Long Range Plan for Developmental Disability Services

Mental Health and Developmental Disability Services Division
Office of Developmental Disability Services
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OREGON DEPARTMENT OF HUMAN RESOURCES
INVESTING IN PEOPLE

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Introduction

Overview

Fairview Training Center opened its doors in 1908 to serve Oregonians with mental retardation. Since that time professional standards and the public's attitude about people with developmental disabilities have changed dramatically.

In the early days accessible walkways, buses, or buildings didn't exist; there was no right to a public education for children with disabilities; and people did not believe that social and health services could be provided successfully in the community.

Since then changes in laws have given people with disabilities full civil rights; education is guaranteed; and society in general believes that people with disabilities should be included in the everyday life of a community. Because of these changes, and improved technologies for providing care, it is now possible for families to care for family members with developmental disabilities at home, and quality care to adults with disabilities can be provided in the community. As a result, over the last 20 years, hundreds of Fairview residents have successfully moved from the institution to the community.

During the last ten years, care provided to residents at Fairview has also been a source of frequent conflict between the state and federal government. This conflict has involved legal action against the state and unexpected cost increases at Fairview. Monthly expenditures of $15,778 per resident at Fairview have been driven in large part by these pressures.

By itself, Fairview consumes about 30% of the budget for Developmental Disability Services to serve about 3% of the population in need. At the same time, almost half of those in need (3,500 people) receive no services at all because Developmental Disability programs don't have sufficient funds to provide the needed services and rates paid to community services providers are too low. Community service providers are hard pressed to recruit and retain direct care staff because the wages they can afford are not competitive.

This proposed long range plan for Developmental Disability services in Oregon continues moving individuals with mental retardation from Fairview into the community and reinvests a significant portion of the budget in areas of high need. By May 2000:

- all current Fairview residents would move into the community and receive quality

services at a more reasonable cost,

- wages paid direct care staff employed by community providers would increase to resolve some of the stability issues, and
- about half of the 3,500 adults on the Community Wait List would begin to get services.

Adopting the Long Range Plan continues the state's commitment to provide quality services that are less costly, and begins to provide some stability to families who have struggled on their own for years. These families are not asking for 24-hour per day institutional care or other types of 24 hour care currently available to some in Oregon's system. They are asking for individualized financial and other supports so that the task of continuing to provide care is somewhat less onerous.

Additionally, this plan will move the overall service delivery system closer to the Oregon Benchmarks related to the percentage of families with a member with a disability who request and receive in-home support (Benchmark #179), and the percentage living in community housing of their choice with adequate support (Benchmark #102).

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Why a long range plan now

The Mental Health and Developmental Disability Services Division was directed to prepare a long range plan for the provision of services to people with developmental disabilities by the United States Department of Justice (USDOJ) and the 1995 Oregon Legislature. The long range plan describes new services for Fairview residents, if Fairview were to close.

Fairview continues to operate under terms of a consent decree that arose from a 1987 lawsuit filed by the USDOJ against the State of Oregon for alleged civil rights abuses at Fairview. Services at Fairview are monitored on a regular basis by the USDOJ. The agreement to prepare a long range plan is contained in a stipulated order approved by the U.S. District Court in April 1995 after a motion was filed by the USDOJ alleging continued violations.

The 1994 Oregon Legislature further directed the Division to:

- seek input from interested parties and review the plan for Fairview with the appropriate Legislative committees,
- examine needs and priorities for serving people on the Community Wait List (currently 3,500 people) and recommend redirection of savings from any source, including savings from closure of Fairview, as might be needed to implement services for this population, and

- examine rates paid to service providers and to report back concerning needed changes in the rate structure.

The issues surrounding the future of Fairview, services to those on the Wait List, and the adequacy of provider rates are so intertwined that they are inseparable for planning purposes. Consequently the Division chose to plan for them simultaneously, through the same planning process, and include them all in a single Long Range Plan document. This document will discuss the issues in each area and conclude with recommendations and cost estimates.

Planning Process

In keeping with instructions to develop the Long Range Plan with input from all interested parties, the following groups and organizations sent representatives to participate in the planning:

Advocates	Providers
• Fairview / Parent & Guardian Association • Oregon Advocacy Center (OAC) • Oregon Developmental Disabilities Council • Partners in Policy Making	• Alternative Services, Inc. • Bethphage, Inc. • Oregon Rehabilitation Assn. • Polk Community Living, Inc. • REACH, Inc. • Residential Provider Assn. of Oregon • Riverside Training Center
State & counties	**Other**
• Dept. Admin. Services • Dept. Human Resources • Fairview Training Center • Lane County • Legislative Fiscal Office • Marion County • Multnomah County • Washington County	• American Federation of State-County & Municipal Employees (AFSCME) • Mid-Willamette Job Council • Oregon Nurses Assn. (ONA) • Oregon Technical Assistance Corp. • University of Oregon

Representatives of these organizations and other interested persons began meeting in October 1995. They were assigned to one or more of seven workgroups that investigated certain aspects of the planning and reported their findings and recommendations to a Steering Committee.

Values and assumptions about future service needs

The Division used the following values and assumptions as reference points for the planning process.

Values

- The family is the "primary service system" and should be supported as long as the family is willing and able, and the public cost of family support is reasonable as compared to the cost for out-of-home care. Administration of funding for family support should provide a maximum of flexibility in use of funds and a minimum of paperwork for families.
- Service options should foster independence, productivity, community integration, and consumer choice.
- The role of state operated programs is to provide specialized backup services for a system of community services that are delivered by the private sector. (See ORS 427.007)
- Services should be designed to operate efficiently, to achieve outcomes, and to protect the health, safety, and rights of individuals.

Assumptions about future services, needs, and funding

- Demand for services will continue to expand commensurate with growth in the state's population.
- An increasing number of individuals on the Wait List will require out-of-home care because of advanced age among parents or other family members presently providing care.
- Significant increases in future funding should not be expected. Federal Medicaid funding, which has contributed about 60% of the growth in the budget during recent years, will likely be "capped" in the future. The state economy is expected to be stable but the need for funds in corrections, education, and elsewhere within human resources, will increase significantly.
- Out-of-home residential care will continue to require the majority of resources available to the service system. A well organized and coordinated program focused on diversion, alternative services, and utilization control will be required for cost containment.
- Maintaining a stable, well trained workforce to provide services, particularly out-of-home care, will be difficult. Attention must be paid to wages, benefits, staff training, and career opportunities.

Fairview Plan

Historical context

Fairview Training Center was established in 1908 as the first of three state institutions serving people with mental retardation. Disabled children were placed in institutions based on the advice of professionals, with the belief that it was better for both the child and the family for the person with the disability to live at Fairview.

In those days accessible walkways, buses, or buildings didn't exist in our communities; there was no right to a public education for children with disabilities; and no one believed that social and health services could be provided successfully in the community.

As more and more individuals were placed in Fairview it grew to be the largest of the state's institutions for people with mental retardation. During the late 1950's and early 60's Fairview's population reached 3,000.

In 1970 Federal funds through the Medicaid program became available to assist states in operation of "Intermediate Care Facilities for the Mentally Retarded" (ICF/MR) programs. However, federal certification, a prerequisite for funding under the ICF/MR program, required that institutions move away from custodial care and towards a higher standard called "active treatment."

In those days ... no one believed that social and health services could be provided successfully in the community.

About this time, professional standards on how to serve people with mental retardation changed and life in the community became more accessible. People with disabilities gained civil rights including the right to a public education. More of society became available to individuals with disabilities as structural accessibility increased and society began to accept disabled persons into the community. Families now had the ability to keep their families intact and keep their disabled children at home.

In the 1970s, state funding was made available for community-based programs which enabled significant declines in the Fairview population. The decline accelerated greatly during the 1980s, spurred by two separate federal initiatives.

- Federal dollars became available for "Home and Community-Based Services" under a "Medicaid Waiver" program to assist states in developing alternatives to services in

large institutional facilities.

- Punitive actions were taken against states that failed to raise care standards in institutions up to acceptable levels, i.e. "active treatment." Punitive actions could include loss of funding under the ICF/MR program or lawsuits filed under the federal Civil Rights for Institutionalized Persons Act.

In 1981 the Oregon Legislature updated its disability policy and found that a significant number of individuals with developmental disabilities lived in institutions because adequate community services did not exist. The Legislature directed the Division to facilitate the development of community services.

In the 1985-87 biennium, the Federal Government discontinued ICF/MR funding and filed suit against the State for alleged human rights violations at Fairview under the Civil Rights for Institutionalized Persons Act. ICF/MR funding was restored after the federal Health Care Financing Administration and the USDOJ accepted Oregon's plan to reduce the size of Fairview's resident population and improve services for those who remained. However, Fairview continues to operate under terms of a consent decree approved by a Federal Court, and the USDOJ continues to monitor the care Fairview residents are receiving.

Families now had the ability to keep their families intact and keep their disabled children at home.

In 1987 the average daily population at Fairview was about 1,200 and the monthly cost of care was $5,040 per person.

By the end of the 1995-97 biennium the average daily population will be about 300 and the monthly cost of care will have risen to $15,778 per person.

This increased cost is due to a combination of factors such as:

- mandated increased staffing to improve programs,
- a declining resident population, and
- some fixed facility costs that do not change with population size.

Development of community services for Fairview residents

Developing community services making it possible to move the remaining Fairview residents into the community has required much planning. Items addressed in the planning process included the array of services needed for this population, the selection of provider types, and the role of state, county, provider, and family members in the placement process.

Identifying the necessary community services involved the following steps:

1 Fairview staff provided information on each resident using an "individual profile" form developed for this purpose.

2 Fairview and Division staff used this information to construct population groupings with similar service needs.

3 Service models and staffing patterns were then considered.

4 The summarized information (which no longer contained confidential information about individuals) was then shared with the larger workgroup.

5 Decisions about the types of services to develop were based on both the needs of the population and the Division's success in developing services for similar populations in recent years.

Community services needed

The array of services was developed without regard to the type of provider organization that might eventually deliver the services. Typical services planned for Fairview residents includes the following:

Typical Services	Clients Served
Foster Care (1-3 people per home, paid relief staff assist foster parents) and/or Supported Living (1-3 people live in a rented apartment or duplex, direct care staff provide care and supervision)	61
Community Homes (5 or less people live in a neighborhood house or duplex, direct care staff provide care and supervision)	236
Vocational/Employment (People are employed in private businesses or supported employment settings where they are trained for specific jobs and receive compensation for work performed. Those who are not able to work participate in other community integrated activities.)	All 297 clients
Case Management (Includes case planning, coordination of services, investigation of abuse and protective services. Services are provided by county employees.)	All 297 clients

Up to a total of 50 community residential sites would be developed for people requiring

full 24 hour services. Most sites would be new construction, using either a single family or a duplex model.

Financing for this development would be provided by the Oregon Housing and Community Services Department with proceeds from sale of Oregon General Obligation Bonds. Due to time requirements for construction and financing, purchase of sites should begin as soon as possible.

Individualized planning

In the implementation phase, each individual would have an individualized, "person centered plan" developed before a community option is selected. The person centered plan would be developed with input from the individual, staff who know the individual well (such as direct care staff at Fairview), and family members. Planning would be coordinated by Division staff responsible for service development.

The choice of living situation and implementation of each individual's service plan would be monitored by the Division and county staff. Corrective actions would be taken when needed to address any transition problems.

Regional and statewide backup services

Closure of Fairview represents a potential loss of resources that are currently not available in some local communities. A workgroup examined this issue in an effort to determine the kind of services that would be needed on a regional or statewide basis to support both people who are already in the community and those who would be entering new community programs if Fairview were to close. This workgroup looked at issues such as professional staffing and the availability of diversion and crisis service.

Diversion and crisis services are provided to ensure that people with developmental disabilities remain in the community. Diversion services are alternative community services that prevent people from going into institutional care in the first place. Crisis services are geared toward short term problems. For example, the individual has medical and behavior problems which the family can't address. The family is in crisis, so respite care (essentially, a short break from caregiving) is provided to the family. People with extreme problems may be placed in another setting, using a crisis bed, which gives the case manager and family time to put together other kinds of supports to address the problem.

Regional services

New regional backup services would be established to augment local crisis response capacity. Savings in the Fairview budget that result from closure of the facility would be rein-

vested in development of services in six regions.

The regional services would provide expertise that is too expensive to provide in each county. Staffing would include both medical staff and program specialists. There would also be funding for crisis/diversion services and additional crisis beds. Resources, including existing funding for crisis and diversion services as well as staff positions within the Division, would be reallocated or reassigned to support the regional efforts.

It is anticipated that counties will collaborate with one another to form regional structures to manage these resources.

Statewide services

New statewide resources would include two positions to provide consultation and technical assistance, plus 15 crisis beds managed by state operated community programs. These services would be available regardless of the region in which the individual lives.

A physician and a psychiatrist who have experience working with people with developmental disabilities and understand the complex medical and behavioral issues would be added to the Division's Office of Developmental Disability Services. They would provide on-call consultation for local service providers and consultation for local professionals such as neurologists, gerontologists, and pharmacists.

The new crisis bed programs would be located in three facilities that would be designed and built specifically for that type of program. Staff employed by state operated community programs would manage these facilities. These crisis beds would be available when regional beds are full or not able to meet the needs of the person needing the crisis service.

Options for service delivery

After an array of necessary services were defined, three options for service delivery were examined:

- all state operated programs,
- all private operated programs, and
- a mix of state and private programs.

All three options are based on the same service delivery model. For example, all three use the same number of new residential sites, the same number and type of staff, etc. The only difference is the cost associated with the type of provider, i.e. state vs. private. State operated programs have a higher cost because wages paid to state employees are higher and the benefit package is more comprehensive. The following table compares the options across several important impact areas.

Recommended option: state/private mix

Impact Areas	All State Operated	All Private	State/Private Mix
Stability of workforce that will serve people who move. (Residential Services)	A 19% annual turnover rate among direct care staff would be expected	A 71% annual turnover rate would be expected. (The recommended wage increase should reduce this turnover rate.)	A 55% annual turnover rate would be expected. (The recommended wage increase for private agencies should reduce this turnover rate.)
Impact on state positions/FTE (Fairview)	-173 FTE	-1,383 FTE	-1,003 FTE
Impact on other state & local agencies		• Requires extensive use of out-of-state providers in addition to expansion of existing programs. • Significantly increases local administration costs for many counties.	• Requires some use of out-of-state providers in addition to expansion of existing programs. • Significantly increases local administration costs for some counties.
Biennial Cost (after full implementation)	$91.9 mil. Total $37.6 mil. GF $ 2.7 mil. OF $51.6 mil. FF	$55.1 mil. Total $24.2 mil. GF $ 0. mil. OF $30.9 mil. FF	$69.3 mil. Total $29.5 mil. GF $ 0.8 mil. OF $39.0 mil. FF
Amount available for reinvestment in Specialized Back-up services, wages and Wait List services	$35.4 mil. Total $ 9.2 mil. GF $ 0.7 mil. OF $25.5 mil. FF	$72.2 mil. Total $22.6 mil. GF $ 3.4 mil. OF $46.2 mil. FF	$58.0 mil. Total $17.3 mil. GF $ 2.6 mil. OF $38.1 mil. FF

The feasibility of using only private providers is questionable. Rapid expansion of the community service system is needed to hold down transition costs.

... some clients represent a level of risk that private agencies would not accept, even if funding for services is available.

- After a decade of continuous downsizing projects, the existing provider network could not expand as rapidly as needed.
- It would be difficult to recruit the number of new providers from other states that would be required to assist the existing provider network in serving this population.
- Moreover, some clients represent a level of risk that private agencies would not accept, even if funding for services is available.

The state needs a reasonable service base that will accept clients for care regardless of risk or availability of funding in order to respond to civil commitments or emergency situations. It is an important part of providing a specialized backup service for community services.

Though they cost more to operate, some state operated programs are desirable for several reasons:

- the state is ultimately responsible for some individuals, as directed by the courts, so it must retain a reasonable capacity to provide direct care,
- some individuals present medical and/or behavior conditions that represent a greater risk of injury to self or others than a nonprofit agency can accept, and
- there may be insufficient interest or capacity in the private sector to develop services in a particular geographic area where services are needed.

However, the expense of using state-operated programs exclusively is unnecessarily high. Using all state operated programs would continue to concentrate a disproportionately large share of resources on a relatively small population, without significantly addressing other critical issues in the service system. This option would also provide more state-operated service capacity than is needed to assure a specialized backup service for the rest of the community system.

The state/private mix option uses private agencies to serve about two-thirds of the population leaving Fairview in a closure plan and state operated programs to serve one-third of this population. In addition to providing a reasonable level of backup services for community programs, this option provides savings of $58.0 million (Total Funds) for reinvestment in critical problem areas.

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Displaced workers

Many of the 1,003 state employees displaced under the recommended plan could benefit from assistance in moving to other employment opportunities or retirement options.

Fairview currently provides assistance, primarily information and referral, through its personnel department. Under this proposal, the hours personnel staff are available would be increased so that employees on all three shifts could more easily make use of the services offered. Services would also be expanded to include peer counseling using volunteers from the Fairview workforce. Training in peer counseling for the volunteers could be provided through the Oregon Economic Development Department from resources available under the Job Training Partnership Act.

Fairview employees would receive first priority in selection of staff applying for new positions in state operated community services. This approach was used successfully in development of state operated programs associated with previous Fairview downsizing projects.

Efforts would also be made to utilize Fairview staff in development of new community services for Fairview residents. Fairview employees would receive first priority in selection of staff applying for new positions in state operated community services. This approach was used successfully in development of state operated programs associated with previous Fairview downsizing projects. The Division will also work with Fairview employees interested in becoming foster parents and providing care for residents who would be leaving Fairview under the plan.

Issues needing further exploration

There are two special arrangements for displaced workers which should be explored further:

- Could the State make contributions to private retirement plans such as a 401K and purchase of medical/dental plans for employees who become foster parents for residents leaving Fairview?
- Could the State provide early retirement incentives for people who qualify? Approximately 13% of Fairview employees are 55 years of age or older. Incentives might include extra payments into PERS or contributions into a private retirement plan while the closure plans are being implemented.

Disposition of campus

Fairview occupies about 260 acres in southeast Salem along Strong Road. There are 61 buildings containing floor space totaling 505,000 square feet. Approximately 192,000 square feet is currently used for residential care and 313,000 square feet is used for resident activities and services, administrative offices, training, and maintenance facilities.

The buildings range in age from 13-88 years old. The average building is 48 years old and requires a significant amount of maintenance and repair. Roofs are failing on several buildings and expenditures will be required in the 1997-99 biennium to prevent structural damage.

For purposes of developing this report, it was assumed that the campus would no longer be needed to provide care for the current resident population at some point in the future. There was no attempt in this planning effort to detail a plan for the future of the campus.

A workgroup established to research this area focused on two primary issues:

- strategies to maximize the return on the property if it were sold, and
- the cost of maintaining the property in an "as is" condition if it becomes vacant.

Proceeds from sale could be available to agency

ORS 270.150 provides a mechanism for a state agency to apply the proceeds of a sale of property to "another capital acquisition" of the agency with the approval of the Department of Administrative Services. The new "capital acquisition" must be owned by the state and constitute an investment in new capacity or real property. It can not be used for improvements or maintenance of existing structures. The intent of the statute is to preserve the state's assets and prevent loss of real property which could be needed later.

Because of this statutory provision, the Division has an opportunity to realize a significant return from the eventual sale of the Fairview property. The Division contracted with an outside appraiser, Capital Valuation Group, Ltd., to perform a preliminary analysis of the property and to suggest a process for determining its marketability. A report prepared by Darr L. Goss, MIA states "Production of a high quality specific development plan will be the most important factor in the marketing process."

The future development of this master plan will need to include all interested parties, including the City of Salem, the Capital Planning Commission, the state Department of Administrative Services and the Division.

After basic decisions about land are made, a formal appraisal will be needed. The appraisal should include an engineering study of the structures and determination of the "highest and best use" given the kind of future development considered for the site. An appraisal of

this type would cost $7,000-10,000. A further investment in consultants would be needed to secure the necessary expertise in property development for preparation of the master plan. These costs have not been projected as part of this long range plan.

Cost to "mothball" vacant campus

The estimated cost of "mothballing" the campus if it becomes vacant was developed by the Physical Plant Unit at Fairview. It assumes the campus and its buildings would be maintained in an "as is" condition. Buildings would be heated to prevent deterioration, the grounds would be maintained and security would be provided to prevent vandalism.

This basic care would cost about $100,000 per month ($1.2 million per year), assuming the boiler could be automated so it would not need constant monitoring. There would be an additional cost for roof repairs or other work needed to prevent structural deterioration. All costs would be charged to the General Fund, since funding from the federal Medicaid program would terminate when the ICF/MR services are discontinued.

Developing a master plan for the Fairview campus would be a time-consuming process, and the cost of maintaining a vacant campus would be significant. If there is a decision to close Fairview as recommended in this plan, it would be advisable to begin work on the master plan immediately so that sale of the property could occur soon after the last residents left. This would minimize "mothballing" costs after the campus is vacant.

Community Workforce Development

Workforce development is the second major issue addressed in this long range plan proposal. A workgroup was formed in response to a budget note in Senate Bill 5553 that instructs the Division to examine the adequacy of rates paid to service providers in relation to the costs of delivering services.

Staff turnover is the overarching issue

At its first meeting, the Workforce Development workgroup unanimously agreed that the single overarching concern in provider rates is the wage level for direct care staff. Compensation for direct care staff is the largest factor in the rate structure, accounting for 80+% of all expenditures in the majority of programs.

A high turnover rate among direct care staff affects the quality of care, which is highly dependent on a stable and well trained workforce.

Direct care staff provide the basic care, supervision, and training that is the essence of residential and vocational services. An estimated 3,874 people are employed as direct care staff by private nonprofit providers that deliver residential and vocational services. (81% employed by residential programs, 19% by vocational programs.)

Providers have found it difficult to remain competitive in the labor market for direct care staff. A continued strong economy, and lack of funds for any cost of living adjustment in 1995-97, has made it even more difficult to recruit and retain qualified staff. Direct care staff turnover is far too high.

A high turnover rate among direct care staff affects the quality of care, which is highly dependent on a stable and well trained workforce. It also threatens the stability of programs as people in leadership positions become discouraged, "burned-out," and seek other employment.

For these reasons, the workgroup decided to study provider wage and turnover rates and to seek information on the job market and comparable wages, with a goal of determining an appropriate wage level.

Wages influence turnover

Though pay is generally not the only factor influencing recruitment and retention, it is certainly one of the most significant factors. Programs that pay more have less difficulty attracting and keeping staff, as illustrated by the following:

- Turnover among Oregon's private nonprofit programs averages 77% per year in residential programs and 42% in vocational programs. Direct care staff are paid an average of $6.45 per hour after one year of employment.
- Turnover in Oregon's state operated community programs is 19% per year. Direct care staff in these programs are paid $9.44 per hour after one year of employment.

> "direct care staff turnover is not perceived as a problem" since wages were increased to more reasonable levels in the 1980's.
>
> —State of Washington official

- The official who manages the rate setting function for similar community programs in the State of Washington reports that "direct care staff turnover is not perceived as a problem" since wages were increased to more reasonable levels in the 1980's. The current wage for direct care staff in the State of Washington is about $9.00 per hour. (It is listed as $12 per hour, including benefits.)

An appropriate wage

The Oregon Employment Services (OES) was asked to provide a market analysis, including a projection of job demand and comparable wages. The report prepared by OES says continued growth and competition for staff should be expected for the next ten years. This is one of the fastest growing segments of the job market, particularly in residential services. The report also compares wages paid for similar jobs in Oregon.

An appropriate wage was developed as follows:

- 9 occupations were selected from the OES data bank. Duties in these occupations seem to be the most like direct care. These occupations focus on residential support, supervision, case planning, medical support and therapies, teaching, and vocational education. The emphasis varies across occupations but that is also true across the range of community residential and vocational programs.
- "Starting wages" quoted in OES job orders were used for comparison and calculation. These wage quotes are considered by OES to be the *minimum* amount actually paid. It is very likely that some employers paid more than the advertised starting wage but there is no data available to confirm it.

- The third quartile shown in the OES database, rather than the average starting wage, was used because the objective is to remain competitive. Working conditions and benefits for direct care staff are not as attractive as those typically available in the other 9 occupations. Paying a little more than average under these conditions seems reasonable.

The results are illustrated in the following chart:

OES Codes	Occupation	Q3* Starting Wage	No. of Job Orders	Cost of All Jobs
27037	Residential Counselor	$ 7.50	10	$75
27308	Human Services Workers	$ 8.65	67	$580
31514	Vocational & Education Counselors	$11.66	135	$1,574
31521	Teacher Aide	$ 8.80	481	$4,233
32317	Recreation Therapists	$12.43	7	$87
32508	Emergency Medical Technician	$13.99	4	$56
66014	Psychiatric Aide	$7.00	261	$1,827
66017	Physical Therapy Aide	$13.26	8	$106
66021	Occupational Therapy Aide	$6.00	18	$108
	Weighted Average	**$8.72**	991	$8,646
		* Third Quartile		

... significant movement towards a more competitive wage is crucial for the 4,000+ people with developmental disabilities who are dependent on these employees for their care.

A starting wage of $8.72 represents an increase of $2.90 per hour over the typical starting wage in residential programs and $2.81 per hour in vocational programs. The total biennial cost to make this wage adjustment would be $56 million ($24.8 General Fund).

While the cost of providing a starting wage of $8.72 is prohibitive, significant movement towards a more competitive wage is crucial for the 4,000+ people with developmental disabilities who are dependent on these employees for their care.

The Wait List

The community Wait List is the third major topic addressed in this proposed long range plan. A budget note in Senate Bill 5553 directed the Division to present a plan to the Legislature that provides services for those on the Wait List

The "Wait List" is a detailed database of named Oregonians who have been found eligible for developmental disability services but not offered services because funding for these services is not available. There is no "entitlement" to developmental disability services in Oregon. There are insufficient funds to serve all those in need.

Those seeking services apply at their county mental health and developmental disability office and may enroll on the Wait List if services are not available. Information from enrollment forms is stored in a statewide database maintained by the Division.

The Wait List was originally intended to help counties provide new services on a "first come, first served" basis. Unfortunately, funding for new services has been scarce and people have remained on the Wait List for many years:

Years on the Wait List	
Less than 2 years	561 individuals
2 to 4 years	1,367 individuals
More than 4 years	1,557 individuals

People on the Wait List

Spending increasing amounts of money on service for people at Fairview has resulted in an ever growing Wait List of people with developmental disabilities in the community. Currently 3,500 people are on the community Wait List, and the numbers grow daily. The following provides a brief description of the population:

Characteristics of the Wait List Population

Gender: Male 52% Female 48%

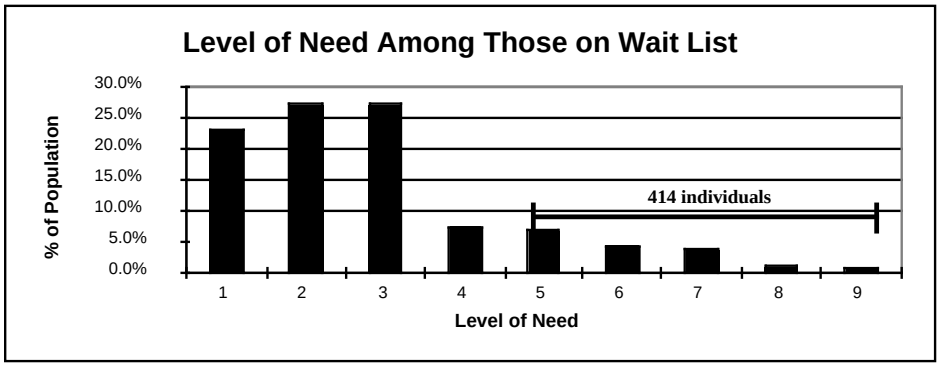
Age: 18-29 years 55%, 30-49 years 28%, 50+ years of age 8%

Disabling Conditions:

Behavior problems	45%	Mental Retardation	100%
Mobility impairment	29%	Auditory impairments	9%
Vision impairments	22%	Communication impairment	52%
Seizures	18%	Other Health impairment	24%
Cerebral Palsy	15%		

In the aggregate, populations in the training centers and community programs are more disabled that those on the Wait List. However, on an individual basis, there are many people living at home whose disabilities are just as severe and challenging as those served in either training centers or community service programs.

Individuals at Level 1 need some assistance with their daily activities; individuals at Level 9 have the most need for assistance.



At the first two levels (shown on the Levels of Need graph), individuals typically need some assistance in scheduling and directing daily activities, supervision in the community, and formal plans to deal with maladaptive behavior. By Level 3, full-time assistance is required for care, supervision and daily activities.

At Level 4 and beyond, services from professionals such as doctors, nurses, psychiatrists, psychologists, physical therapists, and occupational therapists are needed on a regular basis. Services include prescribed medications, treatment regimes, and structured behavior interventions. A care provider must be trained to assist in implementing these plans.

In Level 7 and beyond, 24 hour care and supervision by a trained provider is required to address complex medical and behavioral needs. Maintaining health and safety is a constant concern.

The increasing age of parents and relatives providing care for people on the Wait List is a particular concern. There are considerably more people needing

... there are many people living at home whose disabilities are just as severe and challenging as those served in either training centers or community service programs.

services who are age 35 to 55 than there were ten years ago. Many of the people over 35 live at home with parents who are 55 to 70+ years of age and increasingly less able to continue providing care. A 1990 study of the Wait List by the Human Services Research Institute found that "almost 25% of the persons identified as primary caregivers are 61 years of age or older."

The number of children and adults with developmental disabilities is expected to grow at the same rate as the state's population, about 1.4% per year, through the year 2010. Without increased funding, many of the estimated 116 adults with developmental disabilities added to the state's population each year will join those already on the Wait List.

Inequitable allocation of funds

Allocation of funds, which has been driven largely by federal requirements to downsize Fairview and improve services for those remaining at the facility, has resulted in an inequitable distribution of dollars. The following table illustrates this inequity.

	Percentage of Population	Percentage of Dollars
Training Centers	3.9%	36.6%
Community Services	45.8%	62.6%
Wait List	50.2%	0.8%

The cost to correct this inequity, by fully funding services for those on the Wait List, is prohibitive. If everyone were served in conventional service models designed to meet their level of needs, and the services operated for a full 12 months, it would cost about $59.2 million ($33.62 million General Fund). However, the cost would be considerably less if Family Support and other brokered services were used instead of traditional out-of-home care and 8 hour-shift models.

Alternative service models needed

Two different Focus Groups composed of family members were brought together to participate in the long range planning process. They considered alternative service models and offered the following principles:

- Services must include a full array of individually designed and flexible supports.
- Supports and services must be available to families before there is a crisis.
- "Systems" providing resources and technical assistance must be located close to home and available to individuals and their families.

- Daytime activities, whether employment or alternatives to employment, must be meaningful and valued by the individual.
- All service models must encourage community integration so that individuals are not left lonely and isolated after leaving the school system.
- Residential services must include a variety of options, with very small group living arrangements being favored. (2-3 people in an apartment or duplex.)
- Families must be given opportunities for meaningful involvement with their children throughout their lives.

Considering the prohibitive costs associated with traditional service models that rely on staff who must be hired in a highly competitive job market, plus input from the focus groups, the workgroup recommended the following:

- 24 hour care services should be tightly controlled through a single point of access and all less costly approaches that support the individual and the family should be considered before placement in 24 hour care is approved.
- *Funds that are reinvested in services for those on the Wait List should not be used for traditional service models.* Funds should be used for brokerages or service networks in which specially trained consultants help develop flexible plans for personal care and family support that are based on consumer and family choice. These plans might include respite care, in-home supports, attendant care, short term job coaching, and purchase of adaptive equipment.

The workgroup recognized that implementation of these recommendations would create difficulty because of the pressure that will build over time from population growth and an increasing number of older parents who can no longer provide care. Nonetheless, the Division was encouraged to resist expansion of 24 hour care because it is not an affordable option and will ultimately leave many more families with no services at all.

Funds should be used for brokerages or service networks in which specially trained consultants help develop flexible plans for personal care and family support that are based on consumer and family choice.

Summary of Recommendations and Costs

Overall recommendations

Close Fairview

- Develop an implementation plan to close Fairview.
- Use the service option that offers a mixture of state operated and privately operated community programs to serve the current Fairview resident population.
- Begin implementation in the 1997-99 biennium.

Help Fairview employees

- Give Fairview staff opportunities for future employment in the community services network.
- Give them the priority consideration when applicants are selected to fill the new positions in state operated community programs.
- Provide support and assistance to those interested in becoming foster parents to serve people leaving Fairview under this plan.
- Provide assistance to Fairview staff who wish to retire early or seek employment outside the community services network.

Sale of campus

- Develop a marketing plan for sale of the campus that maximizes potential reinvestment in other capital priorities.

Reinvest savings from closure of Fairview in three areas

- Develop specialized regional and statewide services to support the community service system.
- Increase wages for direct care staff by $1.00 per hour to improve the ability of privately operated programs to recruit and retain staff.
- Develop new community services for an estimated 1,500 people on the Wait List.

Phase in services funded by the reinvestment

- Phase in regional services, direct care staff wages, and services for those on the Wait List as Fairview residents are moved to communities.

Phase-in Schedule

As proposed, placement of Fairview residents would begin early in 1998 and be completed by July 2000.

Development of statewide/regional backup services, increased wages for direct care staff, and services for those on the Wait List are crucial for successful implementation of a Fairview closure plan.

Early placements would focus on services such as foster care and supported living that utilize the existing housing market. They would primarily utilize private provider organizations, leaving state operated programs until later so that a significant management structure and workforce remains at Fairview until it closes. It also allows time to develop the community residential sites needed for the state operated programs. Recruitment and selection of private provider organizations should begin as soon as this plan is approved.

Development of statewide/regional backup services, increased wages for direct care staff, and services for those on the Wait List are crucial for successful implementation of a Fairview closure plan. Consequently, the Long Range Plan calls for phase-in of some expenses in all three of these areas before the full savings at Fairview are realized. Expenditures in these areas would begin as appropriate when placement of Fairview residents begins.

Costs

It currently costs approximately $127.3 million to operate Fairview for a full biennium (two years). Almost 37% of that cost ($46.8 million) is paid with "General Fund" dollars. General Fund dollars are state tax dollars.

If the Long Range Plan is implemented as proposed, the cost in state General Fund dollars would be no more than what Fairview now costs.

Some additional costs would, however, occur during the transition period. Transition costs are onetime or limited duration expenses related to phase-in and phaseout of program operations.

- Phase-in costs relate to start-up expenses for new community programs, e.g. con-

struction of new homes, staff recruitment and training, equipment and furnishings, etc.

- Phaseout costs include expenses at Fairview such as assistance to displaced workers, unemployment compensation, care of vacant buildings, etc.

Transition Costs	
1997-1999 biennium	$10.4 million General Fund
1999-2001 biennium	$ 4.5 million General Fund
2001-2003 biennium	$ 0. General Fund

These additional expenses are due to the transition as well as the need to phase-in some of the expenses in the reinvestment areas before the full amount of savings from Fairview closure are realized.

Beginning in the 2001-2003 biennium, after Fairview has closed, the state would spend no more on the Long Range Plan than it would have otherwise spent on continued operation of Fairview.

Because of the restrictions and requirements on the way Federal Funds are used, some of the community programs used in the proposed Long Range Plan don't bring in as much Federal Funds to match the state General Funds as does Fairview. Approximately $14.7 million Federal Funds that could be claimed by Fairview could not be accessed by using the proposed community service system. However, it has been Department policy for many years to design programs that make sense for Oregonians and then to use Federal Funds to finance these program wherever possible. Even without these additional Federal Funds, the Long Range plan would serve more people and provide better wages than today. And, if Congress redefines the Medicaid program with some kind of block grant program in the next few years there may be no loss of Federal Funds.

The following table compares the two choices:

1. the cost of continuing to operate Fairview at its current funding level and continuing to serve the same number of Oregonians with Developmental Disabilities as receive services today; and
2. the cost of implementing the Long Range Plan over the next four biennia, serving an additional 1,500 people and raising provider wages.

Beginning in the 2001-2003 biennium, after Fairview has closed, the state would spend no more on the Long Range Plan than it would have otherwise spent on continued operation of Fairview.

Estimated Budget Impact over four biennia

The following three tables compare the cost of operating Fairview Training Center to the alternative cost of implementing the Long Range Plan over the next four biennia.

Chart "a" shows the "bottom line" i.e., the difference between the cost to continue services at Fairview and the cost to implement the Long Range Plan. For example, there is an additional General Fund cost for transition in 1997-1999 (10.4 million) and in 1999-2001 (4.5 million), but no additional cost to the State thereafter.

Difference between Fairview cost & Long Range Plan cost				
a	1997-99	1991-01	2001-03	2003-05
	(millions)	(millions)	(millions)	(millions)
Total Cost	-12.7	10.8	20.3	17.3
General Fund	-10.4	-4.5	0.0	0.0
Other Fund	0.7	2.5	2.6	2.6
Federal Fund	-3.1	12.9	17.6	14.7

Chart "b" shows the cost of continuing to operate Fairview at its current funding level.

Cost to continue operating Fairview				
b	1997-99	1991-01	2001-03	2003-05
	(millions)	(millions)	(millions)	(millions)
Total Cost	127.3	127.3	127.3	127.3
General Fund	46.8	46.8	46.8	46.8
Other Fund	3.4	3.4	3.4	3.4
Federal Fund	77.1	77.1	77.1	77.1

Chart "c" shows the cost to implement the Long Range Plan.

Lines 1-3 are costs related to client services, showing a phaseout of services at Fairview and phase-in of community services.

Lines 4-8 are onetime or limited duration costs needed to transition the location of services from Fairview to the community.

Lines 9-11 show reinvestment of savings from Fairview into new regional backup services, increased wages for community direct care staff, and new services for people who currently have no services.

Lines 12-15 show the total cost, and the type of funds used, to implement the Long Range Plan.

Cost to Implement Long Range Plan

		1997-99	1991-01	2001-03	2003-05
		(millions)	(millions)	(millions)	(millions)
Cost to operate programs					
1	Phase-out of services at Fairview	112.6	23.2	0.6	0.0
2	Phase-in of services in Community	12.6	62.4	67.4	67.4
3	Phase-in of community housing	0.3	1.7	1.9	1.9
Transition costs					
4	Community program start-up	2.6	1.4	0.0	0.0
5	Community housing start-up	3.8	2.8	0.1	0.0
6	Assistance to displaced workers at FTC	0.5	0.7	0.0	0.0
7	Unemployment costs at FTC	0.1	0.7	0.0	0.0
8	Care of vacant buildings & campus	0.0	1.2	0.0	0.0
Reinvestment costs					
9	statewide/regional back-up services	0.9	2.8	5.7	5.7
10	Direct care wage increase	5.2	13.1	17.3	21.0
11	Services for people on Wait List	1.4	6.5	14.0	14.0
Total cost of plan					
12	Total Cost	140.0	116.5	107.0	110.0
13	General Fund	57.2	51.3	46.8	46.8
14	Other Fund	2.7	0.9	0.8	0.8
15	Federal Fund	80.2	64.2	59.5	62.4

July 1996