ADSA Aging & Disability Services Administration

FREQUENTLY ASKED QUESTIONS

RESIDENTIAL HABILITATION CENTERS:

PROPOSED CLOSURES AND TRANSFER OF RESIDENTS

January, 2010

1. *Why close a Residential Habilitation Center (RHC) especially when families say their son or daughter is well cared for by RHC staff?*

The proposed closure and downsizing plan is often described as a financial move because it is included in the Governor's proposed 2010 Supplemental Budget. However, the primary reason behind the closure of Frances Haddon Morgan Center and the gradual downsizing of Rainier School is rooted in the belief and experience that persons with developmental disabilities (DD) are best served in integrated community-based settings rather than in large institutions.

Compared to the national trend, Washington has not kept pace with reducing its reliance on large institutions. The State's five RHCs are aging, and were built to serve four times the number of residents who currently live in RHCs. In addition, there has been an increase of Washington children living at RHCs and the Governor believes appropriate community options should be expanded to prevent a new generation of young people from having to leave their homes and communities to grow up in institutions.

Twelve states, including Oregon, have no individuals with developmental disabilities in institutions. Thirteen states have fewer than 100 people in institutions. Thirty states have fewer than 500 in DD institutions. Many who have spent much of their lives in institutions have successfully transitioned into community-based services, both in Washington State and throughout the country. This trend is expected to continue.

2. *Families say they turn to RHCs because their son or daughter has serious disabilities or behavior problems. Don't people living in RHCs have much more serious disabilities than those receiving supports in the community?*

In Washington State, many of the approximately 4,000 people currently served through community-based residential programs have support need levels as high as those residing in the RHCs. Over the past 20 years, DD certified residential providers have obtained the training and skills necessary to support people with very intensive and specialized needs. Today, community based residential programs commonly support individuals with developmental disabilities who are also deaf and blind,

In Dec. 2009 Governor Chris Gregoire proposed a plan that reforms how Washingtonians care for individuals with developmental disabilities. The Governor's proposals are based on the belief that many persons with developmental disabilities are best served in integrated community-based settings rather than in the state's large institutions for the disabled, called Residential Habilitation Centers. The Governor believes this is especially true in the case of children, who are better served in small homes near their local schools. The policy brief: http://www.governor.wa.gov/priorities/reform/facclosureDDD.pdf

Governor's 2010 Supplemental Budget (Dec. 2009) includes:
-Close Frances Haddon Morgan Center by June 2011.
-Begin downsizing Rainier School with target closure by June 2014.
-New community-based residential slots by FY2011.
-Crisis respite capacity.
-Expand specialized community services for children.

Frances Haddon Morgan Center
Location: Bremerton
53 residents, 130 staff

Rainier School
Location: Buckley
367 residents, 948 staff

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who have intensive medical needs, who exhibit very challenging behaviors and who experience mental illness.

3. *What is being done to address the need for services in the community?*

Building, expanding and maintaining resources in the community is important. An initial investment needs to be made for this strategy to be sustainable. That is why the Governor's proposed budget includes investments in community placements such as creating three new State-Operated Living Alternative Programs (SOLAs) specifically for serving children before June 2011. In addition, funds have been included to create community-based residential respite capacity in each region and to increase staff to support RHC clients transitioning to community living.

4. *How can ADSA complete the closures and transfers so quickly after the legislature approves the budget?*

The closures are not immediate, and the safe and successful transfer of a person is always a top priority. The Governor's proposal adds staffing resources and allows more than a year to transition the Frances Haddon Morgan Center residents to SOLAs or other community settings and assumes more than three years to close Rainier School. The Legislative process allows for public testimony and input before the Legislature approves a budget that would reflect their final decision. At that point, a specific transition plan and schedule will be created by the Division of Developmental Disabilities (DDD). The plan will include securing community providers with staff who possess the appropriate skills.

DDD has more than 40 years experience successfully moving people out of institutions through several downsizing initiatives every decade since the 1960's. In the early 1970s, 4,000 residents lived in RHCs but now, there are fewer than 1,000. When the Legislature closed Interlake School in Spokane, DDD transferred all 118 medically fragile residents into another institution or community residential alternative within one year without incident.

5. *What happens before an individual is moved? What is done to ensure their needs are met and health and safety issues are addressed?*

DDD staff will assess and evaluate the needs of RHC residents as part of transition planning. The plan spells-out how the person will move, who will be responsible at the time of transition for continuity of support, and how problems are to be solved. No one is moved unless a new placement is secured. Prior to moving from an RHC, staff will work with community programs, or with another RHC to determine that the person's needs would be fully met at his or her new home. The plan identifies the level of support and the services needed each individual to ensure the person's health and safety needs are thoroughly addressed in the community. Very specific information about likes and dislikes, medical conditions, treatments and medications are all part of the plan. An individual will not return to parents' homes unless that is the best plan and is agreed upon by all parties.

6. *How do you prevent traumatizing a resident by such a move and what kind of follow-up takes place?*

We recognize that moving may result in some stress. Most people, regardless of age, have an emotional reaction when their environment and living arrangement changes. To reduce stress people have choices about where they move and they are encouraged to explore as many options as possible.

DDD's Quality Assurance Managers in each region monitor moves into the community. Visits with each person are conducted three times: at 30 days, 90 days to six months and at one year. After the one-year evaluation, DDD hires independent contractors to conduct residential agency evaluations of services. A few individuals show some anxiety at first, but the person adjusts readily. Family members report that people are happier or their behavior is more positive. Based on DDD's 40 years of experience, we have seen successful transitions repeatedly. Most individuals thrive in their new homes. There are many examples of residents who transitioned to the community with specialized equipment who later did not require the assistance for mobility. Some residents who required a slow, gradual transition plan that included day trips and overnights in the community were ready to make a permanent move within weeks.

7. *I hear that when people move from the RHCs they die, is this true?*

That information is not true. Annual mortality rates in community-based settings are comparable to those in state facilities, with a slightly higher mortality rate in the RHCs. The public can request from DDD reports on mortality rates.

An example is the downsizing effort at Fircrest School when 57 people were moved during the 2003-05 biennium. Of the 57, three people died after moving and a fourth person who was on a short-term stay at Fircrest later died after returning to her home in the community. Each death was carefully reviewed. In every case, the death was not related to the moves from Fircrest. It should be noted that three of the four left the RHC for community-based supports because of their own or their family's request. One person transferred to another institution.

8. *I have heard advocates for community settings say that it is less expensive to live in the community. It's difficult to know if that is true because different calculations account for different services.*

National research shows that on average, serving clients in the community instead of in institutions less costly. This was echoed as one of the main findings of a rigorous comprehensive review of national research on developmental disabilities services by the Washington State Institute for Public Policy published in October 2009.

Similar results were found in a 2004 study by the Department of Social and Health Services (DSHS). DSHS compared "before and after" costs for RHC clients who moved into the community and included medical and other non-DDD costs. On average, the clients who left the RHC had 30% lower total DSHS costs after they moved into the community. The department took a comprehensive look, not just at DDD's costs, but at total DSHS costs (i.e. including medical, dental, food stamps, mental health, etc.).

Just recently, staff compared Fiscal Year 2008 total DSHS costs for RHC clients to the DSHS costs for clients with high needs in the community being served in Supported Living. Supported Living is a service designed for clients being diverted from institutions. Even using the most conservative analysis (lowest RHC costs versus highest community costs), community services cost 29% less. It is acknowledged that there are some clients with exceptionally high needs in the community. Their costs, which exceed the costs of an RHC, are not typical and these costs are included in the averaging.

Current budget restraints prevent DDD from being able to provide paid services for many clients and families. Nearly 14,000 of the 37,000 clients enrolled in DDD do not receive a service beyond case management. Another 1,200 plus have requested home and community-based waiver services as an alternative to institutionalization. The Individual and Family Services Program, which help families, care for their loved one in their own home, has a waiting list of 7,000.

The main reason to reform the system of care for people with developmental disabilities is to reflect the preference and rights of the majority of individuals and their families. The difference in costs is important because resources for developmental disabilities are limited and are in general not an entitlement, and yet reform requires new investment in the community to make it work.

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