refers to a process during a RIF whereby the RIF'ed employee (whose position is actually eliminated) accepts as an option a position that is occupied by another employee of less seniority, when no vacancies exist in the RIF'ed employee's job classification. The employee who is 'bumped' out of their position by the first employee then begins a separate RIF process, generally with greater consequences since they usually have the lowest seniority in that job class within a specified geographical area.

DDD central office had a coordinator who worked with Interlake, regional offices and other RHCs, to plan the moves of individual clients. It took over two years, which was sufficient time to make the moves and close the facility. If the cottage renovation needed at other RHCs had not occurred on time, moves would have been delayed.

People moving from Interlake were given the choice of another RHC or community services. When asking parents to make the choice it was recognized that most, if not all, people wanted to remain at Interlake. A form was developed which said that Interlake was not a possible choice and was going to close. Parents were given the option to choose Interlake and a choice of another RHC or the community. This seemed to help parents have a say as to what they really wanted to see happen.

Experience of Other States in Closing State Operated Institutions

Eight states and the District of Columbia no longer have any state institutions for people with developmental disabilities. A ninth state, Minnesota, has one small 35 bed townhouse facility where people stay up to ninety days. In addition, between 1990 and 2001, 17 other states reduced their large state facility populations by more than 50 percent. Between 1996 – 2001, states closed 41 large state operated facilities.[7]

As part of the process for developing alternatives for the use of the Residential Habilitation Centers (RHCs), the division developed questionnaires to send to states with institutions and states which had closed all of their institutions. The purpose of the questionnaires was to find out about these states' experience in closing institutions. Eight states were selected, four still having institutions and four that no longer have institutions. Only four states responded, one with institutions (Oregon) and three without institutions (New Mexico, New Hampshire, and Minnesota).

These four states had differing reasons for closing their institutions. The reasons are displayed in the chart below:

State	U.S.DOJ Investigation	Cost of Care Increases	Philosophy	Other
New Mexico		X		Lawsuit
New Hampshire				Parent Lawsuit re Conditions
Oregon	X	X	X	
Minnesota		X	Strong support for inclusion and integration.	Negotiated settlement of federal court case & alternative uses for sites

None of the four states closed their facilities due to CMS survey issues. Of the four states, only Oregon continues to have a state operated institution for persons with developmental disabilities. That institution serves 45 people. Minnesota considers itself not to have any institutions. However, they have one program that the state operates for people who are committed to the

[7] Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2001, issued June 2002 by the College of Education, University of Minnesota (known informally as the "Braddock Report"), pp. iii-iv.

state because they present public safety issues. That program is a short term program designed to work with the person and community to return the person to his/her home. The residences are townhomes that serve four to six individuals and are located on a "campus."

When the decision to close an institution was made the enrollment at each was: NM 370, NH 25, OR 300. Minnesota's Legislature decided in about 1989 to close the largest facility and set into place a process to close the rest of the its institutions. At that time there were about 2,000 residents.

It took New Mexico four years to close its institution with 370 residents; New Hampshire six months to close its remaining facility with 25 residents; and Oregon one year for planning and one and a half years to move 300 residents.

Some portions of the New Mexico campus continue to operate and house staff for state run community programs, therapy services and dental facilities. The rest of the campus was converted to other uses including: state/county offices and an alternative high school. New Hampshire converted the campus to a minimum security prison and Oregon took two and a half years to close, finally selling the property, the proceeds of which were dedicated to a housing trust fund for persons with developmental disabilities.

Oregon moved people to a mixture of state operated programs (70) and non-state operated community programs (230). They moved to group homes, supportive living apartments and adult foster homes.

Minnesota moved people mainly to supportive living situations, but some went to community ICF/MRs. One campus became a prison. The others were closed and converted for other uses such as office space, training space, and so forth.

Displaced state workers were offered:	**Minnesota**	**New Hampshire**	**New Mexico**	**Oregon**
Transition training programs	X			X
Resource job development	X			X
Transfer opportunity for state operated community facility	X	X	X	X
Other state job made available	X	X	X	X
Increased community benchmark for direct care salaries in the private sector to meet state rate			Increased rate to provider agencies with intention that it raise direct care staff rates to state DD Tech Level.	

Projected savings from closing the institution were met in two states, Oregon and New Hampshire. The savings were used to further develop and expand the community based service system. In New Mexico, services are provided in the community at a cost that meets CMS cost effectiveness guidelines for HCB Waivers, and many individuals live in the community at a lower cost to the state. However, due to intensive service/support needs of some individuals and loss of the economy of scale, the shift has been primarily cost neutral and has not generated significant cost savings. According to New Mexico, the primary benefit has been a significant increase in the quality of life for individuals formerly living in the institution.

In each of the four states responding, medical services were provided by community medical providers for those people moving from the institution into the community.

Each state ultimately solved the issue of dealing with persons with challenging behaviors in similar ways. They each used small individualized highly staffed residences. Some have specialized programs of state staff to help train community providers.

Oregon used staff intensive homes (experienced three eight hour staffing shifts of 2 staff-3 staff-2 staff, for 3 or 4 people); made specific modifications to homes; for people with the most intensive issues, (criminal history, high intensity, high frequency aggressive behavior). Oregon also used state operated community programs (3 to 5 people in a home, located in the general community – a total of 55 people used these options.)

New Hampshire initially established "behavioral group homes" but the system ultimately realized that placing people with challenging behaviors in group situations made things worse. As a result, the great majority of the people with such problems were transferred to individualized service arrangements.

New Mexico generally does not provide support through facilities. New Mexico uses a three-tier crisis management process, using behavioral/medical specialists funded by the state. Community providers and teams are given support/training and expert staff may be placed at a community provider agency on a temporary basis from a state run community residential program. Limited space is also available in state run community residential programs. For individuals with mental illness and developmental delays, short-term treatment services can be accessed at the state hospital serving people with mental health needs. A pilot program is underway between the state and the University of New Mexico, Continuum of Care Program, to increase local availability of psychologists and psychiatrists who are knowledgeable about developmental disabilities.

Minnesota has a 35 bed townhouse based facility for treating people with challenging behaviors. They work with community providers to return the person to the community, and most return after about 90 days. The counties in Minnesota also may start specialized programs, specific providers have expertise in this area, and the state has a community outreach team that is available for consultation with community providers across the state.

All of the states provide potential models for the community placement of current RHC clients. Each state treats people with significant/multiple medical issues individually, building programs based on the individuals' needs. The programs are not large, but appear to vary in size and intensity of need. Oregon altered staffing patterns that included nursing when delegation was an issue (5 people in a home, need gastrostomy-tube care, may have tracheostomy, significant physical care management.) For people with the most complex needs, Oregon used state operated facilities (ventilator dependent, other technology dependent care needs, frequent hospitalization – a total 15 people with these needs used state operated services.) In New Hampshire, both group and individual service arrangements were used for individuals with significant/multiple medical needs. (The largest community residence in the system serves ten people with such needs.) In New Mexico, all community arrangements were made on an individual basis using an interdisciplinary team process. Some providers have developed expertise in serving persons with complex medical issues. Minnesota has programs for this population that are similar to the programs they have for persons with challenging behaviors.

The three states without institutions, (NM, NH and MN), address the issue of maintaining HCB Waiver compliance differently. New Mexico has six small ICF/MR facilities. They conduct cost effectiveness comparisons to what costs would be if the large state run institution remained in operation. New Hampshire closed down its ICF/MR programs about eight years ago. (Currently there is one privately operated ICF/MR program in the state. This program is not under the developmental disabilities division's jurisdiction and only serves children up to age 16.) If an

individual were to request ICF/MR services specifically, New Hampshire would secure services in another state. (So far no one has made such a request.) To demonstrate cost effectiveness, New Hampshire compares the average waiver cost with the cost of the ICF/MR program. (If the one ICF/MR facility were to close down, CMS told New Hampshire that they could use average ICF/MR rates from the neighboring New England states.) Minnesota has community ICF/MR programs.

We asked each state "What were the top five things that were important for accomplishing the closure?" Their responses are varied but it is obvious that planning, working with stakeholders, and a commitment of resources are necessary for the closure to be successful. The responses are as follows.

Oregon: (1) Planning with all partners for about one year including: labor issues, what services would be developed, expectations of families, individual person centered planning, budget development and Requests for Proposals for services. What this planning allowed was that the year and one half to close was all focused on client moves and institutional closure. (2) Having a specialized team of development staff. The state had a team of five placement planners and two nurses to oversee all of the placements. They met with families, institutional staff, and community provider staff typically six months before placement to confirm transition activities (getting community physicians, developing transition plans, hiring and training staff.) All community staff had to be hired two weeks prior to the home opening and participate in state sponsored/directed trainings. (3) Follow through. The case management to client ratio was reduced for people leaving the institution to 1:35 and the state required a single case manager be assigned to each person. Case managers completed monthly checklists and attended state sponsored meetings quarterly. The monthly information was reviewed with a quality assurance committee. The two state nurses made monthly follow up visits to people who were identified as medically at risk. Any new nurse hired by an agency had to receive training and follow up by the state nurse. For people with complex behavior needs, the state had a contract for technical assistance to the community homes for follow up for one year after placement.

New Hampshire: (1) The transition was made within the context of returning people to their communities and providing them with better services and not within the context of closing the institution. No public announcement was made about closing the institution until the end. The idea for the closure was not stated within the service system until the census had been reduced to a small number. (2) Training in "values" was provided to all staff at the institution. Through this training the great majority of the institutional staff came to realize that individuals belonged in their own communities and would have better lives through community based services. (3) Sufficient resources were made available for community based services to demonstrate that individuals who were moving out of the institution were indeed getting better services and living better lives. (4) Some parents/families were against the idea of their family member moving back to their local community. These parents/families were not forced to accept community based services; instead arrangements were made for them to talk to other parents/families whose family members had already moved back into community based service arrangements. It was the other parents/families who convinced these reluctant parents/families of the advantages of community based services. (Note: If these parents had not agreed to community services, NH was prepared to run a small cottage on campus to serve a handful of people). (5) Staff members who worked in the institution were assisted in finding jobs in other state operated or privately run programs. Some transferred to the community service system themselves and ended up working for DD provider agencies. (In doing so, some accepted lower pay and benefits).

New Mexico: (1) Assuring the health and safety of the persons served. (2) Ability to demonstrate a better quality of life for persons served as a result of the move. (3) The state's commitment of resources to build provider and community capacity. (4) The state's ability to serve as a safety net for individuals during the transition process. (5) Strong legislative support for closure of the institutions.

Minnesota: (1) Political support of the Legislature and executive branch for the closure. (2) Options for state employees working at closing facilities. (3) Integrity in the system for planning and developing the community alternatives so people's needs were met. (4) Flexibility in allocating funding for individual's leaving the facilities and moving into the community. (5) A shared vision and buy-in by all groups that community living was the preferred option.

Experience with Community Placement during 01-03 Biennium

In response to the U.S. Supreme Court decision on Olmstead v. L.C., the 2001 Legislature appropriated funds to DDD to provide community options for people living in the RHCs. The Legislature provided funding to move 80 people during the biennium at a cost of no more than $280 per day.

Sixty-one people actually moved during the biennium, at an average cost of $280.94 per day. The individuals and/or their families who chose to move represent a wide range of service needs. Some individuals who moved were severely mentally retarded and need a supportive environment, and substantial physical assistance with all activities of daily living. A few individuals are fairly independent people who need guidance and supervision but can make choices about their schedules. Many people who moved represent a group of RHC residents who are the most significantly behaviorally challenged. This includes people with Prader Willi Syndrome, people with community protection issues, people who have significant mental illness, and people who are at high risk of assaultive behavior. Currently these individuals' needs are being met and their placement is considered stable.

The number of people desiring to move changed throughout the biennium. People placed themselves on the 'to move' list and other people removed themselves from the list continuously. The department believes that people have changed their minds about moving for different reasons, but one prominent reason is uncertainty brought on at this time by the current state of the economy. Families believe that the state-run RHCs will remain, but there is fear that community services may not always be available or funded appropriately.

For the people who have chosen to move, the time necessary to complete the move has varied greatly. Reasons for this include the following:

- Finding affordable, accessible housing has proven difficult;
- Developing services that remain within the available funding for people who have a high level of challenging support needs has proved difficult; and
- Finding two or more compatible roommates to share living quarters in order to reduce costs takes time, coordination and increased effort.

Additionally, some individuals are choosing to visit more than one residential option and are choosing personal agents to help them plan for their respective community supports. These processes are intensive and take more time than originally planned, but result in satisfied client placements. Given the opportunity to choose where they want to move, most people want to view several options prior to making a choice. The greater the number of options, the longer the process takes.

CHAPTER FOUR
ICF/MR and SNF Eligibility
Descriptors of the People Being Served

ICF/MR Eligibility

The individual must be in need of active treatment, encompassing 24-hour supervision and continuous training in order to function on a daily basis, due to significant deficits in areas of activities of daily living (ADL), including toileting, personal hygiene, self-feeding, bathing, dressing, grooming and communication.

SNF Eligibility

According to WAC 388-825-020 and WAC 388-71-0435, a person is considered eligible for nursing facility care when the person requires twenty-four hour care provided by or under the supervision of a licensed nurse, and meets certain criteria regarding functional deficits in the ADLs: eating, toileting, ambulation, transfer, positioning, bathing, and self-medication. The person must have an unmet need requiring substantial or total assistance with at least two or more of the ADLs; or have an unmet need requiring minimal, substantial or total assistance in three or more of the ADLS; or have a cognitive impairment and require supervision due to one or more of the following: disorientation, memory impairment, impaired judgment, or wandering; and an unmet need requiring substantial or total assistance with one or more of the ADLS.

Waiver Eligibility

Although not precisely defined in the Code of Federal Regulation (CFR), eligibility for the Title XIX Waiver includes fiscal criteria, as well as, a required assessment of need that is comparable to that used to determine ICF/MR eligibility. The assumption is there is a reasonable indication that individuals might need ICF/MR level of services in the near future, unless they have access to home and community-based services.

Some Descriptors of People Living in RHCs

Of the 1,059 clients living at RHCs, 87.5 percent are diagnosed as severely to profoundly mentally retarded. Approximately one-third (34%) of the RHC population has a dual diagnosis of mental retardation and mental illness. Extraordinary supervision (staff within ten feet, up to two to one staffing) is provided to 64 individuals in order to ensure their health and safety. 309 people (or 30 percent) have been identified as having assaultive behaviors. Twenty percent of RHC clients present challenging behaviors two or more times per day; and 234 people (22.4%) engage in serious self-injurious behavior.[8]

The RHC population is an aging population as indicated below.

AGE	Fircrest	Rainier	Lakeland	YVS	FHMC	Total
16-22	5	3	4	8	7	27
22-45	110	116	107	93	46	472
46-55	88	142	87	8	0	325
56-64	42	85	32	1	0	160
65+	19	35	21	0	0	75
Total	264	381	251	110	53	1059

[8] The data in this paragraph was gathered through a survey of the RHCs in June 2003. Refer to Appendix E for more detail.

As people age, they may become eligible for SNF level care. Rainier School does not have any SNF certified beds. There are at least approximately 60 individuals at Rainier who may currently meet the eligibility for SNF in addition to their eligibility for ICF/MR.

Individuals who live in RHCs have tended to live in the same RHC for a long time:

Client Count by RHCs, Length of Current Stay as of July 1, 2003

Client Count	RHC					
Length of Stay	Fircrest	Rainier	Lakeland	YVS	FHMC	Grand Total
Under 5 years	10	16	6	20	7	59
05 - 10 years	23	11	45	10	5	94
10 – 20 years	24	32	39	11	18	124
20 – 30 years	48	36	25	16	21	146
30 – 40 years	60	85	53	49	2	249
Over 40 years	99	201	83	4	0	387
Grand Total	264	381	251	110	53	1059

RCW71A.20.080, known as the "Froberg Law," is one of the bases for the high percentage of people with a length of stay of thirty years or more. This law prevents the state from moving to place a client into the community prior to conclusion of the appeal process, including Superior Court appeals, and RCW71A.10.050(2) places the burden of proof on the department that the placement will provide needed and effective support for the individual.

There has been a belief held by a small, but significant part of the developmental disabilities community that individuals who live in RHCs are somehow different than people who are able to be served in the community. Sixty percent of the people who live in RHCs arrived there prior to the early 1970's before Congress passed the P.L. 94-142 Education for All Act providing training and education for children in their home community. Most of these people were placed there due to the desperation of their parents for some kind of service for their child, and often out of sheer exhaustion from the 24 hour per day/ seven days per week provision of intensive support to their child without relief. Almost three quarters (74%) of RHC residents have been in the RHC for 20 years or over. The ability of community services to meet people's needs has grown considerably in the last twenty years.

While the family members of individuals living in RHCs disagree, there is an assumption in the field of developmental disabilities that anyone who lives in an institution can be served in the community with the proper resources and funding. The people who live in RHCs have needs identical to many people who live in the community. Underscoring this belief is the experience of at least eight states who have been able to close all of their institutions and meet people's needs through community based services.

One of the biggest strengths provided by the RHC from the point of view of families is there is "no refusal" from an RHC due to the severity of disability, medical condition, or the behavioral challenges of a person to be served by an RHC. Admission is not determined by the individual RHC facility. It is determined by the division, and the RHC serves whoever is referred. This has been a significant relief for families who have been told by schools, and service agencies, "we are unable to meet your child's needs."

Information about People Living in the Community

There are approximately 4,000 clients living in the community who are being served by DDD contracted community residential services and State Operated Living Alternatives (SOLA). While there is no specific data regarding how many of DDD's 31,703 clients (May 2003) have a dual

diagnosis, there is research that provides information upon which to base an estimate. Research conducted in September 1992 found that 680 people were dually diagnosed out of 3,202 people identified as being developmentally disabled in the Northern region of Greater Boston, Massachusetts Department of Mental Retardation.[9] A 1991 review of the literature found a range of incidence for people who are institutionalized, but very little for adults who were living in the community. However, one study found research revealed "20 percent to 35 percent of children who are mentally retarded and living in the community have diagnosable mental illness."[10] A 1997 article cites a 1990 study that estimated between "40 percent to 70 percent of individuals with mental retardation have diagnosable psychiatric disorders."[11] Dr. Ruth Ryan, M.D., psychiatrist renowned for her work with people with developmental disabilities quotes other epidemiological studies as estimating between 30 to 50 percent of people with developmental disabilities also having a psychiatric condition.[12]

Applying the more conservative estimate of 30 percent of people with developmental disabilities having a mental illness, indicates that approximately the same percentage of people living in RHCs and people living in the community have a dual diagnosis.

Of the 15,436 adults living in the community for whom a level of retardation has been established, 21 percent (3,264) have a diagnosis of severe or profound mental retardation. Fifty-three percent (1,752) of these individuals are receiving a contracted residential service or SOLA (May 2003), compared to 927 people who live in RHCs and are severely or profoundly mentally retarded.

The department serves people with the co-occurring conditions of developmental disability and mental illness both in the community and in RHCs. Most people who are medically fragile are served in their family homes or in other community settings. People are served in the community who have identical needs to those living in RHCs.

ICF/MRs represent the federally funded service to which eligible people are entitled. Use of the ICF/MR program depends upon whether people choose them. In the future, people who may need or choose the services of RHC ICF/MRs will vary, depending upon the evolution of and investment in the community services system. Throughout the nation, experience shows that community services for people with developmental disabilities are growing in ability to meet the most challenging needs of people. However, there continues to be a need for short, or in some cases longer, term habilitation and treatment at a state facility based program, to ensure individuals' immediate need for a safe environment.

The people who need these services are generally younger individuals (20's-30's) whose challenging behavior consists of extremely assaultive or self-injurious behaviors, that has not been responsive to the array of approaches in community settings. Occasionally, a person with very complex medical conditions the treatment for which has not been well coordinated, with severe life threatening consequences for the person, can benefit from a temporary stay at a state facility based program. In these situations the placement safeguards the person's health while the medical diagnoses and treatments are confirmed and organized, the person's health is stabilized, and communication, ongoing treatment and coordination are arranged in the community.

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[9] Beasley, Joan, Jeri Kroll, and Richard Sovner, M.D., "Community-Based Crisis Mental Health Services For Persons with Developmental Disabilities: The S.T.A.R.T. Model," The Habilitative Mental Healthcare Newsletter, Vol. 11, No. 9, September 1992.

[10] Singh, Nirbhay, Aradhana Sood, Neil Sonenklar, and Cynthia Ellis, "Assessment and Diagnosis of Mental Illness in Persons with Mental Retardation," Behavior Modification, July 1991, p. 422.

[11] Hauser, Mark, M.D., and Van Silka M.D., "Psychiatric Assessment of the Person with Mental Retardation," Psychiatric Annals 27:3, March 1997.

[12] Ryan, Ruth, M.D., Handbook of Mental Health Care for Persons with Developmental Disabilities, Diverse City Press, 2001, p.12.

The community services system is currently able to meet the needs of a significant number of the people described above. If the state focuses on strengthening community based services, fewer and fewer of the described individuals will need large facility based services.

CHAPTER FIVE
Physical Condition and Capital Needs of the RHCs

A. Facility Assessments of The RHCs' Current Conditions

General overview and assumptions

All of the facilities struggle with space issues as clients age and function at a level where additional support is needed. These space requirements include storage of adaptive equipment, more space in the bathrooms, bedrooms, and activity areas as more clients are in wheelchairs or use walkers, or need mechanical lifts. More space is needed for clean and dirty linen, tube feeding equipment, and medicine storage.

As a result of the aging of the residents, many of the cottages built in the past for 14 or 16 residents now can only function well with 10 or 12 residents. This problem was considered in the option solutions as the square footage needed per client was increased in ICF/MR applications from the current average of 395 square feet per client to 525 square feet. The existing average SNF square footage per client is 778 square feet and that figure was maintained.

Status of Lands and Buildings:

Rainier School – 600,000 sq ft on 60 acres

Condition

While the condition of Rainier School facilities is generally good, this is an older institution which opened in 1939, with significant preservation needs of the infrastructure. Water lines, storm water, sanitary sewers, and steam distribution lines need replacement. There are 30 residential cottages at Rainier School. Due to hard client use, a rotating, phased plan to replace damaged walls, doors, and furnishing is ongoing. There are several deteriorated or abandoned buildings on the campus that need to be demolished.

Major issues

- The water supply system, which is jointly operated with the City of Buckley, is in need of major repairs.
- The wastewater treatment plant that is owned and operated by DSHS and serves Rainier is coming under continuous pressure to meet higher water quality standards.
- The sewer collection system needs to undergo the final phase of upgrading to reduce inflow and infiltration.
- The campus emergency power system needs to be upgraded.
- Cottages need to be renovated to repair hard use and recognize that the client population is getting older.
- The laundry needs upgrading.
- The power plant needs adjustments and new equipment to reflect the decreasing demand for steam.
- Aging tile roofs need to be reviewed and repaired or replaced as needed.

Fircrest School – 500,000 sq ft on 70 acres:

Condition

Fircrest School is more than 50 years old and the predictable mix of "old and new" is evident across the campus. Decisions will be made to focus scarce capital dollars on the buildings most useful for service delivery and other client use.

Fircrest School's infrastructure needs are significant. While work was recently completed to replace the fire alarm system none of the living units currently have fire sprinklers. Several phases of the campus electrical system upgrade remain to be completed. Support services, including the kitchen and laundry facilities, are still in need of improvement. Fircrest School's age makes campus work very costly; for example, DSHS has spent more money on asbestos abatement at Fircrest School than at any other institution.

Major issues

- Living units all need fire sprinklers installed.
- The electrical distribution system needs to be upgraded.
- The campus emergency power system needs to be upgraded.
- Cottages need to be renovated to repair hard use and recognize that the client population is getting older.
- Adult training spaces need to be upgraded and replaced.
- The laundry needs upgrading.
- The power plant needs adjustments and new equipment to reflect the decreasing demand for steam.

Lakeland Village – 400,000 sq ft on 52 acres

Condition

While the buildings at Lakeland Village are in generally good condition, this is an older institution (at its present site since 1915) with significant preservation needs. The North campus living units do not have fire sprinklers. Walls, doorways, and equipment in the cottages receive hard use 24 hours a day. There has been significant deterioration of cottage floors due to water migration into the crawl spaces. Storage is inadequate and use of outdoor recreation spaces, such as Clear Lake and Frog Hollow, are limited because of increasingly difficult wheelchair and assisted ambulation accessibility issues. There are several deteriorated or abandoned buildings that need to be demolished.

Major issues

- North campus living units need fire sprinklers installed.
- The campus emergency power system needs to be upgraded.
- Cottages need to be renovated to repair hard use and recognize that the client population is getting older.
- The laundry needs upgrading.

Yakima Valley School – 150,000 sq ft on 30 acres

Condition

The buildings need exterior paint but are generally in very good condition and have been well maintained. Given the number of non-ambulatory residents, special attention needs to be paid to sidewalks, pathways, and circulation routes on campus.

Major issues

- Cottages need to be renovated to repair hard use and recognize that the client population is getting older.
- Laundry needs to be upgraded

Frances Haddon Morgan Center – 100,000 sq ft on 17 acres

Condition

The campus has been very well maintained and the 2003-2005 Capital Plan reflects the institution's efforts to continue to provide adequate attention to preservation needs.

Major issue

Cottages need to be renovated to repair hard use and recognize that the client population is getting older.

B. Current ICF/MR vs. SNF Populations

RHCs	Rainier	Fircrest	Lakeland	Yakima	FHMC	Total
Population	381	264	251	110	53	1059
ICF/MR	381	154	191	0	53	779
SNF	0	110	60	110	0	280

RHCs	Rainier	Fircrest	Lakeland	Yakima	FHMC	Average
Living unit ave ICF/MR sq footage	378	481	372	N/A	355	395
Living unit ave SNF sq footage	N/A	798	847	689	N/A	778
ICF/MR training space sq footage	201,784	110,833	99,777	N/A	8,000	600 sq ft per ICF/MR client

C. Current Facility Capacities

RHCs	Rainier	Fircrest	Lakeland	Yakima	FHMC	Total
Certified beds	450	298	305	128	56	1237
Current Occupancy	381	264	251	110	53	1059

D. Capital / Preservation Needs Long Term

The following descriptive information for each facility attempts to discuss some of the attention each campus would need to continue operating long term. The needs are divided up between long-term operation at the existing population levels and possible adjusted population levels. The "Adjusted Capacity Needs" column identifies what is needed if each facility (except Fircrest) were to operate at increased use level or with a revised certification (i.e. from ICF/MR to SNF).

Rainier School

1. Current Capacity Needs
Water system improvements
Wastewater treatment plant improvements or replacement
Sewer collection system repairs
Emergency power system improvements and upgrades
Cottage repairs
Laundry upgrade
Power plant upgrade
Roof Replacements

2. Adjusted Capacity Needs
Water system improvements
Wastewater treatment plant improvements or replacement
Sewer collection system repairs
Emergency power system improvements and upgrades
Cottage repairs
Laundry upgrade
Power plant upgrade
Roof Replacements
Kitchen upgrades
Remodeling/building to meet additional physical requirements for certification of SNF beds

Fircrest School

1. Current Capacity Needs
Living unit fire sprinklers
Electrical distribution system replacement
Emergency power system improvements
Cottage repairs
Adult training space upgrades
Laundry upgrade
Power plant repairs

2. Adjusted Capacity Needs
Not applicable due to legislative decision to downsize Fircrest.

Lakeland Village

1. Current Capacity Needs
Living unit fire sprinklers
Emergency power improvements
Cottage renovations
Laundry upgrade

2. Adjusted Capacity Needs
Living unit fire sprinklers
Emergency power improvements
Cottage renovation
Laundry upgrade
Remodeling/building if establishment of additional SNF beds are needed.

Yakima Valley School

1. Current Capacity Needs
Cottage renovations
Laundry upgrade
Kitchen Equipment replacement
Resurface roads and walkways

2. Adjusted Capacity Needs
Cottage renovations
Laundry upgrade
Kitchen Equipment replacement
Resurface roads and walkways
New adult training space if ICF/MR beds
New administrative office space
More commissary space
Improved maintenance workshops
Building new cottages if ICF/MR beds are established

Frances Haddon Morgan Center

1. Current Capacity Needs
Cottage renovations

2. Adjusted Capacity Needs
Cottage renovations
New adult training space if ICF/MR beds
Remodeling if additional ICF/MR beds needed
Building SNF facility if a SNF is required

E. Cost to Mothball each RHC

These costs ignore possibilities of immediate sale or other use of these facilities as may have been described in the JLARC's 2002 "Capital Study of DDD Residential Habilitation Centers." The costs described are if the particular RHC must be mothballed. Assumptions used to generate the costs listed below.

One time costs: to be completed during closure period

Secure buildings	.25 / sq ft
Secure sites	$3,000 / acre
Clean up	$2,000 / acre

Ongoing costs: starting first full year of vacancy

Care takers	$100,000 per year
Prevent pipe freeze/mildew	.10 / sq ft (utilities cost)
Fire Monitor	.01 / sq ft

Square footage listed below does not include buildings that are currently vacant. Site acreage only includes the main campuses not any outlying farm or forestland. If only a portion of the campus is closed the assumption is the buildings will remain as is only vacant and the existing maintenance staff (which should not be reduced) will continue on going maintenance.

Summary Table of Cost to Mothball

RHC	Rainier 600,000 sf 60 acres	Fircrest 500,000 sf 70 acres	Lakeland 400,000 sf 52 acres	Yakima 150,000 sf 30 acres	FHMC 100,000 sf 17 acres
One time costs	$450,000	$475,000	$360,000	$187,500	$110,000
On going	$166,000	$155,000	$144,000	$116,500	$111,000

CHAPTER SIX
Options for Service Use of the RHCs

There are an infinite number of possibilities for using RHCs. The options presented below are more accurately described as representative ideas. In considering any of the options, it is assumed that policy makers will take into consideration the findings of the JLARC report, especially related to what is seen as 'best use' for the facilities.

Options described here are (1) reduction in the RHC capacity, (2) complete closure of RHCs, and (3) maintaining the status quo. In this report the options given as examples will take anywhere from nine (9) to fourteen (14) years to implement completely, assuming a beginning date of July 1, 2003. The alternatives shown in the different options can be varied based on timing and movement assumptions. The alternatives presented are based on the best estimates regarding the community capacity that can be built, how rapidly this capacity can be built, and how quickly people can move. Each alternative begins with year one of the 2003-05 Biennium and assumes what the Legislature included in the appropriation for the downsizing of Fircrest. Since the Legislature has made a commitment and financial investment to downsize Fircrest, this report does not include Fircrest as an available RHC in the reduction scenarios. However, cost data related to Fircrest is provided in this chapter and in Appendix C to ensure that information presented is complete.

The number of moves per month/year, except for option two, is based on an estimated average of five people per month made by DDD regional administrators as to how many people they can move per month for a sustained period. The timeframe estimates in the options presented below are based upon our experience with the 2001-03 Olmstead Project, and are estimates only. Timeframes could be shortened with additional funding and FTE resources. Therefore, the number of moves per month that can be made depends upon the option chosen, the number of people who ultimately have to move, the community capacity needed, and the resources available to do it. The models assume placement of residents into the region where the facility is located. Past experience, however, tells us that a greater proportion will move to Region 4 and to a lesser extent to Region 5. Such weighting has not been considered in the models. If this holds true, more time for coordination between regions and resource development may become necessary. The time frames shown may be reduced if direction for several biennia ahead is given by policy makers. With clear future direction, resource developers and providers can work ahead of time knowing that future moves will take place. Not only will this facilitate resource development, it will also facilitate planning with families for moves. The timeframes provided are conservative estimates and based upon previous experience. If additional staff and funding to increase the number of people moving are provided, the time periods can be significantly shortened.

OPTION ONE:

Reduce current RHC capacity, examples studied include:

A. Two 175 bed ICF/MR RHCs and two SNF RHCs (100 bed and 110 bed).
B. Two 60 bed ICF/MR RHCs, and two 60 bed SNF RHCs.
C. One 60 bed ICF/MR RHC and one SNF RHC with 110 beds.
D. Two SNF RHCs for 210 beds; 300 beds in community ICF/MR in 50 homes.
E. One 200 bed ICF/MR in an RHC.

Four of the examples (A,B,C,E) include a fourteen bed respite program at an RHC.

The details are as follows:

A. Total clients served: 560 people. Two 175 bed ICF/MR RHCs, and two SNFs (100 bed and 110 bed).

This example consists of two large state operated ICF/MRs located at RHCs, and two large state operated SNFs located at RHCs. Two 175 bed ICF/MRs would be located on each side of the state, one at Rainier School, and one at Lakeland. Yakima Valley School would provide a 110 bed SNF; and Rainier would provide a 100 bed SNF. Two RHCs would close completely, FHMC and Fircrest.

The RHCs providing ICF/MR care would provide 14 respite beds to serve community clients. Professional services will be maintained to continue to provide clients in the RHCs and in the community the following services: Diagnostic services, psychiatric evaluations, pharmacological review, emergency crisis behavioral intervention, medical intervention, dental services, supportive equipment adaptation.

Assume a starting point of 1059 clients (July 2003), 779 ICF/MR and 280 SNF. The department would move 429 people to supportive living from the ICF/MRs and 70 to SNF level services in the community, a total of 499 people. It is estimated that this scenario could be completed within 8 ½ years.

B. Total clients served: 240 people. Two 60 bed ICF/MR RHCs, and two 60 bed SNF RHCs.

This example establishes two small 60 bed ICF/MRs, and two small 60 bed SNFs, in RHCs in both Western and Eastern Washington. FHMC would be maintained as the small ICF/MR for the Westside of the state, and evaluate adding a 60 bed SNF to the FHMC campus. Use the cottages at Yakima Valley School as the 60 bed ICF/MR, and the central building as the 60 bed SNF.

Maintain one cottage with a 14 bed capacity for respite services at both FHMC and Yakima Valley. Fircrest, Rainier and Lakeland Village would close.

A therapeutic services center at FHMC would have to be constructed, while a portion of the central building at Yakima Valley could serve that purpose there.

Assume a starting point of 1059 clients, 779 ICF/MR and 280 SNF. The department would need to move 659 people to supportive living from the ICF/MRs and 160 to community SNF level services from the RHC SNFs for a total of 819 people. It is estimated that this could be accomplished in approximately 14 years.

C. Total clients served: 170 people. One 60 bed ICF/MR RHC and one 110 bed SNF RHC.

This example includes maintaining 60 ICF/MR beds at FHMC, and 110 SNF beds at Yakima Valley School. Establish one state operated 14 bed respite service at FHMC, included within the 60 beds. Professional services will be maintained to continue to provide clients in the RHCs and in the community the following services: Diagnostic services, psychiatric evaluations, pharmacological review, emergency crisis behavioral intervention, medical intervention, dental services, supportive equipment adaptation. In this option, Fircrest, Rainier School, and Lakeland Village would close completely.

Assume a starting point of 1059 residents, 779 ICF/MR and 280 SNF. The department would need to move 719 people to supportive living from the ICF/MRs and 170 to community SNF level services from RHC SNFs, a total of 889 people. It is estimated this could be accomplished in nearly 15 years.

D. Total clients served: 510 people. Two SNF RHCs for 210 beds; 300 beds in community ICF/MR in 50 homes.

This example maintains two RHCs providing only SNF beds; with Yakima Valley School as a 110 bed SNF, and either FHMC or Rainier School as a Westside 100 bed SNF. However, this option includes provision of 300 community based ICF/MR beds. Four community based respite beds would be provided in each region.

Establish a Therapeutic Service Center in four regions to serve the ICF/MR and SNF community clients, as well as other clients living statewide in the community. The therapeutic service center would provide assistive technology and professional consultation. Such consultation would include dysphagia assistance, dementia assessment, augmentative communication, and wheelchair clinic for adapting mobility devices. Consultation to other professionals in the community would include, medical, psychiatric, dental, and clinical pharmacology consultation. Psychology consultation to families and providers would also be made available.

Assume a starting point of 1059 clients, 779 ICF/MR and 280 SNF. The department would need to move 779 people to supportive living situations, and 70 to SNF level services in the community, for a total of 849 people. It is estimated this option would take approximately 14 years to complete.

Fifty state operated or privately contracted ICF/MR homes would be developed:

Region:	Community ICF/MR state or privately operated	State operated SNF
One (1)	10 cottages 6 beds capacity.	None
Two (2)	10 cottages 6 beds capacity.	110 bed capacity SNF Yakima Valley School
Three (3)	Five cottages 6 bed capacity.	None
Four (4)	10 cottages 6 beds capacity	100 bed capacity SNF at West RHC
Five (5)	10 cottages 6 beds capacity.	None
Six (6)	Five cottages 6 bed capacity.	None
Total	50 cottages/ 300 beds	210 SNF beds

Facility Analysis of option 1D for the cost for community houses and therapeutic service centers. Assumptions below are for the state operated community-based ICF/MR example:

Build 33 houses on purchased land:

3,150 square feet (525 square feet per client, same as in cottages)
I occupancy
Purchase land $ 75,000
Construction cost per house $394,000($125 per square foot total project costs)
Total per site: $469,000
Total for 33 sites built at $544,000 per site equals $17,952,000

Based on several Internet real estate searches it appears some of the 50 houses could be purchased on the existing real estate market:

Purchase 17 of the 50 required houses off the open market.
17 houses at $350,000 per house equals $5,950,000
$50,000 per house for start up and construction work equals $850,000
Total for 17 purchased houses equals $6,800,000

Total for 50 houses equals $24,752,000

Assumptions for medical centers:
Lease space in existing developments
5000 square feet at $18 per square foot per year
Total monthly cost $7,500 per month or $90,000 per year

E. Total clients served: 200 people. One 200 bed ICF/MR in an RHC.

In this example, one 200 bed ICF/MR is established at either Rainier or Lakeland Village. The RHC ICF/MR care would provide 14 respite beds to serve community clients. Professional services will be maintained to continue to provide clients in the RHCs and in the community the following services: Diagnostic services, psychiatric evaluations, pharmacological review, emergency crisis behavioral intervention, medical intervention, dental services, supportive equipment adaptation.

Assume a starting point of 1059 residents; 779 ICF/MR and 280 SNF. The department would need to move 579 people to supportive living and 280 to SNF level services in the community for a total of 859 people moved. It is estimated this could be accomplished in 14 years.

Policy Direction Assumed by Option One:

This option assumes a policy direction that there is a role for state operated facilities for the next several years. In the first four examples there is an assumption that a portion of these individuals need the services of a skilled nursing facility rather than an ICF/MR. Three (A, B, and D) of the examples present a recognition of a need for the accessibility of state operated services by maintaining services on both the Eastern and Western sides of the state; or in the case of C, a centrally located service.

Option one assumes a policy direction toward smaller facilities. It also assumes meeting individuals' needs in the community setting, and presumes that there are a small number of individuals who do require the safety net of state operated SNF to meet their needs. A direction toward cost efficiency is implied by all of the RHC reductions, but strongest in example E.

Example D establishes community based ICF/MRs as a possible service option. The policy direction assumed is to move state-operated RHC services to community-based settings. Unlike SOLAs which provide waiver services, this possible direction presumes the services offered in community-based ICF/MRs (state or privately operated) would be identical to those offered by the large ICF/MR institutions.

The addition of community ICF/MR facility based services (either state operated or privately contracted) in example D recognizes the need of ICF/MR eligible clients for services. This policy presumes that to close off institutional possibilities for people means that other services have to be in place which will prevent or replace the need for the institutions. This example also acknowledges the possibility of Title XIX ICF/MR eligible clients requesting ICF/MR services.

Option one also recognizes the ongoing need for a structured respite care program, and the ability of the state to offer therapeutic and diagnostic services to individuals living in the community when they cannot obtain them elsewhere.

Option one also assumes an additional consistent set of resources is available in order to divert ICF/MR eligible persons to community services options.

Pro

Serves additional people in integrated community settings. Maintains service availability at RHCs. Four of the examples provide both Eastern and Western Washington access. The

community service system is enhanced by additional overall capacity. Respite capacity is safeguarded. Example C would require very little capital investment. Example D provides a way to support people in the community in ICF/MRs and includes retention of more traditional RHC professional services, through the Therapeutic Services Center. Example D also ensures the availability of an ICF/MR setting for ICF/MR eligible people. The larger settings (examples A and E) may benefit from economy of scale.

Con

Some stakeholders would object that this option continues institutional care, some in large settings (examples A and E). These larger settings carry the same risks of existing large settings in terms of compliance with ICF/MR regulations, U.S. Department of Justice scrutiny, and capital investment. Selection of one of these options would need to occur as soon as possible because of current capital issues and projects being initiated. These proposals are in conflict with the Developmental Disabilities Stakeholder Workgroup's position of wanting to let the "marketplace" of potential customers determine what capacity RHCs should be.

OPTION TWO:

This option would direct the development of a plan to close all of the RHCs. The community services system would be expanded by approximately 800 beds. The options for community development include supportive living, SNF level supported living, SNF facility based, private ICF/MR, and state operated community ICF/MR. Options would include a small community based, state-operated 14 bed respite care facility.

Assume the starting point of 1059 beds, 779 ICF/MR and 280 SNF. The department would need to move 779 people to supportive living situations and 280 to SNF level care in the community, for a total of 1059 people. It is estimated this option would take ten years (aggressive placement rate) to 14 years to complete.

Policy Direction Assumed by Option Two:

This policy direction makes a statement that people with developmental disabilities can and should be served in their communities and do not have to leave them to obtain appropriate services. As in option one, option two assumes a policy direction that is consistent with the theory that the smaller the facility, the more individualized services can be. This policy direction is consistent with the trend in the field of developmental disabilities, as well as reflective of actions taken by nearly twenty percent of other states to close all of their large institutions.[13] This policy recognizes, however, that state operated facility based services may be needed as a safety net for a few individuals. Option two assumes a consistent set of resources available to divert ICF/MR eligible persons to community-based services.

Pro

This option gets the state out of the large institution business and eliminates the increasing costs and major capital investments necessary to keep the facilities operating and in compliance with federal and state standards and regulations. Individual residents have the opportunity to participate in the community and live closer to their family members. State operated respite care remains available.

[13] Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2001, issued June 2002 by the College of Education, University of Minnesota (known informally as the "Braddock Report"), p. iii.

Con

Parents and guardians of people living in institutions are strongly opposed to such closure due to perceived risks in the community to the health and safety of their family member. There are some costs to mothballing. The previous reports issued by studies indicate that three of the RHCs have no real alternate use in the near future (Yakima Valley School, Rainier School, and Lakeland Village). Thus, mothballing is a real factor for these facilities. Closing all RHCs is in conflict with the DDD Stakeholders' Workgroup's recommendations.

OPTION THREE:

Option three gradually reduces RHCs through regular downsizing, attrition, and assumes few requests for admission. This is similar to what is happening currently, in that attrition and occasional downsizing (plus Interlake School closure) have resulted in a reduction since 1977 of 1438 people (as of May 2003). This approach would assume downsizing at a fairly aggressive placement rate of 50 people per biennium. This should include a plan to consolidate large institutions when appropriate and cost effective. This option also assumes RHCs continue to provide respite bed capacity. Admissions would be limited to only those individuals whose needs cannot be met in a community setting; an RHC would be considered the most restrictive setting. Assuming an attrition rate of 25 people per biennium and fifty community placements, and four admissions per year, the RHC population would approach zero in approximately twenty-five to thirty years (year 2028-2033). This option assumes additional community based ICF/MR facilities, either private or state operated.

Policy Direction Assumed by Option Three:

As with options one and two, there continues to be a clear statement that RHCs should be reduced, and/or gradually eliminated. This includes an assumption that is consistent with the theory that the smaller the facility, the more individualized services can be, and that people with developmental disabilities can and should be served in their communities. However, this option acknowledges that there are a number of RHC clients who have lived in an RHC for most of their lives and are older, and perhaps should be permitted to remain in an RHC if they choose. It assumes the need for a consistent set of resources available to divert ICF/MR eligible persons to community-based services.

Pro

Permits people who do not wish to move, to remain in RHCs. Permits new admissions, so that a safety net remains available for people in the community. It provides ongoing opportunities for people to move to the community. This is less disruptive than options one and two, to the residents of the RHCs, to their families, to the community. It follows fairly closely what the department has been doing for the last twenty-five years. It establishes, however, a goal toward reduction/elimination. It eliminates one time costs on a major scale associated with closing facilities, as in options one and two. While this option does not match the DDD Stakeholder Workgroup's position, which supports client choice, this option does assume some admissions.

Con

Continues the issues of significant needs for capital investments, and continues the challenges of the larger ICF/MRs meeting ICF/MR compliance over time. Would require a regular, ongoing investment in funding for community placement while also funding RHCs. It may be more costly because of needing to continue the large facilities for a longer period of time, and it takes more time to get to the decision-making point of closure. To some extent, this option is not in concert with the "best use" findings of the JLARC land study report, because continuation of Fircrest and FHMC as RHCs was not considered by JLARC to be their best use.

CHAPTER SEVEN
Program Costs for Options

Forecasting the Future Population

ICF/MR eligibility is more related to the support required for the individual to function on a daily basis, than the person's identified disability. Currently, the data system contains neither an ICF/MR eligibility identifier, nor an ADL score.[14] The forecast for the ICF/MR population was comprised by working with existing caseload characteristics to develop a range to facilitate the discussion of future caseload assumptions. DDD recently requested authority to reformulate its DDD Community Alternatives Program (CAP) waiver from the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. The caseload estimates contained in this submission are reflective of the caseload characteristics present in the current CAP waiver populations. Of significant importance, the populations for the current and future waivers satisfy the federal requirements governing ICF/MR eligibility. The caseload characteristics contained in the division's waiver submission comprise the low-range of the assumption used in this discussion.

In September 1999, "An Analysis of Unmet Service Needs for Washington State's DSHS Division of Developmental Disabilities" was released. The analysis examined ten categories of service needs including residential support. In the report it was estimated that 509 high cost clients (FY99) were not receiving the residential support they needed, and, the report concluded, by FY01 this unserved population would have grown to 602 persons.[15] For purposes of this discussion it is assumed that the upper range of the forecast could be formed if those high need individuals were added to the caseload estimates contained in the waiver submission to CMS. With the range in place, projections specific to future needs were produced.

Residential Location	2003 Lower	2003 Upper	2013 Lower	2013 Upper	2023 Lower	2023 Upper
Community Residential	4,381	5,031	5,189	6,035	5,951	6,982
Community ICFMR	61	61	57	57	52	52
Residential Habilitation Centers (RHC)	779	779	645	645	576	576
State Operated Living Alternatives (SOLA)	112	112	112	112	112	112
State Nursing Facility (RHC)	280	280	321	321	302	302
Total	**5,625**	**6,275**	**6,324**	**7,170**	**6,993**	**8,024**

Table 1. Twenty Year Residential Forecast 2003 – 2023.

[14] The department is currently conducting CARES assessment tools to all Fircrest clients, anyone moving from or to an RHC, and other selected RHC client groupings. The CARES produces a score and other data that is automatically included in the CARES database. Plans include a follow-up CARES approximately one year after placement to determine if persons' needs have changed.

[15] The rate for high cost services is the average expenditure among persons above the 80th percentile of expenditures within the category ($195/day).

Table 1. shows the anticipated ICF/MR caseload growth over the next 20 years with respect to residential services. The average annual growth in ICF/MR caseload ranges from 1.2 to 1.4 percent. Annual caseload growth rates for community residential services are anticipated to increase from 1.7 to 1.9 percent.

Option One

Annual expenditures to provide services for the lower caseload projections during FY 2004, for the five examples under option one, extend from $342 million (Option 1C) to $375 million (Option 1A). Based upon the daily rates for residential services (see Table 5 on page 34), Table 2 provides an estimate of the funding required (in 2004 dollars) per day during the next twenty years to provide a mix of private and public sector residential options for the caseload discussed previously.

			DOLLARS OPTIONS					
	2004		350 RHC beds &210 SNF beds @ RHCs	120 RHC beds & 120 SNF beds @ RHCs	60 RHC beds & 110 SNF @ RHC beds	300 ICfMR beds & 210 SNF@ RHC beds	300 Comm/State Staff ICfMR beds & 210 SNF @ RHC beds	200 RHC beds
			Lower	Lower	Lower	Lower	Lower	Lower
Community Residential			779,846	832,053	843,473	788,003	788,003	838,57
Community ICfMR			-	-	-	59,727	108,903	-
RHC	DaiLy		136,766	46,891	23,446	-	-	78,15
SOLA			28,843	28,843	28,843	28,843	28,843	28,84
SNF @ RHC			82,060	46,891	42,984	82,060	82,060	-
Total	Monthly		31,236,447	29,022,234	28,537,875	29,142,446	30,637,397	28,745,45
Total	Annual		374,837,368	348,266,813	342,454,504	349,709,354	367,648,759	344,945,49
	2013		1A	1B	1C	1Dd	1D	1E
			Lower	Lower	Lower	Lower	Lower	Lower
Community Residential			1,581,544	1,673,847	1,694,038	1,595,966	1,595,966	1,685,38
Community ICfMR			-	-	-	74,061	158,236	-
RHC	DaiLy		198,721	68,133	34,066	-	-	113,55
SOLA			33,804	33,804	33,804	33,804	33,804	33,80
SNF @ RHC			119,233	68,133	62,455	92,820	92,820	-
Total	Monthly		58,772,386	56,055,071	55,460,659	54,618,230	57,177,137	55,715,40
Total	Annual		709,945,234	680,419,455	674,090,504	664,785,363	695,492,249	675,271,48
Including Start-up								
	2023		1A	1B	1C	1Dd	1D	1E
			Lower	Lower	Lower	Lower	Lower	Lower
Community Residential			3,139,890	3,303,081	3,338,779	3,165,389	3,165,389	3,323,48
Community ICfMR			-	-	-	91,836	229,917	-
RHC	DaiLy		288,742	98,997	49,499	-	-	164,99
SOLA			39,619	39,619	39,619	39,619	39,619	39,61
SNF @ RHC			173,245	98,997	90,747	164,106	164,106	-
Total	Monthly		110,701,471	107,637,101	106,966,770	105,212,872	109,410,527	107,254,05
Total	Annual		1,333,337,601	1,300,695,035	1,293,728,422	1,273,759,006	1,324,130,867	1,294,661,99
Including Start-up								

Table 2. Funding Assumptions for ICF/MR Eligible Lower Range Caseload, 2004–2023.

The outlay for this array of residential services for the lower caseload projections accounted for $391.3 million in fiscal year 2003. This picture is considerably different when one examines the funding required to provide these same services to a larger caseload. Table 3 shows the estimated funding required per day to satisfy the residential requirements for the upper range of the forecasted caseload. Annual expenditures to provide services for the upper caseload projections during FY 2004, for the five options, extend from $391 million (Option 1C) to $424 million (Option 1A).

			DOLLARS		OPTIONS			
	2004		350 RHC beds &210 SNF beds @RHCs	120 RHC beds &120 SNF beds @ RHCs	60 RHC beds &110 SNF @RHC beds	300 ICf/MR beds & 210 SNF@RHC beds	300 Comm/State Staff ICf/MR beds & 210 SNF @RHC beds	200 RHC beds
			Upper	Upper	Upper	Upper	Upper	Upper
Community Residential			914,116	966,324	977,744	922,274	922,274	972,849
Community ICf/MR			-	-	-	59,727	108,903	-
RHC	Daily		136,766	46,891	23,446			78,152
SOLA			28,843	28,843	28,843	28,843	28,843	28,843
SNF @RHC			82,060	46,891	42,984	82,060	82,060	-
Total	Monthly		35,318,271	33,104,058	32,619,699	33,224,270	34,719,220	32,827,281
Total	Annual		423,819,252	397,248,696	391,436,387	398,691,238	416,630,643	393,927,377
	2013		1A	1B	1C	1Dd	1D	1E
			Upper	Upper	Upper	Upper	Upper	Upper
Community Residential			1,874,316	1,966,618	1,986,809	1,888,738	1,888,738	1,978,156
Community ICf/MR			-	-	-	74,061	158,236	-
RHC	Daily		198,721	68,133	34,066	-	-	113,555
SOLA			33,804	33,804	33,804	33,804	33,804	33,804
SNF @RHC			119,233	68,133	62,455	119,233	119,233	-
Total	Monthly		67,672,646	64,955,331	64,360,919	64,321,433	66,880,341	64,615,667
Total	Annual		816,748,356	787,222,578	780,893,626	781,223,801	811,930,688	782,074,605
Including Start-up								
	2023		1A	1B	1C	1Dd	1D	1E
			Upper	Upper	Upper	Upper	Upper	Upper
Community Residential			3,749,306	3,912,496	3,948,194	3,774,804	3,774,804	3,932,895
Community ICf/MR			-	-	-	91,836	229,917	-
RHC	Daily		288,742	98,997	49,499	-	-	164,995
SOLA			39,619	39,619	39,619	39,619	39,619	39,619
SNF @RHC			173,245	98,997	90,747	173,245	173,245	-
Total	Monthly		129,227,692	126,163,321	125,492,990	124,016,924	128,214,579	125,780,275
Total	Annual		1,555,652,246	1,523,009,680	1,516,043,067	1,499,407,633	1,549,779,494	1,516,976,644
Including Start-up								

Table 3. ICF/MR Funding Assumptions for Upper Range Caseload, 2004—2023.

The forecasted expenditures for the following two decades are based upon historical expenditure changes (FY1997-2002) for the incorporated services. For rate assumptions, see Table 6 on page 35.

Option Two

In contrast with option one and its five examples, option two assumes the closure of the five institutions by 2014. Continuing with what began as the resizing of Fircrest, this option presumes the department would close 71 ICF/MR and 22 SNF cottages during this ten-year span. The closure would result in the movement of 910 clients into community placements, and the reduction of the FTEs that provide habilitative services.

Direct cost avoidance from cottage closure expands from $7 million in 2006 to $63 million by 2014. By 2014, cost avoidance attributable from indirect costs adds $51 million to the total. It is assumed that for each $1.00 spent to provide service, $1.08 was spent to facilitate the delivery of the service. This closure model assumes, for the most part, this relationship between direct and indirect costs with a six-month lag as noted in the methodology (page 36). Less certain are the indirect costs that must be carried for staff that provide services that are essential to preservation of federal ICF/MR certification.

Direct costs include nursing services, residential care, physical or occupational therapy, pharmaceuticals, medical and dental services, and so forth. Examples of indirect costs are management staff, administrative support services, building and grounds maintenance, pharmacy operations, records management, food services.

Lastly, small project teams engaged in community resource development of residential and nursing level placements are essential. The members of the residential resource development team would work closely with institutional staff and case managers to ensure successful placements. In concert with client movement into the community case management capacity would be expanded at a ratio of one to each 35 clients placed in the community during the resource development and transition period only, moving to a 1:50 ratio when the placement is considered stable.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Total
Direct Costs / 1000											
Fircrest	$1,472	($8,096)	($13,248)	($13,248)	($13,248)	($13,248)	($13,248)	($13,248)	($13,248)	($13,248)	($112,608)
Rainier	$0	$736	(3,680)	(8,096)	(12,696)	(16,192)	(18,400)	(20,424)	(23,552)	(27,600)	(129,904)
Lakeland	$0	$0	0	0	0	184	(736)	(2,760)	(5,888)	(9,936)	(19,136)
FH Morgan	$0	$0	184	(920)	(2,024)	(3,128)	(4,416)	(4,416)	(4,416)	(4,416)	(23,552)
Yakima	$0	$0	184	(920)	(2,024)	(3,128)	(4,232)	(5,336)	(6,440)	(7,728)	(29,624)
	$1,472	(7,360)	(16,560)	(23,184)	(29,992)	(35,512)	(41,032)	(46,184)	(53,544)	(62,928)	(314,824)
Indirect Costs			(14,308)	(18,282)	(25,039)	(32,391)	(38,552)	(43,520)	(46,898)	(51,468)	(387,136)
Client Services											
Total	1,120	12,618	24,091	33,033	41,580	48,990	55,888	62,811	72,800	86,506	439,437
Resource Development											
FTE											
Total	4	4	3	3	3	3	3	4	4	5	5
Dollars											
Total	$298	$299	$224	$224	$224	$224	$224	$298	$299	$373	$2,687
Case Management											
Total	3	6	9	12	15	17	20	23	26	30	30
Dollars											
Total	$224	$447	$672	$895	$1,119	$1,269	$1,492	$1,716	$1,940	$2,239	$12,013
Total	3,114	6,004	(5,881)	(7,314)	(12,108)	(17,420)	(21,980)	(24,879)	(25,403)	(25,278)	(247,823)
In 2003 Dollars											

Table 4 Estimated *Cost (Avoidance)* from the Closure of all RHCs

Option Three

While this option provides the department with the greatest amount of time to plan for and the close the five RHCs, it is difficult to accurately forecast the likely cost savings during the 28-year time frame over which all 71 cottages would be closed and facilities mothballed. However, during the first ten years, from 2005—2014 it is estimated the Department would avoid about $74 million in direct and indirect expenses and by 2023 up to $240 million (in 2003 dollars).

Included are direct and indirect cost at the RHC, community residential services, client startup expenses and ongoing case management. Annual historical cost increases have added 7.7 percent to cost of pertinent community residential services and 4.6 percent to RHC costs.

Methodology

The baseline for the upper and lower ranges of the ICF/MR forecast was constructed from the division's submission to CMS. Since it is the centerpiece of this discussion, residential habilitation services were considered a principal ingredient in the development of future caseload projections. The forecasted series incorporates caseload and expenditure records pertaining to the residential services assumed by the division in its reformulation of the CAP waiver.[16]

The data were extracted from actual caseload and relevant expenditure data from fiscal year 2002. We anticipate that by 2004, 10,500 clients will be enrolled in the CAP waiver. Of the current waiver participants, 4,381 were provided state funded community residential services during fiscal year 2002. This data formed the lower range of the forecast. "An Analysis of Unmet Service Needs for Washington State's DSHS Division of Developmental Disabilities" examined ten categories of service needs including residential support. This analysis estimates the *unserved population* would grow to 602 by FY01 (and to 659 in FY03).

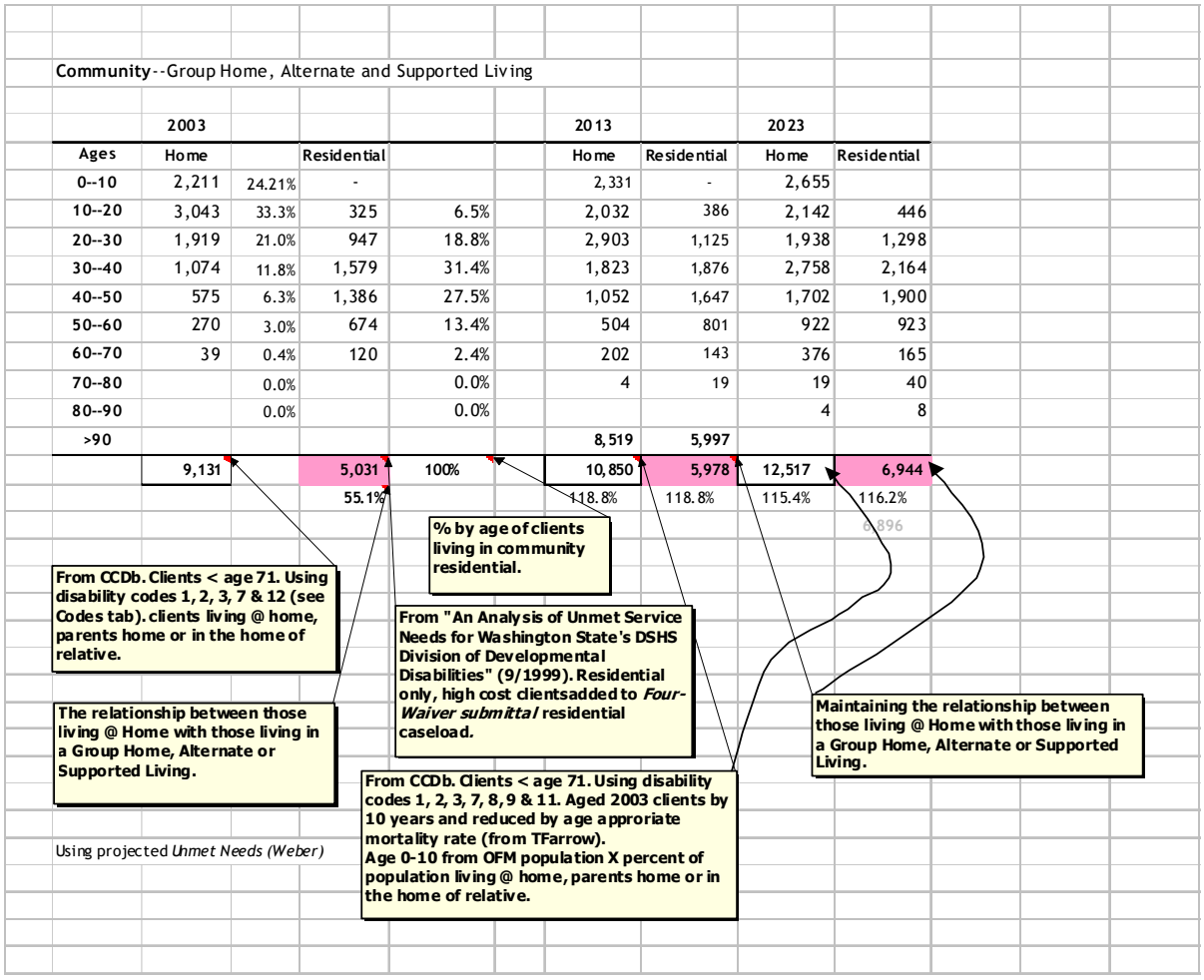

Table 5. Methodology, Estimated Community Residential Caseload 2003-2023.

The upper range of the forecast for residential service in the community was comprised by adding the *unserved population* to the CAP waiver group (5,031), see Table 3. Each range was sorted into ten-year age groupings. The relationship between those eligible for waivered services and those receiving state-supported residential services during fiscal year 2003 was maintained for

[16] For descriptions of DDD waiver programs, please see Appendix F.

the 2013 and 2023 projections. The groups were increased by the appropriate percentage of the birthrate, aged for the projections, and reduced by the anticipated death rate.[17]

It is generally understood that ICF/MR eligible clients, when given the opportunity, will choose to live at home, or with a parent or relative. It is accepted that as clients and those who provide their care age, clients become more difficult to care for and delivery of their care becomes more taxing for the caregivers. In these projections it was assumed that state funded residential services would be extended to and very likely utilized by clients upon their reaching age 40.

Costing for the array of options included in this discussion began with actual expenditures for fiscal year 2003. Costs were increased by an average of historical expenditures for the residential habilitation center services. The projected caseload X the daily rate X 365.4 = annual expense by category for each option.

Rate Assumptions:	**2004**	Decadal Adjustment	**2013**	**2023**
	Daily Rate		Daily Rate	Daily Rate
Community ICF/MR Private	$199.09	1.24	$246.87	$306.12
State Community ICF/MR	363.01	1.453	527.45	766.39
Community Residential Avg	163.15	1.768	288.45	509.97
Com Res for RHC Movers[18]	300.00			
SOLA	257.53	1.172	301.83	353.74
RHC	390.76	1.453	567.77	824.98
SNF Supported Living	250.00		442.00	781.46
SNF @ RHC	390.76	1.453	567.77	824.98
Community Nursing Facility.	250.00	1.768	442.00	781.46
Day & Employ Prgms.	20.00			
Start-up	10,000.00	1.34	13,400.00	17,956.00

Table 6. Daily rates employed for ICF/MR Funding Assumptions.

Methodology for RHC Resizing Effort

Start-up costs. $10,000 per person has been assumed for both community placement and for transfer to a skilled nursing facility. Expenses may cover a wide variety of one-time costs necessary to support a client in the community including special medical equipment, modification to a residence and the purchase of household necessities.

[17] Statistically, of children born in Washington State 1.6% are born with a developmental disability. Only two-tenths of one percent of children aged 0-10 are assumed to require state-paid waiver services.
[18] For individuals moving from RHCs during the 2003-05 biennium, an average daily rate of $300 is appropriated. Individuals who moved from RHCs during 2001-03 had an average daily rate of approximately $280. In 2001-03 biennium, people did not move into community ICF/MRs.

Client Moving Cost. The average cost of moving a single client is estimated to be $1,176. This item includes only the cost of actually transporting the client, not transition costs at either the sending or receiving placement. Assumed in this expense are the use of a van, various levels of clients and staff to included in each transit, and sundry health and safety needs for the client. This expense also assumes two trips to-and-from—the first to acquaint the client with the new environment and the second, the actual move.

Daily residential cost. Included would be residential costs ($261/day), therapy or medical costs ($19/day), and day and employment activities ($20/day). The difference between skilled nursing and community placement is predicated upon the actual residential environment. In skilled nursing, it would be a nursing home (per capita, $250/day).

Therapeutic Services Centers
Staff at the RHCs have traditionally provided therapeutic services for the DDD's institutional and community residential clients. With the resizing of the division's institutional programs the acquisition of these services must also be realigned. It is assumed that four therapeutic service centers would be established. [19] Public employees would be hired to provide ongoing physician, psychological, clinical pharmacological, orthotic/prosthetic services and physical, occupational and speech therapies. Additional medical, psychiatric and pharmaceutical services and physical therapy would be acquired by professional consultation as needed.

The estimated monthly cost for the service centers located at King, Pierce and Spokane counties would be $12,150. The estimated monthly cost for the service center at Yakima County would be $5970.

Staff Cost. Includes the cost for the staff necessary to ensure a healthy and safe outplacement, including a small share of on going case management activities (per capita, $6.35/day). The largest part of this expense is attributable to the development of community resources necessary to safely place the client. Also included are expenses required for goods and services and travel. The same cost is assumed for skilled nursing facility.

People who move from RHCs have intensive service needs at an average cost of $280 per day. In order to effectively monitor the placement to ensure people have the best chance of a successful community placement, it is recommended that the case management to client ratio be 1:50. This ratio is similar to current caseloads of people with the most intense needs, i.e., public safety, community protection, people with intense mental health needs, and so forth.

Direct & Indirect Employee Displacement Costs. Estimates a certain proportion of those employees directly related to the operations of the cottage (30 to 35 percent) and the same proportion of those employees not directly related to the operations (general therapy staff, medical professionals, maintenance, operations staff, and other administrative positions) will receive full unemployment benefits (to $14,800 maximum) or they will receive a moving allowance to facilitate to relocation (an average of $1500) to an available position. No funding is included for any retraining efforts related to staff unemployment.

Assumes that 10 percent of the employees will be immediately reemployed and 30 percent will move to another state position. Funds have been included for moving costs up to $1,500 per relocating employee. Twenty percent of the staff will desire to go through some sort of retraining program to upgrade their skills (two to three years at a unit costs of $12,000/staff, current public or private university/college costs). Ten percent of the employees will receive a one-time grant to develop their own, post separation, private home-care program for clients they served while employed at the RHC (Assumed a unit cost of $7,500 to cover any training and capital start-up costs).

[19] One each in King, Pierce, Spokane and Yakima counties.

Direct & Indirect Cottage Closure Costs. The costs of operating a cottage will continue beyond the actual closure of the cottage. Accumulated vacation and sick leave will need to be paid, double filling of positions resulting from a RIF bumps need to be covered, costs to mothballing the cottage and preparation costs for closing after the cottage is vacated need to be paid; any final bills associated with the operations of the cottage to date need to be liquidated, and so forth.

The assumption is that the daily cost of operations per client is $196.61 and these costs will be equal to two months of operations. Due to minimum staffing required to provide the services required for certification as either a Nursing Facility or ICF/MR, the full savings may be realized only after the RHC is closed. **If a sufficient number of clients are out placed, a cottage may be closed, at which point the cost reduction becomes applicable**. The costs would include all or some portion of the following: 1) management costs both institution wide as well as management of functional area such as health, professional, and business services; 2) maintenance and operations of grounds, facilities, and plant, utilities; and, 3) other general costs. Not all of these costs could be avoided, even if the facility is vacated, until the facility is actually sold or put into some alternative use. The property would need to be protected and basic maintenance performed as long as the property is held by the state. One cottage closure would not likely generate any savings. Savings would only begin to accrue after the closure of a number of cottages (perhaps 25 percent of the total).

Although some lag is to be expected, cost reductions for the closure of each cottage will be closely reflected by the actual movement of clients. Indirect costs will also decline as clients are returned to the community from the RHC; however, a six-month lag is anticipated in the recognition of these reductions in expense. It is assumed that a reduction in indirect costs will abide by the following relationships attributable to cottage closure.

Cottages Closed	Indirect Cost Reduced by
25 Percent	6.50 Percent
50 Percent	25 Percent
75 Percent	50 Percent
100 Percent	100 Percent[20]

[20] This figure does not include the costs to mothball a facility as described on page 22.

CHAPTER EIGHT
Summary of Capital Costs for Each Option

Option 1

A. Total beds 560 (ICF/MR - 350; SNF - 210)
Two ICF/MR facilities, one at Rainier School, and one at Lakeland Village in Medical Lake. Each will have 175 beds each. Two Skilled Nursing Facilities (SNF's) one at Rainier on the Westside at 100 beds and one on the Eastside at Yakima Valley School with 110 beds.

While this scenario assumes the above-described example, information about other possibilities are included below:

	Rainier	Fircrest	Lakeland	Yakima	FHMC	Total Cost
A(1)	175 ICF/MR / 100 SNF	Close	175 ICF/MR	110 SNF	Close	
	$19,601,000	$475,000	$6,385,000	$10,250,000	$110,000	$36,821,000.00
A(2)	175 ICF/MR	100 SNF	175 ICF/MR	110 SNF	Close	
	$12,701,000	$8,970,000	$6,385,000	$10,250,000	$110,000	$38,416,000.00
A(3)	100 SNF	175 ICF/MR	175 ICF/MR	110 SNF	Close	
	$15,940,000	$12,837,000	$6,385,000	$10,250,000	$110,000	$45,522,000.00
A(4)	Close	175 ICF/MR / 100 SNF	175 ICF/MR	110 SNF	Close	
	450,000	$16,250,000	$6,385,000	$10,250,000	$110,000	$33,445,000.00

B. Total beds 240 (ICF/MR - 120; SNF - 120)
Two 60 bed ICF/MR facilities, one on the Westside (Frances Haddon Morgan Center) and one on the Eastside Yakima Valley School. Two Skilled Nursing Facilities (SNFs) one on the Westside (Frances Haddon Morgan Center) and one on the Eastside (Yakima Valley School). Each will have 60 beds.

	Rainier	Fircrest	Lakeland	Yakima	FHMC	Cost
B.	Close	Close	Close	60 ICF/MR / 60 SNF	60 ICF/MR / 60 SNF	
	$450,000	$475,000	$360,000	$12,700,000	$6,930,000	$20,915,000.00

C. Total beds 170 (ICF/MR - 60; SNF - 110)
One ICF/MR facility at Frances Haddon Morgan Center with 60 beds. One SNF at Yakima Valley School with 110 beds.

	Rainier	Fircrest	Lakeland	Yakima	FHMC	Costs
C.	Close	Close	Close	110 SNF	60 ICF/MR	
	$450,000	$475,000	$360,000	$10,250,000	$2,430,000	$13,965,000.00

D. Total beds 510 (ICF/MR - 300; SNF - 210)
50 six bed ICF/MR community houses: Ten houses each in Regions 1, 2, 4, and 5, and five houses each in Regions 3 and 6.

Two SNF facilities, one at Yakima Valley School at 110 beds and one at Rainier School at 100 beds. One Medical Center (dental and some health care) in each region. Since those are to be leased, their costs are not in the chart below.

D.	Rainier	Fircrest	Lakeland	Yakima	FHMC	Houses[21]	Costs
	Close	100 SNF	Close	110 SNF	Close	50	
	$450,000	$8,970,000	$360,000	$10,250,000	$110,000	$24,752,000	$44,892,000.00
	100 SNF	Close	Close	110 SNF	Close	50	
	$15,940,000	$475,000	$360,000	$10,250,000	$110,000	$24,752,000	$51,887,000
	100 SNF	Close	110 SNF	Close	Close	50	
	$15,940,000	$475,000	$11,185,000	$187,500	$110,000	$24,752,000	$52,649,500

E. Total Beds 200 (ICF/MR - 200)
One ICF/MR facility anywhere in the state, 200 beds.

Arrangements to establish this example include:

E(1) Rainier as ICF/MR
E(2) Lakeland as ICF/MR

	Rainier	Fircrest	Lakeland	Yakima	FHMC	Costs
E(1)	200 ICF/MR	Close	Close	Close	Close	
	$13,540,000	$475,000	$360,000	$187,500	$110,000	$14,672,500.00
E(2)	Close	Close	200 ICF/MR	Close	Close	
	$450,000	$475,000	$6,735,000	$187,500	$110,000	$7,957,500.00
E(3)	Close	200 ICF/MR	Close	Close	Close	
	$450,000	$13,575,000	$360,000	$187,500	$110,000	$14,682,500.00

[21] Costs indicated are for state operated community ICF/MRs.

Analysis of the Costs to Adjust Capacity at Each RHC for Option One

Improvement lists will be taken from current capital budget information, capital programs project managers, and facility staff.

Improvement costs will be based upon the following:

- Actual costs if known
- Current project cost if already estimated in budget request
- Dollars per square foot estimate for each improvement has been provided where a scope has not been worked up and cost estimates created.

Costs in this section are order of magnitude estimates at this time and should be accepted for comparison purposes but should not be considered a final accurate cost.

Summary of costs (in millions)

Rainier School	200 IMR	175 IMR	175 IMR / 100 SNF	100 SNF	60 IMR / 60 SNF	60 IMR	60 SNF
Costs	$**13.5**	$**12.7**	$**19.6**	$**15.9**	$**13.3**	$**10.1**	$**12.3**

Fircrest School	200 IMR	175 IMR	175 IMR / 100 SNF	100 SNF	60 IMR / 60 SNF	60 SNF
Costs	$**13.6**	$**12.8**	$**15.8**	$**9.0**	$**9.0**	$**7.8**

Lakeland Village	200 IMR	175 IMR	175 IMR / 110 SNF	110 SNF	60 IMR / 60 SNF
Costs	$**6.7**	$**6.4**	$**13.5**		$**5.6**

Yakima Valley School	200 IMR	60 IMR / 110 SNF	60 IMR / 60 SNF	110 SNF
Costs	$**20.4**	$**14.1**	$**12.7**	$**10.3**

Frances Haddon Morgan Center	60 IMR	60 IMR / 60 SNF
Costs	$**2.4**	$**6.9**

Option 2

Close all RHCs and run one small community based, state operated, 14 bed respite facility.

Since the cost to mothball facilities is provided on page 21, the assumption used for providing capital costs for this option is the cost of one building on purchased land, as follows:

- 7,350 square feet (525 square feet per client)
- Type I occupancy
- Land Costs $150,000
- Construction costs of $918,000 ($125 per square foot total project cost)
- Total Capital cost of option $1,068,000.

Alternate Uses for Existing RHCs

Alternative uses for RHCs are described in JLARC's audit report #2002-12, "Capital Study of DDD Residential Habilitation Centers," issued December 4, 2002.

CHAPTER NINE
Impacts Upon Clients, Families, and Employees

Impact to Employees

To determine impact to employees when reducing RHCs, assumptions need to be made about who these employees are, where they are, and what options could be available to them. Opportunities for employees will be affected by their geographic locations, length of service, their job skills and abilities, and regional job markets. For this exercise, length of time in service and salaries have been averaged for all employees and all regional and economic opportunities are assumed to be the same.

Any actual reduction or closure will occur in phases. Not all employees would be reduced-in-force (RIF) at the same time, but over the course of several years.

The Fircrest closure model presented last legislative session was revised to assume that 15 percent of employees would become unemployed and would receive their entire unemployment benefit. Of the remaining 85 per cent of the employees, it was assumed that some portion will retire, some will move to other positions through a reduction in force, some will find employment outside DSHS and outside state government, and some would become vendors for the department.

Action	Percent of FTEs
Retire	3%
RIF into other positions	60%
Found other employment	15%
Became a vendor	7%
Unemployed	15%
Total	**100%**

The costs associated with employees retiring or leaving state employment are the costs of buying out applicable leave balances and paying employment insurance premiums. The average leave balances for institutional employees are 90 hours of annual leave, and 45 hours of sick leave. Only 25 percent of the sick leave balance is paid while 100 percent of the accumulated annual leave balance is paid upon disconnection from public service. The costs, based upon an average salary of $47,000 would average $2280 per employee buyout.

Prior to the 2003-05 biennium, there was no precedent for offering retraining programs, severance packages, or business development subsidies.

Employees Leaving State Employment

There is no precedent to pay severance packages, or to retrain employees.[22] All employees would be subject to usual merit system rules. DSHS' Human Resources Division would provide informational seminars regarding RIF actions and employee rights to any affected employee group.

As stated in the outset, employee salaries and leave balances were averaged to develop an average cost for employment insurance premiums and leave buyouts. The cost to the department to pay employment insurance for displaced personnel will be $14,800 X 15% per closed RHC:

[22] 2003 legislative budget appropriation includes language to assist Fircrest employees "to relocate or to transition to private sector positions."

RHC	# Of Employees	# Of Affected Employees	Cost For 15% Unemployment
Fircrest	646.8	97.02	$1,435,896
Rainier	926.9	139.03	$2,057,644
Lakeland	548.3	82.24	$1,217,152
Yakima	263.4	39.51	$ 584,748
FHMC	127	19.05	$ 281,940

It is important to note that when Interlake School closed, nearly all employees found jobs. It is difficult to know whether that was an artifact of the number of employees seeking jobs, the geographical location of Interlake, or some other factor. It is safe to say that the more notice employees have, the more planning they can accomplish for their own futures.

Contracts

DDD currently has about 150 residential vendors providing residential services to DDD clients. Most vendors are operating near capacity with few, if any, vacancies. Additional capacity would need to be developed to accommodate any significant increase or shift in the population. Capacity can be developed through increasing the number of people to be served by current contracts or through developing new resources to serve more people.

It is possible some displaced employees could become vendors for DDD. The contracts necessary for residential services would be considered "client service" and would not require a procurement process. DDD has historically paid some start up costs for vendors. This biennium, the Legislature provided up to $10,000.[23] The total cost to the department would be based on the total number of clients receiving services from new vendors.

There is no ethical conflict for institutional employees to leave state employment to work for DDD vendors, or to become vendors themselves.[24] The ethics issue would only arise if the employee had contract or fee-setting authority. While it is possible some employees could receive jobs through current vendors, particularly if current resources were expanded, IRS laws do not permit the department to *require* vendors to hire DSHS employees. DSHS employees would be competing for private jobs with all other job-hunting people in their communities.

Mitigating Factors

As stated previously, this model did not assume a phased approach to closure. In determining a phased approach to RHC closure it has been assumed that generally you have to move 16 people out of an RHC to close a cottage. If it's determined you can only move four people per month from an institution, it would take several years to close that institution. This length of time will have a significant mitigating factor on the number of employees adversely affected by an RHC closure. During this phasing out period RHCs could freeze hiring, and only hire on a

[23] While DSHS doesn't have a history of subsidizing business development for displaced employees, it is possible to provide some start up moneys to any qualified person who wishes to become a residential services provider for DDD clients.

[24] A review of RCW 42.52.080 indicates no ethical conflict exists for RHC employees becoming employed by residential service providers.

temporary/emergency basis allowing the attrition process (retirement/resignation). Also during this time it is possible other resources may be generated, e.g. build 50 state operated ICF/MR cottages or contract for 50 community based homes, and this would create the possibility for additional employment opportunities or employees displaced due to RHC closure. These factors would significantly decrease the number of employees who might end up actually being unemployed.

Approximately 2,512 people are employed at RHCs. This group is composed of professional and para-professional staff, with the large majority being para-professional staff: attendant counselors, (ACs) and adult training specialists (ATS). For the most part, the lifetime working experience for this staff has been at the RHCs. Finding alternative employment equivalent to the salary range of an AC and ATS job class is difficult. Three of five RHCS are located in rural communities.

How Close do Employees Live to the RHC?[25]

Facility	% Employees Living Locally	# Living Locally	Total # Employees (approx)
Rainier School	68%	612	900
Fircrest	35%	250	714
Lakeland Village	37%	222	600
Yakima Valley	82%	236	288
FHMC	73%	118	161

Effect on the Local Community:

Closing an RHC(s) will cause a potentially significant economic impact on the small rural communities. Three of the five RHCs are located in the relatively rural areas of Buckley, Selah, and Medical Lake. In some of the rural communities, the RHC residents are included in the town population count. If employees had to relocate to find employment, there could be an impact upon the town's tax revenue. There would be an impact upon the local businesses that depend upon a customer base from the RHC residents, families, and employees. Some of the RHCs have contracts for services from the local city for utilities, and fire emergency services, which depend on those contracts to support the cost of the infrastructure for those services.

Impact Upon Clients' Relationship with Family Members

The placement of RHC clients in the community affects the client's family if they are involved with the client. Family contact, visits, for at least 8% of RHC residents occur on a weekly basis, while the majority (26/29%) visit on a quarterly and/or yearly basis, respectively. Interestingly, 33 percent of families live within 25 miles of the RHC. Depending upon whether the client is moved closer to the family, which is generally the case, it could have a positive effect upon the client's relationship with their family. Approximately 53 percent of RHC clients are over 46 years old. Their parents are older, some into their 80s and 90s. The adjustment for a client moving to the community could be enhanced if they are moved to a location that makes it easier for elderly parents to visit.

Data revealed that in addition to the 33 percent of resident families that reside within 25 miles of the RHCs, 23 percent live within 50 miles, 15 percent within 100 miles, 21 percent are more distant and nine percent very distant. Families often express concerns of what will happen to their family member when the family care giver(s) reaches the age of 60 or beyond,

[25] Used data from commute reduction surveys 2001 and extrapolated percentages for zip codes considered "local" by the RHC administration.

There are a significant number of families for whom placement of their son or daughter out of an RHC will be especially difficult. These are generally families whose son or daughter has been living in the RHC for a long period of time, thirty years to over sixty years.

Some of these families went through traumatic experiences with their son or daughter when the person was living at home or in a community setting. To make a decision to place their child in an institution is an emotionally challenging experience from which it is difficult to recover. When many parents have to face the decision-making process all over again, many end up reliving the former experience. Some had very bad experiences with community providers. They remember those experiences; they remember never being able to get a full night's sleep; they remember having to go get their child from the provider because the provider could not manage the person's challenges. The gift the RHC has brought them is security. They know where their son or daughter is; they know the RHC will not ask them to come and get their son or daughter because they can't manage them. Intellectually they may understand that community residential services contracted for people with developmental disabilities are very different from generic boarding homes in the 1970s. However, they read the newspapers and sensational stories of vulnerable adults who are abused or neglected by community service providers.

In addition, the individual parents are aging. With 22 percent of RHC clients being 56 years of age and older, their parents are older still. These parents want assurance before their lives have ended that their family member is safe. Their personal experiences, the stories they hear of people being harmed, the wrenching experience of having to relive a decision-making process they thought was over, combined with a natural fear of the unknown future, result in an extremely wary parental decision-maker, who sometimes believes he/she is being forced to make a decision that is actively harmful to their son or daughter. It is unrealistic to expect these parents to accept a reduction or closure of an RHC without anxiety. Therefore, it is critical to any plan for reduction and closure to have in place a process that demonstrates respect for the process a parent has to go through to choose an alternate placement for their son or daughter. There were a few instances during the 2001-03 Olmstead experience that gave DDD the opportunity to work with some parents who were adamant against their son or daughter leaving, but where the son or daughter or a sibling, wanted very strongly to leave the RHC. Efforts to support the parent through this process and to address their fears were successful in these instances.

Another factor to be considered is the RHC residents who have lived the majority of their life in an RHC. The community represents a different cultural experience and that must be considered in any move. Twenty-two percent of people living in RHCs are age 56 years and older, with six percent of the entire population age 65 years or over. The majority of these individuals have resided in the RHC for decades, a few for over sixty years. Requiring the person to move, if they do not choose to, to a community setting could affect their adjustment and health.

AGE:	Fircrest	Rainier	Lakeland	YVS	FHMC	TOTAL
56-64	42	85	32	1	0	160
65+	19	35	21	0	0	75
Total	61	120	53	1	0	235

Other Considerations

As mentioned on page 6, CMS issued an audit report of Washington State's home and community-based waiver, the CAP waiver, in July 2002. One concern noted was that when a CAP waiver client was offered services, there was not documentation that the person had "waived" the ICF/MR service. This was an issue because the purpose of a waiver is to offer community and home based services in lieu of ICF/MR services to an individual who is otherwise eligible for services in an ICF/MR. Of the ICF/MR beds in this state, approximately 740 are state operated, and 60 are delivered through small facility based services from private community vendors. If Washington wants to retain federal match and continue downsizing and closure of

RHCs, it could meet the obligation by making community ICF/MR services available. This strategy would also require a consistent set of community- based resources be made available for ICF/MR eligible people choosing community services.

Legal Analysis – State Law

RCW 71A.20.020 permanently establishes the RHCs, and although not necessary, revision should be considered if one or more RHCs were closed, as was done when Interlake School closed in 1993. During a lawsuit filed at that time, Thurston County Superior Court ruled that this law did not preclude the Legislature from closing an RHC. The State Supreme Court declined to review this decision.

RCW 71A.10.050(1)(f) and (2) provides a right of appeal when the department makes a decision to return a resident of an RHC to the community. Subsection (2) specifies that the department has the burden of proof in an adjudicative proceeding regarding (1)(f).

RCW 71A.20.080 is known as the "Froberg amendment," after the individual who was a parent of an RHC resident and who initiated the effort for the adoption of this provision. This law keeps the department from being able to move forward with a person's placement into the community from an RHC if the person or guardian appeals the decision, until the appeal process is complete, including any appeals to the Superior Court. The appeal must be pursued diligently, and the department can at any time seek a court order permitting placement notwithstanding the appeal. This provision addresses transfers from RHCs to community residential settings; it does not appear to apply to inter-RHC transfers.

RCW71A.20.080 does not appear to apply if RHCs are closed or reduced in capacity due to legislative action. The premise is that RCW 71A.020.80 applies to the department initiating an action to move a specific individual into a community placement based upon the unique needs of that individual. If community placement is made due to action by the Legislature to reduce or close RHCs, the Legislature does so based upon the best interests of the public, not individual residents. In effect, the department is not making the decision per RCW 71A.10.050(2) to return a specific person to the community, where the burden of proof is on the department to justify that the community placement better meets the individual's needs. It is being made based upon a legislative decision to reduce or eliminate capacity, for the public's greater good. However some courts may well reject this argument, and it would be preferable to amend the statutes referenced above to make it clear that 'Froberg' rights do not apply to DSHS actions required by legislation downsizing or closing one or more RHCs.

CHAPTER TEN
Mitigation of Potentially Negative Impacts
Quality Assurance

A basic goal of any RHC reduction and/or closure has to be to implement the actions while safeguarding the clients' health and safety. While we may believe that this can be accomplished, there are certain factors that can be built into the process to provide necessary safeguards.

Mitigating the effects on clients of Reducing RHCs

1. Identify those who want to move.
2. Determine, based upon a consistently applied needs assessment, who will remain in the RHC. The needs assessment could include factors such as the age of the person, where the person's family lives, how long the person has resided at an RHC, what kind of transition process is needed for any particular individual, and similar factors.
3. Provide people and their guardians with choices about the location of other living arrangements, selection of vendors when possible, and choices about housing, and so forth.
4. Implement a quality assurance service that periodically monitors both quality of life and whether needed services are being received at an individual by individual level.
5. Provide adequate case management support for all people leaving RHCs.

Mitigating the effects upon employees

1. Continue local hiring freezes with the possibility of exceptions, determined by the appointing authority. Most of the large RHCs have had local labor management agreed upon freezes since prior to the 01-03 biennium, due to the downsizing and cottage closures anticipated. As a result very few individuals experienced a RIF, even though a significant number of positions were eliminated. With hiring freeze exceptions approved locally, management can respond where needed to urgent client need. An example would be the number of ongoing nurse vacancies. If an RHC recruits a nurse who says they will agree to accept the position only if it is a permanent position, the superintendent has to be able to make a decision on the spot or risk losing the applicant.

2. Direct other state agencies to accept DSHS' RHC Riffed candidates prior to considering other open competitive applicants. Or enable RIF rights to other agencies. A large number of RHC employees do not have higher education; and it would be of benefit to have access to vacancies in other agencies that provide a twenty-four hour service, such as the Department of Corrections, the Department of Veterans Affairs, or have positions that do not require higher education.

3. RHC employees would not be facing RIFs simultaneously. RHCs would be downsizing over a period of time, which would make options for job placement more steadily available.

4. If there is significant reduction or closure of RHCs, it will take a period of time to implement. If retraining is available and employees are permitted to the extent possible some flexibility, employees could take advantage of this prior to actual closure of the facility employing them.

A Quality Assurance Program for People Moving From the RHCs

The quality assurance approach used by DDD during the 2001-2003 biennium for the sixty-one people, who moved under the appropriation for Olmstead placements, proved to be very successful. The division used this quality assurance process for each person who moved, from the time the person and family/guardian became interested in moving, through the first year of the

move. The procedures built on quality assurance activities that began as early as the 1980's in the Rainier Follow-Along project. Critical components of this assurance approach included:

Information and Education:
It is extremely important for people living at the RHCs, and their families and guardians to have good, accurate information about what is available if someone requests to move. They need to know what options and choices they have, what funding is available, what supports will need to be in place in order for the move to be successful, and what difference it will make to the person moving. This information was provided through brochures and through Olmstead coordinators at each RHC and also in each region, as well as, county coordinators who were ready to help work out plans for the person to find work or community activities. The outcome was that quality information was provided to individuals, families, or guardians, which in turn led to good decisions.

Person-centered plan:
When the person living in an RHC and their families/guardians request that the person move to the community, it is very important that comprehensive planning be done to ensure that the person moves where they would like to move and that they have the opportunity to select providers and the supports necessary for a successful transition. The outcome has been that the plan is based on the individual's needs and preferences, which provides a "road map" to a successful placement.

Self-direction Opportunity:
People who moved and their families and guardians were given the opportunity to choose which services the person would use and how they wanted them delivered, based upon the person-centered plan. They also had the opportunity to be as involved as they wanted in the actual service delivery system. The outcome was that the families/guardians who were involved in the decisions that are made are generally much more supportive of the outcomes and helpful in trying to make the community placement work.

Health & Safety focus:
Health and safety needs were addressed at the RHC before the person moved out. It is important that the yearly physical and dental visits are completed before the move, as the transition to new medical supports may take some time. An important part of the quality assurance for people who moved, was the knowledge that they could return to the RHC for additional medical or dental care until they had established these relationships with professionals in the community. The outcome was that health conditions were known and plans were in place to meet the needs of the person who moved. Annual physicals and dental visits were up-to-date.

Quality Assurance "Follow-Along" visits at 30 days, 90 days and one year:
The regional quality assurance manager, or designee, visited each person who had moved, assessed the new community living arrangement, and made a written report to the regional administrator, case resource manager, and DDD central office. During the 90-day and one year visits, community volunteers (usually parents or self-advocates) accompanied the quality assurance manager to provide their insight on the quality of the living arrangement. The outcome was assurance to families that living conditions are being monitored and corrected if needed. Attention was paid to all aspects of the person's life who has moved.

Residential Certification Evaluations:
The agencies that provide services for people who move are part of the residential evaluation certification process. These service providers are evaluated at least every two years to make sure that they are providing required and appropriate supports.

Yearly Plan of Care Reviews:
Plans of Care are up-dated yearly, or more often if needed for people who have moved, by the case/resource manager to ensure that individuals are receiving and will continue to receive the

supports and services they need. The outcome is that changing needs are recorded and addressed on an on-going basis.

Future Plans:
As part of a case management information system, the department proposes to develop a way to collect information on health and quality indicators for people moving. If developed, the information would provide a base line of information on people who move and on-going information on health and safety, both on an individual and system basis. It would also provide the ability to generate reports to demonstrate successes or identify problems that need addressing.

CHAPTER ELEVEN
Closing Summary

Options have been presented which provide policy choices. Policy options include: (1) Reducing to one RHC, or establishing up to four large or relatively small facilities at the RHCs, although one option includes community based state operated ICF/MRs. (2) Closing RHCs altogether. (3) Maintaining the status quo with ongoing reductions and some admissions. The costs for each option are reasonably straightforward. The individual costs are also provided so that all options may be considered.

The assumption is that when formulating the policy related to state facilities, decision-makers will also consider JLARC findings about best valued use when determining what would best serve the State of Washington and its citizens. For instance, option one, example B, provides for two ICF/MRs and two SNFs. The example uses FHMC and Yakima Valley School. However, given the land use report, policy makers would be aware the study concluded that there were other valuable uses benefiting the state for FHMC (and Fircrest), while Rainier School was determined to be at its best use as an RHC. One might conclude, therefore, that if this option were chosen, then Rainier School would be the logical place for the Westside ICF/MR and SNF. The capital costs of using Rainier as an ICF/MR and SNF are a combined $13.3 million, nearly twice what FHMC projected capital costs to convert are, at $6.9 million (page 38).

Per JLARC recommendation, the department reviewed the status of the Fircrest Master Planning Project. The plan is not final, and does not anticipate approval until Spring 2004.[26]

The Developmental Disabilities Stakeholders Report indicated a strong preference for letting the marketplace (of potential consumers) determine what the capacity of RHCs should be.[27] That model assumes resources available to let ICF/MR eligible people choose between a community or RHC option. While a model that strictly implements that recommendation is not included in this report, option 3 assumes admissions, and this acknowledges that some individuals may choose an RHC. During the implementation of Senate Bill 6751 in 1999, funding was appropriated to provide client choices about where to live, including the RHC. Twenty-one individuals whose health and safety were at the highest risk were provided residential services using this proviso; three chose an RHC.

The stakeholders supported the concept of choice as being the most critical dimension. They believed people having a choice about living in community settings or an RHC was more important than the opportunity for community integration, or the value of non-congregate settings.

This report attempts to provide the information needed to make challenging decisions affecting the future of a significant number of clients, their families, and employees. Information about what is the best use of state resources from the JLARC report, combined with this report's information about what capital costs are involved, what is currently seen as the best approach to services for people with developmental disabilities, and what the costs of ongoing care look like in a variety of settings, is provided as a basis for policy decisions.

[26] "Fircrest Master Plan Project Update," correspondence by Gina Mares Kurtz, Arai/Jackson Architects and Planners, dated July 28, 2003.
[27] "Strategies For the Future," Phase Three, The Division of Developmental Disabilities, Washington State Department of Social and Health Services, issued December 1, 2002.

APPENDIX A. REPORTS REVIEWED DURING THE STUDY

Review of Multiple reports:

- The Stakeholder reports "Strategies for the Future," Phase 1, 2 and 3. December 1, 1998, 2000, and 2002.
- JLARC audit report #2002-12 "Capital Study of the DDD Residential Habilitation Centers," issued December 4, 2002.
- "Report on the Potential Excess Property of the DSHS, DDD, RHCs, issued April 11, 2003, by Real Estate Services, Department of General Administration.
- DDD Strategic Plan 2004-2009 (2003-2005 Budget).
- Review of the Senates and Means Committee Report and Presentation by Brian Sims 1/30/03.
- Residential Services for Persons with Developmental Disabilities Status and Trends Through 2001, issued June 2002 by The College of Education & Human Development, University of Minnesota (known as the "Braddock Report").
- Report to the Governor; Interagency Task Force on Intermediate Care Facilities for the Mentally Retarded, issued December 1988.
- "Fircrest Downsizing/Closing Financial Model," used to determine Fircrest downsizing appropriations. June 2003.

Books reviewed include:

Disability at the Dawn of the 21st Century and The State of the States, David Braddock, editor, American Association on Mental retardation, Washington D.C. 2002.
The History of Institutional Services for the Developmentally Disabled in the State of Washington.

Also reviewed were the results of questionnaires sent to other states that have closed large state operated institutions.

APPENDIX B. LAWS GOVERNING RHC SERVICES:

RCW 71A was passed by the 1998 Legislature, which reorganized and clarified laws regarding the provision of services to person with developmental disabilities.

RCW 71A.10.011

Intent -- 1995 c 383.

The Legislature recognizes that the emphasis of state developmental disability services is shifting from institutional-based care to community services in an effort to increase the personal and social independence and fulfillment of persons with developmental disabilities, consistent with state policy as expressed in RCW 71A.10.015. It is the intent of the Legislature that financial savings achieved from program reductions and efficiencies within the developmental disabilities program shall be redirected within the program to provide public or private community-based services for eligible persons who would otherwise be unidentified or unserved. [1995 c 383 § 1.]

RCW 71A.10.015

Declaration of policy.

The Legislature recognizes the capacity of all persons, including those with developmental disabilities, to be personally and socially productive. The Legislature further recognizes the state's obligation to provide aid to persons with developmental disabilities through a uniform, coordinated system of services to enable them to achieve a greater measure of independence and fulfillment and to enjoy all rights and privileges under the Constitution and laws of the United States and the state of Washington. [1988 c 176 § 101.]

RCW 71A.10.050

Appeal of department actions -- Right to.

(1) An applicant or recipient or former recipient of a developmental disabilities service under this title from the department of social and health services has the right to appeal the following department actions: (a) A denial of an application for eligibility under RCW 71A.16.040; (b) An unreasonable delay in acting on an application for eligibility, for a service, or for an alternative service under RCW 71A.18.040; (c) A denial, reduction, or termination of a service; (d) A claim that the person owes a debt to the state for an overpayment; (e) A disagreement with an action of the secretary under RCW 71A.10.060 or 71A.10.070; (f) A decision to return a resident of an [a] habilitation center to the community; and (g) A decision to change a person's placement from one category of residential services to a different category of residential services.
The adjudicative proceeding is governed by the Administrative Procedure Act, chapter 34.05 RCW.

(2) This subsection applies only to an adjudicative proceeding in which the department action appealed is a decision to return a resident of a habilitation center to the community. The resident or his or her representative may appeal on the basis of whether the specific placement decision is in the best interests of the resident. When the resident or his or her representative files an application for an adjudicative proceeding under this section the department has the burden of proving that the specific placement decision is in the best interests of the resident.

(3) When the department takes any action described in subsection (1) of this section it shall give notice as provided by RCW 71A.10.060. The notice must include a statement advising the recipient of the right to an adjudicative proceeding and the time limits for filing an application for an adjudicative proceeding. Notice of a decision to return a resident of a habilitation center to the community under RCW 71A.20.080 must also include a statement advising the recipient of the right to file a petition for judicial review of an adverse adjudicative order as provided in chapter 34.05 RCW.

[1989 c 175 § 138; 1988 c 176 § 105.]

NOTES:

Effective date -- 1989 c 175: See note following RCW 34.05.010.

RCW 71A.12.040

Authorized services.

Services that the secretary may provide or arrange with others to provide under this title include, but are not limited to: (1) Architectural services; (2) Case management services; (3) Early childhood intervention; (4) Employment services; (5) Family counseling; (6) Family support; (7) Information and referral; (8) Health services and equipment; (9) Legal services; (10) Residential services and support; (11) Respite care; (12) Therapy services and equipment; (13) Transportation services; and (14) Vocational services. [1988 c 176 § 204.]

RCW 71A.20.080

Return of resident to community -- Notice -- Adjudicative proceeding -- Judicial review -- Effect of appeal.

Whenever in the judgment of the secretary, the treatment and training of any resident of a residential habilitation center has progressed to the point that it is deemed advisable to return such resident to the community, the secretary may grant placement on such terms and conditions as the secretary may deem advisable after consultation in the manner provided in RCW 71A.10.070. The secretary shall give written notice of the decision to return a resident to the community as provided in RCW 71A.10.060. The notice must include a statement advising the recipient of the right to an adjudicative proceeding under RCW 71A.10.050 and the time limits for filing an application for an adjudicative proceeding. The notice must also include a statement advising the recipient of the right to judicial review of an adverse adjudicative order as provided in chapter 34.05 RCW.

A placement decision shall not be implemented at any level during any period during which an appeal can be taken or while an appeal is pending and undecided, unless authorized by court order so long as the appeal is being diligently pursued.

The department of social and health services shall periodically evaluate at reasonable intervals the adjustment of the resident to the specific placement to determine whether the resident should be continued in the placement or returned to the institution or given a different placement.

[1989 c 175 § 143; 1988 c 176 § 708.]

NOTES:

Effective date -- 1989 c 175: See note following RCW 34.05.010.

RCW 71A.20.020

Residential habilitation centers.

The following residential habilitation centers are permanently established to provide services to persons with developmental disabilities: Lakeland Village, located at Medical Lake, Spokane county; Rainier School, located at Buckley, Pierce county; Yakima Valley School, located at Selah, Yakima county; Fircrest School, located at Seattle, King county; and Frances Haddon Morgan Children's Center, located at Bremerton, Kitsap county.

[1994 c 215 § 1; 1988 c 176 § 702.]

APPENDIX C. DETAIL OF FACILITY COST ANALYSIS

Rainier School 200 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Cottage repairs ICF/MR 12 existing cottages ok	1,100,000	5 Cottages, 12 clients per cottage, 6,300 sf/ cottage, $35/ sf remodel
Laundry upgrade	3,400,000	$17,000 per bed/laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	13,540,000	

Rainier School 175 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Cottage repairs ICF/MR 12 existing cottages okay	661,000	3 Cottages, 12 clients per cottage, 6,300 sf/ cottage, $35/ sf remodel
Laundry upgrade	3,000,000	$17,000 per bed/laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	12,701,000	

Rainier School 175 ICF/MR bed and 100 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Cottage repairs ICF/MR 12 existing cottages okay	661,000	3 Cottages, 12 clients per cottage, 6,300 sf/ cottage, $35/ sf remodel
Laundry upgrade	4,700,000	$17,000 per bed/laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
New SNF Beds 70	5,200,000	Pre design estimate, $75,000 per bed
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	19,601,000	

Rainier School 100 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Laundry upgrade	1,700,000	$17,000 per bed/laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
New SNF Beds 70	5,200,000	Pre design estimate, $75,000 per bed
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	15,940,000	

Rainier School 60 IMR bed and 60 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Laundry upgrade	2,100,000	$17,000/bed – Laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
New SNF Beds 30 30 beds existing	2,200,000	Pre design estimate, $75,000 per bed
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	13,340,000	

Rainier School 60 IMR bed capacity cost details

Need	Estimated Cost	Cost Source
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Laundry upgrade	1,100,000	$17,000/bed – Laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	10,140,000	

Rainier School 60 SNF bed capacity cost details

Need	**Estimated Cost**	**Cost Source**
Water system improvements	1,000,000	Existing budget request
Waste water plant	2,500,000	Pre design estimate
Sewer system upgrades	700,000	Existing budget request
Emergency power	1,500,000	Existing budget request
Laundry upgrade	1,100,000	$17,000/bed – Laundry study
Power plant upgrade	500,000	Existing budget request
Roof replacements	2,000,000	Existing budget request
New SNF Beds 30 30 beds existing	2,200,000	Pre design estimate, $75,000 per bed
ADA Doors Installation	140,000	Existing budget request
Kitchen Equipment	300,000	Existing budget request
Steam Improvements	190,000	Existing budget request
Fuel Storage Tank	125,000	Existing budget request
Building Wiring	85,000	Existing budget request
Total	12,340,000	

Fircrest School 200 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	525,000	14 cottages, 7,500 sf/cottage, $5/sf
Electrical distribution improvements	2,100,000	Existing budget request
Emergency power improvements	1,500,000	Pre design estimate
Cottage repairs ICF/MR 6 existing cottages okay	2,100,000	8 Cottages, 14 clients per cottage, 7,500 sf/ cottage, $35/ sf remodel
Training space replace	2,000,000	40,000 sf @ $50/sf
Laundry replacement	3,400,000	$17,000 per bed/laundry study
Interior Lighting	70,000	Existing budget request
Kitchen Equipment	405,000	Existing budget request
Water System Repairs	270,000	Existing budget request
Steam System Repairs	415,000	Existing budget request
Campus Paving	790,000	Existing budget request
Total	13,575,000	

Fircrest School 175 ICF/MR bed and 100 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	900,000	19 cottages, 181.500 sf total at $5/sf
Electrical distribution improvements	2,100,000	Existing budget request
Emergency power improvements	1,500,000	Pre design estimate
Cottage repairs ICF/MR 6 existing cottages okay	1,800,000	7 Cottages, 14 clients per cottage, 7,500sf/ cottage, $35/ sf remodel
Cottage repairs SNF	1,300,000	6 cottages, 18 clients per cottage, 14,000 sf per cottage, $15/ sf remodel
Training space replace	2,000,000	40,000 sf @ $50/sf
Laundry replacement	4,700,000	$17,000 per bed/laundry study
Interior Lighting	70,000	Existing budget request
Kitchen Equipment	405,000	Existing budget request
Water System Repairs	270,000	Existing budget request
Steam System Repairs	415,000	Existing budget request
Campus Paving	790,000	Existing budget request
Total	16,250,000	

Fircrest School 175 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	487,500	13 cottages, 7,500 sf/cottage at $5/sf
Electrical distribution improvements	2,100,000	Existing budget request
Emergency power improvements	1,500,000	Pre design estimate
Cottage repairs ICF/MR 6 existing cottages okay	1,800,000	7 Cottages, 14 clients per cottage, 7,500 sf/ cottage, $35/ sf remodel
Training space replace	2,000,000	40,000 sf @ $50/sf
Laundry replacement	3,000,000	$17,000 per bed/laundry study
Interior Lighting	70,000	Existing budget request
Kitchen Equipment	405,000	Existing budget request
Water System Repairs	270,000	Existing budget request
Steam System Repairs	415,000	Existing budget request
Campus Paving	790,000	Existing budget request
Total	12,837,500	

Fircrest School 100 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	420,000	6 cottages, 14,000 sf/cottage at $5/sf
Electrical distribution improvements	2,100,000	Existing budget request
Emergency power improvements	1,500,000	Pre design estimate
Cottage repairs SNF	1,300,000	6 cottages, 18 clients per cottage, 14,000 sf per cottage, $15/ sf remodel
Laundry replacement	1,700,000	$17,000 per bed/laundry study
Interior Lighting	70,000	Existing budget request
Kitchen Equipment	405,000	Existing budget request
Water System Repairs	270,000	Existing budget request
Steam System Repairs	415,000	Existing budget request
Campus Paving	790,000	Existing budget request
Total	8,970,000	

Fircrest School 60 IMR bed and 60 SNF bed capacity cost details

Need	**Estimated Cost**	**Cost Source**
Install Cottage Fire Sprinklers	430,000	8 cottages, 86,000 sf total, $5/sf
Electrical distribution improvements	2,100,000	Existing budget request
Emergency power improvements	1,500,000	Pre design estimate
Cottage Repairs SNF	900,000	4 cottages, 18 clients per cottage, 14,000 sf per cottage, $15/ sf remodel
Laundry replacement	2,100,000	$17,000/bed – Laundry study
Interior Lighting	70,000	Existing budget request
Kitchen Equipment	405,000	Existing budget request
Water System Repairs	270,000	Existing budget request
Steam System Repairs	415,000	Existing budget request
Campus Paving	790,000	Existing budget request
Total	8,980,000	

Fircrest School 60 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	280,000	4 cottages, 14,000sf/cottage, $5/sf
Electrical distribution improvements	2,100,000	Existing budget request
Emergency power improvements	1,500,000	Pre design estimate
Cottage Repairs SNF	900,000	4 cottages, 18 clients per cottage, 14,000 sf per cottage, $15/ sf remodel
Laundry replacement	1,100,000	
Interior Lighting	70,000	Existing budget request
Kitchen Equipment	405,000	Existing budget request
Water System Repairs	270,000	Existing budget request
Steam System Repairs	415,000	Existing budget request
Campus Paving	790,000	Existing budget request
Total	7,830,000	

Lakeland Village 200 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	300,000	12 cottages, 5,000 sf/cottage at $5/sf
Emergency Power Upgrades	1,000,000	Based on estimates other campuses
Cottage repairs ICF/MR 8 existing cottages okay	2,400,000	14 Cottages, 9 clients per cottage, 5,000 sf/ cottage, $35/ sf remodel
Laundry replacement	2,200,000	Laundry Study
Outdoor Lighting & Pave	200,000	Existing budget request
Hab Center Roof	125,000	Existing budget request
Hab Center Dishwasher	130,000	Existing budget request
HVAC Duct Cleaning	150,000	Existing budget request
Parking Lot Improvement	175,000	Existing budget request
Admin Building Steps	55,000	Existing budget request
Total	6,735,000	

Lakeland Village 175 IMR bed and 110 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	500,000	20 cottages, 5,000 sf/cottage, $5/sf
Emergency Power Upgrades	1,000,000	Based on estimates other campuses
Cottage repairs IMR 8 existing cottages okay	2,100,000	12 Cottages, 9 clients per cottage, 5,000 sf/ cottage, $35/ sf remodel
New SNF beds 92 3 existing cottages okay	6,900,000	$75,000 per bed
Laundry replacement	2,200,000	Laundry study
Outdoor Lighting & Pave	200,000	Existing budget request
Hab Center Roof	125,000	Existing budget request
Hab Center Dishwasher	130,000	Existing budget request
HVAC Duct Cleaning	150,000	Existing budget request
Parking Lot Improvement	175,000	Existing budget request
Admin Building Steps	55,000	Existing budget request
Total	13,535,000	

Lakeland Village 175 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	250,000	10 cottages, 5,000 sf/cottage at $5/sf
Emergency Power Upgrades	1,000,000	Based on estimates other campuses
Cottage repairs ICF/MR 8 existing cottages okay	2,100,000	12 Cottages, 9 clients per cottage, 5,000 sf/ cottage, $35/ sf remodel
Laundry replacement	2,200,000	Laundry Study
Outdoor Lighting & Pave	200,000	Existing budget request
Hab Center Roof	125,000	Existing budget request
Hab Center Dishwasher	130,000	Existing budget request
HVAC Duct Cleaning	150,000	Existing budget request
Parking Lot Improvement	175,000	Existing budget request
Admin Building Steps	55,000	Existing budget request
Total	6,385,000	

Lakeland Village 110 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	250,000	10 cottages, 5,000 sf/cottage, $5/sf
Emergency Power Upgrades	1,000,000	Based on estimates other campuses
New SNF beds 92 3 existing cottages okay	6,900,000	$75,000 per bed
Laundry replacement	2,200,000	Laundry study
Outdoor Lighting & Pave	200,000	Existing budget request
Hab Center Roof	125,000	Existing budget request
Hab Center Dishwasher	130,000	Existing budget request
HVAC Duct Cleaning	150,000	Existing budget request
Parking Lot Improvement	175,000	Existing budget request
Admin Building Steps	55,000	Existing budget request
Total	11,185,000	

Lakeland Village 60 IMR bed and 60 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Install Cottage Fire Sprinklers	400,000	16 cottages, 5,000 sf/cottage, $5/sf
Emergency Power Upgrades	1,000,000	Based on estimates other campuses
Cottage repairs SNF 3 existing cottages okay	1,200,000	7 Cottages, 6 clients per cottage, 5,000 sf/cottage, $35/sf remodel
Laundry replacement	2,200,000	Laundry study
Outdoor Lighting & Pave	200,000	Existing budget request
Hab Center Roof	125,000	Existing budget request
Hab Center Dishwasher	130,000	Existing budget request
HVAC Duct Cleaning	150,000	Existing budget request
Parking Lot Improvement	175,000	Existing budget request
Admin Building Steps	55,000	Existing budget request
Total	5,635,000	

Yakima Valley School 200 ICF/MR bed capacity cost details

Need	Estimated Cost	Cost Source
New Cottages ICF/MR	10,700,000	12 cottages, 12 clients per cottage, 6,300 sf/cottage, $142/sf build new
Cottage repairs ICF/MR	1,540,000	7 Cottages, 12 clients per cottage, 6,300 sf/cottage, $35/sf remodel
Laundry upgrade	2,200,000	Laundry Study
Kitchen Equipment	200,000	Estimate
Roads and sidewalks	50,000	Existing budget request
New adult training space	1,800,000	36,000 sf @ $50 / sf
New office space	2,000,000	20,000 sf @ $100 / sf
New commissary space	800,000	10,000 sf @ $80 / sf
New maintenance space	800,000	10,000 sf @ $80 / sf
Security and Nurse call	100,000	Existing budget request
Total	20,190,000	

Yakima Valley School 60 IMR bed and 110 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
New Cottages IMR	1,100,000	5 cottages, 12 clients per cottage, 6,300 sf/cottage, $142/sf build new
Cottage repairs SNF	2,000,000	9 cottages, 9 clients per cottage, 6,300 sf/cottage, $35/sf remodel
New Cottages SNF 29 beds	2,200,000	$75,000 per bed
Laundry upgrade	3,000,000	$17,000/bed – Laundry study
Kitchen Equipment	200,000	Estimate
Roads and sidewalks	50,000	Existing budget request
New adult training space	1,800,000	36,000 sf @ $50 / sf
New office space	2,000,000	20,000 sf @ $100 / sf
New commissary space	800,000	10,000 sf @ $80 / sf
New maintenance space	800,000	10,000 sf @ $80 / sf
Security and Nurse call	100,000	Existing budget request
Total	14,050,000	

Yakima Valley School 60 ICF/MR bed and 60 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
New Cottages ICF/MR	2,700,000	3 cottages, 12 clients per cottage, 6,300 sf/cottage, $142/sf build new
Cottage repairs SNF	1,600,000	7 cottages, 9 clients per cottage, 6,300 sf/cottage, $35/sf remodel
Cottage repairs ICF/MR	450,000	2 Cottages, 12 clients per cottage, 6,300 sf/cottage, $35/sf remodel
Laundry upgrade	2,200,000	Laundry Study
Kitchen Equipment	200,000	Estimate
Roads and sidewalks	50,000	Existing budget request
New adult training space	1,800,000	36,000 sf @ $50 / sf
New office space	2,000,000	20,000 sf @ $100 / sf
New commissary space	800,000	10,000 sf @ $80 / sf
New maintenance space	800,000	10,000 sf @ $80 / sf
Security and Nurse call	100,000	Existing budget request
Total	12,700,000	

Yakima Valley School 110 SNF bed capacity cost details

Need	Estimated Cost	Cost Source
Cottage repairs SNF	1,900,000	9 cottages, 9 clients per cottage, 6,300 sf/cottage, $35/sf remodel
Laundry upgrade	2,200,000	Laundry Study
Kitchen Equipment	200,000	Estimate
Roads and sidewalks	50,000	Existing budget request
New office space	2,000,000	20,000 sf @ $100 / sf
New commissary space	800,000	10,000 sf @ $80 / sf
New maintenance space	800,000	10,000 sf @ $80 / sf
New SNF beds 29	2,200,000	$75,000 per bed
Security and Nurse call	100,000	Existing budget request
Total	10,250,000	

Frances Haddon Morgan Center 60 bed ICF/MR capacity and 60 bed SNF cost details

Need	Estimated Cost	Cost Source
Cottage Repairs ICF/MR	660,000	3 cottages, 12 clients per cottage, 6,300 sf/cottage, $35/sf remodel
New adult training space	360,000	7,200 sf @ $50 / sf
Kitchen Equipment	235,000	Existing budget request
Water System Upgrades	225,000	Existing budget request
Storm Drains	50,000	Existing budget request
12 ICF/MR beds (1cottage)	900,000	6,300 sf / cottage $142/sf
New SNF beds 60	4,500,000	$75,000 per bed
Total	6,930,000	

Frances Haddon Morgan Center 60 bed ICF/MR capacity cost details

Need	Estimated Cost	Cost Source
Cottage Repairs ICF/MR	660,000	3 cottages, 12 clients per cottage, 6,300 sf/cottage, $35/sf remodel
New adult training space	360,000	7,200 sf @ $50 / sf
Kitchen Equipment	235,000	Existing budget request
Water System Upgrades	225,000	Existing budget request
Storm Drains	50,000	Existing budget request
12 ICF/MR beds (1cottage)	900,000	6,300 sf / cottage $142/sf
Total	2,430,000	

APPENDIX D. STATISTICAL REPORTS

Washington State Population Growth[28]

Year	State Population	Year	Total number of births
1998	5,750,000	1998	77,874
1999	5,830,800	1999	78,141
2000	5,894,121	2,000	81,004

The Levels of Mental Retardation of People Served[29]

RHCs	Fircrest	Rainier	Lakeland	YVS	FHMC	Total
Level of Retardation	N/Percent	N/Percent	N/Percent	N/Percent	N/Percent	N/Percent
Mild	8 / 3%	26 / 7%	4 / 2%	3 / 3%	2 / 4%	43 / 4.1%
Borderline	0 / 0%	0 / 0%	1 / 0%	0 / 0%	0 / 0%	1 / 0%
Moderate	11 / 4%	50 / 13%	20 / 8%	3 / 3%	4 / 8%	88 / 8.3%
Severe	34 / 13%	69 / 18%	58 / 23%	12 / 11%	32 / 60%	205 / 19.4%
Profound	211 / 80%	236 / 62%	168 / 67%	92 / 83%	15 / 28%	722 / 68.2%
Total	264 / 100%	381 / 100%	251 / 100%	110 / 100%	53 / 100%	1059 / 100%

RHC Residents' Age

The RHC population is an aging population as indicated below.

AGE	Fircrest	Rainier	Lakeland	YVS	FHMC	Total
16-22	5	3	4	8	7	27
22-45	110	116	107	93	46	472
46-55	88	142	87	8	0	325
56-64	42	85	32	1	0	160
65+	19	35	21	0	0	75
Total	264	381	251	110	53	1059

Length of Stay

Individuals who live in RHCs have tended to live in the same RHC for a long time:

Client Count by RHCs, Length of Current Stay as of July 1, 2003

Client Count	RHC					
Length of Stay	FHMC	Fircrest	Lakeland	Rainier	YVS	Grand Total
Under 5 years	7	10	6	16	20	59
05 - 10 years	5	23	45	11	10	94
10 – 20 years	18	24	39	32	11	124
20 – 30 years	21	48	25	36	16	146
30 – 40 years	2	60	53	85	49	249
Over 40 years	0	99	83	201	4	387
Grand Total	53	264	251	381	110	1059

[28] (Source: Considering the Future of RHCs; Senate Ways and Means Committee presentation by Brian Sims, January 30, 2003) Residential Habilitation Centers, Published on January 27-28, 2003.
[29] Total figure (100%) is data gathered by the RHCs and does not include respite care clients.

RESIDENTS FAMILIES LIVE AT DIFFERENT DISTANCES FROM THE RHC:

25 Miles	347	33%
50 Miles	248	23%
100 Miles	158	15%
Distant	219	21%
Very Distant	96	9%
Total	1,062	100%

Checklist for Client Need Assessment 7/22/03

	Questions	Fircrest (264)		Lakeland (251)		Rainier (381)		FHMC (53)		Yakima (110)		TOTAL (1059)	
		#	%	#	%	#	%	#	%	#	%	#	%
A	**Level of Retardation**												
1	Profound	211	80%	168	67%	236	62%	15	28%	92	83%	722	68%
2	Severe	34	13%	58	23%	69	18%	32	60%	12	11%	205	19%
3	Moderate	11	4%	20	8%	50	13%	4	8%	3	3%	88	8%
4	Mild	8	3%	4	2%	26	7%	2	4%	3	3%	43	4%
5	Borderline	0	0%	1	0%	0	0%	0	0%	0	0%	1	0%
B	**Challenging Behaviors** (Duplication is possible due to overlapping)												
1	Assaultive behaviors	61	23.50%	61	24%	135	36%	37	72%	15	15%	309	29%
2	Arson	1	0.00%	0	0%	2	0%	0	0%	0	0%	3	0%
3	Pica	24	9.20%	7	3%	32	8%	10	20%	6	6%	79	7%
4	Property destruction	19	7.30%	13	5%	64	18%	29	57%	14	14%	139	13%
5	Serious self injurious behavior	49	18.80%	37	15%	96	25%	35	67%	17	17%	234	22%
6	Sexual deviancy/sexual offending	3	1.20%	11	4%	18	5%	1	0%	2	2%	35	3%
7	Stealing (shoplifting or stealing from public area on & off campus)	3	1.20%	7	3%	19	5%	13	25%	2	2%	44	4%
8	Elopement	8	3.30%	10	4%	17	4%	20	39%	3	3%	58	5%
9	Other inappropriate behaviors (public nudity, purposeful smearing)	10	3.80%	59	24%	100	26%	27	53%	7	7%	203	19%
10	Dual Diagnosis DD/MH (diagnosis in chart)	50	19.20%	10	4%	247	65%	36	70%	18	18%	361	34%
C	**Behavior Frequencies**												
1	Challenging Behaviors*** 2 or more times per day	23	8.80%	17	7%	132	35%	27	53%	4	4%	203	19%
2	Challenging Behaviors*** 2-10 times per week	31	11.90%	26	10%	114	30%	16	31%	8	8%	195	18%
3	Challenging Behaviors*** 2-10 times per month	73	28.10%	43	14%	117	31%	3	5%	14	14%	250	24%
4	Challenging Behaviors*** less than once per month	40	15.40%	30	12%	44	12%	5	9%	2	2%	121	11%
D	**Treatment Plans for Challenging Behavior**												
1	Positive Behavior Support Plans	91	35%	117	47%	221	58%	8	16%	12	12%	449	42%
2	Behavior Support Plans with Restrictive Component	3	1.20%	46	18%	69	18%	1	-1%	1	1%	120	11%
3	Psychotropic Medications & Positive Behavior Support Plans	72	27.70%	85	34%	213	56%	19	37%	16	16%	405	38%
4	Psychotropic Medications & Restrictive Behavior Support Plans	16	6.20%	30	12%	58	15%	20	39%	1	1%	125	12%

Checklist for Client Need Assessment 7/22/03

	Questions	Fircrest (264)		Lakeland (251)		Rainier (381)		FHMC (53)		Yakima (110)		TOTAL (1059)	
		#	%	#	%	#	%	#	%	#	%	#	%
E	**Supervision for Health and Safety**												
1	2:1 Staffing	0	0%	0	0%	1	0%	0	0%	0	0%	1	0%
2	1 :1 (16-24 hours per day)	8	3.10%	4	2%	11	3%	1	-1%	4	4%	28	3%
3	1:1 (8-16 hours per day)	1	0.40%	0	0%	0	0%	1	-1%	1	1%	3	0%
4	1:1 (up to 8 hours per day)	1	0.40%	0	0%	2	0%	1	-1%	0	0%	4	0%
5	Arm's reach at home	0	0%	0	0%	0	0%	1	-1%	0	0%	1	0%
6	Within 10 feet at home	14	5.40%	0	0%	5	0%	7	13%	0	0%	26	2%
7	Visual (able to see all the time)	184	70.80%	174	69%	195	51%	20	39%	58	58%	631	60%
8	Occasional (goes from point A to B without visual contact)	32	12.30%	36	14%	58	26%	10	20%	25	25%	161	15%
9	Exempt (can independently go from point A to point B)	20	7.70%	35	14%	97	26%	0%	20%	12%	12%	152	14%
10	Can go off campus without supervision	0	0%	2	-1%	0	0%	0	0%	0%	0%	2	0%
F	**Nursing/Medical Needs** (*Use data from last 6 months*) Does not include Med Passes												
1	Nursing Intervention once every 3 months	55	21.20%	14	6%	9	2%	0	0%	16	16%	94	9%
2	Nursing Intervention once every month	56	21.50%	34	14%	75	20%	0	0%	36	36%	201	19%
3	Nursing Intervention once a week	50	19.20%	59	24%	207	55%	0	0%	0%	33%	316	30%
4	Nursing Intervention every day	76	29.20%	139	55%	94	25%	53	100%	15	15%	377	36%
G	**Seizure Frequency**												
1	Seizures 2 or more per day	2	0.80%	3	1%	4	0%	0	0%	1	1%	10	1%
2	Seizures 2 or more per week	9	3.50%	14	6%	16	4%	1	-1%	6	6%	46	4%
3	Seizures 2 or more per month	22	8.50%	22	9%	38	10%	5	9%	14	14%	101	10%
4	Seizures 2 or more per year	41	15.80%	71	28%	67	18%	4	9%	15	15%	198	19%
H	**Mobility** (Count only in one category, if n	4	1.50%										
1	Dependent upon gurney	8	3.10%	0	0%	0	0%	0	0%	0	0%	8	1%
2	Staff Dependent in Wheel Chair for Mobility	83	31.90%	49	20%	31	8%	1	-1%	39	39%	203	19%
3	Specialized Wheel Chair (adaptive hip, trunk or head/shoulder positioning systems not just seatbelt)	38	14.60%	34	14%	33	8%	0	0%	14	14%	119	11%
4	Wheel Chair needed for off unit mobility staff dependent	5	1.90%	41	16%	73	19%	19%	0%	8	8%	127	12%
5	Independent in Wheel Chair	4	1.50%	7	3%	2	0%	0	0%	2	2%	15	1%
6	Independent Mobility with Devices (walkers, crutches, etc.)	118	45.40%	1	-1%	19	5%	0	0%	8	8%	146	14%
7	Independent Mobility without Devices			119	47%	241	64%	50	98%	29	29%	439	41%

Checklist for Client Need Assessment 7/22/03

	Questions	Fircrest (264)		Lakeland (251)		Rainier (381)		FHMC (53)		Yakima (110)		TOTAL (1059)	
		#	%	#	%	#	%	#	%	#	%	#	%
I	**Nutrition**												
1	Uses tube feeding	59	22.70%	45	18%	19	5%	0	0%	23	23%	146	14%
2	Need > 20 minutes to eat with total physical staff assistance	32	12.30%	34	14%	20	5%	0	0%	24	24%	110	10%
3	Need < 20 minutes to eat with total physical staff assistance	2	0.80%	4	2%	14	3%	2	4%	0	0%	22	2%
4	Partial physical staff assistance to eat	66	25.40%	46	18%	70	18%	13	25%	7	7%	202	19%
5	Verbal/Gesture assistance to eat	55	21.20%	66	26%	194	51%	26	51%	8	8%	349	33%
6	Independent eating, no visual supervision needed	46	17.70%	56	22%	63	17%	10	20%	38	38%	213	20%
J	**Positioning** (Medically at risk if not positioned due to aspiration, asymmetry, spinal or breathing issues)												
1	Specialized positioning accessories	53	20.40%	50	20%	41	11%	0	0%	41	41%	185	17%
2	Have specialized bed or needs one	53	20.40%	32	13%	87	23%	0	0%	0	0%	172	16%
3	Can maintain position independently	154	59.20%	64	25%	177	47%	51	100%	59	59%	505	48%
K	**Toileting** (Do not overlap the categories)			105	42%	59	16%						
1	Full physical assistance needed in toileting	106	40.80%	20	8%	60	16%	1	-1%	3	3%	190	18%
2	Incontinent of bladder/bowel	56	21.50%	26	10%	36	9%	2	4%	73	73%	193	18%
3	Partial physical staff assistance needed in toileting	41	15.80%	31	12%	61	16%	11	21%	8	8%	152	14%
4	Verbal/gesture assistance needed in toileting	40	15.40%	89	35%	164	43%	12	23%	3	3%	308	29%
5	Independent (goes on his/her own)	17	6.50%	85	34%	66	17%	25	49%	13	13%	206	19%
L	**Dressing**												
1	Full physical assistance needed in dressing	109	41.90%	106	42%	66	17%	2	4%	82	82%	365	34%
2	Partial physical staff assistance needed to dress	68	26.20%	37	15%	129	34%	15	29%	7	7%	256	24%
3	Verbal/gesture assistance needed to dress	47	18.10%	37	15%	79	21%	14	27%	6	6%	183	17%
4	Independent	36	13.80%	71	28%	106	28%	20	39%	5	5%	238	22%

Note: 1. All counts are unduplicated except in Behavior Category B.
2. Data will be collected on all permanent clients and on respite clients who have been at the Facility for more than 30 days.

APPENDIX F. DESCRIPTION OF WAIVERS

DDD submits New Waiver Applications to CMS

On March 25, 2003 DSHS submitted four separate applications for Home and Community-Based Services waivers for DD clients. The waivers were submitted to the Center for Medicare and Medicaid Services (CMS) for approval. These waivers are intended to replace the current Community Alternatives Program (CAP) Waiver. The CAP waiver covers 11,700 children and adults who live at home with their families, in residential settings, or independently in the community. There is a broad spectrum of need among waiver recipients because of the variety in age, level of disability and natural supports.

The scope of the current CAP waiver is so broad that it obligates the state for costs years into the future. The multiple waiver approach addresses this concern and meets people's current needs through targeted waivers each with specific limits on benefits, services, and enrollees.

Proposed Waiver Groupings

Basic Waiver: This waiver is intended for clients who live with their families or in their own homes. They have considerable natural support and require limited services to maintain community living. The basic waiver would have limits on services and would not offer residential services making it our low-cost waiver.

Basic Plus Waiver: This waiver is intended for clients who live with their families or in other settings with assistance. They are at high risk of out of home placement or loss of current living situation. This waiver would also have limits on services and would not offer residential services.

Core Waiver: This waiver is intended for clients who need residential services or who live at home but are at immediate risk of out of home placement due to extraordinary needs.

Public Safety Waiver: This waiver is intended for a limited number of clients who need 24 hour, on-site, supervision to maintain safety for themselves or others. Services on this waiver would be limited to assure protection for providers and clients.

What happens next?

The department received a response to the waiver applications from CMS on June 13, 2003 in the form of a Request for Additional Information (RAI). The department may take as long as is needed to respond to the RAI. The projected timeframe for the department response is September 15, 2003. CMS will have ninety days to respond to the department's written comments on the RAI.

Status of the CAP waiver

CMS has granted an extension of the CAP waiver to September 25, 2003. Extensions are granted for ninety-day periods. The department anticipates that CMS will continue to grant extensions until the new waivers are approved and ready for implementation. We expect no interruption or reduction in services for current waiver recipients during transition to the new waivers.

All of those eligible for the CAP and the new waiver are, by definition, also eligible for ICF/MR services. In its submittal, DDD has assumed that those currently receiving services under the CAP waiver (N=10,558) would continue to receive services under the reformulated waiver. The division has also assumed that clients will only be added if funding is provided by the Legislature. The baseline for the forecasted community caseload and the services provided to the caseload (based upon 2002 data) has been derived from the submission to CMS. For subsequent years

the baseline has been increased in proportion to the state's population, and reduced by the mortality rate experienced by clients during 2002.

APPENDIX G. ACKNOWLEDGEMENTS

The members of the department's work group and who consulted with the work group include:

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Harlan Solomon	Bob Humenthal
Frank Sanborn	Edward J. Dee
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Larry Merxbauer, Superintendent, Rainier School
Asha Singh M.D., Superintendent, Fircrest
Paul Sugden, Superintendent, Yakima Valley School

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Jean Hodgson
Debbie Jennings

For further information or if there are questions about this report, please contact Linda Rolfe, Director, Division of Developmental Disabilities, (360) 902-8484.