Transform State Residential Services for Persons with Intellectual and Developmental Disabilities

SUBMITTED TO THE 82ND TEXAS LEGISLATURE **JANUARY 2011**

LEGISLATIVE BUDGET BOARD STAFF

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LEGISLATIVE BUDGET BOARD

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Honorable Governor of Texas
Members of the Eighty-second Texas Legislature

Ladies and Gentlemen:

Pursuant to Chapter 322 of the Texas Government Code, Legislative Budget Board staff conduct biennial performance reviews to evaluate the effectiveness and efficiency of state agencies. The Legislative Budget Board's Agency Performance Review team performed in-depth analysis of state supported living centers to provide the Texas Legislature with timely information about this complex subject.

This report, *Transform State Residential Services for Persons with Intellectual and Developmental Disabilities*, provides detailed analysis of the cost of services delivered at the state centers, identifies ongoing challenges in care delivery, and includes recommendations to reshape and modernize the system of state supported living centers.

Increasing consumer preferences for community-based services and the declining census at state centers provide Texas with an opportunity to redesign its system of state supported living centers. These recommendations to reduce the size of the system would enable redirection of limited state resources to community services and to improve the quality of care for residents in remaining state centers.

Respectfully submitted,

John O'Brien
Director

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DECREASE THE NUMBER OF STATE SUPPORTED LIVING CENTERS TO REDUCE COSTS AND IMPROVE CARE

Texas' reliance on the institutional model of care for persons with intellectual and developmental disabilities persists despite 40-year nationwide trends of deinstitutionalization and expansion of community services. Texas has the largest institutionalized population with intellectual and developmental disabilities of any state and comprises a disproportionate amount of the U.S. total. Texas continues to operate 13 state supported living centers for persons with intellectual disabilities/developmental disabilities even as demand for those services has declined. Decreasing the number of residents instead of closing facilities has resulted in a costly arrangement of dual-funded systems of care in which funding for community and institutional services continue to increase. Closing at least one institution and establishing a process to review continually the size of Texas' system of state supported living centers would enable the state to concentrate resources on persons remaining in the system and redirect savings to expansion of community programs.

FACTS AND FINDINGS

- The national census of persons with intellectual and developmental disabilities residing in state institutions peaked at 194,650 in 1967. Since then, a national movement of deinstitutionalization has occurred. From 1960 to 2008, the average daily populations of large state-operated Intermediate Care Facilities for Persons with Mental Retardation declined by 78.2 percent and the total number of facilities in operation declined from 354 to 168.
- Texas has the greatest total persons with intellectual and developmental disabilities residing in public and private Intermediate Care Facilities for Persons with Mental Retardation of any state, and a disproportionate amount of the U.S. total (12 percent). Texas also operates more large institutions than most other states, given the average size of its institutions relative to other states.
- Texas operates 13 campuses, the same amount it operated in 1996 when the last institution was closed. Since then, the system census decreased from 5,724 residents to 4,241 (25.9 percent decrease).
- The U.S. Department of Justice found after its investigation of the 13 state supported living centers that provision of care is not optimal. The Department found evidence that the centers violated the civil rights of residents and failed to protect them from harm.
- Confirmed allegations of abuse, neglect, and exploitation in the state supported living centers have increased 65.1 percent since fiscal year 2006 despite increased appropriations to the Department of Aging and Disability Services to hire more staff and improve staff training.

CONCERNS

- The number of state supported living centers operating in Texas is not supported by the demand for system services. Texas has opted to decrease the number of residents served at all institutions instead of closing institutions as demand has changed, which has committed the state to a significant outlay of resources.
- Texas operates an unsustainable dual-funded system of services to persons with intellectual and developmental disabilities. Expenditures to state supported living centers increased 93 percent from fiscal years 2000 to 2009, and expenditures on community waiver programs increased by 246.1 percent. However, because Texas has not closed institutions, the state has not realized significant cost savings or been able to redirect appropriations to community programs.
- The aging state supported living center facilities require significant ongoing maintenance and future commitment of resources to address deficiencies. The total spent on routine and preventive maintenance in fiscal year 2009 was $9.0 million and in fiscal year 2010 was $8.8 million. The amount estimated to address critical deficiencies within the next four years is $213.8 million.
- Additional funding is unlikely to resolve many of the operational challenges confronting state supported living centers in the near future, including the

recruitment and retention of direct-care workers and professional staff. The Texas Legislature has appropriated increased funding to address these concerns over the past several biennia, but many campuses still struggle to hire and retain workers.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the Department of Aging and Disability Services' bill pattern in the 2012–13 General Appropriations Bill that directs the Department to close at least one specified state supported living center by May 31, 2013.
- **Recommendation 2:** Include a rider in the Department of Aging and Disability Services' bill pattern in the 2012–13 General Appropriations Bill requiring the Department to submit a closure plan that takes into account feedback from relevant internal and external stakeholders by March 1, 2012 to the Governor and the Legislative Budget Board.
- **Recommendation 3:** Include a rider in the Department of Aging and Disability Services' bill pattern in the 2012–13 General Appropriations Bill authorizing the Department to reclassify 1 full-time equivalent position to direct the closure process.
- **Recommendation 4:** Include a rider in the Health and Human Services Commission's bill pattern in the 2012–13 General Appropriations Bill requiring the Commission to certify the savings associated with the closure and document the resulting changes in personnel and transfers of appropriations at all relevant health and human services enterprise agencies, and to submit a report documenting the savings and closure implications to the Governor and Legislative Budget Board by August 31, 2013.
- **Recommendation 5:** Amend the Texas Health and Safety Code to establish a commission on state-supported living center realignment to consider further closure or consolidation of existing facilities.
- **Recommendation 6:** Include a contingency rider in the Department of Aging and Disability Services' bill pattern in the 2012–13 General Appropriations Bill to appropriate funds to reimburse members of the commission on state supported living center realignment for travel expenses.

DISCUSSION

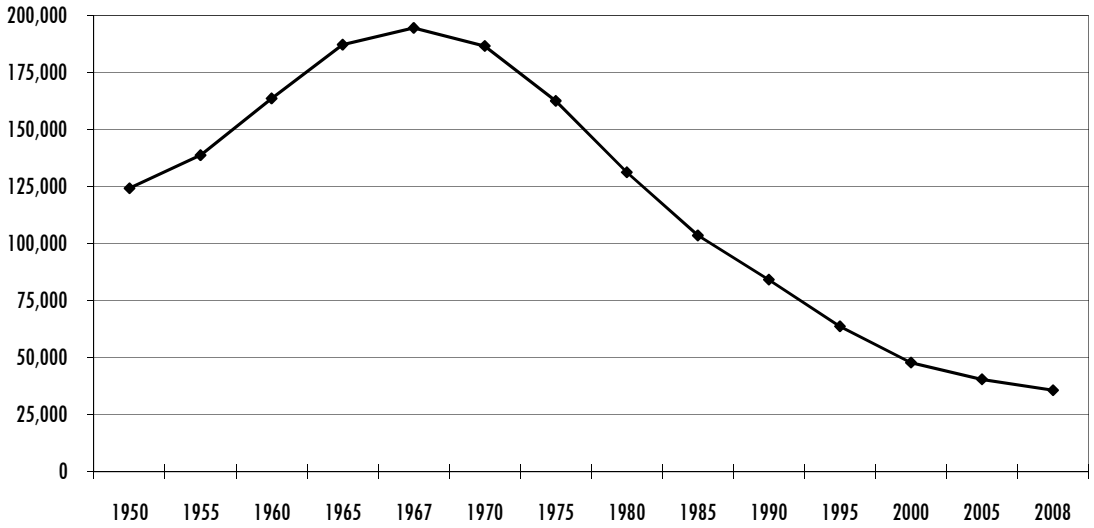
Prior to the Twentieth Century, most residential care provided to persons with intellectual disabilities/developmental disabilities (ID/DD) in the U.S. occurred in psychiatric hospitals. Beginning in the Twentieth Century, growth in the number of separate state facilities to house persons with ID/DD continued such that by 1967, the national census of persons with ID/DD served in state institutions reached its zenith at 194,650 residents, shown in **Figure 1**. During this era, the average facility size was 1,422 residents. Today, most states serve persons in smaller, more home-like settings in their communities and there is much less reliance on large state-operated institutions.

Reforms to state institutions were triggered in the late 1960s by several media exposés that revealed inadequate conditions, overcrowding, and lack of treatment provided in institutions for persons with ID/DD across the U.S. In 1971, the federal government established the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) program, enabling states to provide "intermediate care" in an institution (defined as having four or more beds) or distinct part of an institution that:

- is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and
- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability."

This benefit enabled states to receive federal funding, provided that their institutions were certified and complied with federal standards. Most states chose to participate in the program, and the number of people receiving ICF/MR services grew rapidly during the 1970s. States spent $1 billion from 1978 to 1980 to obtain ICF/MR certification for large state-operated facilities serving persons with ID/DD. In addition to improving the quality of care, the availability of the ICF/MR benefit resulted in significant decreases in the number of residents served in state institutions because many institutions were overcrowded by the new federal standards.

FIGURE 1
NATIONAL TREND IN ID/DD RESIDENTS OF LARGE STATE-OPERATED INSTITUTIONS
1950 TO 2008



SOURCE: Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2008, 2009.

NATIONWIDE DEINSTITUTIONALIZATION MOVEMENT

While early advocate activity in the 1960s focused on improving the conditions and quality of services of state institutions, the focus shifted in the 1970s to expanding community living options and closing state institutions. Several public policy interventions contributed to deinstitutionalization, or the shift in persons receiving services in institutional settings to community settings.

In addition to establishing the ICF/MR program, the federal government contributed to the expansion of other service settings that would eventually replace the state as the primary provider of services. In 1977, privately operated ICFs/MR became eligible for federal reimbursement. By 1993, most persons receiving ICF/MR services were served in privately operated institutions, and that trend continues today.

The federal Omnibus Budget Reconciliation Act of 1981 established Medicaid Home and Community-Based Services (HCS) waiver authority, which allowed states to finance "non-institutional," community-based services for Medicaid-eligible clients who would otherwise be served in institutions (Skilled Nursing Facilities, Intermediate Care Facilities, and Intermediate Care Facilities for Persons with Mental Retardation). States had to demonstrate cost effectiveness of their waivers (cost neutral in the aggregate). States were afforded further flexibility in the federal Deficit Reduction Act of 2005 which enabled them to offer HCS services as an optional Medicaid benefit instead of requiring a waiver, and to limit the number of people eligible.

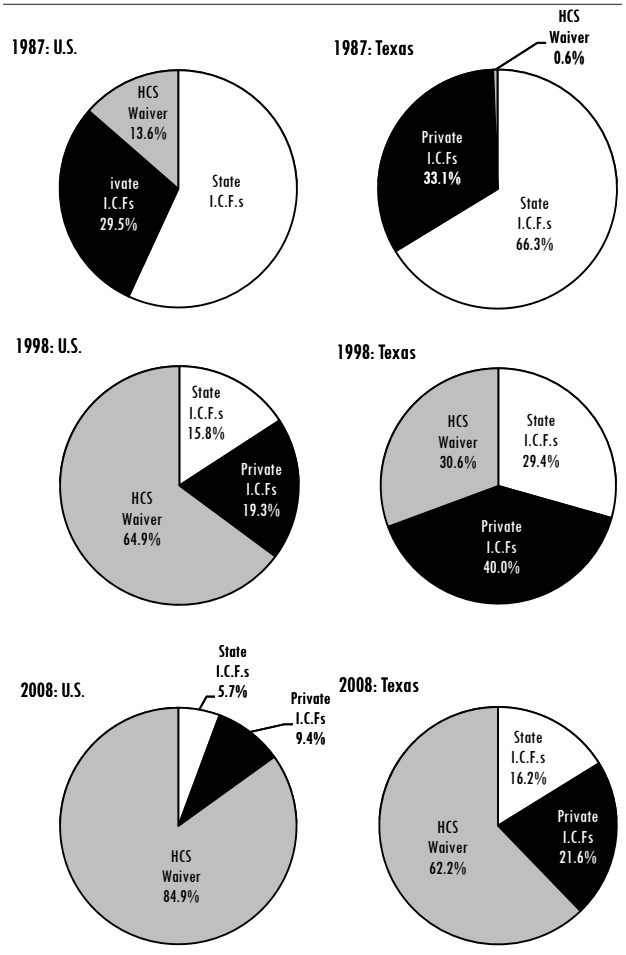
Although states had the option to serve persons in community settings, it was not until passage of the federal Americans with Disabilities Act (ADA) in 1990 and the *Olmstead v. L.C. and E.W.* decision in 1999 that states significantly expanded community services. The ADA prohibits discrimination based on disability in employment, public services, public accommodations, and telecommunications. It requires a public entity to provide services "in the most integrated setting appropriate to the needs of the person" and "make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the services, program, or activity."

In *Olmstead v. L.C. and E.W.*, the U.S. Supreme Court affirmed the lower court's ruling that Georgia violated the "integration mandate" of the ADA by unnecessarily institutionalizing two women. The *Olmstead* ruling defined institutionalization as unnecessary when the state's treatment professionals determine community placement is appropriate, transfer from the institutional care is not opposed by the

individual, and placement can be reasonably accommodated. *Olmstead* did not prohibit states from operating ICFs/MR and permitted them to operate a waiting list for community services, as long as it "moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated."

Taken together, the ADA and *Olmstead* significantly changed the way states provide services to persons with ID/DD. Many states downsized or closed state-operated ICFs/MR and made substantial investments in community services. **Figure 2** shows the predominant trends in deinstitutionalization that have occurred over several decades: first, a shift from public to private ICF/MRs as reliance on state-operated services decreased, and then a shift away from the ICF/MR institutional model toward smaller, home-like settings in the community.

FIGURE 2
CHANGING SHARE OF RESIDENTS BY SETTING 1987 TO 2008



NOTE: Data reporting began using odd-numbered years and switched to even-numbered years.
SOURCE: Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2008, 2009.

STATE EFFORTS TO SERVE PERSONS WITH ID/DD

In 2008, states provided services to a total of 47,389 persons in state-operated ICFs/MR of any size. The 10 states with the largest total ICF/MR populations in state-operated institutions are shown in **Figure 3**. The total population served in Texas is 10.1 percent of the U.S. total.

FIGURE 3
TEN STATES WITH THE GREATEST NUMBER OF RESIDENTS IN STATE-OPERATED ICFS/MR, 2008

STATE	RESIDENTS	RESIDENTS/STATE POPULATION
New York	9,727	49.9
Texas	4,799	19.7
New Jersey	2,897	33.4
California	2,530	6.9
Illinois	2,403	18.6
Mississippi	2,207	75.1
Massachusetts	1,937	29.8
North Carolina	1,666	18.1
Connecticut	1,656	47.3
Ohio	1,521	13.2
U.S. Total	47,389	15.6

SOURCE: Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2008, 2009.

To provide a complete picture of the institutional population, **Figure 4** shows the 10 states with the largest number of residents served in private ICFs/MR. Texas provides services to 11.1 percent of the total number of persons served in private ICFs/MR in the U.S.

Figure 5 shows the 10 states with the greatest number of residents in large state-operated ICFs/MR and the number of people served in these settings per capita. Large ICFs/MR are defined as those with 16 or more beds. Texas serves the greatest number of clients in large ICFs/MR of any state, and 13.7 percent of the U.S. total.

Figure 6 shows the 10 states with the greatest reliance on large state-operated ICFs/MR and the average size in number of residents per large state-operated ICF/MR.

FIGURE 4
TEN STATES WITH THE GREATEST NUMBER OF RESIDENTS IN PRIVATELY OPERATED ICFS/MR, 2008

STATE	POPULATION
California	6,849
Illinois	6,620
Texas	6,378
New York	5,537
Ohio	4,897
Indiana	3,982
Louisiana	3,653
North Carolina	2,594
Pennsylvania	2,579
Florida	2,020
U.S. Total	57,638

SOURCE: Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2008, 2009.

FIGURE 5
TEN STATES WITH THE GREATEST NUMBER OF RESIDENTS IN LARGE, STATE-OPERATED ICFS/MR, 2008

STATE	RESIDENTS	RESIDENTS PER CAPITA
Texas	4,789	19.7
New Jersey	2,897	33.4
California	2,530	6.9
Illinois	2,403	18.6
New York	2,119	10.9
North Carolina	1,666	18.1
Ohio	1,521	13.2
Mississippi	1,314	44.7
Virginia	1,304	16.8
Pennsylvania	1,275	10.2
U.S. Total	35,035	11.5

SOURCE: Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2008, 2009.

TEXAS SYSTEM OF SERVICES FOR PERSONS WITH ID/DD

National data reveal a consistent trend of deinstitutionalization, as well as shifts from state-operated to private ICFs/MR and from the ICF/MR model to the HCS group home model. As these shifts have occurred, the average size of service setting has also decreased. Texas is an exception and stands in contrast to these trends. Although demand for institutional services has declined in Texas, and the state has implemented initiatives to assist persons in ICF/MR in moving to the community, efforts have not resulted in a significant shift of persons from institutions to the community and do not represent planned deinstitutionalization. Texas continues to serve the greatest total institutionalized ID/DD population of any state and a disproportionate amount of the U.S. total (12 percent), when including state-operated and privately operated ICFs/MR. Texas also operates more large facilities than most other states. Only New York operates more large institutions than Texas, but as of 2008, the average large institution size in New York was 41 residents compared to Texas at 368 residents.

FIGURE 6
TEN STATES WITH THE GREATEST NUMBER OF LARGE STATE-OPERATED ICFS/MR INSTITUTIONS, 2008

STATE	NUMBER OF ICF/MR	AVERAGE SIZE OF ICF/MR
New York	52	41
Texas	13	368
Ohio	10	152
Georgia	10	96
Illinois	9	267
California	7	361
Louisiana	7	171
Massachusetts	7	133
New Jersey	7	414
Connecticut	7	109
U.S. Total	215	163

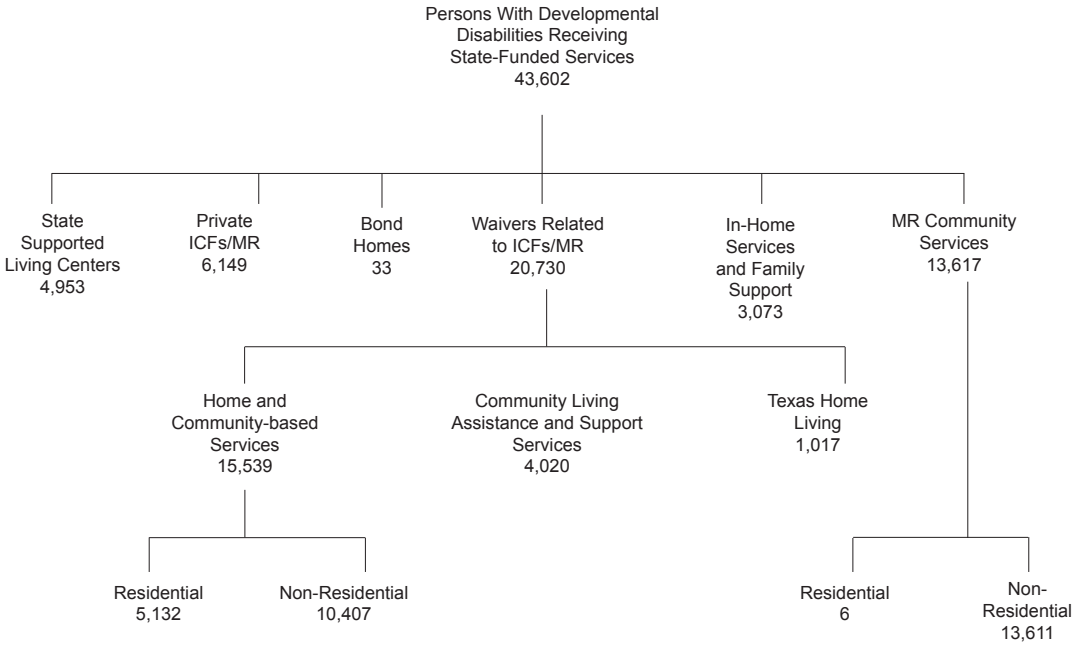
SOURCE: Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2008, 2009.

The Department of Aging and Disability Services (DADS) provides state-funded services to 43,602 persons with ID/DD, including through private and state-operated ICFs/MR, community waiver programs, in-home services and supports, and MR community services. **Figure 7** shows the number of persons served in each of these settings at the end of fiscal year 2009.

Texas operates 13 ICFs/MR, known as state supported living centers (SSLCs). This includes 12 SSLCs operated by DADS and the ICF/MR component of the Rio Grande State Center, operated by the Department of State Health Services. These facilities were known previously as state schools, and were renamed by Senate Bill 643, Eighty-first Legislature, 2009. **Figure 8** shows the distribution of ICFs/MR throughout the state.

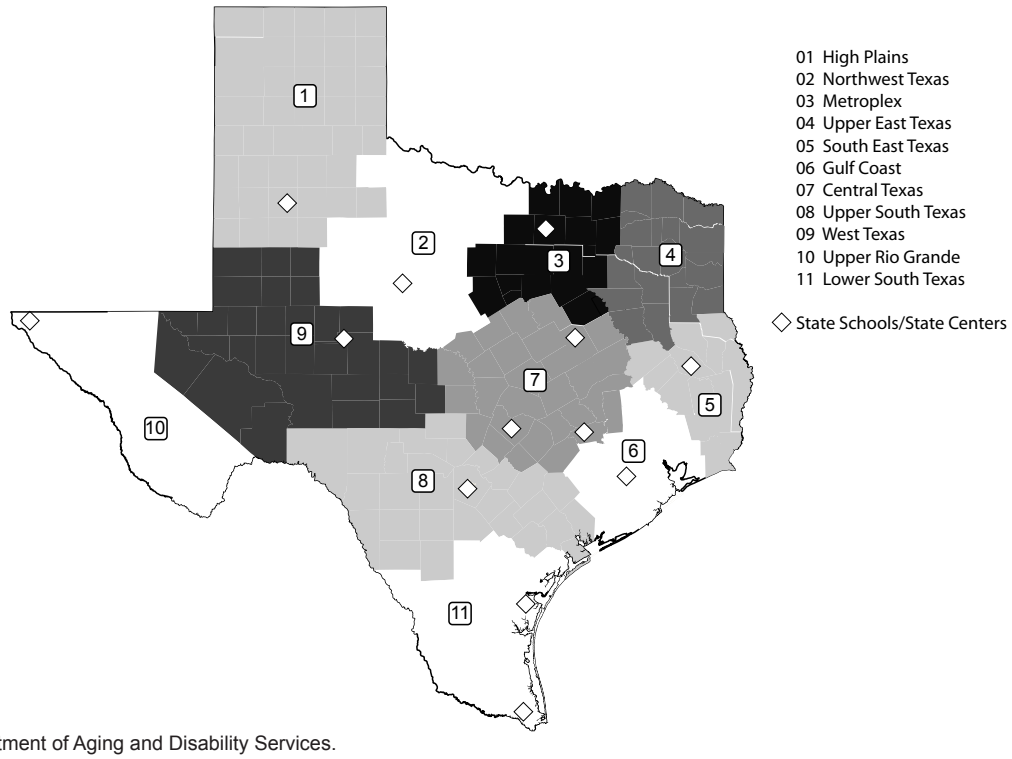
Texas SSLCs provide 24-hour residential services, day habilitation, behavioral treatment, and comprehensive

FIGURE 7
SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES IN TEXAS, FISCAL YEAR 2009



NOTE: The chart reflects the total, unduplicated count of persons who received state supported living center services.
SOURCE: Texas Department of Aging and Disability Services.

FIGURE 8
LOCATION OF STATE SUPPORTED LIVING CENTERS IN TEXAS, 2010



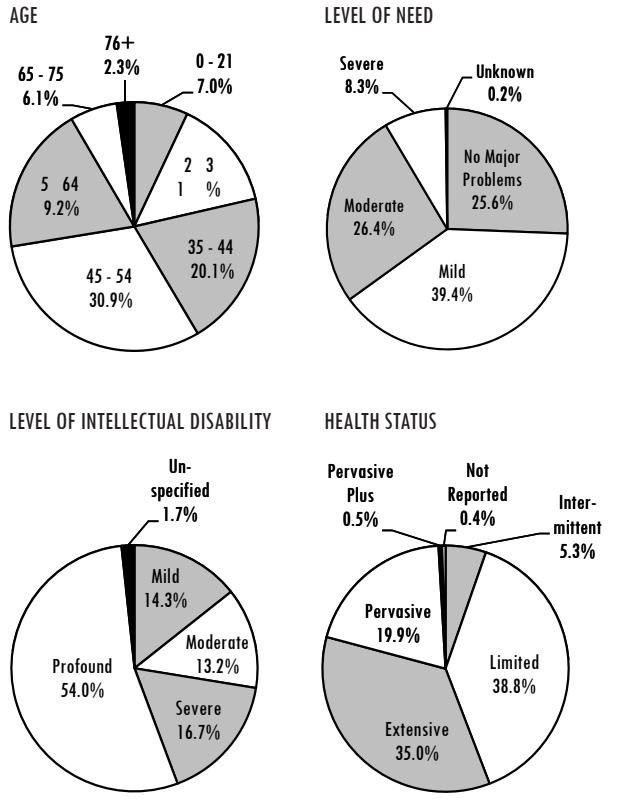
SOURCE: Department of Aging and Disability Services.

medical treatment (physician, nursing, and dental services). Speech, occupational, and physical therapy and vocational programs are also provided. SSLCs provide short-term respite and emergency services, and long-term placement for persons who are voluntarily or involuntarily admitted. SSLCs also receive juveniles and adults committed under the Texas Family and Criminal Codes for evaluation and more extensive services.

Federal law specifies that to be eligible for ICF/MR services, a person must have a determination of mental retardation or documentation from a physician of a related condition. The term "related condition" refers to a severe, chronic disability that manifests before the person reaches age 22, is expected to continue indefinitely, and results in a substantial number of functional limitations (e.g., cerebral palsy, epilepsy, or autism).

While the demographic characteristics of residents vary by SSLC, **Figure 9** shows system-wide trends with regard to age, level of intellectual disability/developmental disability (known as level of retardation), health status, and level of need.

FIGURE 9
DEMOGRAPHIC CHARACTERISTICS OF STATE SUPPORTED LIVING CENTERS RESIDENTS
FISCAL YEAR 2009



SOURCE: Department of Aging and Disability Services.

FACTORS INFLUENCING TEXAS' ICF/MR SYSTEM

Texas served an average of 4,627 persons per month in SSLCs in fiscal year 2009. The state operated the same number in of facilities in 1996 when the census was 5,724 residents. While demand for SSLCs in Texas has decreased over time, Texas has opted to downsize all facilities instead of closing facilities. This has resulted in significant ongoing costs to operate an institutional system and an increasingly large community system, and prevents the state from realizing cost savings that would be associated with closure of a facility.

INITIATIVES TO RESHAPE TEXAS' SYSTEM OF SSLCS

Litigation and implementation of initiatives in response to the ADA and *Olmstead* have contributed to some movement of persons from SSLCs to the community in Texas, however they do not signify a conscious choice to deinstitutionalize and have not resulted in a reduced emphasis on the institutional model.

The only state schools closed in Texas were closed as a result of the *Lelsz v. Kavanaugh* lawsuit. Plaintiffs filed a class action lawsuit against the state in 1974 to challenge the quality of care provided in three state schools. The case was settled in 1983, but the state was found to be out of compliance with the settlement agreement and litigation continued until the parties reached a new agreement in 1991. After the Texas Department of Mental Health and Mental Retardation (TDMHMR), the legacy agency that operated state schools, agreed to close the Travis and Fort Worth State Schools, a federal judge dismissed the lawsuit in November 1995. The dismissal ended 21 years of court supervision of TDMHMR's operation of the Texas state schools. The *Lelsz* settlement agreement also required TDMHMR to assist at least 600 persons in moving from state schools to community settings. In total, Lelsz resulted in the movement of 1,286 individuals from state schools to the community.

After the *Olmstead* decision, Texas began expanding community services, which further reduced institutional populations. In 1999, the Governor issued an executive order requiring the Health and Human Services Commission (HHSC) to conduct a comprehensive review of services available to persons with disabilities, to involve consumers, advocates, providers, and agencies in the review, and issue a report of findings to the governor and legislature. After

completion of this review, the Legislature directed HHSC and other appropriate agencies to implement a working plan to provide services and supports to serve persons in the most integrated setting.

In 2002, the Governor issued an executive order that required the state to further its promoting independence initiatives and highlighted the priority areas of housing, employment, children's services, and community waiver services.

After consolidation of the health and human services agencies in 2003, HHSC directed DADS through Circular 002 to assume responsibility for the Promoting Independence Initiative, which includes preparing the Promoting Independence Plan and providing staff support for the Promoting Independence Advisory Committee. The Promoting Independence Plan, due every two years, serves as a comprehensive working plan in response to *Olmstead* and assists with implementing the Governor's 2002 executive order. It also fulfills the statutory requirements. The committee is responsible for producing an annual report for the HHSC Executive Commissioner containing recommendations for the agency's legislative appropriation request for exceptional items and the Promoting Independence Plan.

Several ongoing initiatives were implemented to reduce institutional populations in Texas. **Figure 10** summarizes each initiative and shows the number of persons moved to the community as a result of the initiative for fiscal year 2009 and since the initiative's inception.

These initiatives have decreased the number of individuals living in SSLCs, but have not resulted in a decrease in the number of SSLCs in operation.

CHANGING DEMAND FOR SERVICES

The sprawling SSLC campuses were created to house significantly more people than are served currently. The Abilene, Austin, Denton, Mexia, Richmond, and Travis campuses each housed over 1,000 people in 1977. **Figure 11** illustrates the change in census at each campus from fiscal years 1977 to 2010.

According to data provided by DADS, the system's census has changed from 12,132 persons in fiscal year 1977 to 4,241 persons in fiscal year 2010, a decline of 65.0 percent. **Figure 12** shows the changing census for the entire SSLC system.

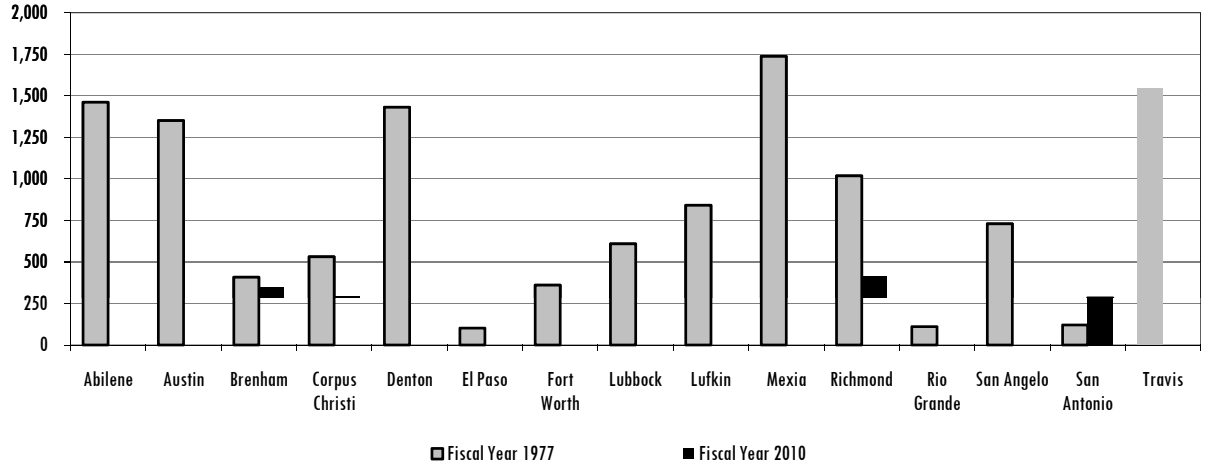
The demographic composition of system residents is also changing, as shown in **Figure 13**. While voluntary admissions

FIGURE 10
INITIATIVES TO REDUCE PRIVATE AND STATE-OPERATED ICFS/MR IN TEXAS, 2010

INITIATIVE	INITIATIVE SUMMARY
Money Follows the Person (MFP)	MFP came out of the Promoting Independence Initiative. The Centers for Medicare and Medicaid Services developed a multi-state, multi-year demonstration program that provides states with enhanced federal funding for each person who resides in an institution for at least six months and then transfers to a community waiver program. 2,314 persons have moved out of public and private ICFs/MR since the inception of the Promoting Independence Initiative. One activity under the demonstration enables medium or large ICF/MR providers (9 or more beds) currently contracted, licensed, and certified by DADs to apply for funding to convert their ICF/MR to community-based waiver services or a small ICF/MR (4-6 beds) in certain circumstances, given the provider's acceptance of other program requirements. 248 closures have occurred cumulatively since the program's inception.
Community Living Options Process (CLOIP)	TDMHMR implemented the process in state schools and private ICFs/MR in 2000 to inform residents about alternate living options. Senate Bill 27, Eightieth Legislature, 2007, strengthened the process and transferred responsibility for the new CLOIP process to Mental Retardation Authorities (MRAs). The CLOIP process requires service coordinators at MRAs to meet with each resident and their legally authorized representative at least once a year before the individual's annual planning meeting.
Section 48, Article II Special Provisions, 2010-11 General Appropriations Act,	Section 48 included a number of provisions to reshape Texas' system of SSLCs and expand community services. Elsewhere in the General Appropriations Act, DADS was appropriated $157.7 million in General Revenue Funds and the section directs that it be used to create 7,832 slots in community waiver programs. DADS is required to increase the number of HCS slots for individuals moving out of medium and large ICFs/MR, children aging out of foster care at the Department of Family and Protective Services, children who are at risk of being institutionalized in ICFs/MR, and individuals who are at imminent risk of institutionalization as a result of emergency or crisis situations. The appropriation was contingent upon DADS reducing the number of SSLC residents through census management, not closure, limiting the number of residents per SSLC, and the transfer of the case management function from HCS providers to Mental Retardation Authorities.

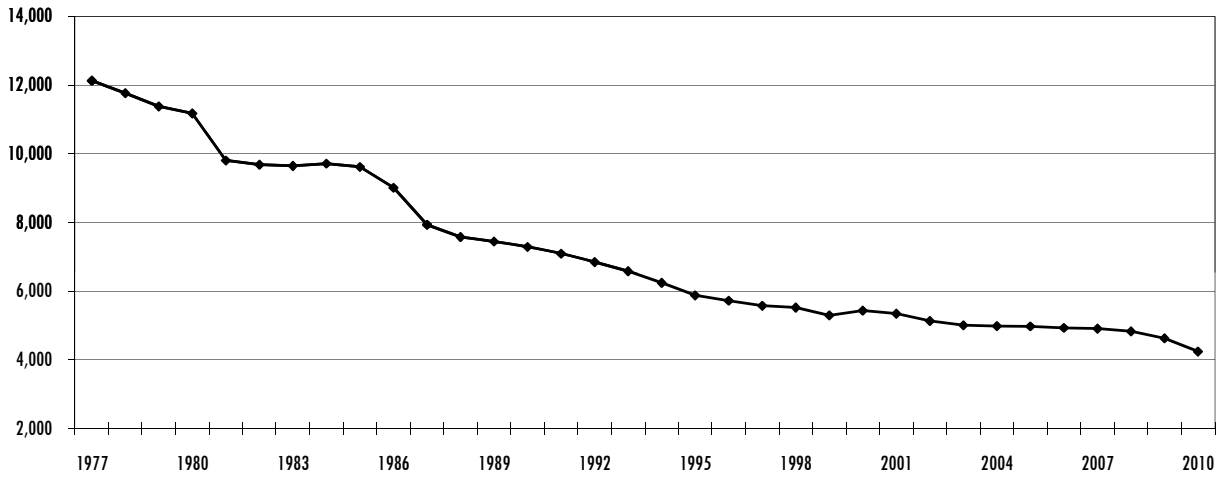
SOURCE: Legislative Budget Board.

FIGURE 11
AVERAGE DAILY CENSUS AT STATE SUPPORTED LIVING CENTERS
FISCAL YEARS 1977 AND 2010



NOTE: The Fort Worth and Travis campuses closed in 1995 and 1996, respectively. The El Paso campus data is from 1985, San Antonio campus data is for FY 1978.
SOURCE: Department of Aging and Disability Services.

FIGURE 12
CHANGE IN AVERAGE DAILY CENSUS FOR STATE SUPPORTED LIVING CENTERS
FISCAL YEARS 1977 TO 2010



SOURCE: Department of Aging and Disability Services.

have been decreasing since 2004, juvenile and adult court commitments, shown in **Figure 13** as Texas Family and Criminal Code Evaluations and Texas Criminal Code, remain relatively constant across years. When comparing the demographic characteristics of admitted persons in fiscal years 2009 and 2010 with all SSLC residents in the system at the beginning of fiscal year 2009, several differences emerge between the populations. New admissions are more likely to be juvenile or adult court commitments, male, have improved health status, and have a lower level of intellectual disability and level-of-need than persons already residing in the system.

The declining census of the SSLC system is expected to continue. DADS forecasts the system census will be 4,007 by the end of fiscal year 2011, as of September 2010. LBB analysis indicates that at the current rate of decline, the average monthly census could be 4,024 in, and 3,886 at the end of, fiscal year 2011; by fiscal year 2015, the average monthly census is projected to be 2,780.

FIGURE 13
ADMISSIONS BY TYPE IN TEXAS
FISCAL YEARS 2004 TO 2010

	VOLUNTARY ADMISSIONS			INVOLUNTARY ADMISSIONS				
FISCAL YEAR	RESPITE	EMERGENCY	REGULAR	FAMILY CODE EVALUATION	CRIMINAL CODE EVALUATION	CRIMINAL CODE	REGULAR	TOTAL
2004	63	13	0	43	7	21	136	283
2005	48	35	0	45	7	8	141	284
2006	52	22	0	34	5	10	156	279
2007	41	5	0	43	3	16	187	295
2008	2	8	0	46	14	18	172	271
2009	0	5	0	40	13	12	96	177

SOURCE: Department of Aging and Disability Services.

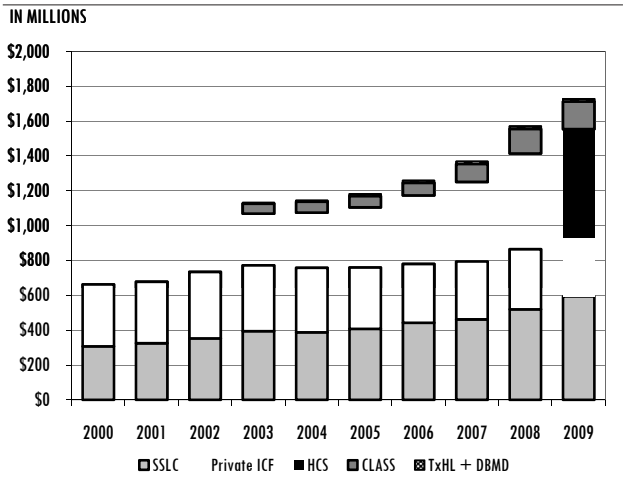
SIGNIFICANT ONGOING COSTS

The National Conference of State Legislatures noted in a 2000 report that when states begin to shift from a heavily institutional model of care to community services, they expend more resources by funding dual systems. As the institutional population declines, states must continue to keep facilities operational by investing in maintenance and repair and maintaining appropriate staffing ratios, while also expanding funding for waiver programs to serve the increasing number of clients. States cannot achieve savings or redirect appropriations to community services unless they are able to effectively downsize facility operations and staffing as the population declines, and eventually, close institutions.

Texas remains suspended between two systems delivering services for persons with ID/DD. **Figure 14** shows growing expenditures for institutional and community-based care from fiscal years 2000 to 2009, and **Figure 15** shows total enrollees by program for the same time period. From fiscal years 2000 to 2009, total spending for institutional and community-based increased. Community waiver spending grew by 246.1 percent from fiscal years 2000 to 2009, corresponding to a 213.4 percent growth in waiver enrollment. However, total spending on SSLCs increased 93.0 percent, despite a decrease in the system census by 802 persons (14.8 percent).

Although enrollment in community services is growing while the SSLC population is declining, Texas continues to fund two systems of care as if the decline in the SSLC population were not occurring. This approach commits the state to a significant outlay of expenditures over the long-term, and is not sustainable because SSLC expenses continue to increase. **Figures 16 and 17** show the changing share of spending and enrollees by program for fiscal years 2000 to 2009. In fiscal year 2009, institutional care (SSLCs and private ICF/MR) comprised 53.9 percent of system expenditures, while containing about 34.9 percent of system clients. SSLCs make up a disproportionate amount of system costs (34.4 percent) compared to their share of clients (14.9 percent).

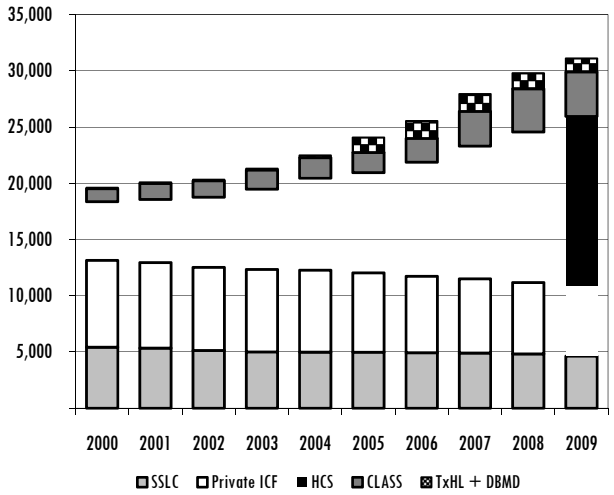
FIGURE 14
TOTAL SPENDING FOR INSTITUTIONAL AND COMMUNITY WAIVER SERVICES FOR PERSONS WITH INTELLECTUAL DISABILITIES/DEVELOPMENTAL DISABILITIES
FISCAL YEAR 2009



NOTE: Excludes acute care expenditures for waiver recipients.
SOURCE: Legislative Budget Board.

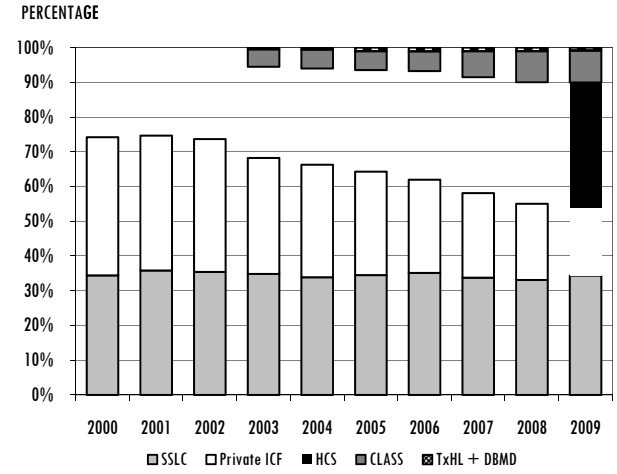
To understand per diem cost increases at SSLCs, LBB staff analyzed SSLC fiscal years 2007 to 2009 cost reports, using a methodology developed for the 2008 LBB staff report *Analyzing Shifts in Care from State Schools to Community Settings*. Costs were segmented into five categories to facilitate a comparison of cost growth over time, including Resident Care, Comprehensive Medical, Administration, Quality Assurance Fee, and Other. From fiscal years 2007 to 2009,

FIGURE 15
ENROLLMENT BY INTELLECTUAL DISABILITY/ DEVELOPMENTAL DISABILITY PROGRAM
FISCAL YEARS 2000 TO 2009



NOTE: Includes persons served through Promoting Independence Initiative.
SOURCE: Legislative Budget Board.

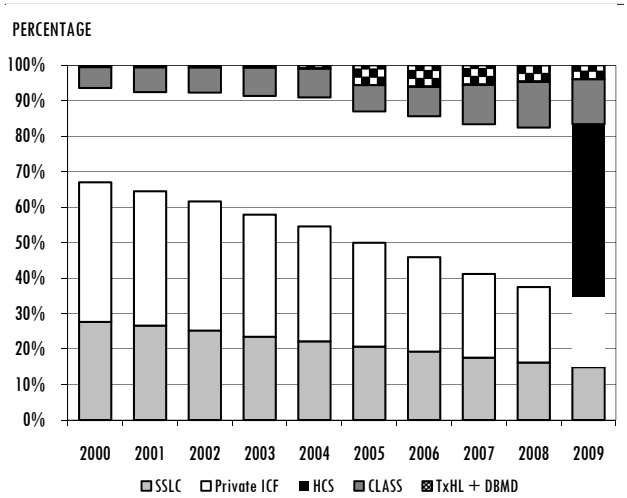
FIGURE 16
SHARE OF EXPENDITURES BY INTELLECTUAL DISABILITY/ DEVELOPMENTAL DISABILITY PROGRAM
FISCAL YEARS 2000 TO 2009



NOTE: Excludes acute care expenditures for waiver recipients.
SOURCE: Legislative Budget Board.

costs increased across all categories, but increases in resident care and administrative expenses comprised the greatest share of the increase. **Figure 18** shows the per diem cost across all SSLCs for fiscal years 2007to 2009, segmented by cost category. The per diem cost in fiscal year 2007 was $343.62. By fiscal year 2009, this was $425.45, an increase of 23.8 percent.

FIGURE 17
SHARE OF INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY CLIENTS BY PROGRAM
FISCAL YEARS 2000 TO 2009



NOTE: Includes persons served through Promoting Independence Initiative.
SOURCE: Department of Aging and Disability Services.

One consequence of maintaining dual systems of care is the continued financial investment required in the facilities of the 12 campuses operated by DADS to ensure their safe operation and compliance with state and federal standards. The Rio Grande State Center is excluded from this analysis because DADS does not operate the facility, and only contracts for the number of beds needed. **Figure 19** shows the facilities range in year opened from 1917 (Austin) to 1978 (San Antonio). Each campus requires varying amounts of resources for routine and preventive maintenance, and also to correct deficiencies including the replacement of failed or failing systems. Routine and preventive maintenance costs from fiscal year 2009 include labor and parts for all maintenance work orders on SSLC campuses. This data serves as an estimate of the annual maintenance required by SSLCs. The deficiency costs shown in **Figure 19** reflects the critical needs that must be addressed to correct failing systems or systems that are expected to fail within four years. For the Corpus Christi, Richmond, and San Angelo campuses, the deficiency costs exceed the value of the land and buildings.

The challenge with operation of a dual system of care is that with changing demand and reductions in the institutional system's census, savings cannot be realized and redirected to expand community programs or for use in other programs. Some of the largest potential gains from closure (e.g., cost savings from staffing reductions, cost avoidance of routine/

FIGURE 18
STATE SUPPORTED LIVING CENTERS PER DIEM COST BY CATEGORY
FISCAL YEARS 2007 TO 2009

	RESIDENT CARE			COMPREHENSIVE MEDICAL						
PERIOD	SALARY/ WAGES	BENEFITS	TOTAL	ACUTE/ PRESCRIPTION	DIRECT/ INDIRECT STAFF	TOTAL	ADMIN	QAF	OTHER	TOTAL
FY 2007	$140.76	$32.95	$173.71	$10.47	$31.99	$42.46	$73.07	$17.99	$36.40	$343.62
FY 2008	$155.95	$34.45	$190.40	$10.69	$32.67	$43.36	$74.36	$20.49	$40.97	$369.58
FY 2009	$184.19	$38.87	$223.06	$11.14	$34.03	$45.17	$90.37	$21.37	$45.47	$425.45
Difference 2007 to 2009 ($)	$43.43	$5.93	$49.36	$0.67	$2.04	$2.71	$17.30	$3.38	$9.07	$81.83
Difference 2007 to 2009 (%)	30.9%	18%	28.4%	6.4 %	6.4%	6.4%	23.7%	18.8%	24.9%	23.8%

SOURCE: Legislative Budget Board.

FIGURE 19
FACILITY DATA BY STATE SUPPORTED LIVING CENTERS
FISCAL YEARS 2009 AND 2010

	YEAR OPEN	ACRES	NUMBER OF BUILDINGS	TOTAL SQUARE FEET	2009 VALUE OF LAND AND PROPERTY	2010 DEFICIENCY COSTS	2009 PREVENTIVE AND ROUTINE MAINTENANCE COSTS	2010 PREVENTIVE AND ROUTINE MAINTENANCE COSTS	2010 BONDED INDEBTEDNESS
Abilene	1957	337.9	98	626,936	$18,305,000	$16,875,450	$1,025,140	$907,129	$22,297,155
Austin	1917	93.37	112	676,530	$20,900,000	$20,712,791	$281,350	$284,136	$13,965,048
Brenham	1974	198.3	33	371,099	$9,833,115	$8,043,921	$975,315	$755,881	$8,982,756
Corpus Christi	1970	104	52	299,787	$7,929,000	$11,586,803	$534,033	$457,480	$8,578,179
Denton	1960	189.2	72	491,477	$35,600,000	$19,480,489	$799,965	$772,570	$16,240,700
El Paso	1974	20	19	119,128	$5,330,000	$1,001,655	$41,822	$148,585	$4,781,766
Lubbock	1969	226.1	41	320,786	$12,133,000	$11,928,098	$444,964	$706,327	$11,439,346
Lufkin	1962	159.2	72	364,603	$11,160,000	$8,069,979	$359,672	$332,158	$12,370,405
Mexia	1946	841.6	175	702,020	$10,170,000	$7,465,165	$1,816,802	$1,439,753	$22,218,891
Richmond	1968	241.8	49	506,607	$12,700,000	$50,028,010	$502,552	$705,312	$28,128,975
San Angelo	1969	1031	84	492,044	$9,258,000	$52,282,637	$1,562,857	$1,337,636	$13,036,340
San Antonio	1978	0	38	234,962	$35,500,000*	$6,362,996	$658,852	$924,591	$6,305,906

NOTES: The figure only includes campuses operated by the Department of Aging and Disability Services. Bonded indebtedness includes General Obligation bond debt, Master Lease payments, and SECO energy loans. The deficiency costs reflect the critical needs that must be addressed to correct failing systems or systems that are expected to fail within four years.
SOURCES: Legislative Budget Board; General Land Office; Department of Aging and Disability Services; Health and Human Services Commission.

preventive maintenance and resolution of deficiency costs, and revenue gain from sale of the property) cannot be realized without making a choice to close institutions when demand no longer exists and committing to service delivery in the community.

IMPROVING CARE AT STATE SUPPORTED LIVING CENTERS IN TEXAS

Concerns with the quality of care provided in SSLCs have existed for the past four decades, since the Leslz lawsuit was filed in 1974. In recent years, the U.S. Department of Justice (DOJ) investigation of SSLCs has drawn renewed attention to the rights of residents and gaps in care. In addition, the

Texas Legislature has sought to address quality of care issues through passage of legislation and increased appropriations.

The DOJ began an investigation into civil rights violations of residents at the Lubbock State School in 2005. In August 2008, the investigation expanded to all institutions. In its letter to the Governor following completion of the investigation, DOJ reported "numerous conditions and practices at the Facilities violate the constitutional and federal statutory rights of their residents…the Facilities fail to provide their residents with adequate protection from harm," among other deficiencies. Texas entered into a five-year, $112 million settlement agreement, which requires DADS to hire up to 1,160 new staff and implement new employee training. Under the settlement, each institution will be evaluated independently for each area of deficiency until satisfactory progress results in the fulfillment of the settlement agreement.

The Eighty-first Legislature, Regular Session, 2009, enacted Senate Bill 643 to improve the safety of residents in SSLCs through creation of a mortality review process, creation of an independent ombudsman, and use of employee drug testing, more stringent background checks for employees, and a video surveillance program, among other measures. The Legislature appropriated $38 million ($19 million General Revenue Funds and $19 million Federal Funds) for implementation of the legislation (House Bill 4586, supplemental appropriations bill).

Since 2005, when the DOJ investigation at the Lubbock SSLC began, the centers have continued to receive increased appropriations to hire more staff, improve staff training, and enact measures to improve resident safety. Expenditures for SSLC services have increased by 93 percent from fiscal years 2000 to 2009, as previously shown in **Figure 14**. In the last two legislative sessions, specifically, increased appropriations were targeted at staffing. The Eightieth Legislature, Regular Session, 2007, appropriated $1 billion including $48.8 million in additional General Revenue Funds to enable DADS to hire 1,690 people to meet national staffing ratios. As a result of the DOJ agreement and funds appropriated in the Eighty-first Legislature, Regular Session, 2009, DADS intends to hire an additional 1,100 staff. With some of the funds appropriated over the past several biennia, DADS has contracted with the Columbus Organization for technical assistance to develop and implement a new training curriculum for professional and direct-care staff. From April 2005 to November 2009, DADS paid the organization $7.1 million.

Despite these investments, DADS has not been able to correct system deficiencies. In the baseline reports used for evaluation of DADS' compliance with the settlement agreement, which included findings from visits made to each center in spring 2010, monitors noted deficiencies were present that had previously been identified to DADS as requiring correction. For example, in the Lubbock SSLC Baseline Monitoring report, monitors noted, "As was discussed with State Office staff during the review, serious potential for harm was observed during this review. The risk was known because it had been documented in various reports, but it had not been addressed adequately. The risk was found in more than one residential unit." One of the risk factors was "extremely serious staffing concerns."

More telling, the increased training and staffing have not reduced abuse, neglect, and exploitation of residents. Since 2006, confirmed allegations of abuse, neglect, and exploitation of SSLC residents have increased 65.1 percent, according to Department of Family and Protective Services' data. While it is likely that improved staff training has improved reporting, data reveal abuse continues to be a significant issue despite the training dedicated to correcting it, as shown in **Figure 20**.

FIGURE 20
TOTAL CONFIRMED INCIDENCES OF ABUSE, NEGLECT, AND EXPLOITATION AT TEXAS STATE SUPPORTED LIVING CENTERS
FISCAL YEARS 2006 TO 2009

YEAR	INCIDENTS
2006	427
2007	475
2008	572
2009	784
2010	705

SOURCE: Department of Family and Protective Services.

Hiring staff remains a challenge despite additional resources appropriated to address the issue. The rate at which DADS is able to fill positions, or "fill rate," is generally improving relative to past performance, but coverage gaps exist at several SSLCs for several types of key staff including direct-care workers and professional staff such as nurses. The system fill rate for direct-care workers at the end of May 2010 was 96.1 percent, but Austin, Rio Grande, and San Angelo had below average rates of 91.4 percent, 79.2 percent, and 92.2 percent, respectively. The system fill rates for nurses was 84.4 percent

at the end of May 2010, with Austin (79.0 percent), Brenham (82.6 percent), Denton (66.6 percent), Lubbock (53.2 percent), Rio Grande (61.5 percent), and San Angelo (81.8 percent) performing below the system's average.

Staff turnover also remains high. **Figure 21** provides the average turnover rate across all positions at each SSLC from fiscal years 2006 to 2009.

Taken together, these problems illustrate that despite the state's significant investment in SSLCs, the increased funding has not been linked to improved quality of care, nor has it improved the turnover or hiring of staff. Funding alone will not improve the quality of care at SSLCs and the quality of life of residents; other issues remain unaddressed. The next report in this publication entitled, "Modernize Care Delivery at State Supported Living Centers," examines these issues in greater detail and outlines recommendations to address them.

FIGURE 21
AVERAGE STAFF TURNOVER RATE BY STATE SUPPORTED LIVING CENTER
FISCAL YEARS 2006 TO 2009

SSLC	2006	2007	2008	2009
Abilene	23%	27%	35%	35%
Austin	42%	53%	63%	51%
Brenham	25%	32%	34%	32%
Corpus Christi	29%	38%	51%	34%
Denton	37%	44%	49%	41%
El Paso	18%	19%	29%	24%
Lubbock	38%	47%	49%	41%
Lufkin	20%	23%	31%	29%
Mexia	25%	31%	40%	28%
Richmond	16%	24%	24%	16%
San Angelo	38%	49%	50%	46%
San Antonio	36%	43%	65%	40%

NOTE: Fiscal year 2008 data include the additional positions funded by the Eightieth Legislature, 2007.
SOURCE: Texas Department of Aging and Disability Services.

CURRENT STATE RESHAPING AND CLOSURE EFFORTS

The growing resources required to sustain Texas' dual system of care for persons with ID/DD coupled with challenges in providing quality care suggests Texas should reconfigure its ICF/MR system. Many other states have reshaped their systems and their experiences could prove instructive to Texas.

Since 1967, states have achieved reductions in their state-operated ICF/MR censuses through significant system reshaping, including downsizing of resident populations and closure of institutions. From 1960 to 2008, average daily populations of large state-operated ICFs/MR declined by 78.2 percent, and institutional populations at all but three states declined by at least 50 percent. The total number of state-operated facilities declined from 354 operating from 1960 to 2008 to 168 as of June 30, 2008. The greatest average number of closures occurred from 1988 to 1999, averaging 9.7 closures annually. As of July 30, 2008, eight states and Washington, D.C. did not have any large state-operated residential facilities. These states include: Alaska, Hawaii, Maine, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia.

To collect data on other states that reshaped their ICF/MR systems or closed state-operated institutions since 2000, Legislative Budget Board (LBB) staff surveyed 32 states that operate at least one ICF/MR serving at least 100 residents, excluding Texas. **Appendix A** provides a summary of state responses to the LBB survey.

Together, the states that responded to the survey operate 94 institutions. **Figure 22** shows the number of institutions by size, as of fiscal year 2009, for the 17 states that responded to that question.

Fifteen states indicated they have intentionally changed (reshaped) the overall number of residents served in large ICFs/MR since 2000. Some states shared information on the strategies used to reshape their systems. Six states closed one or more institutions, six closed part of an institution, and two conducted inter-institutional transfers. Seven responded that they had developed community resources and increased Medicaid waiver services or taken advantage of *Olmstead*

FIGURE 22
NUMBER OF STATE-OPERATED LARGE ICF/MR BY FACILITY SIZE OPERATED BY STATES SURVEYED
FISCAL YEAR 2009

SIZE	16 TO 50	51 TO 100	101 TO 200	201 TO 300	301 TO 400	401 TO 500	501 TO 600	TOTAL
Number	15	24	36	7	4	5	3	94

SOURCE: Legislative Budget Board.

provisions to reduce the number of residents in large state-operated ICFs/MR.

Six states that responded indicate they have closed at least one institution since 2000, but only five provided detailed information on their closure process. Of five reporting states that closed a total of six institutions, the average number of residents by institution at the time of closure was 116.3 with a range of 0 to 242 residents. The average percentage of residents who moved to another state-operated institution was 61 percent, ranging from 10 percent to 100 percent. The average percentage of residents who moved into the community was 38 percent, ranging from 0 percent to 90 percent.

The period required to complete the closure varied by state. One state reported the closure occurred within 6 to 12 months after the announcement, three states reported the closure took between 12 to 24 months, and two states indicated the closure process exceeded 24 months.

Of the states that responded to a question about whether they realized cost savings with the closure of an institution, four noted a net cost savings and one noted a neutral cost impact. Of the states that realized savings, two noted savings in institution operating costs, three reported savings in staffing costs, and three noted savings in direct/indirect client care costs. When asked to identify when savings were realized, one state noted in the same fiscal year as the closure, two states noted in the fiscal year after the closure, and one state noted in two or more years after the closure. Four states indicated that net cost savings were realized beyond the initial year.

To gain an in-depth understanding of how they achieved their system transformations, LBB staff also interviewed officials from six of the survey states. **Figure 23** summarizes the experiences of these states.

ADDRESSING CHALLENGES OF CLOSURE

Other states have faced many of the same challenges with downsizing and closure, and some of the strategies they have employed to overcome those challenges to reconfigure their ICF/MR system can serve as guides to Texas. **Figure 24** summarizes approaches used by six states to minimize adverse effects of closure on residents, staff, and local economies and how they disposed of the property or repurposed the land and buildings after closure.

PROCESS TO CLOSE A TEXAS STATE SUPPORTED LIVING CENTER

Closure of at least one SSLC now, and implementation of a process to review continually the size of the SSLC system, would enable the state to shift to a smaller system that provides high quality care to persons most in need while freeing resources to expand community services for persons who choose community care.

Recommendations 1 to 4 would provide a transparent, accountable process to oversee closure of a SSLC within the next biennia. Because Texas has not closed a SSLC in 15 years, and it is likely that future closure/consolidation will be necessary given the inevitable, ongoing deinstitutionalization occurring now, monitoring and documenting the closure process and client and fiscal outcomes is necessary to inform future closure decisions. Recommendation 5 would establish a long-term process to continually reevaluate the size and configuration of the SSLC system.

Recommendation 1 would include a rider in DADS' bill pattern in the 2012–13 General Appropriations Bill, requiring DADS to close at least one SSLC by May 31, 2013. The rider would identify the institution(s) for closure based on legislative deliberations.

Direction from the Texas Legislature to close a SSLC is required because the Texas Health and Safety Code Section 533.084 requires DADS to obtain legislative approval before closing or consolidating a facility. Setting an initial closure date within the biennia is feasible, based on the experiences of other states surveyed by LBB staff.

Many approaches could be used to determine which institution to close. In 1991, prior to the closure of the Fort Worth and Travis State Schools, the Texas Performance Review recommended broad criteria to use in evaluating the suitability of institutions for closure, including the effects on residents and families, alternate uses for the facility, effects on facility employees, effects on the community where the facility is located, and effects on receiving facilities.

When the Texas Legislature, via the 2004–05 General Appropriations Act, directed HHSC to complete an evaluation of the feasibility of closure or consolidation of state schools and hospitals, the factors of interest to the Legislature in determining which, if any facility, to close included:

- Proximity to other facilities and geographical distribution

FIGURE 23
STATE EXPERIENCES IN INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY SYSTEM RESHAPING: 2010

	GEORGIA	KANSAS	MARYLAND	NEW YORK	NORTH CAROLINA	OHIO
Current System Composition	Large ICF/MR by number of residents: 5 3 – 51 to100 1 – 101 to 200 1 – 301 to 400 Residents of large ICF/MR: 1,104	Large ICF/MR by number of residents: 2 2 – 101 to 200 Residents of large ICF/MR: 374	Large ICF/MR by number of residents: 3 1 – 16 to 50 2 – 51 to 100 Residents of large ICF/MR: 170	Large ICF/MR by number of residents: 25 10 – 16 to 50 12 – 51 to 100 3 – 101 to 200 Residents of large ICF/MR: 1,600	Large ICF/MR by number of residents: 4 1 – 201 to 300 2 – 301 to 400 1 – 501 to 600 Residents of large ICF/MR: 1,450	Large ICF/MR by number of residents: 10 10 - 101 to 200 Residents of large ICF/MR: 1,314
Factors contributing to system reshaping	As the Olmstead state, the state of Georgia including the legislature and advocates, supported the agency taking a lead on deinstitu-tionalization. The state has one of the country's oldest HCS waiver programs.	Downsizing in the 1990s was driven by a desire to serve persons in the most integrated setting, and occurred alongside implementation of a new model of person-centered care in remaining state-operated ICF/MR. Budgetary concerns are influencing the current reshaping effort.	Initial downsizing was driven by the governor and operating agency's belief that the majority of persons could served in the community. In 2009, the state closed an institution that had a history of challenges identified by the state's licensing agency, which coincided with a Department of Justice investigation of the institution.	Lawsuits surrounding operation of the Willowbrook State School continue to shape deinstitu-tionalization.	Gaps in the safety net have resulted in the development of specialty programs to serve specific populations.	Budgetary concerns have driven the latest round of downsizing.
Overview on reshaping process	Georgia began closing institutions in the 1990s and has closed one institution since 2000. The state has reoriented its system to focus on providing treatment to specific populations including the forensic population and persons with mental health and ID/DD diagnoses.	Kansas reshaped its system in the 1990s, closing two institutions. A closure commission made recommendations to the governor on the institutions to close.	Maryland closed two facilities in the mid-1990s and began the process of downsizing remaining facilities.	New York has previously closed ICF/MR but not since 2000. The agency has downsized its population by about 200 since 2000.	During the 1990s, North Carolina downsized significantly and used the HCBS waiver to serve persons in the community.	Ohio has engaged in closure of institutions (seven since 1982) and downsizing. Six centers are actively downsizing now.

FIGURE 23 (CONTINUED)
STATE EXPERIENCES IN INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY SYSTEM RESHAPING: 2010

	GEORGIA	KANSAS	MARYLAND	NEW YORK	NORTH CAROLINA	OHIO
Overview on reshaping process (continued)		Currently, as a result of the governor's direction, the state is downsizing the two remaining institutions by limiting admissions and placing residents in the community, with the expectation consolidation that could occur within 3 to 4 years. Savings from downsizing and closures in the 1990s were reinvested in community services.	As part of the downsizing, legislation passed to limit admissions to state ICFs/MR by requiring the Secretary of Health to approve all new admissions. In the 2009 closure, the state phased-out the facility over 18 months to enable community capacity to grow. Funds from the closure were deposited in an account and the interest was directed toward expansion of enrollment in community waivers, as required by statute.	The operating agency had the authority to downsize without additional legislative direction. The agency is also repurposing some of its facilities for short-term programs for people with intense needs (e.g., autism). Savings were reinvested in community services.	Since 2000, the state has not closed an institution, but has been undergoing system reshaping. Several specialty programs have been created including a program for persons with dual diagnoses of IDD and mental health disorder. In addition, a community based crisis prevention and intervention program was developed for individuals with IDD who experience behavioral health challenges (NC START).	The agency has the authority to downsize without further legislative oversight. The agency has downsized without closing admissions. Statute specifies a process to oversee closure decisions. If the governor announces s/he would like to close a facility, a Commission forms to evaluate the evidence and make a recommen-dation to the governor. Legislative staff prepare a report to assist the Commission. The governor's decision is final.
Outcomes of reshaping	Throughout downsizing and closures, the majority of persons have transitioned to the HCS waiver program. There is a minimal presence of private ICF/MR in the state.	In the downsizing and closures of the 1990s, some residents transferred to other state-operated institutions but the majority transferred to the HCS waiver program. During the major deinstitutionalization of the 1990s, very few residents of state-operated institutions returned to those institutions after a community placement.	Most residents moved to the HCS waiver program or to supported living arrangement in their own homes. There are no private ICF/MR in the state.	Historically, persons transitioning from state institutions moved into private ICF/MR. Recent transfers have been to the HCS waiver program. New York is unique in that the state operates HCS group homes known as Individualized Residential Alternatives (IRAs), with an average size of 6 beds.	In the 1990s, efforts to downsize resulted in more persons served in the HCS waiver. Many of the higher needs persons currently transitioning to the community have chosen placement in a private ICF/MR.	With the closures, about half of residents transferred to other state facilities. With downsizing, residents were given the option to transition to other state ICFs/MR, private ICFs/MR, or HCS group homes. The majority went to other ICFs/MR.

SOURCE: Legislative Budget Board.

FIGURE 24
STATES' APPROACHES TO DOWNSIZING AND CLOSURE OF LARGE STATE-OPERATED ICFS/MR, 2010

	GEORGIA	KANSAS	MARYLAND	NEW YORK	NORTH CAROLINA	OHIO
Strategies to Minimize Resident Impact	Georgia worked with each resident on a one-on-one level to identify new placements. Such placements were developed for 90% of consumers. After an initial wave of residents moved to the community, the state arranged for visits of current residents and their families to see how their counterparts were faring.	Kansas worked one-on-one with residents to determine the appropriate placement. State funds were used to pay rent and purchase furniture in order to assist persons transition to community living.	Maryland conducted individual planning. Residents were encouraged to visit and stay overnight in community placements. Residents also received information about community living from former residents and department employees.	New York chose to operate small group homes.	North Carolina used extensive transition planning. State funding has been utilized for community provider staff to come to the centers to get to know residents and receive training prior to their transition.	Ohio used overnight visits to enable residents to experience new settings. The state tracked outcomes of residents that moved out of closed state ICF/MR for three years. For downsizing efforts, outcomes were tracked for one year. The state provided technical assistance to private ICF/MR and HCS providers to enhance the success of placements of former center residents.
Strategies to Minimize Staffing Impact	Most staff transitioned to jobs in the community with the consumers they served. Others moved to vacant jobs at other state facilities.	Staff downsizing occurred gradually. Some staff found positions at other state agencies. Many moved to the community to continue serving the same population. The legislature appropriated funds to provide severance packages and six months of health insurance to those unable to find work.	Maryland gave center staff priority in hiring for other state agency vacancies in the region. The state's hiring freeze was lifted for these positions. Employees received assistance with resume writing and job search. As a result, less than 10% had no job when facility closed. Retention bonuses were used to keep staff during closure.	State chose to operate small group home and staff with former employees of centers.	North Carolina was open with staff about downsizing and made staff part of the process. Vacant positions were eliminated first.	Ohio started to eliminate positions with attrition. Staff from institutions that were closing or downsizing were given the opportunity to transfer to other centers. Employees had access to counseling sessions including job preparation and resume assistance. Staff members with seniority eligible for retirement or within one year of retirement was given one year additional paid retirement benefits.

FIGURE 24 (CONTINUED)
STATES' APPROACHES TO DOWNSIZING AND CLOSURE OF LARGE STATE-OPERATED ICFS/MR, 2010

Strategies to Minimize Staffing Impact (continued)						Staff members were given the option of becoming community waiver providers (although few took advantage of the opportunity).
Strategies to Minimize Impact to Local Economies	The community services were developed close to the facilities involved in the downsizing/closure.	No information provided.	No impact to local economy.	No information provided.	No information provided.	A few new waiver provider homes were developed in the same communities that previously housed the centers.
Strategies to Repurpose Land/ Buildings	The land was repurposed by state for other needs.	Two closed institutions eventually became correctional facilities.	Some of the institutions that closed were eventually sold. The state has not disposed of the 2009 property.	As institutions closed, some were turn-keyed, and others were converted to day programs, regional offices, or were used for other administrative purposes.	No information provided.	Several alternative options for each center were considered. Ultimately, both properties were sold.

SOURCE: Legislative Budget Board

- Administrative cost of the facility
- Availability of other employment options in the area for employees displaced
- Condition of existing facilities
- Marketability of the property
- Ease of client transfer capability
- Capacity at remaining facilities to accommodate persons transferred
- Identification of specialty programs and services

HHSC and its consultant developed criteria to measure differences among facilities based on those categories.

One factor that could influence which SSLC to close is availability of community providers. However, DADS contracts with HCS providers to serve an entire region, and it should have a provider base that can expand to meet the needs of residents leaving SSLCs. When the Eighty-First Legislature, 2009, authorized 5,120 new HCS slots, via the 2010–11 General Appropriations Act, DADS was able to develop that capacity, and closure of an institution would require many fewer slots. In addition to HCS capacity, private ICFs/MR have some capacity, according to DADS, and could serve as another residential option for SSLC residents.

Appendix B provides comparative data for 12 SSLCs operated by DADS across seven categories that could be used in determining which SSLC(s) to close. The categories include client impact, capacity to accommodate clients, cost, facility condition, marketability, employment, and geography. Data from the Rio Grande State Center is excluded from this analysis, but closing the ICF/MR component of the center remains an option.

Recommendation 2 would implement a formal planning process to oversee facility closure, not unlike that used in other states such as Florida and California. The recommendation would include a rider in DADS' bill pattern of the 2012–13 General Appropriations Bill, requiring DADS to submit a closure plan that considers feedback from relevant internal and external stakeholders by March 1, 2012 to the Governor and the LBB. The rider would require the agency to submit status reports on implementation of the plan on August 31, 2012, March 1, 2013, and August 31, 2013. The agency would be required to publish the plan and updates on its website.

In the initial closure plan, the rider would direct the agency to outline major milestones and timelines in the closure process, and to identify strategies and related tasks for implementation related to the following areas:

- identifying residents for community placement who have the strongest desire to receive care in the community;
- establishing a process to successfully transfer residents including creation of programs to increase the likelihood of success in transition modeled after best practices in other states;
- ensuring the quality of care in the SSLC identified for closure does not decline during the closure process;
- monitoring outcomes of former residents of SSLCs in the community; and
- closing the physical facilities.

The status reports would provide progress on completion of major milestones and tasks for implementation outlined in the closure plan, and include available information on the outcomes of former residents of SSLCs in the community. DADS would also identify barriers to closure to enable the Legislature to consider statutory changes that might facilitate the closure process.

DADS may encounter many of the challenges experienced by other states in the closure process. As previously shown in **Figures 23 and 24**, there are strategies DADS could incorporate in its closure plan to address the needs of residents, staff, and local communities. In addition to these concerns, the closure plan might also identify additional issues including addressing concerns of residents/families opposing community care and ensuring oversight of community care.

Some residents of SSLCs and families might oppose closure of a SSLC campus. This occurred in the mid-1990s when Texas closed two institutions. Many of these consumers opted to be served by other state schools instead of transferring to the community. The experiences of other states suggests the most effective way to alleviate the concerns of residents and families is to work one-on-one with them over an extended time period in order to find the best placement for that individual. One state encouraged residents and their families to visit former peers from the institution that had already moved to the community to see how they successfully transitioned. Another state agency director personally escorted a family with significant concerns about community

care on tours of community living options. Two states offered private ICF/MR services as an alternative to waiver services and some families of persons transitioning from state institutions chose the private ICF/MR setting for their relatives because they preferred the more comprehensive nature of the ICFs/MR benefit to the HCS waiver program.

Some resistance to SSLC closure might stem from the assumption that certain SSLC residents could not live successfully in the community. While it may not be cost-effective to serve all persons in community settings, empirically, many other states including Texas have served persons with higher needs in community settings. According to DADS, in fiscal year 2009, 635 HCS residential clients had a level-of-need of Pervasive or Pervasive-Plus for any point in the year, out of a population of 6,035 clients. Although persons with high medical needs are more infrequently served in the HCS residential program, 0.5 percent of HCS residential clients required the highest available amount of nursing services per week, a service level DADS has identified as an indicator of health status. DADS also reports that in fiscal year 2009, 35.2 percent of HCS residential clients had a behavior program in place and 3.8 percent of clients had at least one high-behavior score in the following categories: likelihood for self-injury, serious disruptive behavior, aggressive behavior, and sexually aggressive behavior.

Oversight of community remains an issue for DADS to address in its closure plan. Senate Bill 643, Eighty-first Legislature, 2009, increased community oversight by requiring DADS to conduct annual unannounced visits of each HCS group home. DADS may consider additional measures including enhanced tracking of outcomes of persons transitioning to the community, as Ohio did. In addition, if DADS identifies gaps in oversight, it should include discussion on those gaps in status updates of the closure plan to enable the Legislature to address them.

Recommendation 3 would include a rider in DADS' bill pattern of the 2012–13 General Appropriations Bill, permitting DADS to reclassify one full time equivalent (FTE) position to direct the closure process given the attention the closure process will require.

Recommendation 4 would include a rider in HHSC's bill pattern of the 2012–13 General Appropriations Bill, requiring HHSC to certify the savings associated with the closure and document the resulting changes in personnel and transfers of appropriations at all relevant health and human services enterprise agencies and to submit a report documenting the savings and closure implications to the Governor and LBB by August 31, 2013.

Closure of a SSLC will involve a complicated set of short and long-term costs and savings, cost avoidance, and potential revenue through sale of the SSLC property. Multiple health and human services agencies will be affected directly or indirectly by the closure, which could also result in changes in FTE positions. This recommendation would provide the Legislature with transparency into the outcomes of the closure process to ensure the closure process used is cost-effective and savings are redirected to serve clients in the community.

Additional transparency is provided by DADS' Rider 9, included in the 2010–11 General Appropriations Act. The Rider specifies a process for DADS to use related to the transferability of funds. As persons move from SSLCs to other settings, savings will be realized in strategy A.8.1, State Supported Living Centers, and DADS will need to transfer savings to other strategies. In addition, because DADS allocates statewide and agency overhead costs to Strategy A.8.1, the agency will need to transfer savings from the SSLC strategy to other strategies to enable reallocation of overhead costs. Rider 9 requires DADS to obtain permission from the Governor and the LBB for any transfers between strategies, and this rider will enable the Legislature to monitor the redistribution of funds following the closure. Should Rider 9 be modified by the Eighty-second Legislature, additional oversight of the closure process would be needed to monitor transfers between programs.

Recommendation 5 would provide a long-term process to reevaluate the size of the SSLC system. It would amend the Texas Health and Safety Code to establish a commission on state supported living center realignment. The commission would receive administrative support from DADS. The commission would be required to submit a report with recommendations on the need for closure or consolidation of SSLCs to the Governor and the LBB by September 1 of even-numbered years.

The commission's composition would include a representative from DADS, a representative from a parent's association of SSLC residents, representatives of private providers of services to persons with ID/DD, advocates, and ex officio members from the Office of the Speaker of the House, the Office of the Lieutenant Governor, and the chairs of the

Senate Health and Human Services Committee and House Committee on Human Services.

The commission could serve as a model for addressing other systems of state-owned and operated facilities including correctional facilities, and the Legislature could expand the commission's scope and composition to take on greater responsibilities.

Several states have used commissions to oversee the closure or realignment of state-owned and state-operated facilities. In Kansas in 2009, the governor established a facilities closure and realignment commission through executive order, charging the group with determining whether to close or consolidate any state-owned and operated facilities, or to use the facilities for alternate purposes. The governor and legislature appointed its members and the group's recommendations were presented to the governor.

In Ohio, statute specifies a process to oversee closure of ICFs/MR. When a governor announces that s/he intends to close one or more developmental centers, the announcement triggers formation of a developmental disabilities center closure commission and completion of an independent study by the Legislative Services Commission to assist the commission. The commission has six members including agency representatives, private executive with expertise in facility utilization and/or economics, a representative of the civil service employees association, a family member of a resident or a representative of an advocacy group, and a law enforcement official. The group issues recommendations to the governor and the governor has the options of following the recommendations of the commission, closing no developmental center, or taking other action for the purposes of expenditure reductions or budget cuts.

Recommendation 6 would include a rider in the Department of Aging and Disability Services' bill pattern in the 2012–13 General Appropriations Act to appropriate funds to reimburse Commission members for their travel expenses.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 to close at least one SSLC will have complex short and long-term fiscal implications. Cost savings, cost transfers, and revenue generation will occur in varying degrees depending on the campus identified for closure. The five-year fiscal impact is provided in **Figures 25 through 28**. **Figure 28** shows the fiscal impact for both fiscal year 2015 and fiscal year 2016 because the impact is the same in each year. The net fiscal impact for the biennium shown in **Figure 29**.

The net fiscal impact of closure is calculated individually for each of the 12 SSLC campuses operated by DADS, and the estimate assumes only one SSLC would be selected for closure. The estimate assumes cost savings would be incurred at the SSLC as residents transition to other residential settings, but that some costs would transfer with residents. The estimate extends the cost savings and cost transfers

FIGURE 25
FISCAL IMPACT, FISCAL YEAR 2012

	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUND	PROBABLE SAVINGS/(COST) TO FEDERAL FUNDS 555	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED ACCOUNT 5080
Abilene	$2,924,899	$4,131,464	($395,819)
Austin	$2,295,762	$3,247,525	($316,349)
Brenham	$1,898,537	$2,689,424	($271,912)
Corpus Christi	$1,992,706	$2,821,731	($266,981)
Denton	$3,754,258	$5,296,716	($500,311)
El Paso	$770,921	$1,105,120	($109,547)
Lubbock	$2,046,966	$2,897,966	($258,505)
Lufkin	$1,963,961	$2,781,345	($288,286)
Mexia	$3,144,974	$4,440,670	($413,032)
Richmond	$3,050,758	$4,308,297	($398,936)
San Angelo	$1,775,216	$2,516,156	($236,071)
San Antonio	$1,226,728	$1,745,530	($187,211)

SOURCE: Legislative Budget Board.

FIGURE 26
FISCAL IMPACT, FISCAL YEAR 2013

	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUND	PROBABLE SAVINGS/(COST) TO FEDERAL FUNDS 555	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED ACCOUNT 5080
Abilene	$13,711,662	$18,534,278	($2,262,211)
Austin	$8,543,220	$11,555,970	($1,605,850)
Brenham	$6,914,356	$9,356,716	($1,378,980)
Corpus Christi	$7,742,192	$10,474,441	($1,354,550)
Denton	$14,596,447	$19,728,894	($2,539,803)
El Paso	$2,815,658	$3,822,751	($555,843)
Lubbock	$8,614,437	$11,652,125	($1,312,474)
Lufkin	$6,582,185	$8,908,226	($1,462,349)
Mexia	$12,481,290	$16,873,058	($2,094,702)
Richmond	$12,184,965	$16,472,968	($2,023,396)
San Angelo	$6,979,239	$9,444,320	($1,197,131)
San Antonio	$3,854,446	$5,225,298	($948,771)

SOURCE: Legislative Budget Board.

FIGURE 27
FISCAL IMPACT, FISCAL YEAR 2014

	PROBABLE SAVINGS/ (COST) TO GENERAL REVENUE FUND	PROBABLE SAVINGS/ (COST) TO FEDERAL FUNDS 555	PROBABLE REVENUE GAIN TO GENERAL REVENUE FUND	PROBABLE SAVINGS/ (COST) TO GENERAL REVENUE–DEDICATED ACCOUNT 5080
Abilene	$12,540,644	$22,343,310	$0	($3,053,458)
Austin	$19,575,220	$17,087,707	$6,934,952	($2,440,405)
Brenham	$11,065,707	$13,813,636	$850,359	($2,097,604)
Corpus Christi	$10,863,994	$15,565,929	$0	($2,059,571)
Denton	$41,041,549	$29,295,975	$19,359,300	($3,859,540)
El Paso	$4,711,533	$5,642,304	$548,234	($845,076)
Lubbock	$13,576,786	$17,415,617	$693,654	($1,994,178)
Lufkin	$8,442,728	$13,054,548	$0	($2,223,920)
Mexia	$6,559,628	$25,145,898	$0	($3,186,249)
Richmond	$2,744,752	$24,558,851	$0	($3,077,504)
San Angelo	$6,621,137	$14,062,243	$0	($1,821,120)
San Antonio	$34,822,288	$7,620,171	$29,194,094	($1,444,199)

NOTE: Revenue gain for the San Antonio State Supported Living Center reflects the combined value of sale of the State Hospital and State Supported Living Center.
SOURCE: Legislative Budget Board.

through fiscal year 2016. The estimate also includes the revenue gain from the sale of the SSLC property in fiscal year 2014, but reduces the amount of the gain to take into account outstanding debt. The annual cost of Recommendation 5, creation of the Commission on State Supported Living Center Realignment, is included each year. Should the legislature identify additional campuses for closure, the fiscal impact would need to be adjusted to prevent duplication of the cost of creating this Commission.

The estimate assumes cost savings would accrue as residents transition to other less costly residential settings. The estimate assumes DADS would plan for closure for the first four months of the biennium and begin transitioning residents to

FIGURE 28
FISCAL IMPACT, EACH YEAR, FISCAL YEARS 2015 AND 2016

	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUND	PROBABLE SAVINGS/(COST) TO FEDERAL FUNDS 555	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED ACCOUNT 5080
Abilene	$16,532,799	$22,343,310	($3,053,458)
Austin	$12,640,269	$17,087,707	($2,440,405)
Brenham	$10,215,348	$13,813,636	($2,097,604)
Corpus Christi	$11,513,173	$15,565,929	($2,059,571)
Denton	$21,682,249	$29,295,975	($3,859,540)
El Paso	$4,163,299	$5,642,304	($845,076)
Lubbock	$12,883,133	$17,415,617	($1,994,178)
Lufkin	$9,653,133	$13,054,548	($2,223,920)
Mexia	$18,608,519	$25,145,898	($3,186,249)
Richmond	$18,173,727	$24,558,851	($3,077,504)
San Angelo	$10,399,476	$14,062,243	($1,821,120)
San Antonio	$5,628,194	$7,620,171	($1,444,199)

SOURCE: Legislative Budget Board.

FIGURE 29
FISCAL IMPACT, FISCAL YEARS 2012–13

	PROBABLE NET POSITIVE/(NEGATIVE) IMPACT TO GENERAL REVENUE–RELATED FUNDS		
	FISCAL YEAR 2012	FISCAL YEAR 2013	TOTAL
Abilene	$2,529,080	$11,449,451	$13,978,531
Austin	$1,979,413	$6,937,370	$8,916,783
Brenham	$1,626,626	$5,535,376	$7,162,001
Corpus Christi	$1,725,724	$6,387,642	$8,113,366
Denton	$3,253,948	$12,056,644	$15,310,592
El Paso	$661,374	$2,259,814	$2,921,188
Lubbock	$1,788,461	$7,301,963	$9,090,424
Lufkin	$1,675,675	$5,119,835	$6,795,511
Mexia	$2,731,942	$10,386,588	$13,118,529
Richmond	$2,651,822	$10,161,569	$12,813,392
San Angelo	$1,539,145	$5,782,109	$7,321,253
San Antonio	$1,039,517	$2,905,674	$3,945,191

SOURCE: Legislative Budget Board.

other settings in January 2012. Because it was assumed residents would transfer out of a SSLC in even amounts over eighteen months, the estimate systematically reduces the costs of operation by the same proportion each month.

The estimated costs of operation for each SSLC were determined by adjusting the final audited 2009 cost reports by SSLC to reflect growth in costs. The cost reports are inclusive of all Medicaid allowable costs including direct and indirect-care costs, comprehensive medical costs, administrative costs (less central office administration), the Quality Assurance Fee, and Other costs (i.e., transportation, facility and operation costs). The analysis assumed all categories of costs would decrease with a decrease in the residential population except central office administration costs, which include the Statewide Cost Allocation Plan, HHSC enterprise costs, and DADS allocated costs, among other items. The analysis assumed these costs would remain and shift to other DADS' or state programs. To the extent

that they shift to programs with less favorable federal participation rates, there could be additional costs incurred. Non-Medicaid allowable costs are not reported on the cost reports and were excluded from this estimate. They represent additional savings of General Revenue Funds.

The savings were reduced to account for costs of SSLC residents who transferred to other service settings. It is difficult to identify the share of residents that would shift to other settings because placements are made on an individual level and involve the personal preference of residents and their guardians. This estimate assumed 70 percent of residents would choose to be served in the HCS waiver program (residential), 15 percent would choose a private ICF/MR, and 15 percent would choose another SSLC. These assumptions are based on a combination of the experiences of other states and historical closure and downsizing in Texas. If a greater share of residents transfer to other SSLCs, the savings to the state would decrease.

The estimate assumes an even reduction in the number of residents beginning in January 2012, starting with the 2010 census. The costs to serve these persons in their new settings were calculated by adding the product of the cumulative number of persons in each new setting by month and the average monthly cost of serving an individual in that program.

After these costs and savings were determined and summed for each campus, the state and federal shares were calculated using the Federal Medical Assistance Percentage.

The state's savings in each year were reduced to account for the annual cost to implement Recommendation 5 ($15,640 in General Revenue Funds). This cost reflects the travel reimbursement expenses for the Commission on State Supported Living Center Realignment. It is assumed the Commission members would not receive compensation. A contingency rider to the General Appropriations Act would be required to implement Recommendation 5.

The estimate also assumed closure would result in a loss of General Revenue–Dedicated and Federal Funds. Texas applies a Quality Assurance Fee (QAF) to each SSLC. The QAF is an allowable federal Medicaid expense which is used by the state to draw additional federal funding. Closure of a campus would result both in elimination of the need for the General Revenue used to draw the federal match and also loss of some QAF collections into General Revenue–Dedicated Account 5080 and additional federal funds. The analysis estimates a loss in General Revenue–Dedicated and federal funds based on the number of persons transferring to the HCS residential waiver program. To the extent that more residents transfer to other SSLCs or private ICFs/MR, a provider type the QAF also applies to, this loss will decrease.

The analysis assumes the state would experience a one-time General Revenue Fund gain from the sale of the SSLC property identified for closure. The analysis assumes the General Land Office (GLO) will manage the property sale and begin preparation during fiscal years 2012–13 to enable a sale in fiscal year 2014. Because each campus has outstanding debt, the revenue gained from the sale would need to be applied toward the debt, either to pay off the debt or to set funds aside in a cash defeasance. As shown in **Figure 19**, there are six campuses in which the property value exceeds the level of outstanding debt based on current GLO estimates. In the instances in which the debt exceeds the property value, the difference was included as an additional cost to the General Revenue Fund, and the revenue gain is reflected as $0. Once a specific property is identified for sale, an updated property estimate would need to determined. To the extent that the property is sold for a higher amount than this analysis assumes, the revenue gain would be greater. Because the San Antonio SSLC is co-located with the San Antonio State Hospital, determining the property values for the SSLC component only and the outstanding debt for the State Hospital was not possible, which results in the appearance of a greater revenue gain than could actually be realized.

This estimate also assumes there will be cost shifts at several agencies but that the net effect will be cost neutral. For example, DFPS investigates abuse/neglect at SSLCs and in other settings. When residents shift to other settings, there will be less need for investigations in SSLCs and more need in other areas.

Recommendations 2, 3, 4, which pertain to DADS' management and HHSC's oversight of the closure processes, can be accomplished within existing resources. DADS has existing staff and processes to assist residents in transferring to other settings; Recommendation 1 only increases the number of persons using these processes. Because the estimate allows for four months of planning prior to relocating persons and assumes an even, gradual rate of decline in the campus census, it is assumed DADS would not require additional resources to close an SSLC.

The introduced 2012–13 General Appropriations Bill includes riders to implement Recommendations 1 to 4 and a contingency rider to implement Recommendation 5.

MODERNIZE CARE DELIVERY AT STATE SUPPORTED LIVING CENTERS

Texas operates 13 state supported living centers which provide intermediate care services for persons with intellectual or developmental disabilities. Concerns surrounding the quality of care provided to these individuals have been long-standing, and the U.S. Department of Justice continues to monitor Texas' efforts to address deficiencies and prevent additional civil rights violations. The Department of Aging and Disability Services is working to improve the intermediate care facility system, implementing changes required by the Eighty-first Legislature and adopting policies aimed at reducing the incidents of resident abuse and retaining qualified staff.

Due to changes in consumer demand, the census of state supported living centers continues to decline which leaves the state favorably positioned to implement the culture change model of care. This model focuses on the values of the individuals receiving the care instead of asking the individuals to adapt to the institution. It also incorporates workforce and quality improvement practices. The implementation of the culture change model of care would modernize how services and supports are designed and delivered to state supported living center residents and improve workforce quality and residents' safety. Implementing the culture change model at one state supported living center would allow the state to improve care and identify lessons that may be transferrable to the entire intermediate care facility system.

FACTS AND FINDINGS

- In 2009, Texas entered into a settlement agreement with the U.S. Department of Justice to improve the health, safety, and quality of care at all state supported living centers. The settlement requires the Department of Aging and Disability Services to implement corrective action to protect residents from harm, reduce restraint use, implement a quality assurance system, provide individualized training and skill acquisition programs, and improve medical, psychological, and dental services.
- State supported living centers are trying to improve the safety of residents by implementing the requirements of legislation enacted by the Eighty-first Legislature, 2009, such as installing a video surveillance system, fingerprinting employees, creating a forensic center for high-risk alleged offenders, and establishing an independent ombudsman office.

CONCERNS

- The rates of resident abuse and employee turnover at state supported living centers continue to increase despite training and other efforts to improve the quality of resident care.
- Unfounded abuse allegations reported by residents at state supported living centers have increased since fiscal year 2006 and may be an indicator of a deteriorating relationship between resident and caregiver.
- Current performance measures on abuse/neglect incidents at state supported living centers do not provide adequate information for ongoing legislative oversight.
- Serving large populations in an institutional setting like a state supported living center inhibits the staff's ability to create on-going opportunities that allow residents to participate in their daily routines and for individual preferences to be met.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the 2012–13 General Appropriations Bill that directs the Department of Aging and Disability Services to use $250,000 of existing General Revenue Funds to hire a consultant to provide training and technical assistance, and direct the agency to submit a report on the culture change process and its progress to the Governor and the Legislature.
- **Recommendation 2:** Include a rider in the 2012–13 General Appropriations Bill that directs the Department of Aging and Disability Services to report quarterly for each state supported living center on non-key measures added to the Legislative Budget Board's Automated Budget and Evaluation System of Texas.
- **Recommendation 3:** Include new performance measures in the 2012–13 General Appropriations

Bill relating to the Department of Aging and Disability Services' administration of state-operated Intermediate Care Facilities for Persons with Intellectual or Developmental Disabilities.

DISCUSSION

The Intermediate Care Facility (ICF) program was developed to be a less medically oriented and less expensive program for elderly and disabled adults than skilled nursing facilities. The federal government established the ICF program in 1967 because of a marked increase in the number of new patients in skilled nursing facilities (SNF). Further research into the reason for the increasing numbers revealed many of the patients were persons with mental retardation, now referred to as persons with intellectual or developmental disabilities. They were placed in SNFs by states and were receiving more medical care than they required. This resulted in greater costs being borne by the federal government because most of the costs for SNFs were reimbursed through the federal Title XIX program. In 1971, the SNF and ICF programs were combined under Title XIX of the federal Social Security Act. As a further incentive not to place persons with intellectual or developmental disabilities in SNFs but provide health and habilitation services to them, the legislation made federal funds available for providing "intermediate care" to persons with intellectual or developmental disabilities. This became known as the ICF/MR program.

Other events occurring during this time spurred Congress to provide federal funding to states to improve the care to persons with intellectual or developmental disabilities. Published reports and articles throughout the 1960s and 1970s exposed sub-standard care and abuse and neglect in many state institutions. Lawsuits by residents' families over the inadequate conditions of state facilities also played an important role in the development of standards to govern services and to provide a wide range of new community-based services that were seen as a way to prevent isolation and abuses. By accepting federal funding, states had to meet minimum standards. Researchers believe this was a significant step in improving residential care for individuals with disabilities. Providing funding to states through the federal Medicaid program has significantly influenced the long-term care services provided to persons with intellectual or developmental disabilities. For example, the purpose of the funding was meant to improve care only at large state-operated facilities. Because states are reimbursed through the Medicaid program, services were focused on the medical needs of residents and not on habilitation services and programs.

The quality of services in the ICF/MR program has been scrutinized since its inception. In the 1960s and 1970s, improving quality services meant improving residents' safety and living conditions. In the mid 1970s, critics of ICFs/MR believed that the program created by the federal government had created financial incentives for housing people with intellectual or developmental disabilities in state institutions and that using a single standard for care that did not account for the differences of residents' disabilities and capacity for independence. Today, researchers and advocates are questioning the meaning of quality in the ICF/MR program—both in services and in life satisfaction because an ICF/MR that scores well on safety and sanitation measures may also be an impersonal and monotonous place to live and work. New best practices reinforce the role of the individuals, their families, and community involvement when designing supportive services.

QUALITY OF CARE IN TEXAS STATE SUPPORTED LIVING CENTERS

Texas operates 13 state supported living centers (SSLC) which provide intermediate care services for persons with intellectual or developmental disabilities. Approximately 4,300 individuals (as of April 30, 2010) with a diagnosis of severe or profound intellectual or developmental disability and who are medically fragile or who have behavioral problems are served through these 13 locations across the state. Each SSLC campus ranges in size from 20 to 1,031 acres and serves 140 to 580 individuals. The oldest SSLC opened in 1917 and the most recent center opened in 1978.

Up until the mid-1970s, caring for persons with intellectual or developmental disabilities at an institutional campus-setting using one uniform model of care was the standard promoted by the federal government. Beginning in the late 1970s, deinstitutionalization and the development of community services became the new norm due to growing consumer demand and inadequate living conditions within state institutions. Inadequate care was an issue in Texas SSLCs throughout the 1970s due to the *Lelsz v. Kavanaugh* lawsuit. As a result of the settlement agreement from the lawsuit, Texas' state supported living centers remained under court monitoring until 1995.

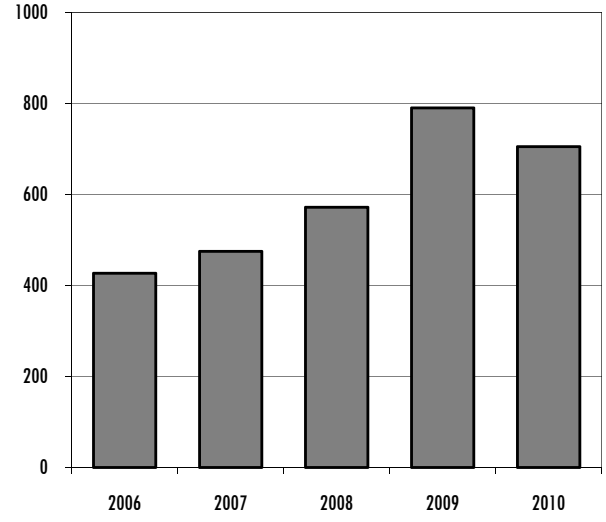
Court monitoring of Texas SSLCs started again in 2009 based on the settlement agreement between the state and the Department of Justice (DOJ). Reports of widespread abuse

and neglect at the Lubbock SSLC first prompted the DOJ to launch an investigation in 2005 and then expand the investigation to the entire SSLC system in 2008.

ABUSE AT STATE SUPPORTED LIVING CENTERS

One of the most enduring and visible issues surrounding the quality of care at SSLCs is resident abuse. The state's record of abuse at the SSLCs is an area that has not seen improvement in the past five fiscal years. Despite recent interventions, such as increased training for staff since the DOJ investigation, the number of confirmed incidents of abuse has increased since fiscal year 2006 as shown in **Figure 1**. Besides the human cost of abuse, abuse results in secondary costs to the state. Secondary costs of abuse include: paid employee administrative leave while an investigation occurs, overtime incurred by other staff because of staff reassignments, the salaries of full-time equivalent positions needed to investigate the abuse allegations, and legal expenses resulting from settlements pursued by victims.

FIGURE 1
TEXAS STATE SUPPORTED LIVING CENTERS CONFIRMED ABUSE INCIDENTS
FISCAL YEARS 2006 TO 2010

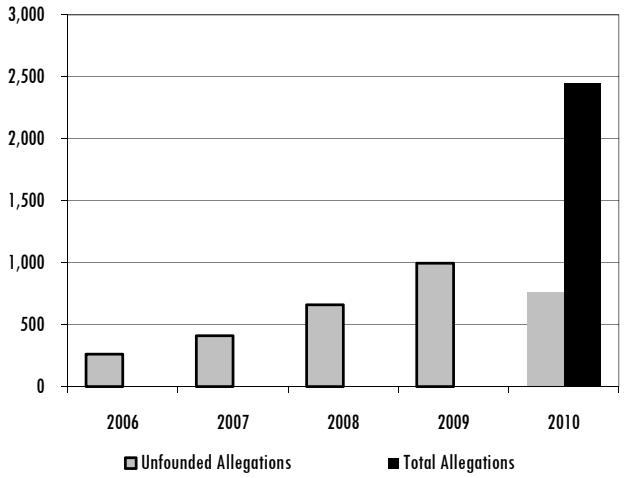


SOURCE: Texas Department of Family and Protective Services.

In an effort to address the issue, SSLC staff have received training in areas such as: protections from harm, human rights and dignity, and positive behavior techniques. From April 2005 to November 2009 the Department of Aging and Disability Services (DADS) has spent an estimated $7.1 million for technical assistance and staff training. Since 2006, while training was ongoing, 97 class-one abuse incidents occurred. Class-one abuse is defined as an incident in which sexual abuse or physical abuse causing serious physical injury or death has occurred. Incidents of neglect have also increased 100 percent from 227 in 2006 to 457 in 2010.

An increase in the number of unfounded abuse allegations by residents has also been occurring since fiscal year 2006. Unfounded allegations are those for which the evidence proves the claim is without basis of fact. According to researchers, unfounded abuse allegations by residents against staff may be a symptom of problems in the relationships between staff and residents. Since fiscal year 2006, the Texas Department of Family and Protective Services (DFPS) has conducted 19,916 investigations of alleged abuse at SSLCs and 4,949 or 25 percent were determined to be unfounded, without basis of fact. In 2009, approximately 80 percent of reports of abuse of SSLC residents were received from three sources: staff (43 percent), residents (26 percent), and anonymous reporters (10 percent). Of the allegations reported by a victim in fiscal year 2009, 35 percent were determined to be unfounded by DFPS investigators. **Figure 2** shows the total number of abuse allegations as reported by victims and the number of abuse allegations as reported by victims that DFPS investigators determined to be unfounded for fiscal years 2006 to 2010.

FIGURE 2
ABUSE ALLEGATIONS AT TEXAS STATE SUPPORTED LIVING CENTERS, AS REPORTED BY VICTIMS
FISCAL YEAR 2006 TO 2010



SOURCE: Texas Department of Family and Protective Services.

STAFF SHORTAGES AT STATE SUPPORTED LIVING CENTERS

Staffing shortages of professional and direct-care workers continue at SSLCs for several reasons, one of which is due to unfounded abuse allegations. DADS's policy requires reassigning accused staff while an investigation occurs. In the May 2010 baseline monitoring report for Mexia SSLC, settlement agreement monitors confirmed that it was not unusual for 30 to 40 staff to be reassigned and out of direct contact with residents due to abuse allegations. Without sufficient staff, the settlement agreement monitors raised concerns about a facility's ability to provide adequate support services with trained staff.

Historically, recruiting and retaining qualified staff has been and remains a hard-to-solve issue for SSLCs. Turnover in long term care facilities also remains a serious issue that can affect quality of care. According to a report in 2001 by the Institute of Medicine, "...a high turnover rate for a large percentage of employees in a facility is likely to have more widespread effect on quality of care." Individual SSLC turnover rates in fiscal year 2009 ranged from a low of 16 percent to a high of 51 percent. Reports from the court settlement monitors have noted and made recommendations regarding staff turnover and retention at certain SSLCs. Without consistent staffing levels, reaching compliance with the settlement agreement will remain difficult.

DADS continues to work to improve the services and conditions at SSLCs. Implementation of corrective measures and policies created by the DOJ settlement agreement is ongoing. The settlement agreement says that the state agrees to undertake a variety of measures to improve conditions at the SSLCs. They include: providing a safe and humane environment with zero tolerance for abuse or neglect of residents; providing adequate medical care, nursing services, and nutritional and physical support, including therapy and communication support; providing adequate psychological and behavioral services and psychiatric care; providing adequate habilitation; providing adequate integrated protections, services, treatments, and supports; and, ensuring that residents are free from undue bodily restraint. The agreement also states that Texas will also ensure that each resident is served in a setting that is as well integrated into the community as possible. As part of complying with the settlement agreement, the state must fund and work with settlement agreement monitors, who will oversee the state's compliance with the agreement. DADS is currently working with the monitoring teams as they review each of the SSLCs and recommend needed changes to comply with the settlement agreement.

DADS also continues to make progress implementing the requirements set forth in Senate Bill 643, Eighty-first Legislature, 2009. This bill was intended to improve conditions at SSLCs and address federal concerns about widespread abuse. Key provisions of the bill include: fingerprinting all state center employees, conducting criminal background checks on state center employees and volunteers, conducting random drug testing of state center employees, installing video surveillance, establishing an independent ombudsman at DADS and an assistant ombudsman for each state center, and creating the position of assistant commissioner at DADS who is responsible for activities at state supported living centers. Establishing the DADS assistant commissioner position for SSLCs is a critical link to ensuring that conditions at SSLCs do not deteriorate to previous levels that warrant federal intervention. Moreover, the assistant commissioner's role will provide a permanent focus on SSLCs, which can help improve services and maintain improvements once they are achieved.

SSLC staff has received various training since 2007. For example, SSLC staff has been trained in standardized values-based culture training which provides staff an understanding of the values that are important to the individuals served at SSLCs. The curriculum includes: recognizing the individual as a whole person, treating individuals with respect, and supporting and encouraging individuals to make their own choices. A standardized person-directed planning system has been implemented to ensure a standardized process for developing a personal support plan that is directed by the individual served. Training on the person-directed planning process has occurred at all centers.

However, despite the trainings and technical assistance, a deeper and longer lasting response to ongoing issues such as incidents of abuse and staff turnover within the SSLCs is needed. All changes should be sustainable, financially and programatically, and last long after the settlement agreement monitoring ends. Moreover, as demonstrated by other states' experience, the declining census of the SSLC system and increased demand for community placements provide the state with a unique opportunity to decrease the size of the system. A smaller SSLC population would enable the state to implement a new model of care, known as culture change, to improve the quality of care. Additional information about SSLC system downsizing is available in "Decrease the

Number of State Supported Living Centers to Reduce Costs and Improve Quality" in this publication.

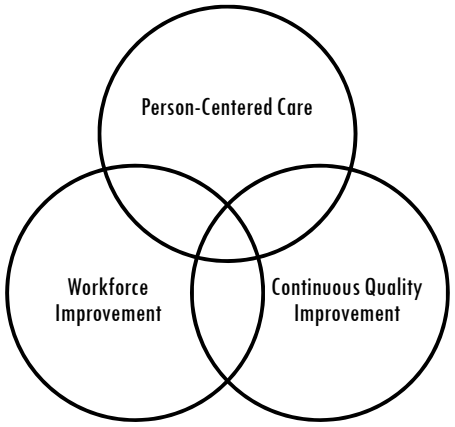
CULTURE CHANGE AT LONG-TERM CARE FACILITIES

Providing a better quality of life to those receiving residential long-term care services is one goal of "culture change," a form of systems change. According to the Pioneer Network, a stakeholder group advocating for person-centered care, culture change is "the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voice of the elders and those working with them are considered and respected. Core values include: choice, dignity, respect, self determination, and purposeful living."

Culture change's origins can be traced back to the early 1970s. Several nursing home staff independent of each other decided to turn away from the traditional institution-directed culture and make a culture change at their facilities. As **Figure 3** shows, culture change has three strategic objectives: person-centered care, continuous quality improvement, and workforce improvement.

Engaging in person-centered care means that caregivers assume that persons with disabilities both need and want to be a decisive factor in their lives even if they are unclear and not articulate about what this might mean in actual practice. The key factor is the caregivers' assumption to seek guidance from the person with a disability about life decisions rather than relying on professionals or others to make these choices.

FIGURE 3
FRAMEWORK FOR CULTURE CHANGE, 2010



SOURCE: American Association of Homes and Services for the Aging.

Person-centered is distinct from person-directed. Person-centered moves decision-making as close to the person as possible, while person-directed is decision-making done by the individual. **Figure 4** shows that the culture of person-centeredness exists on a continuum and its impact on everyday activities, such as dining.

The two other objectives of culture change, continuous quality improvement and workforce improvement help to ensure the sustainability of culture change in an organization. Continuous quality improvement emphasizes the use of objective data to analyze and improve practices and services

FIGURE 4
CONTINUUM OF PERSON-CENTERED CULTURE, 2010

ACTIVITY	PROVIDER-DIRECTED	STAFF–CENTERED	PERSON-CENTERED	PERSON-DIRECTED
Dining	Meals are served at fixed times. Residents who are independent eat in a dining room and others who require assistance eat in their rooms. Meals are brought on trays from central kitchen. Residents who do not prefer meal may choose alternate meal.	Meals are served during fixed periods of the day (i.e., breakfast 7 to 9:30 AM). Meals are prepared from a main kitchen and each meal offers residents two choices for a main meal, except for breakfast which is buffet style. Residents who are independent eat in a dining room and the others who require assistance eat in their rooms.	Residents have input on meal times and the menu. Residents are served freshly-prepared food from a rolling steam table. The food is not prepared in large industrial kitchen, but a smaller residential one. Aides serve the food to residents on dishes and not trays. The steam table is taken to residents who cannot come to the dining room.	Residents decide on the menu and where they want to eat and at what times. Meals are prepared in a residential kitchen near where the residents' rooms are located. Meals are served family style, where serving bowls and platters are placed on the table and residents, who are able, can help themselves. Those who require assistance receive it from staff.

Low — Person-centeredness continuum — High

SOURCE: Pioneer Network.

through the establishment of continuous feedback from all stakeholders. Workforce improvement addresses improving the recruitment and retention of a stable and qualified workforce for an organization. Workforce improvement activities may include improving or updating training, creating self-directed work teams, and establishing career ladders for direct-care staff.

Culture change requires systemic changes in all aspects of an organization, such as, structure, policies and processes, work schedules, budget priorities, physical environments, and working relationships between staff and residents. Culture change can vary in scope and size and may best be thought of on a continuum because it is ongoing and occurs to varying degrees of intensity shown in **Figure 4**.

INTERMEDIATE CARE FACILITY IMPROVEMENT THROUGH CULTURE CHANGE

Many of the culture change objectives and principles that are applicable to elder populations are also applicable to non-elder populations. Person-centered services and supports are usually more appropriate for persons with intellectual or developmental disabilities due to the cognitive limitations of their diagnosis. Conversely, person-directed care is typically desired for persons who may only have physical limitations but can make informed decisions about their medical care.

Culture change can improve the service delivery and living conditions at ICFs/MR. Despite having its origins in nursing homes, culture change is relevant to ICFs/MR due to the many similarities both institutions share. Both nursing homes and ICFs/MR serve a population in need of supports to live life as independently as possible. Both are neither full-fledged health facilities, like hospitals, nor are they completely residential facilities where no health care services are provided. In both settings, health professionals lead teams and make key decisions that affect a resident's quality of life. Both populations served depend strongly on the relationships with staff which are vital to their health outcomes. Lastly, culture change may be more relevant to a non-elder population, like persons with intellectual and developmental disabilities, because typically they live longer with long-term care needs than an elder person.

Regulatory barriers have not hindered the implementation of culture change in nursing facilities. In fact, the Centers for Medicaid and Medicare Services (CMS) support the culture change movement in nursing homes because it is an "optimum implementation of the federal Omnibus Budget Reconciliation Act of 1987." The act established mandates for quality of life, quality of care, and residents' rights.

While CMS has not commented on culture change and its role in ICFs/MR, other states have implemented culture change in their state operated ICF/MR systems. In the early 1990s, Kansas state-operated ICF/MR facility directors met with state and federal regulatory surveyors before implementing culture change. Facility staff discussed their vision and ideas for Kansas facilities to ensure that regulatory compliance and culture change efforts would not conflict. Meeting with regulatory officials facilitated culture change's implementation and established ongoing communication between the two groups to ensure compliance with regulations. Kentucky also implemented culture change activities at Oakwood, a state-operated ICF/MR facility. Culture change's implementation began after the U.S. Department of Justice (DOJ) and the state reached a settlement agreement about improving conditions at Oakwood. Culture change efforts aligned with the changes the DOJ wanted to see implemented. Moreover, changes made at Oakwood are currently being implemented at all state-operated ICFs/MR. In January 2010, the Legislative Budget Board (LBB) staff surveyed states that operate large ICFs/MR. Fifteen states have begun the culture change process or are implementing culture change activities.

CULTURE CHANGE MODELS

A range of culture change models exist and are in use throughout the country in various long-term care settings. While no one model guarantees success, there are several established culture change models that have been implemented successfully in nursing homes and facilities for persons with cognitive disabilities. **Figure 5** shows four culture change models currently in use in long-term care facilities.

EVALUATION OF CULTURE CHANGE MODELS

Culture change is an innovation in care delivery. Due to its newness, research regarding outcomes and effects has not kept pace with the implementation and experimentation methods of culture change. However, despite the newness of the culture change philosophy, many culture change innovations are promising and worth trying, according to a 2008 article published in *The Gerontologist*.

In 2006, CMS funded a quantitative analysis of nursing homes implementing culture change to see how their performance differed on certain clinical and workforce

FIGURE 5
CULTURE CHANGE MODELS, 2010

MODEL	PHILOSOPHY	KEY POINTS	EVALUATION
Eden Alternative	Based on 10 principles that aim to flatten hierarchies, shift decision-making to residents and direct-care staff, normalize institutional life.	Implementation of the 10 principles varies by facility. This aspect is what allows each facility to adapt the principles to best fit or "Edenzie" their organization.	A 2000 Southwest Texas State University study examined staff stability and clinical outcomes in seven facilities that adapted the Eden Alternative principles. The results showed: A 60 percent reduction in behavioral incidents between residents. 57 percent decrease in decubitus ulcer formation. 25 percent decrease in bedfast residents. 18 percent decrease in the use of restraints. 11 percent increase in census sustained over two year period. 48 percent decrease in staff absenteeism.
Green House	Based on the belief that elders and others should enjoy excellent quality of life and quality of care; where they, their families, and the staff engage in meaningful relationships built on equality, empowerment, and mutual respect; where people want to live and work; and where all are protected, sustained, and nurtured without regard to the ability to pay.	Residences for 6 to 10 elders who require skilled nursing care. The model alters facility size, interior design, staffing patterns, and methods of delivering skilled professional services. Its primary purpose is to serve as a place where elders can receive assistance and support with activities of daily living and clinical care, without the assistance and care becoming the focus of their existence.	From May 2003 to December 2004, the Commonwealth Fund evaluated the health outcomes and quality of life of Green House residents and traditional nursing home residents in Mississippi. The Green House residents were found to experience a better quality of life with the same or better quality of care, better emotional well-being, and lower rates of depression, bed rest, reduced activity, and decline in functional abilities than those in the traditional nursing home.
Eden Life Long Living	Based on the Eden Alternative 10 principles and meets the needs of non elders who have a cognitive disability, while emphasizing person-centered supports, individual autonomy to the greatest extent possible, community involvement, meaningful relationships between staff and residents, consistent staff assignments, and collaborative decision-making and responsibility.	In 2006 through a partnership with a Texas non-profit, Seaton Foundation, the first Eden Alternative home for persons with cognitive disabilities was established in Austin, Texas.	No evaluation to date.

FIGURE 5 (CONTINUED)
CULTURE CHANGE MODELS, 2010

MODEL	PHILOSOPHY	KEY POINTS	EVALUATION
Wellspring	An alliance of skilled nursing facilities with the objectives to improve clinical care and create a better work environment by giving employees the skills needed to do their jobs and allow workers to have a voice in how their work should be performed so that staff work as a team toward common goals.	Each alliance member contributes a standardized monthly fee to cover the costs for an advanced practice nurse and other clinical experts in geriatrics who will work with alliance facility staff to initiate research-based best practices into everyday care of residents. Staff trainings include management training and clinical training modules. Seven clinical modules are taught. A care resource team is established by every facility for each clinical module. The teams are responsible for ensuring each facility is using best practices in resident care for each module taught. A care resource team is composed of professional and direct-care staff. A critical component is the facility coordinator role. The coordinator is a registered nurse who acts as a coach to the care resources teams.	The Institute for Future Aging Services and the Commonwealth Fund conducted a 15-month evaluation in 2001 and showed rates of staff turnover were lower and increased more slowly than in comparable nursing homes over the same period of time. No additional increases in net resources were used for implementation of the model and Wellspring facilities had lower costs than a comparison group of facilities. Wellspring staff appears to be more vigilant in assessing problems and took an active approach to residents' care. Residents observed seem to enjoy a better quality of life and interaction between residents and staff improved.

SOURCES: Eden Alternative; Culture Change in Long Term Care, 2002; Commonwealth Fund.

outcome measures. As a part of this project, an extensive literature review was conducted to identify methods and instruments measuring culture change, common core elements of culture change measurement tools, and publications examining the relationship of culture change to certain outcomes. Through the project, CMS identified 25 practices relating to the measurement of culture change which are shown in **Figure 6**.

Twenty of the practices produced evidence of affecting one or more of the following outcomes through reductions in: pressure ulcers, physical restraints, depression, pain, incontinence, transfer rates to acute care, medication safety, and staff turnover. Five practices did not have documented evidence on one or more of the outcomes. The five practices were: enabling staff to handle scheduling, implementing cross training for all staff levels, conveying mission, vision, and direction of culture change, monitoring staff turnover and longevity, and monitoring financial information. These practices may have value in the culture change process, but did not affect the outcomes the CMS project addressed.

KANSAS STATE-OPERATED ICFS/MR

There is no one way to approach lasting organizational culture change; a variety of models have been used and at least one state, Kansas, developed its own model and vision of culture change. LBB staff conducted a site visit to the Kansas Neurological Institute (KNI), one of two remaining state-operated ICFs/MR in Kansas. KNI implemented culture change in the 1990s when funding was increased to support more persons living in the community. Admissions were also kept to a minimum at the time.

The culture change process at KNI is ongoing and grew gradually throughout the campus as new processes and systems were tested and feedback was received. A former KNI superintendent spearheaded the culture change process in an effort to improve services at KNI by trying a new approach at management and changing the delivery of care away from an institution-directed culture. At the time, KNI executive staff became interested in the concept of Total Quality Management (TQM) and paired that philosophy with person-centered planning. TQM is a set of management practices aimed at ensuring an organization consistently

FIGURE 6
PRACTICES RELATED TO CULTURE CHANGE, 2006

1. Restoring dining choices
2. Providing options for bathing
3. Assisting residents in determining their own daily schedules and care plans
4. Promoting all remaining capacities for self-care and mobility
5. Redesigning resident rooms for privacy, personalization and individual needs
6. Introducing plants, pets, children, and surroundings that are reminiscent of past lives
7. Redesigning public and outdoor living spaces for stimulation and activity
8. Developing neighborhoods or households with dedicated areas for dining and living
9. Committing to consistent staffing
10. Promoting a sense of community
11. Including family members in decision making
12. Providing intergenerational and volunteer programs and activities
13. Honoring death and dying with dignity
14. Involving staff in care planning and care conferences
15. Enabling staff to handle scheduling
16. Implementing cross-training for all staff levels
17. Promoting staff development and empowerment
18. Developing self-managed work teams and encouraging teamwork
19. Modifying hiring and retention practices to promote staff satisfaction
20. Promoting strong leadership qualities among management
21. Promoting open communication at all levels
22. Conveying the mission, vision and direction of culture change
23. Monitoring and evaluating quality of care and services
24. Monitoring staff turnover and longevity
25. Monitoring financial information

SOURCE: Colorado Foundation for Medical Care.

meets or exceeds customer needs. Person-centered planning was used only for persons returning to the community. It is a process that focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems or its professionals. KNI staff determined person-centered planning was an approach that should be used for all persons with intellectual or developmental disabilities regardless of where they choose to reside.

KNI began its transformation by creating a simple mission statement that could be envisioned and communicated to everyone at the facility. KNI staff's mission is to "support each person who lives at KNI to have a meaningful life." In mapping out what changes were needed, KNI staff posed the question to each other, "What would a person-centered life look like at KNI?" Answering the question initiated changes in every area, process, and policy of the facility. The shift to person-centered care took four years to realize, but is an evolving and ongoing process to continually improve to benefit the residents.

Examples of systems changes KNI made to become more person-centered included: decentralizing many systems and practices, creating self-directed home teams and empowering direct-care professionals, designing training to support values and mission statement, implementing task partnering, reducing professional staff, housing fewer residents per home, personalizing care plans and goal setting, and creating employment opportunities according to residents' preferences. Processes such as purchasing, medicine administration, and meal preparation that were centralized made providing person-centered services more difficult.

Purchasing: KNI changed its purchasing practices by establishing annual budgets for each house on campus. The budget for each house is based on the number of people living in the home and a history of the cost of home operation. Direct-care staff in each house became responsible and accountable for staying within their budget and purchasing the necessary food, cleaning supplies, and household items. Purchases are made with a pre-paid debit card. Safeguards were established to prevent unauthorized purchases. Purchases for less than $150 are approved by home coaches. A purchase of more than $150 must be approved by a higher level supervisor. The campus business office monitors expenditures and staff must submit receipts for reconciliation. A spending report is given to coaches of each house. Regular financial audits are conducted too.

Changing the purchasing system allowed for more changes to occur that would provide savings and even more opportunities for residents to become involved in new activities. Savings were realized through closing the central kitchen and reducing staff. Moreover, by allowing home staff to make purchasing decisions, residents' preferences for foods are fulfilled and residents can participate in shopping for

household items which provide them with another opportunity to participate in the community activities. Additionally, less money is spent on food than before culture change. Less food is wasted because food purchasing and preparation is more accurate and residents participate in meal preparation which stimulates their appetite.

Medication Distribution: Prior to culture change at KNI, medicines were administered by a registered nurse on campus. After culture change, residents' medications are administered by direct-care staff because all are certified medication and nurse aides. This change allows residents' schedules more flexibility and opportunities to go off campus. Medication can be administered by staff while on an outing. There is no disruption of the medication schedule or an interruption of the outing by forcing a return to campus.

Task Partnering: Through culture change, KNI staff creates an environment that supports each individual's ability to participate in daily living. Task partnering is a concept that allows for greater resident participation in everyday life. Staff is trained to look at daily tasks from a resident's perspective and ability and create an opportunity for him to participate in the task. For example, if a resident is able to unscrew a lid, he can participate in washing his own clothes by unscrewing the lid to a container of premeasured laundry soap and hand it to the staff to pour into the washing machine. Or, if a resident can only press a button, a device is made by KNI staff to allow him to turn on and off the fan and lights in his room, thereby allowing him more control over his environment. This ability increases the resident's skill set but also builds autonomy and pride. KNI staff builds or creates most devices used on campus that can increase residents' autonomy. Resources are saved by making and not purchasing these aids. More importantly, it allows KNI staff to further personalize supports for residents which would not occur if the devices were purchased commercially at a higher cost.

Empowered Direct-care Staff: KNI officials attribute the key to the success of culture change at their facility was the decision to rely more heavily on direct-care staff and to use professionals in a coaching or supportive role to the direct-care workers. Changing direct-care worker training and empowering them through responsibility and accountability is a vital aspect of culture change. At KNI, training hours increased to ensure direct-care workers' success on the job. All direct-care staff complete 171.5 hours of training upon hiring. Each is required to pass a reading comprehension test. Based on its results, an additional 18 hours of study skills and additional 48 hours of developmental disability training may be required of a new employee. After the initial training is completed, direct support staff's hourly wage increases from $10.68 to $12.35. At this point, direct-care staff receives an additional 105 hours of training to become a certified nurse aide and medication aide.

Before culture change, KNI had traditional interdisciplinary teams led by professionals; direct-care staff played a limited role. After culture change, self-directed work teams of direct-care staff have a primary role in residents' care and professional staff (i.e., nurses, psychologists, occupational and physical therapists, dieticians, speech therapists, etc.) serve primarily as consultants to the direct-care teams. Teams are composed of 10 to 15 direct-care workers who work in one household where 5 to 8 residents live. The workers are consistently assigned to the same house. Should a team member not come to work, it is up to the team to cover the shift to ensure the appropriate staffing ratio is maintained. One coach, a professional staff, is assigned to each team to assist the team in whatever it needs.

Teams have weekly meetings and must complete 18 hours of training together each year.

To further individualize the support and services at KNI, each direct-care staff is also assigned as a personal advocate to one resident. As a personal advocate, the direct-care worker develops a friendship with the KNI resident and learns about his likes and dislikes, as well as advocates for the resident in any situation. The personal advocate works closely with the assigned qualified developmental disability professional to ensure the resident's person-centered care plan is truly reflective of the resident's preferences. The personal advocate also communicates directly with a residents' family and guardians as needed.

KNI's leadership believed in increasing control and input of direct-care staff for many reasons. Their rationale is built on the belief that direct-care workers have better knowledge of residents than professional staff. Direct-care workers identify what is important to a resident's daily life, while professional staff know about medical and diagnosis-related information such as, a resident's weight, diet, and medicine. The direct-care staff spends the most time with residents and is usually the first to identify resident issues and solutions. Moreover, KNI leadership is confident in the belief that the more responsibility a worker is given results in more buy-in and ownership in their work. Finally, from an economic perspective, direct-care workers cost less than professional staff. To make this significant shift in responsibility, managers

had to trust others and believe that team members want to do their best.

Personalized Resident Program Plans: The contents of individual program plans are another example of culture change's influence at KNI. Individual program plans are called personalized lifestyle designs (PLD). The contents of the PLD include all the federal requirements of an individual program plan, but also include elements that are important to ensuring a KNI resident is living the life he desires. The name, PLD, conveys a very different perspective of a resident's life and future goals. It is personal and positive, not focused on diagnosis or disability.

The essential lifestyle plan in the PLD contains "non-negotiables," a list of habits and preferences of a resident that if were not allowed or taken away would cause disruption or disorder to a resident's life. Knowing the non-negotiables of residents allows staff to ensure continuity of support which results in predictability and comfort for residents. Also contained in the essential lifestyle plan is a list of positive attributes and traits about the resident, resident's accomplishments and dreams for the future, as well as information such as needed medical or behavioral supports.

The entire PLD is reviewed annually. Since culture change occurred at KNI, the PLD reviews are treated like a celebration rather than a typical care plan review led by medical professionals. The review is often led by direct-care staff or the qualified developmental disability professional. Family and guardian participation is strongly encouraged. Their participation is so important that many times KNI staff will bring the resident and the PLD review to the family/guardian to ensure their inclusion. During the review, KNI staff found on many occasions, that this is the first time family members have heard positive and personal information about the resident. Previously, many families heard about the medical or behavioral issues with their loved one and little else.

Employment: KNI residents participate in employment if it is their preference to do so. All KNI residents who are employed work at jobs based on their vocational preferences and for not less than minimum wage. During the culture change process, KNI adopted an entrepreneurial mindset to employ residents and promote community involvement. KNI staff created on-campus businesses that could benefit the Topeka community and incorporate residents' strengths and preferences. They include a balloon delivering service, a thrift shop, and a plant nursery. KNI staff who oversees the on-campus business joined the Topeka Chamber of Commerce and are working to make the businesses self-sustaining. Residents who do not work on-campus are employed at a community jobs and some residents work two or more jobs.

KNI leadership attribute part of its success of embracing culture change is having fewer residents living at the facility and in close proximity of each other. Peer-on-peer aggression at KNI is uncommon. Staff attributes this accomplishment to grouping residents in living areas by their preferences and personalities instead factors such as age, level of need, diagnosis, or space limitations as well as providing a satisfactory amount of personal space for each resident. The KNI campus currently has 157 residents but previously accommodated more than 400.

TEXAS STATE SUPPORTED LIVING CENTERS

Texas' SSLCs are organized differently than the Kansas Neurological Institute. While KNI, adopted culture change and with it a person-centered model of care, Texas SSLCs resemble an organization with an institution-directed culture. **Figure 7** compares an institution-directed culture and a person-centered culture in a facility.

Other characteristics of institution-directed culture that Texas SSLCs exhibit are planned, structured activities and schedules and daily routines designed by the facility or staff. For example, SSLC residents' daily schedule is set around facility-established meal times, day programs or employment schedules to ensure each resident is successfully engaged in activity throughout the day. The current implementation of SSLC work programs, internal structure, centralized functions, staffing tasks, and relationship to residents are further examples of institutional-directed culture characteristics.

Facility-designed Work Programs: Most SSLC residents participate in a day or work program that pays piece-rate wages on campus. A resident receives financial compensation based on the number of units he assembles. The work programs include repetitive tasks such as folding towels, assembling rosaries, spice packets, putting plastic electrical coverings into small bags, and using an pneumatic dispenser to squirt oil in plastic electrical coverings. While these activities may provide engagement for residents, they are not activities necessarily chosen by the resident. They are activities available to residents based on work contracts pursued by SSLC staff. According to a March 2010 baseline report by settlement agreement monitors, the SSLCs' vocational

FIGURE 7
COMPARISONS OF ORGANIZATIONAL CULTURES: INSTITUTION-DIRECTED AND PERSON-CENTERED, 2003

INSTITUTION-DIRECTED CULTURE	PERSON-CENTERED CULTURE
Staff provides standardized treatments based on medical diagnosis.	Staff establishes a caregiving relationship based on individualized needs and desires.
Schedules and routines are designed by facility and staff.	Schedules are designed based on residents' schedules and desires.
Work is task oriented and staff rotates assignments.	Work is relationship-centered and staff is consistently assigned to same residents.
Decision-making is centralized.	Decision-making is decentralized with decisions made as close to the resident as possible.
Structured activities are planned by an activity director.	Spontaneous activities occur all the time.

SOURCES: Pioneer Network; Paraprofessional Healthcare Institute.

assessment does not adequately address a resident's strengths, needs, and preferences which prevent an accurate vocational profile from being established. One resident's file stated that the resident's performance objective was to attend work two days a week, however the resident had voiced several times that he does not want to work at his job of shredding paper because it hurts his hands. Without understanding a resident's interests or goals, staff cannot develop meaningful work or day program activities that are sufficient to motivate a resident to want to work at an activity that will increase and improve his skill set.

Strained Relationships: Persons with intellectual or developmental disabilities may rely strongly on the relationships with their caregivers. At SSLCs, the caregiver and resident relationship is important because whether positive or negative, the relationship affects both parties. A hostile or untrusting relationship will create a tense home environment for residents and work environment for staff, as well as strain the patience and tolerance of the resident and the caregiver. Conversely, a positive relationship will enhance and motivate both resident and caregiver in their respective daily activities. As mentioned previously, unfounded allegations may be a symptom of strains in the resident-caregiver relationship. Since fiscal year 2006, the Texas Department of Family and Protective Services (DFPS) has conducted 19,916 investigations of alleged abuse at SSLCs and 4,949 or 25 percent were determined to be unfounded, without basis of fact. Negative behavior, such as reporting a false or misrepresented incident, by a resident is a form of communication that his needs are not being met to his satisfaction. Staffing shortages are a side effect from unfounded allegations because of required policy and procedures. Staffing shortages may also increase tension in the resident-caregiver relationship. Researchers believe that determining the cause of reporting unfounded allegations can eliminate the behavior and improve relationships between staff and residents.

Task-Focused: Direct-care staff work is task oriented and less relationship-focused. SSLC direct-care staff focus on documenting a resident's level of engagement and well-being, as well as concentrating on medically-focused tasks such as documenting residents' fluid intake and bowel movements. During site visits to several SSLCs, LBB staff rarely observed staff having the time to interact on a one-to-one basis with residents.

Hierarchical Structure: An organizational structure with clearly defined channels of communication and centralized decision-making are also characteristics of an institution-directed culture. The SSLCs' structure assigns more responsibility and control at the top of the organization. For example, there is a structured chain-of-command at each SSLC. A Mental Retardation Assistant (MRA) I and II report to an MRA III. All MRAs report to the Residential Coordinator who reports to the Unit Director. Depending on the SSLC, the Unit Director reports to either the Director of Residential Services or Assistant Director of Programs. If a SSLC is utilizing a Director of Residential Services then he/she reports to the Assistant Director of Programs. The Assistant Director of Programs reports to the Director of the SSLC. Compared to KNI, the multiple layers of management at SSLCs limits direct-care workers from fully utilizing their day-to-day knowledge of residents. Moreover, settlement agreement monitors recommend that direct-care staff become a more integral part of the reform effort at SSLCs.

Centralized Functions and Efficiencies: Texas SSLCs centralize functions that allow for efficiencies and economies of scale to be realized. For example, activities such as meal

planning, food preparation, food purchasing, laundry, transportation, and recreational activities are all areas where if done collectively once can save money, time, and staff resources. Planning a menu and preparing a meal for several hundred residents is more easily accomplished with a pre-determined menu with pre-purchased bulk food that is prepared in a central kitchen by kitchen staff. Moreover, transporting residents in large vehicle to a pre-determined activity allows for more residents to participate.

While efficiencies may be needed to ensure successful operation of an institution caring for a large population, disadvantages exist to serving large numbers of individuals in this type of setting that affect the quality of care and how it is delivered. For example, individual preferences cannot be met frequently or consistently due to the number of residents at SSLCs. It would be prohibitive for staff because of the amount of staff time and resources it would take to do so. Creating more individual opportunities for a resident to participate in community activities is also restricted. To ensure as many residents as possible have community interaction, more group activities take place and few individual outings occur. Moreover, the current SSLC population size inhibits the staff's ability to create opportunities that allow all residents to participate regularly in daily routines such as preparing meals, shopping for groceries, or washing clothes because the institution's focus is on efficiency.

COMPARING TEXAS AND KANSAS ICFs/MR

Figure 8 compares activities and processes at KNI and Texas' SSLCs. The figure shows how the same activities or processes are carried out through a person-centered culture (Kansas) and an institution-directed culture (Texas).

Texas and Kansas have similar demographic populations in their respective state-operated ICFs/MR, to further facilitate a comparison between Kansas and Texas, **Figure 9** shows

FIGURE 8
COMPARISON OF ACTIVITY/PROCESS AT KANSAS NEUROLOGICAL INSTITUTE AND TEXAS STATE SUPPORTED LIVING CENTERS, 2010

ACTIVITY/PROCESS	KANSAS NEUROLOGICAL INSTITUTE	TEXAS STATE SUPPORTED LIVING CENTERS
Food Planning	Menus are prepared in advance and diets are simplified when possible. Food is purchased fresh and locally at community grocery stores or other entities. Meal times consistent with residents' preferences.	Menu set on 31-day cycle. Same menu for all centers. Food is purchased in bulk, frozen and shipped to centers. Set meal times by facility.
Meal Preparation	Prepared by direct-care staff in residents' home, including gastro meals. Staff receives training on special diets and food handling. Homes have appliances to modify food textures as needed.	Food prepared in large industrial kitchen by kitchen staff. Food is delivered to residents' home in carts and trays.
Menus	Menus are consistent with residents' preferences and checked monthly with dietician.	Menu set by DADS central office. Checked with a dietician.
Purchasing	Decentralized. Direct-care staff teams manage individual homes annual budgets for food, small home appliances, home furnishings, garden supplies, cleaning supplies, and cookware. Residents help direct-care staff shop.	Centralized food purchasing. Other purchases are made at each center through procurement cards, purchase orders, and coordination for goods in warehouse operations.
Activities / Community Outings	All activities are chosen by resident. Residents go on frequent individual outings with staff. Few group outings.	Frequent group outings.
Employment	Residents work for minimum wage or better. All jobs are consistent with residents' interests and preferences. Residents only work if they desire.	Residents work based on available opportunities. Piece-rate wages. Congregate day programs.
Terminology	Staff uses person-centered language. No jargon or medical terminology-- only simple, plain language in speaking and writing.	Care plans and terminology have a medical focus. Some information about personal preferences is available.
Individual Program Plans	Plans are person-centered, personal, and positive. Documentation includes: Individual Dreams and Lifestyle Assessment, Essential Lifestyle Plans and Support Plans, Personal Goals and Dreams, Daily Maps, Comprehensive Functional Assessment, Target Skills, and Relationship Diagrams/Action Plans.	Documents have a medical/behavioral focus with some personal information or resident preferences.

FIGURE 8 (CONTINUED)
COMPARISON OF ACTIVITY/PROCESS AT KANSAS NEUROLOGICAL INSTITUTE AND TEXAS STATE SUPPORTED LIVING CENTERS, 2010

ACTIVITY/PROCESS	KANSAS NEUROLOGICAL INSTITUTE	TEXAS STATE SUPPORTED LIVING CENTERS
Laundry	Residents assist in their personal laundry. Done in home or at community laundry. Sheets and towels sent off campus for cleaning.	Personal clothing washed on site in residents' home by direct-care staff or by resident. Towels and linens washed at central locations.
Direct-care	Direct-care self directed work teams with many responsibilities for residents' care.	Direct-care teams overseen by home supervisor. Supervisors participate in care planning assessments and meetings.
Organizational Structure	Flat organization. Professional staff acts as coaches and consultants, not leaders. Direct-care staff leads teams and have most responsibility for residents' day-to-day care.	Hierarchal organization. Professional staff leads teams. Direct-care staff input varies by center.
Training for Direct-care Staff	171.5 hours – initial training 105 hours – additional required CMA/CNA certification 18 hours – annual team training	80 hours – initial training 13.5 hours – annual training
Medication Scheduling	Flexible medication administration. May occur on or off campus. All direct-care staff are certified medication and nurse aides.	Medication administered on campus by physician, nurse, or medication aide.
Living Environment	5 to 8 residents per home.	Centers with cottages range from 8 to 16 residents per home. Centers without cottages house residents in dorm-like setting with 3 to 4 residents per room.
Staffing	3 staff for 8 residents	Staff assignments based on resident need.
Resident Grouping	Based on individual preferences and common resident interests.	Based on needs of individual. This may include age, personal preferences, guardian preferences, specialized staff, environment/adaptive equipment, behavioral challenges, skill development and support needs.

SOURCES: Kansas Neurological Institute; Texas Department of Aging and Disability Services.

demographic information about the current KNI and Texas SSLCs' population. **Figure 10** shows the level of disability for the residents at KNI and at Texas SSLCs.

The age and gender of KNI and Texas SSLC's resident populations are similar. At KNI, 70 percent of the residents are older than age 40; in Texas, 65 percent of SSLC residents are middle aged or older. At both institutions, males are approximately 60 percent or more of the population. Two differences between the populations include no resident at KNI is younger than age 21, and most of the residents at KNI have a diagnosis of profound intellectual disability. In Kansas, persons with a profound intellectual disability also live in community settings. In Texas, half of the SSLC's residents have a diagnosis of profound intellectual disability and the other half of the population is nearly evenly distributed with a mild, moderate, or a severe intellectual disability diagnosis.

RESULTS OF KNI CULTURE CHANGE

The results of implementing culture change at KNI have positively impacted most outcomes affecting its residents. **Figure 11** shows lower rates of turnover for direct-care staff at KNI when compared to Texas SSLCs turnover rate for all staff as shown in **Figure 14**.

Figure 12 shows the number of confirmed abuse incidents at KNI. According to KNI officials, a small number of abuse and neglect cases occur each year at their facility, but none has resulted in a death or serious injury to a resident. This is contrast to Texas' 97 class-one confirmed cases of abuse that occurred from 2006 through 2010. A comparison of the rates of abuse for KNI and Texas SSLCs is shown in **Figure 13**. This data includes all classifications of abuse.

According to KNI leadership, it is rare that a false allegation is reported by a KNI resident which KNI officials attribute to residents living satisfied lives and maintaining positive relationships with staff.

FIGURE 9
KANSAS NEUROLOGICAL INSTITUTE POPULATION BY AGE AND GENDER, 2009

AGE	PERCENTAGE
70 and older	2%
60 to 69	4%
50 to 59	27%
40 to 49	39%
30 to 39	23%
21 to 29	5%
TOTAL	**100%**
GENDER	
Male 64% Female 36%	

SOURCE: Kansas Neurological Institute.

FIGURE 9
TEXAS STATE SUPPORTED LIVING CENTER POPULATION BY AGE AND GENDER, 2009

AGE	PERCENTAGE
70 and older	5%
60 to 69	11%
50 to 59	27%
40 to 49	27%
30 to 39	14%
21 to 29	10%
< 21	6%
TOTAL	**100%**
GENDER	
Male 61% Female 39%	

SOURCE: Texas Department of Aging and Disability Services.

FIGURE 10
KANSAS NEUROLOGICAL INSTITUTE POPULATION BY INTELLECTUAL DISABILITY LEVEL, 2009

INTELLECTUAL DISABILITY LEVEL	PERCENTAGE
Mild Intellectual Disability	1%
Moderate Intellectual Disability	2%
Severe Intellectual Disability	9%
Profound Intellectual Disability	88%
TOTAL	**100%**

SOURCE: Kansas Neurological Institute.

FIGURE 10
TEXAS STATE SUPPORTED LIVING CENTER POPULATION BY INTELLECTUAL DISABILITY LEVEL, 2009

INTELLECTUAL DISABILITY LEVEL	PERCENTAGE
Mild Intellectual Disability	14%
Moderate Intellectual Disability	13%
Severe Intellectual Disability	17%
Profound Intellectual Disability	54%
Not Reported	2%
TOTAL	**100%**

SOURCE: Texas Department of Aging and Disability Services.

FIGURE 11
KANSAS NEUROLOGICAL INSTITUTE DIRECT-CARE STAFF TURNOVER RATES, 2005 TO 2009

YEAR	KNI DIRECT–CARE STAFF TURNOVER
2005	22%
2006	17%
2007	17%
2008	15%
2009	14%

SOURCE: Kansas Neurological Institute.

FIGURE 12
KANSAS NEUROLOGICAL INSTITUTE ABUSE INCIDENTS, FISCAL YEARS 2006 TO 2010

FISCAL YEARS	INCIDENTS
2006	7
2007	12
2009	17
2009	16
2010*	4

*2010 data as of May 2010.
SOURCE: Texas Department of Family and Protective Services.

FIGURE 13
RATE OF ABUSE FOR KANSAS NEUROLOGICAL INSTITUTE AND TEXAS STATE SUPPORTED LIVING CENTERS, FISCAL YEARS 2006 TO 2009

	2006	2007	2008	2009
Texas	9%	10%	12%	17%
Kansas	4%	7%	9%	6%

SOURCE: Legislative Budget Board.

FIGURE 14
AVERAGE TURNOVER RATE FOR TEXAS' STATE SUPPORTED LIVING CENTERS
FISCAL YEARS 2005 TO 2009

	2005	2006	2007	2008	2009
SSLC	AVERAGE TURNOVER RATE	AVERAGE TURNOVER RATE	AVERAGE TURNOVER RATE	AVERAGE TURNOVER RATE	AVERAGE TURNOVER RATE
Abilene	27%	23%	27%	35%	35%
Austin	40%	42%	53%	63%	51%
Brenham	22%	25%	32%	34%	32%
Corpus Christi	30%	29%	38%	51%	34%
Denton	43%	37%	44%	49%	41%
El Paso	23%	18%	19%	29%	24%
Lubbock	47%	38%	47%	49%	41%
Lufkin	24%	20%	23%	31%	29%
Mexia	23%	25%	31%	40%	28%
Richmond	18%	16%	24%	24%	16%
San Angelo	38%	38%	49%	50%	46%
San Antonio	44%	36%	43%	65%	40%

SOURCE: Texas Department of Aging and Disability Services.

IMPLEMENTING CULTURE CHANGE AT TEXAS STATE SUPPORTED LIVING CENTERS

Each SSLC has its own strengths and weaknesses, and none is the same despite being a part of one state-operated system. Some SSLCs excel in areas where other centers need more assistance. Recommendation 1 would direct DADS to hire a consultant to assist the agency to begin the culture change process at one facility, to be selected by DADS. The SSLC selected to implement the culture change model of care should be representative of the SSLC system to ensure the lessons learned throughout the culture change process are transferable to the other SSLCs in the newly downsized system. The selection of the SSLC should be based on the following criteria:

- Campus physical characteristics;
- Staffing size and turnover rates;
- Resident's level of need and disability;
- Number of confirmed abuse allegations;
- Use of restraints;
- Opportunity for community involvement; and
- Facility leadership.

Leadership is an important consideration in any systems change process. Facilities, such as KNI, who have gone through the culture change process report that it is a lengthy process that involves collaboration of stakeholders, staff, residents, family members, and regulators. Researchers and KNI staff agree that successful culture change should emanate from institutional leadership to prevent it from becoming another passing trend.

Recommendation 1 would include a rider in the 2012–13 General Appropriations Bill that directs the DADS to use $250,000 in existing funds to hire a consultant that has expertise in implementing culture change to provide training and technical assistance to SSLC staff at one facility and appropriate DADS central office staff in the implementation of culture change. In addition, DADS would also be directed to reclassify one full-time equivalent (FTE) positions at the selected SSLC as a placement coordinator or post-move monitoring specialist to assist more residents to move successfully to community placements. As community placements increase as a result of complying with the settlement agreement, additional staff will be needed to ensure the 180-day deadline is met once a resident requests to move to the community. The rider would also require DADS to report on the culture change process and its progress to the LBB and the Governor by May 1, 2012.

To ensure transparency and allow for more frequent monitoring of the occurrence of abuse incidents at SSLCs, Recommendation 2 would direct DADS through a rider in

the 2012–13 General Appropriations Bill to submit data to the LBB's Automated Budget and Evaluation Tracking System of Texas on a quarterly basis for each SSLC regarding the annual number of abuse allegations confirmed by DFPS investigators and the annual number of abuse allegations as reported by victims that have been determined to be unfounded by DFPS investigators.

Recommendation 3 would make these performance measures key so they would be reported in the 2012–13 General Appropriations Bill relating to DADS' administration of state supported living centers. The measures would be reported on a consolidated basis for all SSLCs.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations have no fiscal impact. It is assumed that costs associated with implementing Recommendation 1 could be absorbed within existing resources appropriated to the DADS. Recommendation 1 would also direct DADS to reclassify one full-time FTE position at the facility designated by DADS to begin the culture change process as a placement coordinator or post move monitoring specialist to assist more residents to move successfully to community placements. Recommendations 2 and 3 would add key and non-key performance measures relating to DADS's administration of state supported living centers and would have no fiscal impact.

The introduced 2012–13 General Appropriations Bill includes a rider implementing Recommendations 1 and 2. Two new key and non-key performance measures for SSLCs have been added to the introduced bill as a result of Recommendations 2 and 3.

APPENDIX A
SUMMARY OF SURVEY OF STATES OPERATING LARGE ICFS/MR

In January 2010, staff of the Texas Legislative Budget Board (LBB) surveyed 32 states that operate large Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) to gather information about how they provide care to persons with developmental disabilities, resolve operational challenges related to these institutions, and manage system size through system reshaping or facility closure. LBB staff limited the states surveyed to those that operate at least one institution with 100 residents or more. Texas was not included in the survey.

Eighteen states completed at least some portion of the survey. Because the survey included optional questions, the response rate varied by question. In the discussion of each question, the response rate is noted. Section 1 is omitted from the summary because it was used to capture identifying information of survey participants.

SECTION 2: SYSTEM OF SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

1. **Provide the unduplicated annual number of persons with developmental disabilities served using state and/or federal funding in the following settings for state fiscal year 2009 (i.e., the most recently completed fiscal year). Note: an ICF/MR is an Intermediate Care Facility for Persons with Mental Retardation.**
   Sixteen states responded to this question. Collectively, they use state and federal funds to serve 244,205 persons with developmental disabilities. Across all states, most of persons were served through waiver programs (including residential and non-residential programs) or through in-home supports. Approximately 6.0 percent of persons were served in state-operated institutions. **Figure A-1** shows the number of persons served by setting for all states.

2. **Provide the number of large ICF/MR institutions the state operated at the end of state fiscal year 2009 next to the appropriate number of residents. Note: a large ICF/MR is an institution with 16+ beds.**
   Seventeen responding states provide services in a total of 94 large ICFs/MR. **Figure A-2** shows the number of institutions by size ranges.

3. **What rate reimbursement methodology is used for large state-operated ICFs/MR?**
   Fourteen states responded to this question, with seven (50.0 percent) using a cost-based reimbursement methodology, five (35.7 percent) using a prospective payment system (cost-report based), and two (14.3 percent) using a retrospective payment methodology.

4. **Explain how the state's cost allocation plan works. Include, if applicable, how the state apportions central management costs across programs for persons with developmental disabilities. Also discuss whether the plan requires and has received federal approval.**
   Eleven states provided information on their cost allocation plan methodology. States allocate costs differently. Some methods used by states allocate costs by FTE count, personnel cost, or salaries.

FIGURE A-1
PERSONS SERVED BY SETTING, FISCAL YEAR 2009

	STATE ICF/MR	PRIVATE ICF/MR	WAIVER - RESIDENTIAL	WAIVER – NON-RESIDENTIAL	IN-HOME	NURSING HOME	OTHER	TOTAL
Number of Persons	14,613	13,458	72,419	46,201	91,860	5,651	3	244,205
Percentage	6.0	5.5	29.7	18.9	37.6	2.3	0.0	100.0

SOURCE: Legislative Budget Board.

FIGURE A-2
NUMBER OF LARGE STATE-OPERATED ICF/MR BY FACILITY SIZE, AS OF FISCAL YEAR 2009

SIZE	16 TO 50	51 TO 100	101 TO 200	201 TO 300	301 TO 400	401 TO 500	501 TO 600	601	TOTAL
Number	15	24	36	7	4	5	3	0	94

SOURCE: Legislative Budget Board.

SECTION 3: STATE OPERATION OF LARGE ICFS/MR

1. **States were asked to select the best answer to describe staffing at large state-operated ICFs/MR.**
   Of the 16 responding states, 15 indicated that most staff at large ICFs/MR are state employees. One state indicated most staff are contractors.

2. **What are the typical staffing ratios in large Ices/MR?**
   Direct-care worker to resident: Fifteen states provided their ratio of direct care worker to resident. Responses ranged from ratios of 1:8 to 1.33:1. Common ratios provided include 1:3 and 1:4. Several states noted the use of 1:1 staffing ratios in certain circumstances. Four states also provided night shift ratios, which ranged from 1:16 to 1:6.

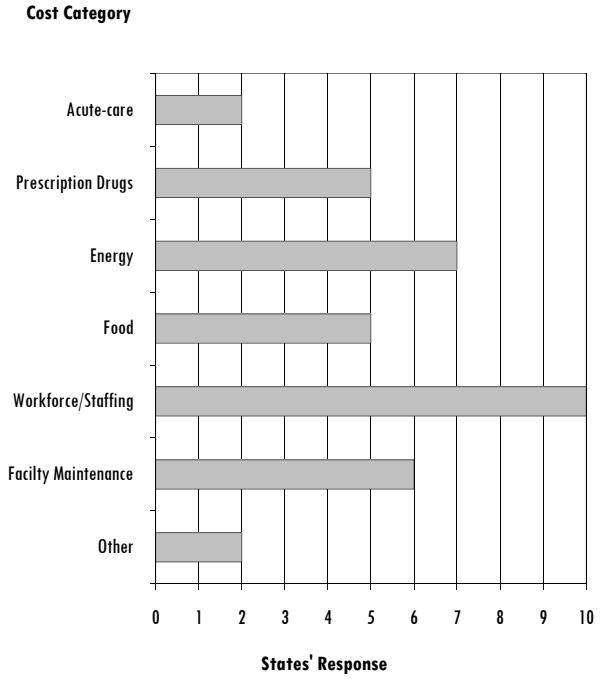
   Supervisor to direct-care worker: Thirteen states supplied this ratio. Responses ranged from 1 to 17 to 1 to 5.

3. **What were the areas where cost growth was most difficult to contain over the past two state fiscal years (select up to 3)?**
   Fifteen states responded to this question and **Figure A-3** summarized the number of states selecting each of the provided cost categories. Workforce/staffing issues, energy costs, and facility maintenance costs were the most commonly selected cost categories, with 10, 7, and 6 states selecting these categories, respectively.

4. **Provide the methods used to contain costs.**

5. **Which of the cost containment methods were most effective?**
   Figure A-4 shows the strategies used by states to control costs. When more than one state indicated use of a particular strategy, the number of states that mentioned that strategy is noted in parentheses. The most effective strategies, as self-identified by states, are listed in the third column.

FIGURE A-3
MOST DIFFICULT TO CONTAIN COST CATEGORIES
FISCAL YEARS 2008–2009



SOURCE: Legislative Budget Board.

SECTION 4: PROVISION OF CARE IN LARGE STATE-OPERATED ICFS/MR

1. **How has the state addressed resident safety in the past five years?**
   Sixteen states responded to this question. Most commonly used strategies included staff training (16 states), mortality reviews (13 states), incorporation of best practices/lessons from other states (11 states), and changing staffing ratios (10 states). Eleven states supplied examples of additional resident safety initiatives, which ranged from greater involvement of residents in various processes such as hiring of staff to improved risk management practices and revisions to abuse/neglect/exploitation policies.

FIGURE A-4
STRATEGIES USED BY STATES TO CONTAIN COSTS, FISCAL YEARS 2008 AND 2009

COST AREA	ALL STRATEGIES	MOST EFFECTIVE
Acute care medical	Infection control (2); wellness (3); case management; resident education/diet; preventive care (2); group purchasing organization	--
Prescription drug	Contract pharmacy (2); generics (2); bulk purchasing; bidding; group purchasing; auto dispensing; policy changes; Medicare Part D (4);	Contract pharmacy; generics (2); bulk/group purchasing (2); and Medicare Part D
Energy	Conservation (2); Energy Efficiency (audits, fixtures, staff training, new HVAC) (6); closing/consolidating units; centralized negotiation (2); building remodel; meetings across state	Energy efficiency; conservation, energy audits; and a negotiated central contract
Food	Contract food service (2); reduced staff meals; donations; gardens; coupons/bargain shopping (2); meal planning; bulk purchasing/group purchasing organization/statewide commodity contract/bidding (6); decentralized purchasing; staff training	Reduced staff meals; statewide purchasing; and bidding
Workforce/Staffing	Voluntary unpaid leave or furlough (2); overtime management/reduction (3); recruitment/retention bonuses (3); hiring freeze/salary/position freeze (3); training/education; self-directed teams; fewer contractors; vacancy savings; reducing injury/increased safety; extended childcare with private provider; reclassification of positions	Voluntary unpaid leave; reduction in overtime; recruiting bonuses; reclassification of positions; and extended childcare
Facility maintenance	Deferred maintenance (4); closing units/buildings (10); dispensers for cleaners; preventive maintenance; scheduled maintenance; HVAC upgrade	Chemical dispensers for cleaners and closing units/buildings

NOTE: If more than one state used a strategy, the number of states that used the approach is reflected in parentheses.
SOURCE: Legislative Budget Board.

2. **Briefly describe outcomes of initiatives selected in the previous question.**
   Fifteen states provided additional information on the outcomes associated with resident safety initiatives. Some of the commonly-noted outcomes included reduced use of restraints, reduced accidents/injuries, decreased serious incidents and confirmed allegations of abuse/neglect/exploitation, improved resident health, and increased resident satisfaction.

3. **Does the state utilize enhanced payment rates for quality initiatives in non-state-operated ICFs/MR or waiver services?**
   Thirteen of fifteen responding states indicated no enhanced payment rates were used. Of the two states that indicated use of enhanced payments, funds were used to provide enhanced staff benefits and to create a community-based program for difficult to serve populations.

4. **Does the state collect data to evaluate the quality of life for residents of large state-operated ICFs/MR? If yes, please specify the assessment instrument used.**
   Twelve of fifteen responding states collect data to evaluate resident quality of life and three states do not. Assessment instruments varied across states, with some states surveying residents and some surveying family members/guardians. Four responding states use National Core Indicators in measuring satisfaction and two use Council on Quality and Leadership outcome measures or a related tool.

5. **Has the state pursued additional certification for any state-operated ICFs/MR?**
   Five of fifteen responding states have pursued additional accreditations. Of the five, two specified pursuing Council on Quality and Leadership accreditations and two specified pursuing Commission on Accreditation of Rehabilitation Facilities accreditation.

Section 4 of the survey also included questions about culture change in state-operated ICFs/MR. To facilitate shared meaning of the term "culture change," the survey included the following definition, as formulated by long-term care researchers: "Culture change is a deep system change where institutions are transformed from an acute care medical model to a consumer-centered model. It de-institutionalizes how care is delivered and seeks to individualize care to each resident. It also creates a working environment that brings more autonomy and responsibility to direct-care staff."

6. **Is culture change occurring in any privately-run ICF/MR institution in your state?**
   Culture change is occurring in privately-run ICFs/MR in at least six of fifteen responding states. One state indicated culture change is not occurring. Eight states indicated that the occurrence of culture change among private ICF/MR providers is unknown.

7. **Is culture change occurring in any large state-operated ICF/MR institutions?**
   Fourteen states noted that culture change is occurring in large state-operated ICFs/MR and one state indicated that while such change is not underway, discussions about culture change have taken place.

8. **Survey participants were asked to check all the reasons that describe why culture change may not have been implemented at their large state-operated ICF/MR institutions.**
   Most participants responding to this question indicated culture change is occurring (11 of 14 states). Of the states that indicated it is not occurring, one state indicated that state institutions have more urgent needs than implementing culture change, another noted that its facility has always operated as a consumer-centered model, and a third state mentioned a need to have culture change implemented and led by facility leadership.

9. **Survey participants were asked to check any of 23 consumer-directed practices that are currently taken by large state-operated ICFs/MR.**
   Consistent adoption of consumer-directed practices varied across states, but all states that participated in this survey have adopted some consumer-directed practices. **Figure A-5** shows the number of states

FIGURE A-5
CONSUMER-DIRECTED PRACTICES ADOPTED BY STATES, FISCAL YEAR 2009

Offering residents meal choices	15
Offering residents options for bathing	14
Allowing residents to wake/go to bed at time they choose	11
Allowing residents to choose activities or outings	15
Providing residents with options in determining other daily schedule and care plans	14
Redesigning resident rooms for privacy, personalization, and individual needs	13
Introducing pets, plants, and community members into the daily resident schedules	13
Redesigning public and outdoor living spaces for stimulation and activity	14
Redesigning living areas to resemble a home-like atmosphere	15
Using consistent staffing	14
Allowing staff to handle own scheduling	3
Promoting direct care staff education, development, and empowerment	15
Developing self-managed work teams and encouraging staff teamwork	5
Allowing direct care workers to participate in weekly resident care plan meetings with nurses, doctors, and other health professionals	12
Modifying hiring and retention practices to promote staff satisfaction	8
Practicing open communication at all workforce levels	14
Giving awards/recognition to staff to recognize person-centered care ideas	12
Actively conveying mission, values, and direction of culture change ideas	15
Monitoring and evaluating care quality and services	15
Tracking staff turnover and longevity	14
Incorporating evaluation results and feedback into service delivery and workforce development	13
Providing wage increases/benefit packages for direct care workers	9
Ongoing management commitment to culture change values	14

SOURCE: Legislative Budget Board.

that have adopted each of these consumer-directed practices.

10. **Briefly discuss outcomes of initiatives selected in the previous question.**
    Twelve states provided diverse responses to this question. Six states discussed improved quality of life and satisfaction of individuals residing in state-operated ICFs/MR. Five states identified the outcome of improved satisfaction of parents/guardians and staff. At least three states reported reduced turnover of direct-care staff. Other states mentioned reductions in the use of restraints, behavioral incidents, and medication errors.

SECTION 5: SYSTEM RESHAPING

Has the state intentionally changed the overall number of residents served in large ICFs/MR since 2000?

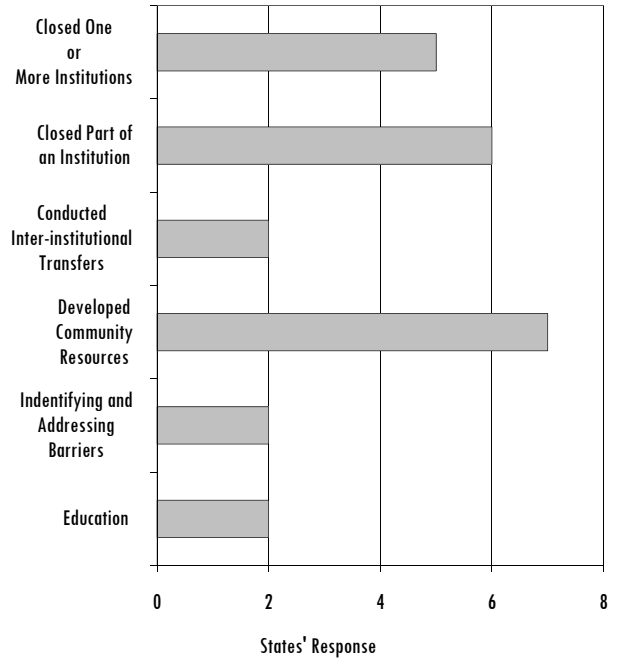
Of the 18 states responding to this question, most states (83.3 percent) indicated reshaping since 2000. Subsequent questions were only completed by states indicating reshaping had occurred.

1. **Provide the annual unduplicated number of residents in state fiscal year 2000 and 2009.**
   Nearly all responding states indicated that they had intentionally reduced the overall number of residents served in their large state-operated ICFs/MR since state fiscal year 2000. The reductions ranged from approximately 11 percent to 57 percent.

2. **How was the new number of residents per institution determined? States could select up to two factors.**
   Of fourteen responding states, eight determined the reduction based on changed demand for community-based services. Four states identified the desired population reduction and spread it across institutions and four states indicated they were seeking better resident outcomes.

3. **How was the change in the number of residents per institution achieved?**
   States identified a number of strategies to achieve a change in the number of residents per institution, summarized in **Figure A-6**. Six states closed one or more institutions, six closed part of an institution, and two conducted inter-institutional transfers. Seven states responded that they had developed community resources and increased Medicaid waiver services or taken advantage of Olmstead provisions to reduce the number of residents in the large state-operated ICFs/MR.

FIGURE A-6
STRATEGIES USED TO RESHAPE INSTITUTIONS
FISCAL YEARS 2000–2009



SOURCE: Legislative Budget Board.

SECTION 6: CLOSURE

Has your state closed any ICFs/MR facilities since 2000?

Of the 17 states that responded, 6 (35.3 percent) closed a large state-operated ICF/MR since 2000, but only five provided detailed information on their closure process. Subsequent questions were only completed by states indicating a closure had occurred since fiscal year 2000.

1. **How many large state-operated ICFs/MR has the state closed since 2000?**
   Five reporting states closed a total of six institutions. Six states responded to indicate they have closed at least one institution since 2000, but only five provided detailed information on their closure process. Of the five reporting state that closed a total of six institutions.

2-5. Information about closed institution.

The average number of residents by institution at the time of closure was 116.3 with a range of 0-242. The average percent of residents who moved to another state-operated institution was 61 percent, ranging from 10 percent to 100 percent. The average percent of residents who moved into the community was 38 percent, ranging from 0 percent to 90 percent.

6. **In the closure process, how was the impact on the residents minimized?**
   All of the responding states conducted extensive planning to determine new resident placements after an institution's closure was announced. Other strategies used by states included provision of technical support to private providers for two years following closure and resident visits to their new homes prior to their moves. Two states tracked the outcomes of persons who had resided in state institutions after they moved to the community.

7. **In the closure process, how was the impact on staff minimized?**
   States deployed strategies to help employees find other jobs when an institution closed. Several states offered opportunities either within the state agency or in other state agencies. Other strategies included lifting hiring freezes so staff affected by closure could apply to available positions, giving eligible staff early retirement options, and offering staff employment services such as assistance with resumes.

8. **In the closure process, how was the impact on the local economy minimized?**
   Four states developed community services in the same local community where the closed institution was located in order to minimize the adverse impact to the economy. One state noted no impact to the local economy.

9. **Indicate the number of all institutions that have closed since 2000 by the duration of the closure process.**
   Of the five states that closed a total of six institutions, the lengths of closure included 6-12 months (1 institution), 12-24 months (3 institutions), and 24 months or more (2 institutions).

10. **Who made the final decision to close the institution(s)?**
    The final decision to close the institution(s) was made by the state agency in three states and by the governor in two states.

11. **Briefly explain the decision-making process for closure and the roles of key participants.**
    Three states discussed the leadership role taken by the state agency. In a third state, the governor made the initial announcement of closure and the MR/DD Department announced the specific facilities to be closed. A non-partisan commission was created to review closure decisions. The commission and Governor validated the department's closure decisions.

12. **Were alternative uses for the land and buildings considered?**
    Four states responded that alternative uses for the land and buildings were considered including property sale and repurposing to meet other agency needs; one state had not considered other uses for the land and buildings.

13. **Were alternative uses for the land and/or buildings implemented?**
    Of states with a closure, two states sold and/or leased the land and buildings. Examples of alternate uses for the facilities provided by states includes conversion of the facility into a county office building, utilization as a community recreation center, and utilization to meet other hospital needs.

14. **Did the state realize a net cost impact as residents moved from institutions to the community?**
    Most of the states that closed facilities realized net savings as a consequence of closing the facility. Four states realized net savings and one noted a neutral cost impact.

15. **In which areas did the state realize net cost savings?**
    Of the four states that experienced savings, two noted savings in institution operating costs, three experienced savings in staffing costs, and three noted savings in direct/indirect client care costs.

16. **How soon were net cost savings realized?**
    Of the four states that realized net cost savings, one state realized savings in the same fiscal year that the facility was closed, two states realized net savings in the following fiscal year, and one state realized net

savings two or more fiscal years after the facility was closed.

17. **Were net cost savings realized beyond the initial year?**

    Of the four states that realized net savings after a facility closure, all realized a net savings beyond the initial year.

APPENDIX B: FACILITY-BY-FACILITY ANALYSIS

FIGURE B-1
FACILITY-BY-FACILITY ANALYSIS

NUMBER	CRITERIA	ABILENE	AUSTIN	BRENHAM	CORPUS CHRISTI	DENTON	EL PASO	LUBBOCK
Client Impact								
1	Ratio of SSLC Census to Service Area Census	73.1	17.1	42.5	31.0	12.3	18.9	22.5
2a	FY 2009 Enrollment	486	401	378	325	582	142	242
2b	FY 2010 Enrollment	453	380	347	294	548	138	230
3	FY 2009 Enrollment in Bed Days	180,497	148,472	137,208	122,411	215,209	51,475	90,042
4	Percent of persons placed in the community within 180 days	10.0%	14.3%	6.3%	0.0%	50.0%	100.0%	37.5%
5	Percent Elderly Residents	29.8%	36.9%	21.4%	21.2%	32.8%	17.6%	22.3%
6	Percent Residents with Pervasive or Pervasive+ Level-of-Need	25.7%	23.7%	13.2%	26.2%	25.3%	14.8%	27.3%
7	Percent Residents with Length of Stay Exceeding 20 Years	62.6%	52.1%	50.0%	46.2%	58.6%	38.7%	56.2%
8	Percent Residents with Severe Health Status	2.7%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%
9	Percent of Residents with Legally Authorized Representative or Contact Person within 40 Miles	20.0%	50.1%	14.9%	30.5%	47.8%	79.0%	28.6%
10	Confirmed incidences of Abuse/Neglect/ Exploitation per 100 residents	31.3	11.0	25.1	34.8	7.7	43.7	15.7
Capacity to Accommodate Clients in other SSLCs and the Community								
11	Vacant and Presently Unfunded Certified Beds	209	94	173	138	168	17	206
12	Immediately available beds	114	58	63	79	141	10	82
13	HCS Providers by Waiver Contract Area	103	126	126	69	138	44	34
Specialty Program								
14	Admits from Criminal Justice System	No	Yes	No	Yes	Yes	No	Yes
15	Presence of Children's Homes	Yes	No	Yes	No	No	No	No
Cost								
16	Total Cost/Day	$429.78	$411.10	$389.80	$425.31	$448.08	$414.26	$551.70

FIGURE B-1 (CONTINUED)
FACILITY-BY-FACILITY ANALYSIS

NUMBER	CRITERIA	ABILENE	AUSTIN	BRENHAM	CORPUS CHRISTI	DENTON	EL PASO	LUBBOCK
17	Administration Cost/ Day	$91.29	$81.22	$86.21	$94.93	$82.92	$97.98	$109.13
Facility Condition								
18	Facility Condition Index	0.16	0.20	0.11	0.19	0.20	0.04	0.19
19	Forecasted Renewal Costs/ Funded Bed	$22,878	$51,918	$18,571	$70,523	$21,620	$15,079	$37,112
20	Deferred Maintenance/ Funded Bed	$34,092	$51,524	$20,785	$35,005	$32,795	$6,908	$48,097
Marketability								
21	Market Value of Land and Buildings	$18,305,000	$20,900,000	$9,833,115	$7,929,000	$35,600,000	$5,330,000	$12,133,000
22	Deed restrictions	No	No	No	Yes - Reversion to city: Must be used as MHMR facility	No	Yes - Reversion: Must be used for operation of a human develop-ment center	Yes - Reversion to city: Must be used as MHMR facility
23	Bonded Indebtedness	$22,297,155	$13,965,048	$8,982,756	$8,578,179	$16,240,700	$4,781,766	$11,439,346
Employment								
24	State Employees/ 10,000 Population	72.9	6.9	29.2	20.2	2.8	5.9	23.9
25	County unemployment rate	6.7	7.1	6.7	8	7.7	10.2	6.7
26	Number of Employers of Equal or Greater Size	1	106	2	23	8	472	10
27	Number of Employees Affected by Closure	1463	1216.78	1045.5	986.2	1715.3	445.25	897.86
28	Fill rate, all staff	94.6%	89.9%	94.3%	96.7%	91.7%	93.2%	90.2%
29	Turnover rate, all staff	32.1%	50.3%	29.3%	36.8%	39.0%	27.0%	39.2%
Geography								
30	Travel Distance in Miles to 2 Closest Facilities	122.7	83.1	76.3	158.9	153.7	367.6	171.1
31	Travel Distance in Minutes to 2 Closest Facilities	166	107	112	169	162	437	221

NUMBER	CRITERIA	LUFKIN	MEXIA	RICHMOND	RIO GRANDE	SAN ANGELO	SAN ANTONIO
Client Impact							
1	Ratio of SSLC Census to Service Area Census	31.8	18.7	8.0	6.1	43.4	15.5
2a	FY 2009 Enrollment	415	477	462	71	274	286
2b	FY 2010 Enrollment	405	430	409	71	253	283
3	FY 2009 Enrollment in Bed Days	151,036	159,092	169,610	26,442	100,899	102,908

FIGURE B-1 (CONTINUED)
FACILITY-BY-FACILITY ANALYSIS

NUMBER	CRITERIA	LUFKIN	MEXIA	RICHMOND	RIO GRANDE	SAN ANGELO	SAN ANTONIO
4	Percent of persons placed in the community within 180 days	40.0%	10.6%	56.4%	0.0%	7.7%	40.0%
5	Percent Elderly Residents	24.3%	28.9%	27.9%	14.1%	32.1%	25.5%
6	Percent Residents with Pervasive or Pervasive+ Level-of-Need	16.6%	7.5%	23.6%	2.80%	15.0%	28.3%
7	Percent Residents with Length of Stay Exceeding 20 Years	56.4%	40.3%	65.4%	45.10%	19.0%	17.8%
8	Percent Residents with Severe Health Status	0.0%	0.0%	0.6%	2.80%	1.1%	0.0%
9	Percent of Residents with Legally Authorized Representative or Contact Person within 40 Miles.	16.5%	9.3%	58.5%	64.3%	9.5%	70.9%
10	Confirmed incidences of Abuse/Neglect/ Exploitation per 100 residents	4.1	21.3	1.7	12.7	25.9	9.8
Capacity to Accommodate Clients in other SSLCs and the Community							
11	Vacant and Presently Unfunded Certified Beds	81	186	255	39	122	56
12	Immediately available beds	36	165	106	2	26	24
13	HCS Providers by Waiver Contract Area	150	126	248	69	44	107
Specialty Program							
14	Admits from Criminal Justice System	Yes	Yes - Designated High-Risk Alleged Offender Facility	No	Yes	Yes	Yes
15	Presence of Children's Homes	Yes	No	No	No	No	No
Cost							
16	Total Cost/Day	$373.73	$510.47	$461.61	$545.30	$460.88	$362.84
17	Administration Cost/ Day	$72.61	$105.04	$97.81	$115.53	$104.99	$81.10
Facility Condition							
18	Facility Condition Index	0.12	0.06	0.55	0.2218** Includes data for entire facility	0.56	0.15
19	Forecasted Renewal Costs/ Funded Bed	$32,250	$33,559	$27,824	--	$59,533	$15,867
20	Deferred Maintenance/ Funded Bed	$19,033	$15,204	$105,544	--	$188,067	$21,210

FIGURE B-1 (CONTINUED)
FACILITY-BY-FACILITY ANALYSIS

NUMBER	CRITERIA	LUFKIN	MEXIA	RICHMOND	RIO GRANDE	SAN ANGELO	SAN ANTONIO
Marketability							
21	Market Value of Land and Buildings	$11,160,000	$10,170,000	$12,700,000	$5,700,000** Includes data for entire facility	$9,258,000	$35,500,000* Co-located with San Antonio State Hospital
22	Deed restrictions	No	No	No	No	No	No
23	Bonded Indebtedness	$12,370,405	$22,218,891	$28,128,975	$3,479,608*** Includes total facility debt	$13,036,340	$6,305,906
Employment							
24	State Employees/ 10,000 Population	33.7	43.3	2.7	1.9	61.0	3.9
25	County unemployment rate	8.4	7.2	8.4	11.7%	6.7	7.9
26	Number of Employers of Equal or Greater Size	4	1	9	196	9	120
27	Number of Employees Affected by Closure	1153	1611	1388.75	223.25	813.7	798.15
28	Fill rate, all staff	93.9%	94.8%	94.9%	79.9%	93.9%	95.4%
29	Turnover rate, all staff	33.9%	25.0%	16.3%	27.4%	40.2%	43.2%
Geography							
30	Travel Distance in Miles to 2 Closest Facilities	134.3	121.5	105.7	191.38	135.2	109.7
31	Travel Distance in Minutes to 2 Closest Facilities	187	153	147	181.5	184	111

FIGURE B-2
METHODOLOGY AND SOURCE MATERIAL

NUMBER	CRITERIA	DEFINITION	DATA SOURCE AND DATE
Client Impact			
1	Ratio of SSLC Census to Service Area Census	(Campus census * 100,000)/Combined population of counties in campus' service area	Counties in DADS' Service Area: DADS, 2010 SSLC Census: DADS, 08/31/09 County populations: US Census Bureau Population Estimates, FY 2009
2a	FY 2009 Enrollment	Census in Persons	DADS, 08/31/09
2b	FY 2010 Enrollment	Census in Persons	DADS, 08/10
3	FY 2009 Enrollment in Bed Days	Total Adjusted Census (Bed Days)	DADS, Fiscal Year 2009 Final Settlement Calculated for Large, State-Operated ICF/MR
4	Percent of persons placed in the community within 180 days	Percent of Residents that wait up to 180 days for Community Placement	DADS, 09/01/09 - 02/28/10
5	Percent Elderly Residents	Percent of Residents over age 55 (Number / Census)	DADS, 08/31/09
6	Percent Residents with Pervasive or Pervasive+ Level-of-Need	Percent of Residents with Pervasive or Pervasive Plus LON (Number / Census)	DADS, 08/31/09
7	Percent Residents with Length of Stay Exceeding 20 Years	Percent of Residents with Length of Stay Exceeding 20 Years (Number / Census)	DADS, 08/31/09
8	Percent Residents with Severe Health Status	Percent of Residents with Severe Health Status (Number / Census)	DADS, 08/31/09
9	Percent of Residents with Legally Authorized Representative or Contact Person within 40 Miles	Percent of Residents with LAR or Contact Person (typically another relative) within 40 miles of the SSLC.	DADS, 02/28/10 and 11/30/10
10	Confirmed incidences of Abuse/Neglect/ Exploitation per 100 residents	Substantiated allegations of A/N/E per 100 residents	Confirmed incidences: DFPS, Fiscal Year 2009 FY 2009 census used (row 2a)
Capacity to Accommodate Clients in other SSLCs and the Community			
11	Vacant and Presently Unfunded Certified Beds	Vacant certified beds (Total certified beds - Census)	Total certified beds DADS, 04/10 FY 2009 census used (row 2a)
12	Immediately available beds	Immediately available vacant certified beds	DADS, 04/10
13	HCS Providers by Waiver Contract Area	Total program providers in the waiver contract area corresponding to the SSLC campus	DADS, 04/10
Specialty Program			
14	Admits from Criminal Justice System	The SSLC houses any alleged offender residents (includes Adult Criminal Code and Chapter 55 adults and juveniles).	DADS, 09/09/10
15	Presence of Children's Homes	The SSLC operates homes designed for children. Some SSLCs have some child residents, but do not operate homes designed for children.	DADS, 07/31/10

FIGURE B-2 (CONTINUED)
METHODOLOGY AND SOURCE MATERIAL

NUMBER	CRITERIA	DEFINITION	DATA SOURCE AND DATE
Cost			
16	Total Cost/Day	Per Diem Cost (Total Allowable Expenses/Total Adjusted Census)	DADS, Fiscal Year 2009 Final Settlement Calculated for Large, State-Operated ICF/MR
17	Administration Cost/ Day	Administrative Costs (Administrative Costs / Total Adjusted Census) (LBB methodology; includes central office administration, allocated expenses including insurance state contribution, Statewide Cost Allocation Plan, lump sum terminations, DADS central office expenses, HHSC consolidation expenses, and program administration costs)	DADS, Fiscal Year 2009 audited cost reports
Facility Condition			
18	Facility Condition Index	Deficiency Costs (Priority Levels 1-3) / Current Replacement Value	HHSC, CAFM System Reports, 03/15/10 and 12/14/10
19	Forecasted Renewal Costs/Funded Bed	5 Year Sum Renewal Projection / Funded Beds	HHSC, CAFM System Reports, 03/15/10 and 12/14/10 Funded beds: DADS, 04/10
20	Deferred Maintenance/ Funded Bed	Deficiency Costs (Priority Levels 1-3) / Funded Beds	HHSC, CAFM System Reports, 03/15/10 and 12/14/10 Funded beds: DADS, 04/10
Marketability			
21	Market Value of Land and Buildings	Total Market Value of Land and Buildings	Texas General Land Office, Real Property Evaluation Reports, for the 81st Legislature
22	Deed restrictions	Deed restrictions with reversion clauses	Texas General Land Office, Real Property Evaluation Reports, for the 81st Legislature
23	Bonded Indebtedness	Sum of Capital Construction G.O. Bonds, TPFA MLPP Loans, and SECO LoanStar Loans	DADS, SSLC Construction Expenditure and Debt Analysis as of 02/28/10; DSHS, State Hospital Construction Expenditure and Debt Analysis as of 08/31/10
Employment			
24	State Employees/10,000 Population	(Number of filled positions at a SSLC campus / Population of contiguous counties) x 10,000	Filled positions: DADS, 08/31/10; DSHS, 08/31/10 Population: US Census Bureau Population Estimates, FY 2009
25	County unemployment rate	County unemployment rate (point-in-time July 2010)	Texas Workforce Commission, Labor Market & Career Information, 07/10
26	Number of Employers of Equal or Greater Size	Number of employers in the county within the same size class or a higher size class (i.e., 1000+, 500-999, 100-499). Used filled positions to determine the size class.	Texas Workforce Commission Socrates System, 09/10/10
27	Number of Employees Affected by Closure	Number of filled positions at a SSLC campus	DADS, 08/31/10; DSHS, 08/31/10
28	Fill rate, all staff	Fill rate, all positions	DADS, 06/30/10
29	Turnover rate, all staff	Turnover rate, all positions	DADS, 06/30/10; DSHS 2010
Geography			
30	Travel Distance in Miles to 2 Closest Facilities	Average of travel in miles to 2 closest facilities, using Texas Comptroller's Mileage Guide	HHSC, Rider 55 Report, FY 2005; Mapquest website, 2010
31	Travel Distance in Minutes to 2 Closest Facilities	Average of travel in minutes to 2 closest facilities using Mapquest	HHSC, Rider 55 Report, FY 2005; Mapquest website, 2010

APPENDIX C
SUMMARY OF CONTRACTED SERVICES PROVIDED TO STATE SUPPORTED LIVING CENTER STAFF

FIGURE C-1
SUMMARY OF CONTRACTED SERVICES PROVIDED TO STATE SUPPORTED LIVING CENTER STAFF, FISCAL YEARS 2005 TO 2011

CONTRACT DATE/ AMENDMENT	SERVICES	COST
Columbus Organization		
April 2005*	Expert will evaluate programs and services at Lubbock SSLC. Will provide short and long-term recommendations after site visit.	$48,500
May 5, 2005	Focused review of Lubbock SSLC	$99,900
April 11, 2006	Contract extension for one year through May 4, 2007.	
December 12, 2006	Contract extension for one year through August 31, 2007. Professional and targeted technical assistance to Lubbock SSLC and prepare for and respond to DOJ investigation. Deliverables: Protections from Harm, Behavioral Psychology, Physical and Nutritional Mgt., Habilitation, Medical and Psychiatric, Nursing and Infection Control, Quality Assurance and Human Rights, Project direction and professional advice on negotiations with DOJ.	$100,000
February 1, 2007	Focused review of Denton SSLC including client protections/ risk management, health care services, physical and nutritional mgt., habilitation, behavioral psychiatric services, and serving residents in most integrated setting.	$53,750
August 1, 2007	Training for direct care staff at Corpus Christi SSLC and Denton SSLC. Training includes: rights & dignity, active treatment and recognition of abuse and neglect, health care, function of human rights committee. Contract extended to August 31, 2008.	$109,000
October 1, 2007	Training and technical assistance to SSLCs. Training includes: rights & dignity, active treatment and recognition of abuse and neglect, and health care. Technical assistance and follow up will be provided to staff who scored <90% on training tests.	$565,385
November 30, 2007	Follow up review of Lubbock SSLC and assist DADS state office and Lubbock SSLC staff implement DOJ agreement. Contractor staff will address major sections of settlement agreement and provide written report of their findings. Report will address progress of meeting agreement terms, recommendations to areas to achieve compliance, and any findings not related to agreement but should be addressed.	$86,500
March 11, 2008	Provide behaviorist consultation and training services to assess the clinical program of the Abilene SSLC adolescent program.	$10,620
March 24, 2008	Follow-up review of programs and services at Denton SSLC and to provide professional and targeted technical assistance during the DOJ on-site visit, and to provide ongoing technical assistance to assist DADS with preparing for DOJ investigation. Review will include: client protections/ risk management, health care services, physical and nutritional mgt. and therapy, habilitation, behavioral and psychiatric services, and community placement. Written report will be issued. Contractor staff will participate in DOJ visit and provide on-going technical assistance.	$99,500
April 15, 2008	Provided supplemental training to SSLC staff regarding habilitation therapies, nursing, active treatment, person-directed planning, positive behavior support, and self determination.	$295,055
May 12, 2008	Provide Phase II nursing training and technical assistance at Corpus Christi, Denton, San Angelo, and Mexia SSLCs. Phase II training includes: critical thinking, nursing documentation, and refinement of nursing process.	$50,100
May 27, 2008	Provide a focused review and a report of programs and services at 11 SSLCs. Review includes: client protections/ risk management, health care services, physical and nutritional mgt. and therapy, habilitation, behavioral psychiatric services, and community placement. Affected SSLCs: Corpus Christi, Mexia, San Angelo, Brenham, Lufkin, Abilene, Richmond, Austin, San Antonio, El Paso, Rio Grande Center. Also, DADS requested 3-4 day training sessions for up to 10 DADS Operations Coordinators and other senior staff to focus on development of core competencies required to monitor and assess SSLC plan of improvement.	$690,000

FIGURE C-1 (CONTINUED)
SUMMARY OF CONTRACTED SERVICES PROVIDED TO STATE SUPPORTED LIVING CENTER STAFF, FISCAL YEARS 2005 TO 2011

CONTRACT DATE/ AMENDMENT	SERVICES	COST
August 7, 2008	Contract extended to August 31, 2009 and payments changed to 3 monthly payments instead of 5.	
November 10, 2008	Provide training and on-site technical assistance in active treatment, psychology, nursing, medical/pharmacy, psychiatry, and adolescent services and as needed technical assistance. Training areas include: active treatment, positive behavior techniques, psychology training and technical assistance, autism-related technical assistance, restraint training and usage technical assistance, nursing assessments, pharmacy quarterly drug reviews, medical annual and quarterly assessments, psychiatric training, and adolescent services training. Shadowing of DOJ staff during inspections and central office assistance.	$1,421,110
March 27, 2009	Conduct a critical status review of each SSLCs and Rio Grande Center ICF-MR component. Review includes: health care, protection from harm (including incident management and psychology services), and staffing.	$381,186
August 31, 2009	Provides experts on site during monitors' baseline evaluations and monitoring visits at SSLC, daily briefings with DADS and central office administrators.	$1,419,600
September 10, 2009	Clarifies number of trainers and training days and technical assistance and financial projections.	
November 16, 2009	Training and technical assistance to SSLCs include: root cause analysis training and process implementation, technical assistance on risk management systems, QMRP training and technical assistance, vocational skills training, development and expansion of supported living employment options, psychology training and technical assistance, psychology off-site review. Other technical assistance includes: monitor team meeting facilitation and other as needed.	$1,681,633
	Columbus Organization - Subtotal	**$7,111,839**
H&W Independent Solutions		
Fiscal Year 2010**	Quality assurance system	$71,717
Fiscal Year 2011**	Continuation of services to strengthen quality assurance process at SSLCs	$445,223
	H&W Independent Solutions - Subtotal	**$516,940**
	Grand Total	**$7,628,779**

*Date is based on proposal submitted by Contractor.
**Specific contract dates unavailable.

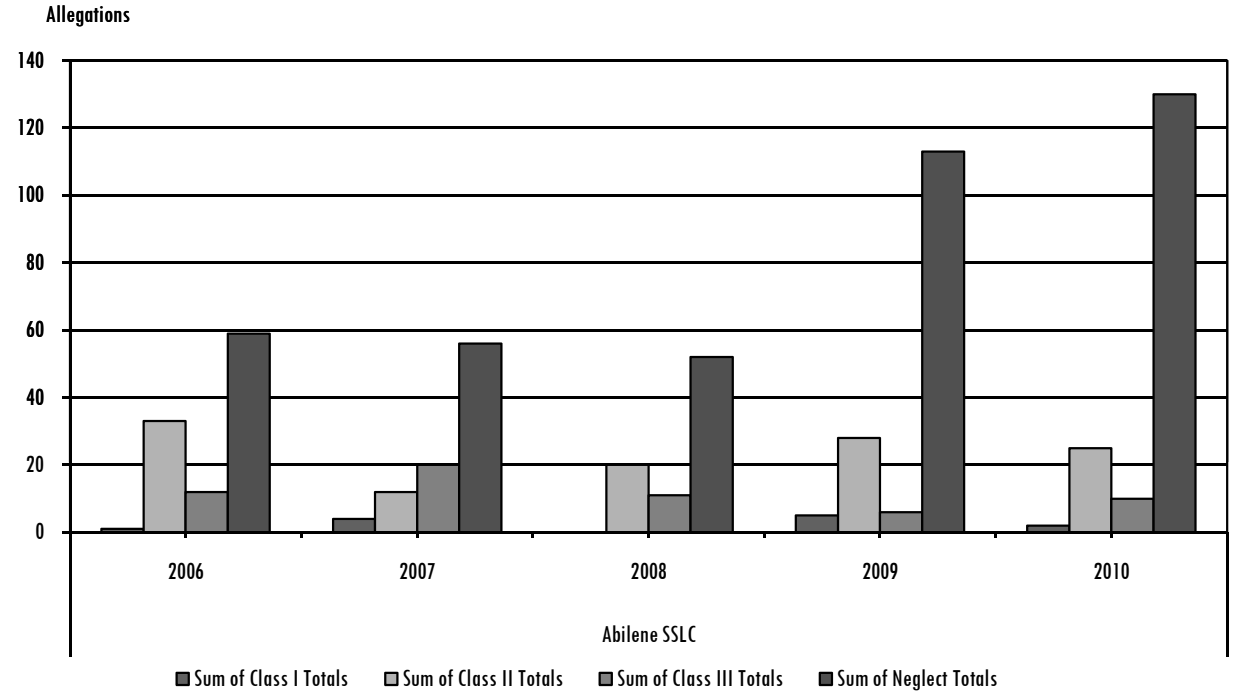
APPENDIX D
CONFIRMED ALLEGATIONS OF ABUSE BY CLASS AND FISCAL YEAR, 2006 TO 2010

This appendix includes charts showing confirmed allegations of abuse and neglect by class for each state supported living center for fiscal years 2006 to 2010. Abuse classifications according to Texas Administrative Code, Title 40, Rule 711.425 are defined as:

- Class I is defined as physical abuse which caused or may have caused serious physical injury or death, or sexual abuse.
- Class II is defined as physical abuse which caused or may have caused non-serious physical injury, or exploitation.
- Class III is defined as verbal/emotional abuse.

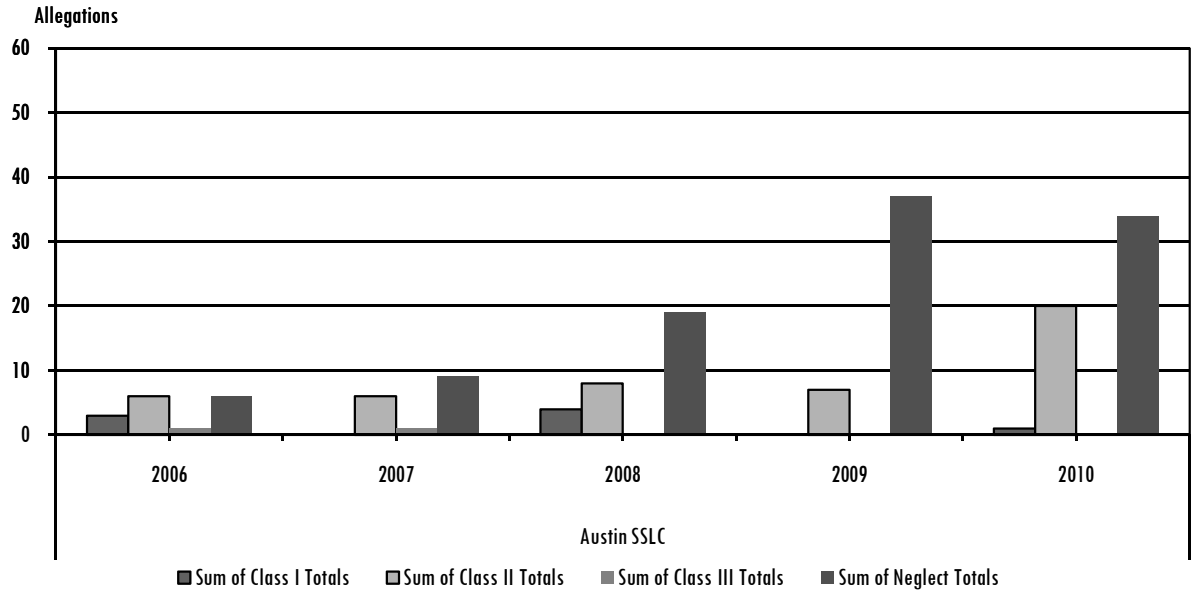
SOURCE: Texas Administrative Code, Title 40, Rule 711.425.

ABILENE STATE SUPPORTED LIVING CENTER



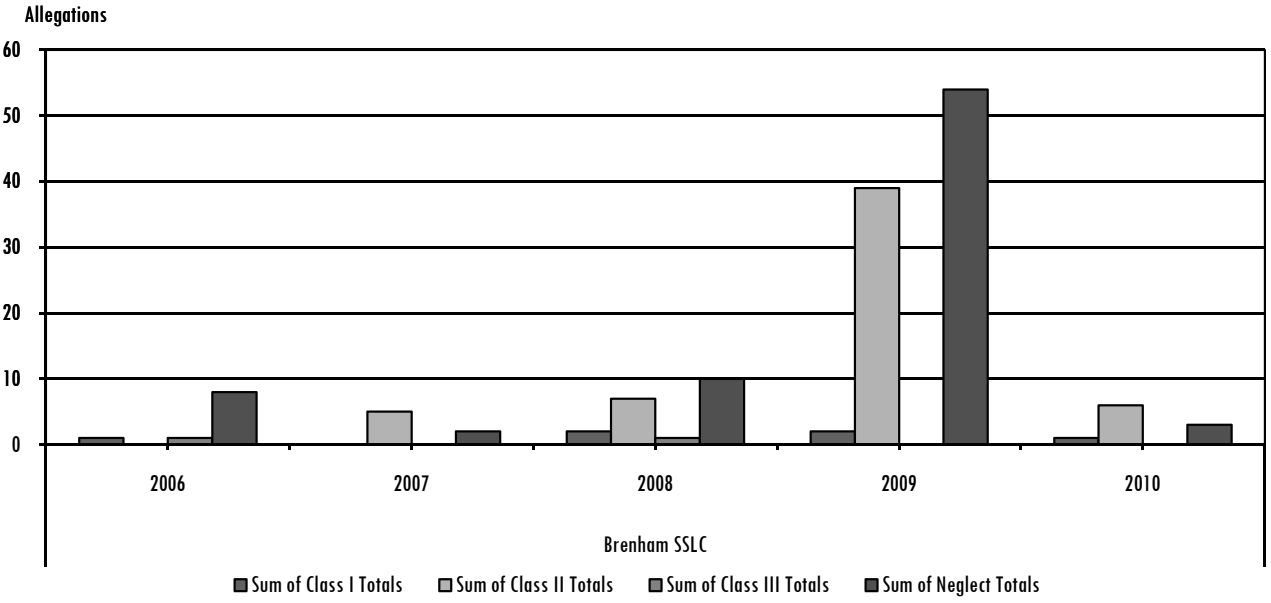
SOURCE: Texas Department of Family and Protective Services.

AUSTIN STATE SUPPORTED LIVING CENTER



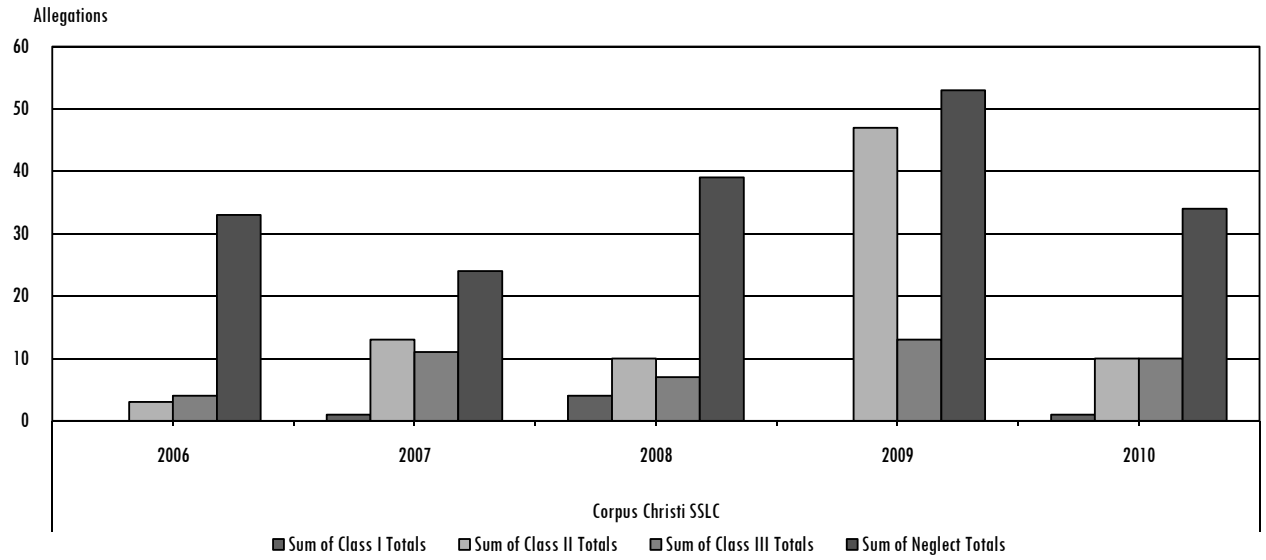
SOURCE: Texas Department of Family and Protective Services.

BRENHAM STATE SUPPORTED LIVING CENTER



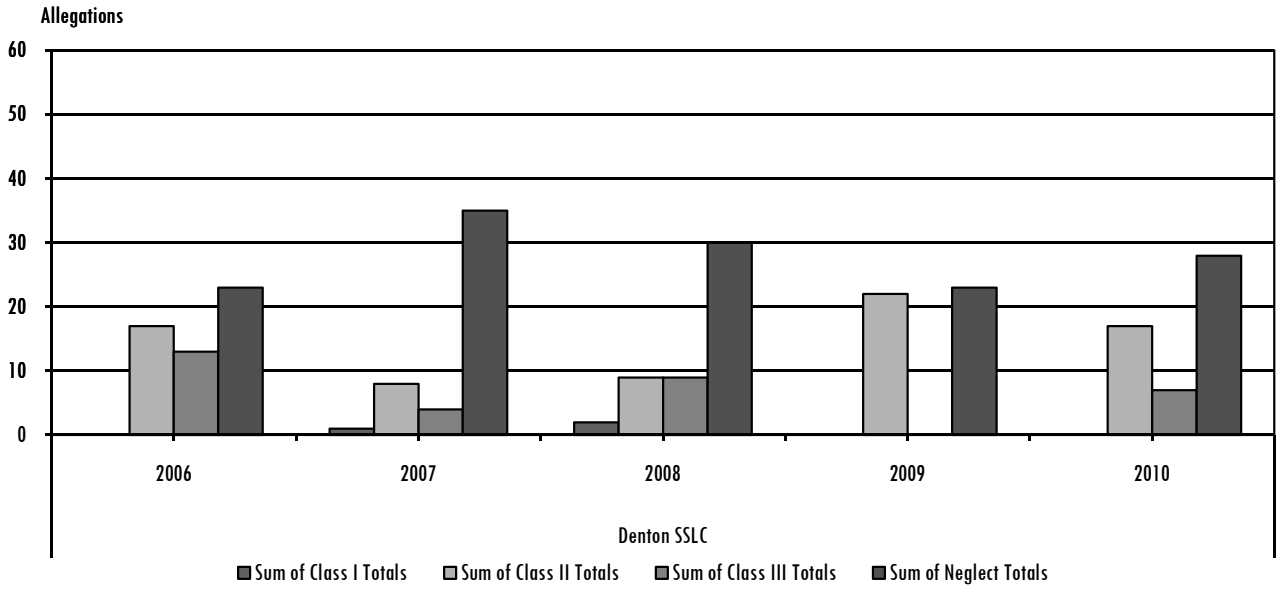
SOURCE: Texas Department of Family and Protective Services.

CORPUS CHRISTI STATE SUPPORTED LIVING CENTER



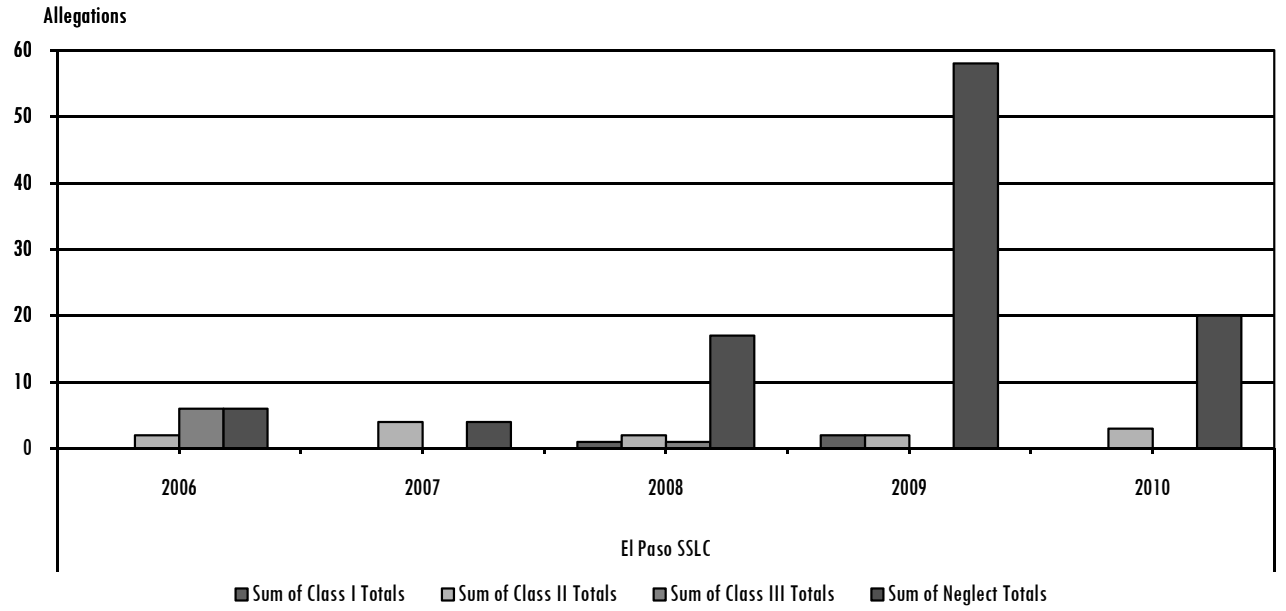
SOURCE: Texas Department of Family and Protective Services.

DENTON STATE SUPPORTED LIVING CENTER



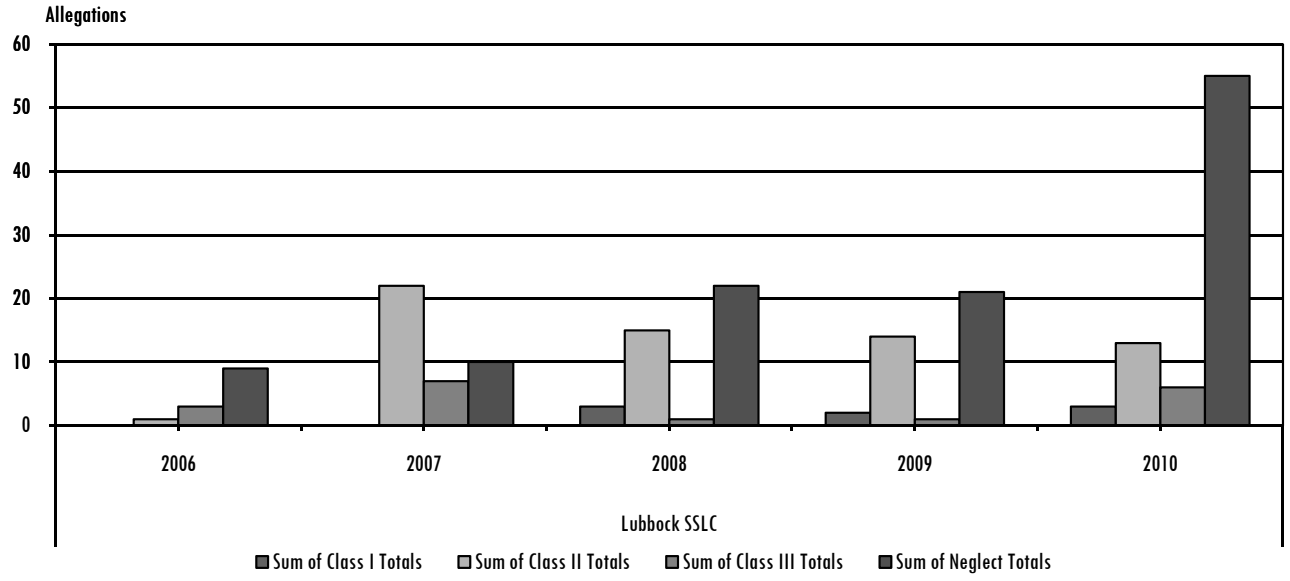
SOURCE: Texas Department of Family and Protective Services.

EL PASO STATE SUPPORTED LIVING CENTER



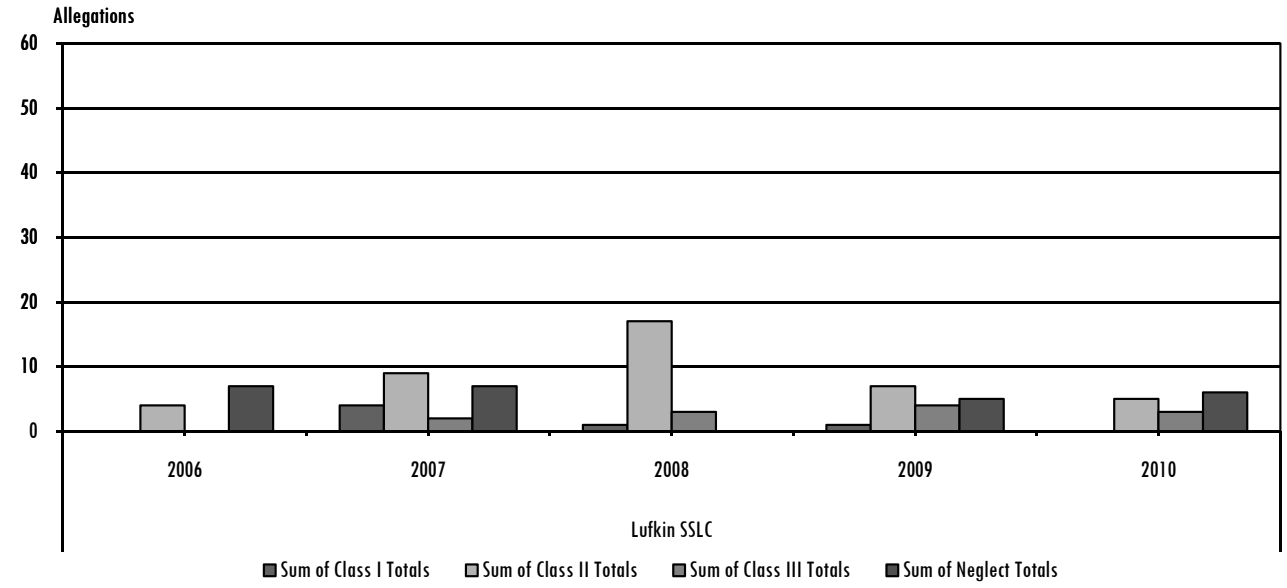
SOURCE: Texas Department of Family and Protective Services.

LUBBOCK STATE SUPPORTED LIVING CENTER



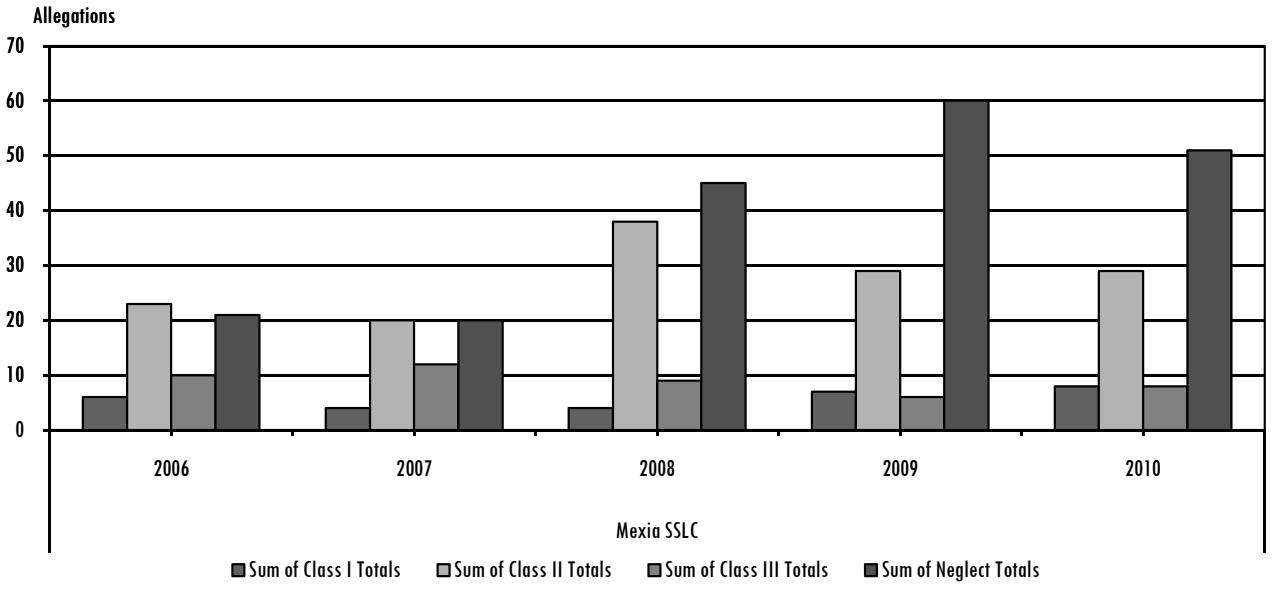
SOURCE: Texas Department of Family and Protective Services.

LUFKIN STATE SUPPORTED LIVING CENTER



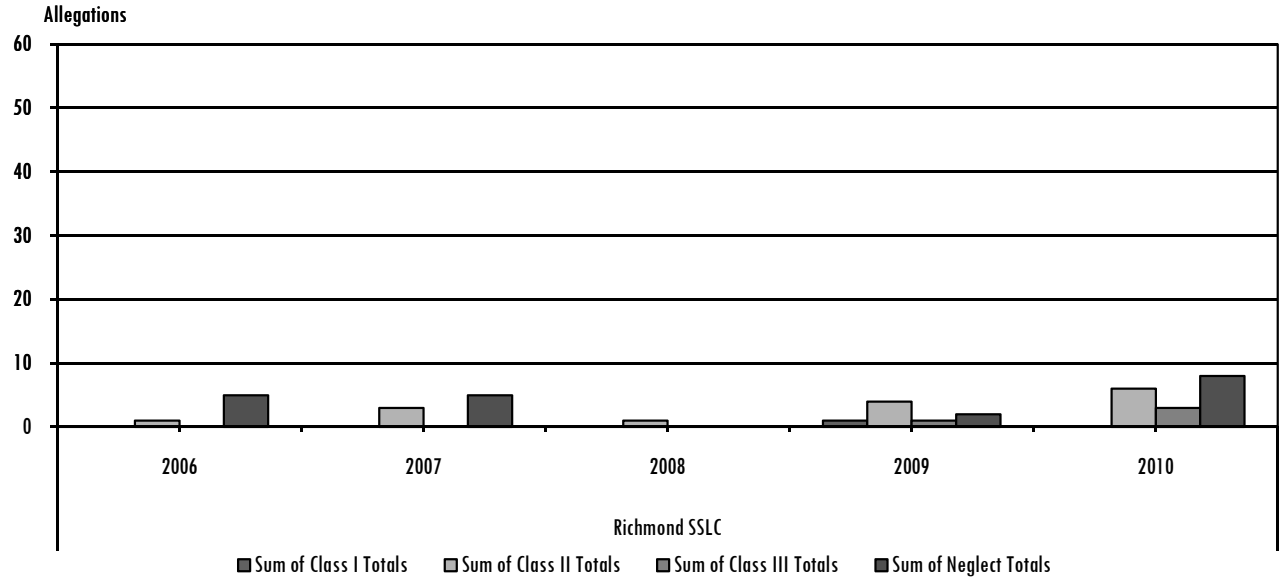
SOURCE: Texas Department of Family and Protective Services.

MEXIA STATE SUPPORTED LIVING CENTER



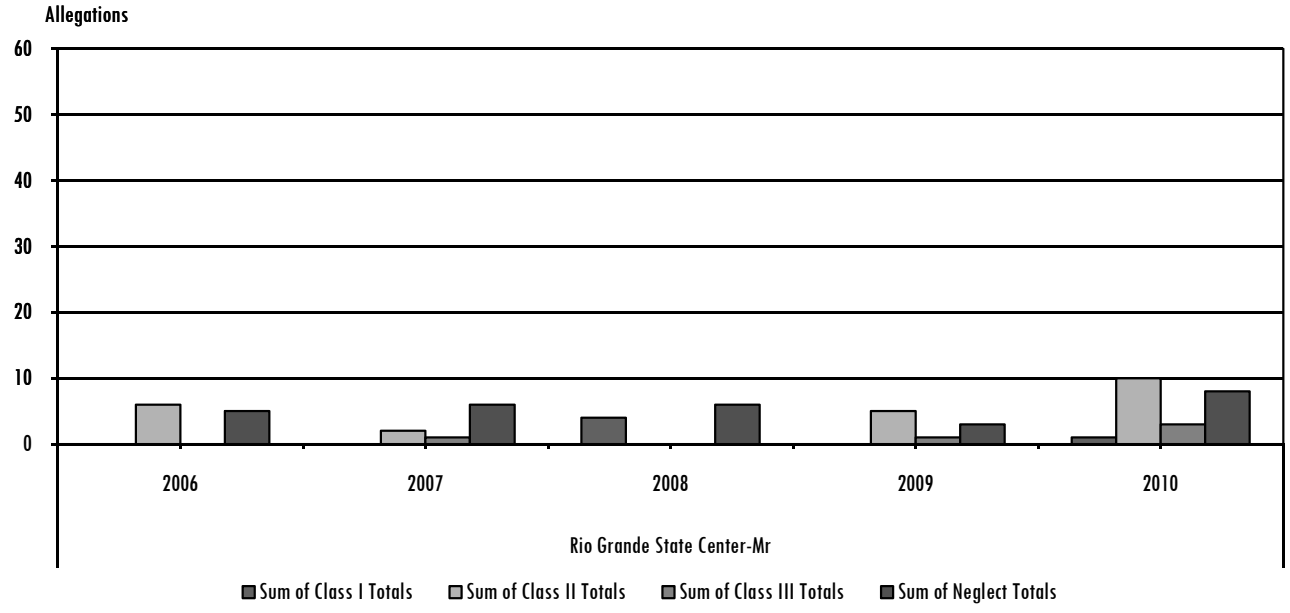
SOURCE: Texas Department of Family and Protective Services.

RICHMOND STATE SUPPORTED LIVING CENTER



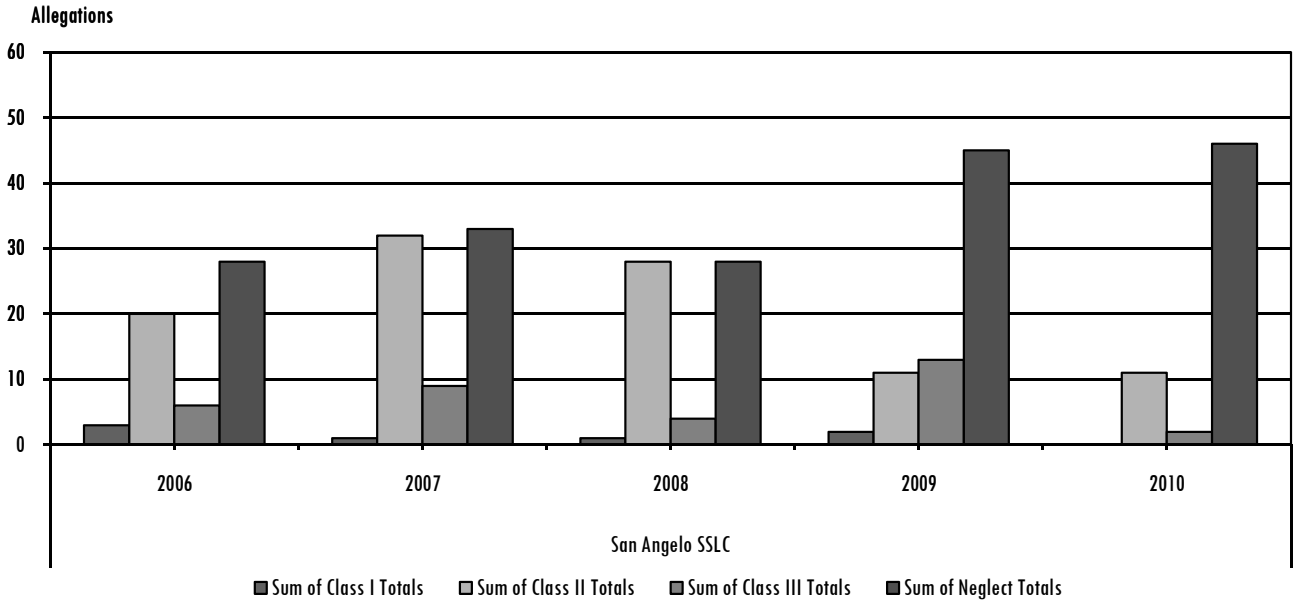
SOURCE: Texas Department of Family and Protective Services.

RIO GRANDE STATE SUPPORTED LIVING CENTER



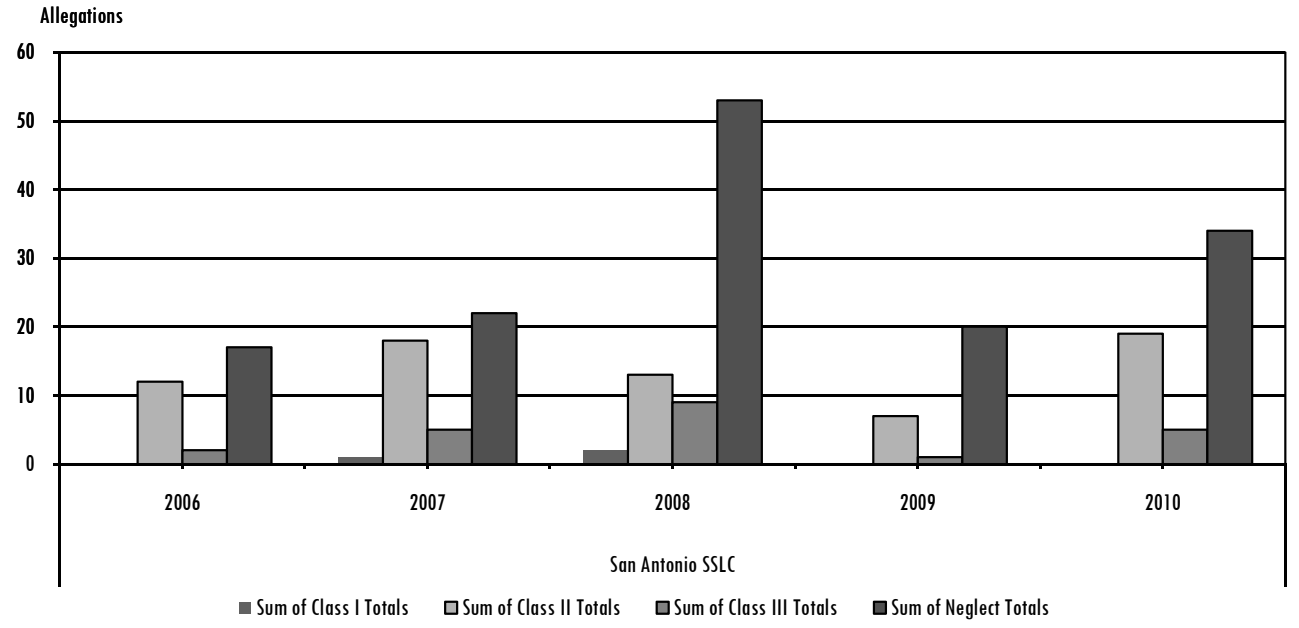
SOURCE: Texas Department of Family and Protective Services.

SAN ANGELO STATE SUPPORTED LIVING CENTER



SOURCE: Texas Department of Family and Protective Services.

SAN ANTONIO STATE SUPPORTED LIVING CENTER



SOURCE: Texas Department of Family and Protective Services.