

***FEASIBILITY STUDY FOR THE CLOSURE OF
STATE INSTITUTIONAL FACILITIES***

Part 3: Developmental Disabilities Facilities

APPENDICES

November 1, 2009

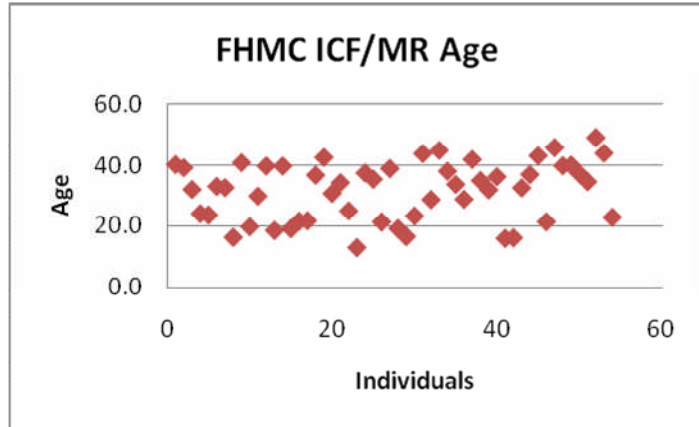
ATTACHMENTS

The following supportive documentation and materials are appended to this report as attachments

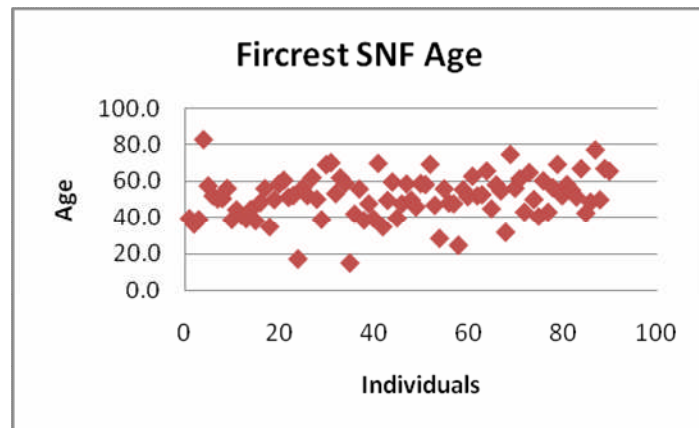
1. Age & Length of Stay data for people living in RHCs
2. Stakeholder Survey Findings
3. Description and analysis of RHC options
4. Affected Employee & Community Impact
5. Pricing Assumptions for people leaving RHCs
6. Financial impact statement for recommended options
7. Electronic files: three electronic files are contained in CD “Feasibility Study Workbooks” which are attached to this study. These files contain confidential information about people who live in the RHCs and staff who work in the RHCs. As such, these files are protected and access must be requested through OFM and / or DSHS. Electronic files are:
 - Microsoft Excel file: RHC staff data secure
 - Microsoft Excel file: RHC consumer database ALL secure
 - Microsoft Excel file: Downsizing worksheet MASTER 10/21/2009

ATTACHMENT #1: AGE AND LENGTH OF STAY DATA FOR PEOPLE LIVING IN THE RHCs

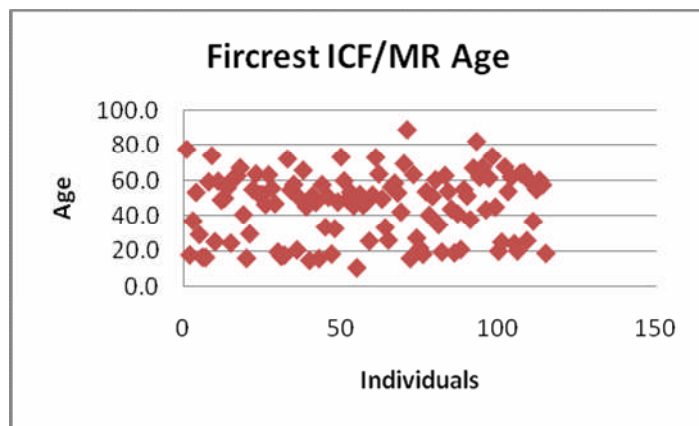
<i>FHMC</i>	<i>Age</i>
Mean	31.6
Standard Error	1.3
Median	33.3
Mode	#N/A
Standard Deviation	9.5
Sample Variance	91.2
Range	36.3
Minimum	12.8
Maximum	49.1
Sum	1705.9
Count	54.0



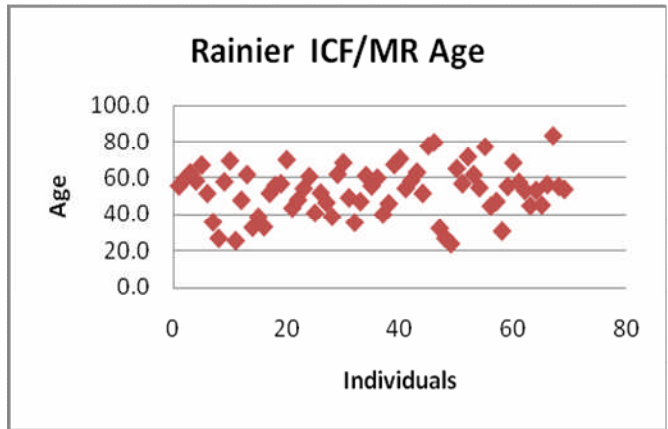
<i>Fircrest SNF</i>	<i>Age</i>
Mean	51.5
Standard Error	1.3
Median	51.9
Mode	56.2
Standard Deviation	12.3
Sample Variance	151.0
Range	68.1
Minimum	15.0
Maximum	83.1
Sum	4635.0
Count	90.0



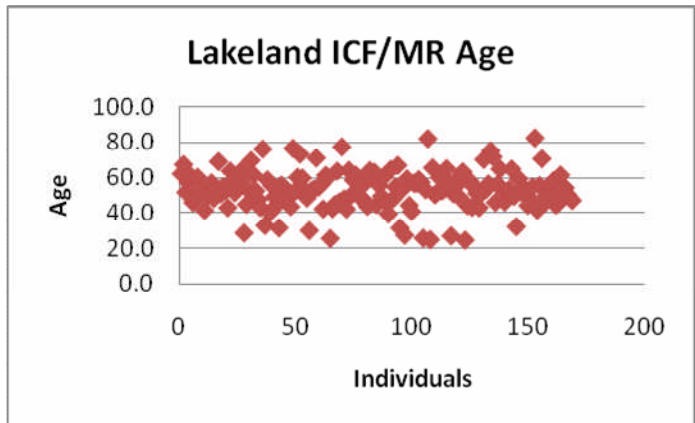
<i>Fircrest ICF/MR</i>	<i>Age</i>
Mean	45.8
Standard Error	1.7
Median	49.9
Mode	51.9
Standard Deviation	18.5
Sample Variance	342.5
Range	78.7
Minimum	10.2
Maximum	89.0
Sum	5265.8
Count	115.0



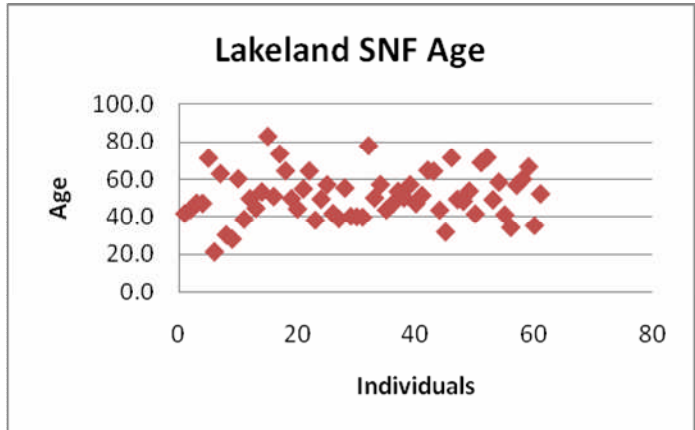
<i>Rainier ICF/MR</i>	<i>Age</i>
Mean	54.5
Standard Error	0.6
Median	55.7
Mode	63.0
Standard Deviation	11.6
Sample Variance	135.6
Range	69.3
Minimum	21.7
Maximum	91.0
Sum	20728.2
Count	380.0



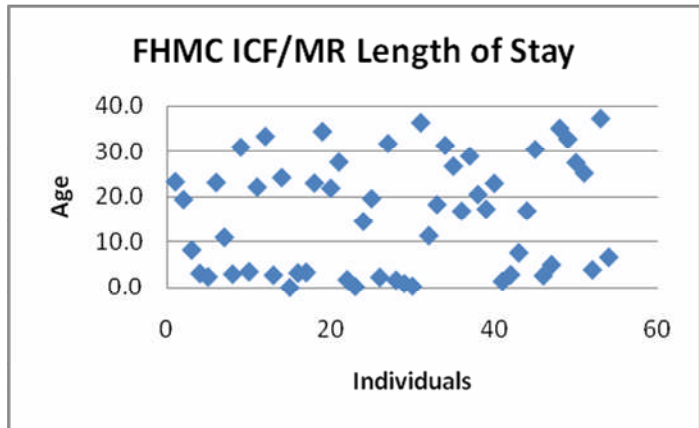
<i>Lakeland ICF/MR</i>	<i>Age</i>
Mean	53.0
Standard Error	1.0
Median	53.0
Mode	#N/A
Standard Deviation	11.1
Sample Variance	124.3
Range	57.5
Minimum	24.9
Maximum	82.4
Sum	6099.6
Count	115.0



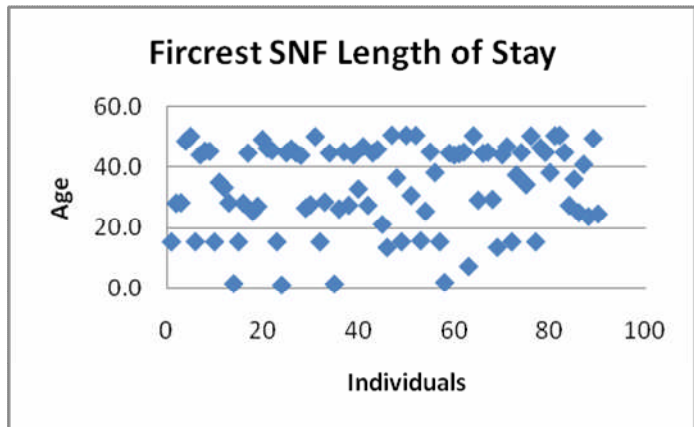
<i>Lakeland SNF</i>	<i>Age</i>
Mean	51.4
Standard Error	1.6
Median	50.0
Mode	#N/A
Standard Deviation	12.7
Sample Variance	160.1
Range	61.6
Minimum	21.5
Maximum	83.2
Sum	3137.7
Count	61.0



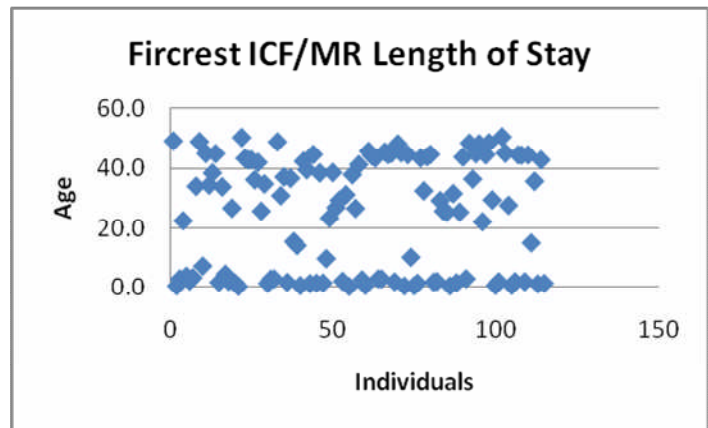
<i>FHMC ICF/MR</i>	<i>Length Stay</i>
Mean	30.1
Standard Error	1.5
Median	35.1
Mode	5.4
Standard Deviation	13.8
Sample Variance	190.4
Range	48.8
Minimum	1.0
Maximum	49.7
Sum	2650.1
Count	88.0



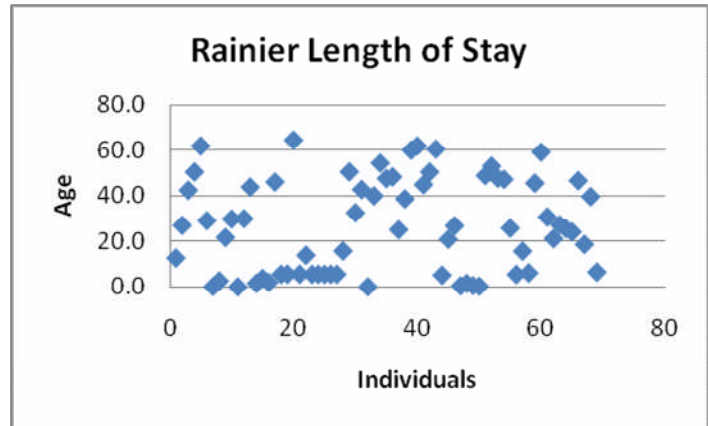
<i>Fircrest SNF</i>	<i>Length Stay</i>
Mean	33.8
Standard Error	1.5
Median	37.0
Mode	15.3
Standard Deviation	14.0
Sample Variance	196.9
Range	49.6
Minimum	1.0
Maximum	50.6
Sum	3045.4
Count	90.0



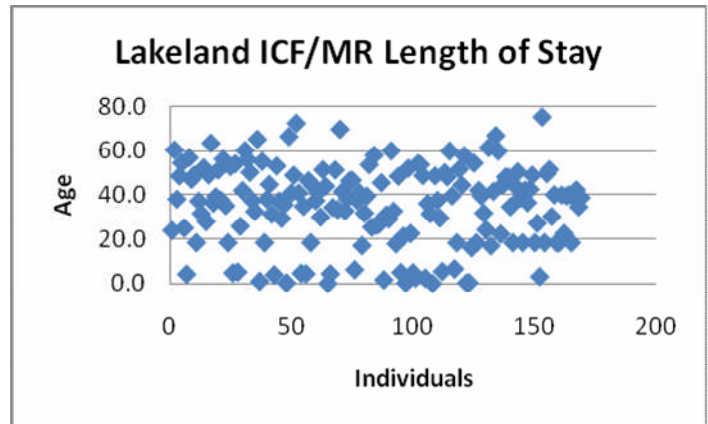
<i>Fircrest ICF/MR</i>	<i>Length Stay</i>
Mean	24.4
Standard Error	1.8
Median	29.2
Mode	0.3
Standard Deviation	18.9
Sample Variance	357.9
Range	50.5
Minimum	0.1
Maximum	50.6
Sum	2810.1
Count	115.0



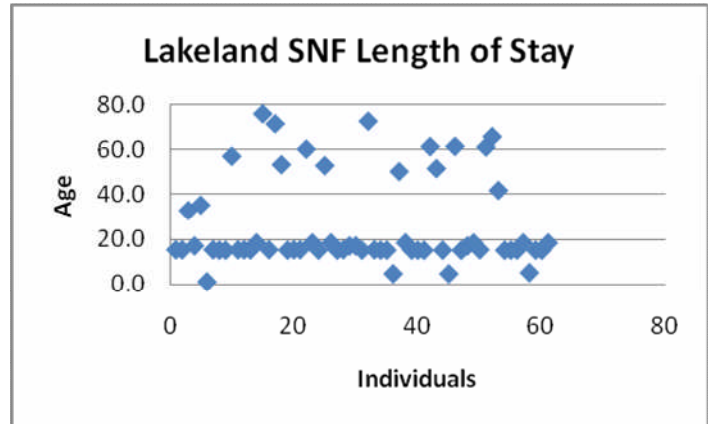
<i>Rainier ICF/MR</i>	<i>Length Stay</i>
Mean	33.3
Standard Error	1.0
Median	36.2
Mode	5.6
Standard Deviation	19.5
Sample Variance	380.1
Range	69.8
Minimum	0.1
Maximum	69.9
Sum	12652.8
Count	380.0



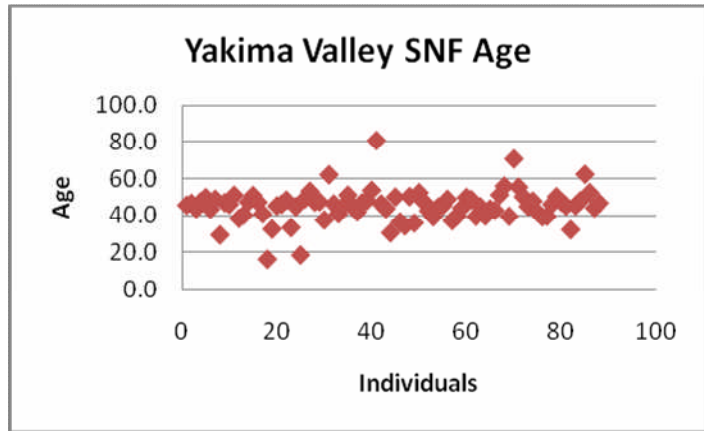
<i>Lakeland ICF/MR</i>	<i>Length Stay</i>
Mean	37.9
Standard Error	2.3
Median	38.3
Mode	18.5
Standard Deviation	18.2
Sample Variance	332.8
Range	72.3
Minimum	0.4
Maximum	72.7
Sum	2309.5
Count	61.0



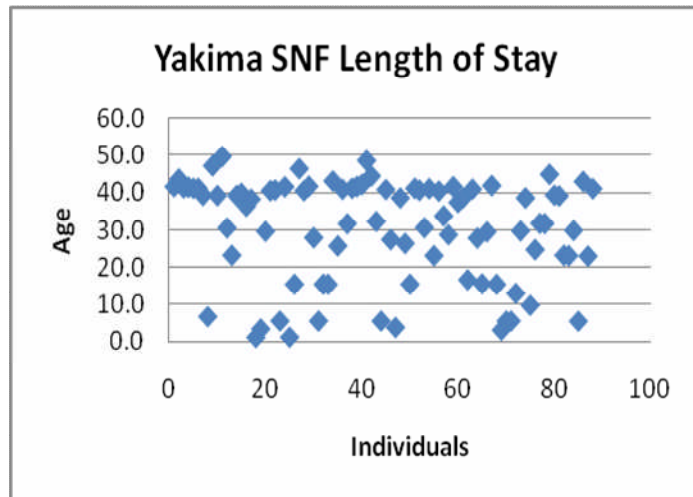
<i>Lakeland SNF</i>	<i>Length Stay</i>
Mean	25.9
Standard Error	2.5
Median	15.5
Mode	15.2
Standard Deviation	19.8
Sample Variance	390.9
Range	74.7
Minimum	1.3
Maximum	76.0
Sum	1581.2
Count	61.0



<i>Yakima Valley SNF</i>	<i>Age</i>
Mean	45.2
Standard Error	0.9
Median	45.8
Mode	#N/A
Standard Deviation	8.7
Sample Variance	74.9
Range	64.0
Minimum	16.4
Maximum	80.4
Sum	3977.8
Count	88.0



<i>Yakima Valley SNF</i>	<i>Length Stay</i>
Mean	30.1
Standard Error	1.5
Median	35.1
Mode	5.4
Standard Deviation	13.8
Sample Variance	190.4
Range	48.8
Minimum	1.0
Maximum	49.7
Sum	2650.1
Count	88.0



ATTACHMENT #2: STAKEHOLDER SURVEY FINDINGS

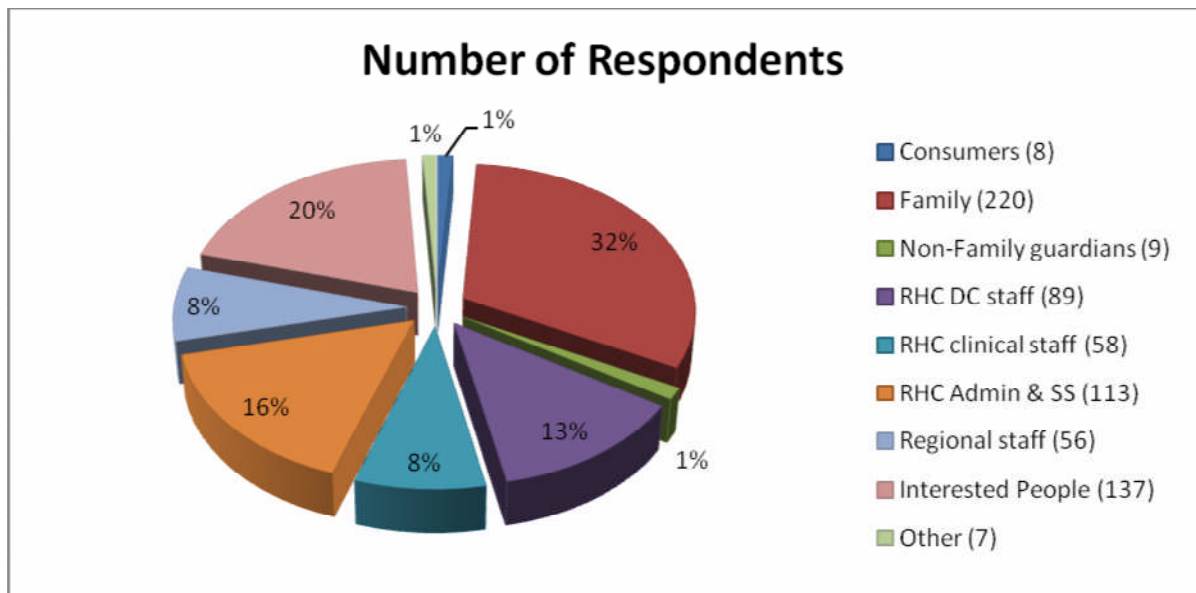
SURVEY FINDINGS FUTURE OF DD RESIDENTIAL HABILITATION CENTERS SEPTEMBER 2009

PURPOSE OF THE SURVEY

This survey is one piece of a larger stakeholder input process for a Washington State Legislative study requested by the 2009 legislative session; this study is to examine the feasibility of reducing adult corrections, juvenile rehabilitation, and developmental disabilities institutional capacity. This survey relates specifically to developmental disabilities residential habilitation centers (RHC). Stakeholder input included holding structured focus groups at every RHC with consumers, families, staff and community leaders and asking a set of questions. These questions were then made available in this survey, via web, electronic and paper versions, to other interested people who did not attend the focus groups. The survey was not designed to capture a statistically valid sample, but rather to be used in conjunction with other stakeholder input to capture as many diverse perspectives as possible.

RESPONDENTS TO SURVEY

There were 697 total respondents to this survey. Respondents to the survey broke roughly in half with DD staff representing 45% of the responses, and families/consumers/legal guardians and interested persons (includes advocates) providing the other 54%. Families, consumers, and guardians were 34%; interested persons were 20%.



FINDINGS FROM THE DATA ARE PRESENTED BELOW IN THESE CATEGORIES

- Family member/family guardian and consumers that use RHC services
- RHC staff including direct care, clinical and support staff
- DSHS/DDD Regional staff
- Interested persons including advocates, community leaders, providers and others
- Family member/guardian and consumers currently in community or SOLA settings
- Individuals who have recently moved from an RHC to a SOLA or a community setting

FAMILY MEMBERS /FAMILY GUARDIANS & CONSUMERS WHO USE RHC SERVICES

1. Families and consumers currently using RHC services for either long or short term care, including respite care, reported positively on a number of their experiences with RHC services. Of these respondents:
 - - 100% reported feeling safe at the RHC
 - 100% reported that staff were knowledgeable of their needs
 - 89% indicated that the staff working with them had been with them for 2 years or more
 - 90% indicated liking the staff that worked with them
 - 92% said they received services when needed
 - 98% felt they received good medical care
 - Only 35% agreed they can choose their roommates, with 29% reporting that they were not able to choose
 - 81% indicated that their friends lived at the RHC
 - 83% reported being able to participate in community, social events
 - 85% agreed they had fun activities to do while at the RHC
 - 98% indicated the family could visit easily, and
 - A lower percent, 59%, reported that they earned money while at the RHC, while 29% stated that they did not
2. When asked what families/consumers disliked about their long term living situation at the RHC, there was a low number of responses, 15; the concerns were split fairly evenly between: *not being able to choose a roommate, having too few community outings*, and six write-in answers indicating *dislike of the threats to close the RHC*.
3. When asked to rank the most important items in relation to their long-term placement, RHC users indicated their highest ranking four items in order of importance were:
 - *Safety*
 - *24/7 supervision*
 - *Knowledgeable/trained staff, and*
 - *Consistent staff.*
 -

4. There was minimal support for reducing RHC size from the RHC users who answered, “What do you think the RHC’s should look like in 10 years.” Eighty-eight percent felt there should be no change or some type of expansion. The following chart shows all responses.

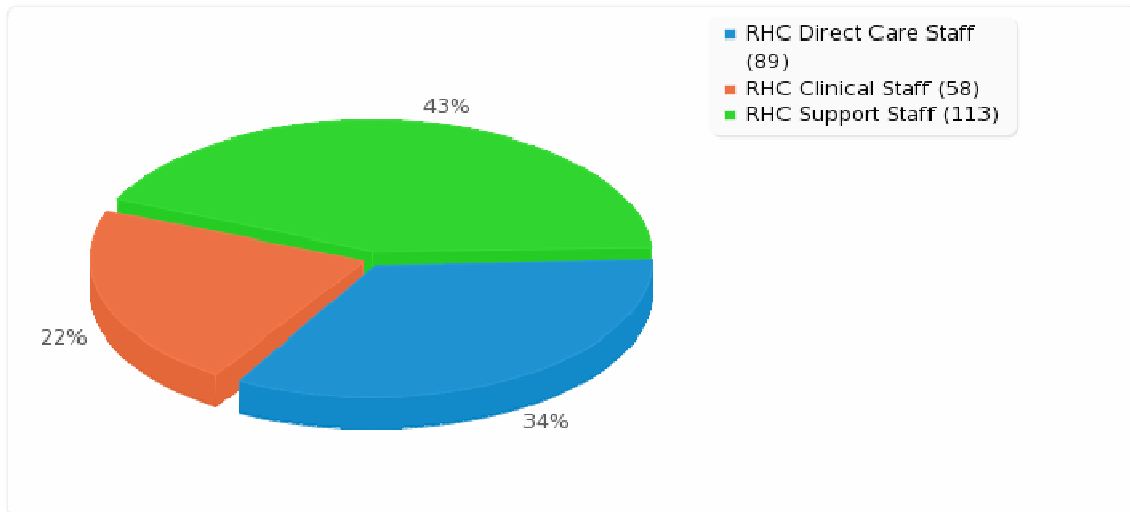
IN 10 YEARS FROM NOW, WHAT DO YOU THINK THE RHC’S SHOULD LOOK LIKE? (FAMILY/GUARDIAN/CONSUMER RESPONSES)	PERCENT RESPONSE
No change from now	63%
Other – write ins indicating an expansion in size or services offered by RHC	25%
RHC’s would provide emergency & respite community support service only	5%
A network of SOLA like homes would replace RHC’s	3.5%
Do not know	3.5%
Totals	100%

5. To the question “If you or your family member currently lives in an RHC and were approached by DDD to consider **community placement**, what would you say”, 75% answered, “No way; do not ask again.”

Only 14% of the respondents currently using RHC services would be willing to consider community placement if approached by DDD; with 5% selecting “Maybe, I would like to check my options” and 9% selecting “Not at this time; ask me again later.”

6. If the RHC’s were gone, the most frequently chosen supports that would be needed to make the transition to the community were the following in order of importance to the respondents:
- *Personal safety and protection*
 - *“Fail-safe” right of return to the RHC*
 - *Access to health and behavior supports*
 - *Staff training and knowledge*
 - *Living close to family and friends*
7. If their current RHC were to close, families and consumers ranked their preferences for where they would move. There was a strong preference expressed for some type of state provided service.
- For 87% of the respondents, their first choice was to move to another RHC,
 - And for 8%, their first choice was a SOLA with health care staff and programs.
 - For the second choice of placement, the most frequently chosen were the SOLA with health care staff and programs (50%) and the SOLA (25%).
 - For the third choice, the two SOLA options represented 69% of the total with private DD community programs selected 18% of the time.

1. A total of 260 staff responded to the survey as follows:



2. A significant number of RHC staff (66% of the people responding to this question) reported that the most important aspect of their current job was working with the people with disabilities that they supported. Another 16% ranked this same item as their second highest ranking.

RANK THE MOST IMPORTANT ASPECTS OF YOUR JOB-RANKED # 1	PERCENT
People with disabilities whom I support	66%
Employment stability; my tenure and retirement	10%
Work duties; what I do on a daily basis	8%
Sense of personal contribution; self worth	7%
Colleagues; the people with whom I work	4%
Organizational identity; my pride in the organization	3%
Compensation; how much I get paid	2%
Totals	100%

For their second and third most important aspects, staff ranked *work duties* and *sense of personal contribution* equally highly, followed by *employment stability*.

3. When asked what future employment options they would consider if the RHC were to close, the most frequently noted options included the following with the top four choices being state funded positions. Each person could select more than one option:

- - Find another state position still working in the developmental disabilities field (103),
 - Find another state position outside the developmental disabilities field (90),
 - Transfer to another RHC (71),
 - Transfer to a SOLA or SOLA-like program (56),
 - Find a private position outside the developmental disabilities field (44),
 - Stop working for the time and / or retire (36),

- *Transfer to a community provider operating in your local area (30), and*
 - *Start a private business to support some of the people currently in your care (14).*
4. When asked about the future of RHC's in 10 years, 44% favored keeping the RHC's as they are now. A majority of the "other" comments, which were at 30%, also indicated keeping some or all of the RHC's in place while adding or increasing other activities such as respite, emergency placements and providing other support services.

IN 10 YEARS FROM NOW, WHAT DO YOU THINK THE RHC'S SHOULD LOOK LIKE? (RHC STAFF)	PERCENT RESPONSE
No change from now	44%
RHC's would no longer exist and be replaced by private community providers	3%
A network of SOLA like homes would replace RHC's	5%
RHC's would provide emergency & respite community support service only	15%
RHC's would provide clinical health and behavioral outreach services only	3%
Other	30%
Totals	100%

DSHS/DDD REGIONAL STAFF

1. When asked about the future of RHC's in 10 years, there was some support from DD Regional staff for reducing RHC size, and, in particular, to use them to provide emergency and respite support (25%), and to provide health and behavioral outreach (11%). In addition, 20% indicated their preference as "no change."
- - A quarter of the respondents chose "other", and these comments ranged from expanding the RHC's (2 people) to combining several of the choices, so that RHC's would continue some residential capacity while expanding services to people placed in the community.

IN 10 YEARS FROM NOW, WHAT DO YOU THINK THE RHC'S SHOULD LOOK LIKE? (DDD REGIONAL STAFF RESPONSES)	PERCENT RESPONSE
No change from now	20%
RHC's would no longer exist and be replaced by private community providers	7.5%
A network of SOLA like homes would replace RHC's	9.5%
RHC's would provide emergency & respite community support service only	25%
RHC's would provide clinical health and behavioral outreach services only	11%
Other	27%
Totals	100%

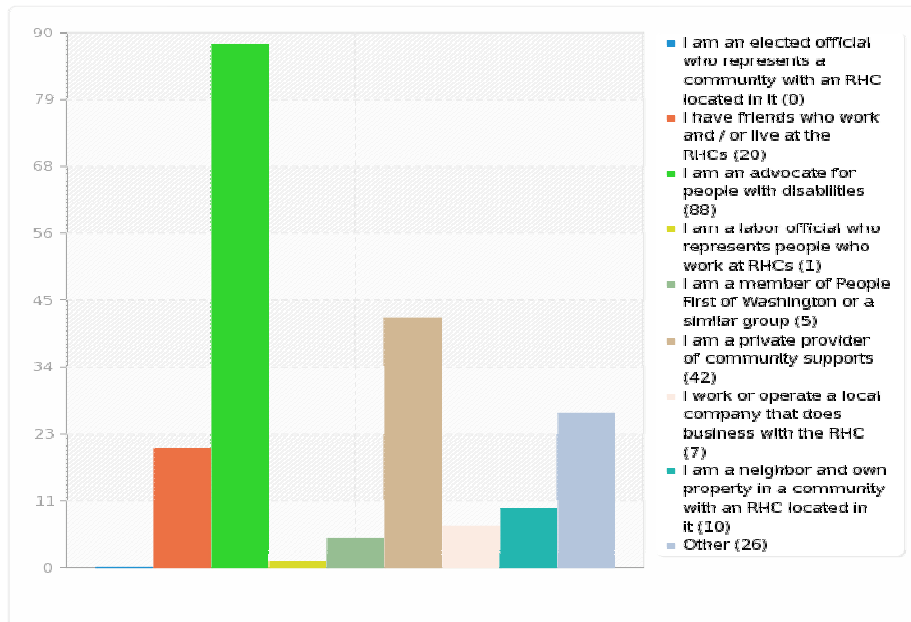
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- Over half (54%) of Regional staff indicated that closure of RHC beds will negatively affect their work with people and their families by removing a critical part of the DD network and safety net. An additional 12% indicated that they would lose a staff training/consultation source. Four of the seven “other” comments expressed the concern that they would lose their job.

HOW WOULD CLOSURE OF AN RHC AFFECT YOUR WORK? REGIONAL STAFF RESPONSE	DDD	PERCENT RESPONSE
The RHC serves as a safety net for some of the people I serve and I would lose a resource of emergency and short-term placements.		28%
The RHC is a critical part of the DDD service network that I manage		26%
It would not change how I deliver services		15%
I would lose a source of staff training and clinical consultation		12%
I would use the funds from the RHC closure to purchase short-term and emergency supports from private contract agencies		4%
I would use the funds from the RHC closure to purchase staff training and clinical consultation from private contract agencies		4%
I no longer need to use RHC services and they should be closed		1%
Other		10%
TOTALS		100%

INTERESTED PEOPLE

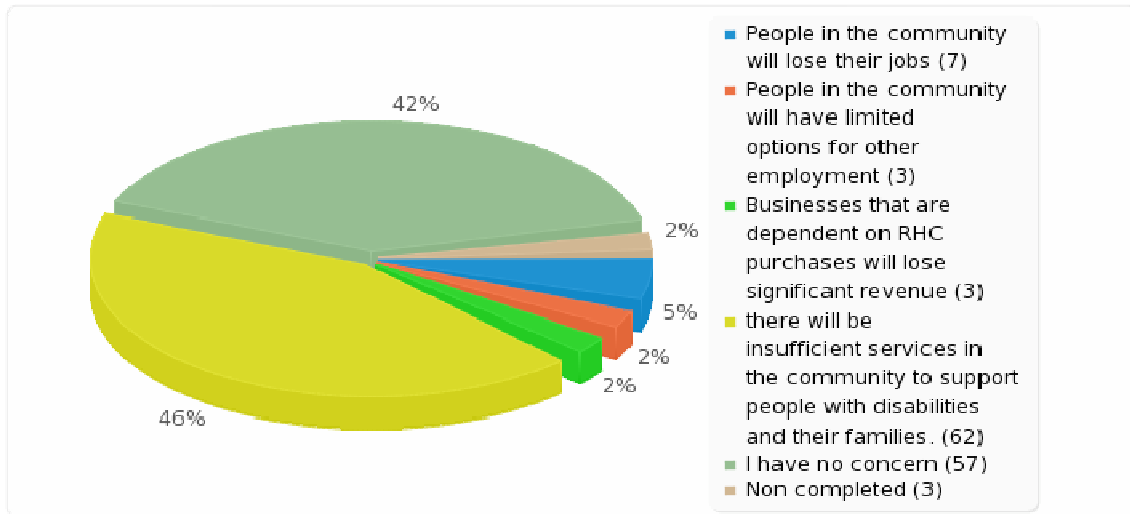
- This category included advocates, providers, neighbors of RHC’s, friends of consumers and families, and local businesses in RHC communities. The breakdown of respondents is shown in the chart below.



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-
- 2. The responses from interested persons to the question of what RHC's should look like in 10 years differ substantially from the RHC families'/consumers' and staff responses. Almost half (46%) of the respondents to this question indicated that RHC's should no longer exist and be replaced by community providers. Only 10% saw no change from the current use.
-

IN 10 YEARS FROM NOW, WHAT DO YOU THINK THE RHC'S SHOULD LOOK LIKE? (INTERESTED PERSONS)	PERCENT RESPONSE
No change from now	10%
RHC's would no longer exist and be replaced by private community providers	46%
A network of SOLA like homes would replace RHC's	12%
RHC's would provide emergency & respite community support service only	16%
RHC's would provide clinical health and behavioral outreach services only	7%
Other (most indicated a combination of the change options above)	9%
Totals	100%

-
-
- 3. When asked to rank what their greatest hopes would be if the RHC in their community closed, interested persons chose “*the quality of life for people/families with disabilities will improve*” most frequently. Sixty-two percent (62%) of the completed responses to this question chose this as their number one ranking. The list below shows this and the other items chosen in order of preference:
 - *The quality of life for people/families with disabilities will improve,*
 - *Savings from RHC closures will be directed to unserved people in the local community*
 - *Other private programs will be created to meet the needs of people with disabilities*
 - *Other state programs will be created to meet the needs of people with disabilities*
-
-
- 4. When asked to rank what their greatest concerns would be if the RHC in their community closed, the majority of interested persons chose one of two items for their highest rank: “*there will be insufficient services in the community to support local people and family members with disabilities*” (46% of the responses), or “*I have no concern*” (42%). After these two, the next highest area of concern in the following rankings was a combination of people in the community either losing their job or having limited employment options. The following chart shows the items ranked #1.



FAMILIES/CONSUMERS CURRENTLY IN COMMUNITY OR SOLA SETTINGS

1. This respondent group had 45 individuals with 44 living in community settings, and one living in a SOLA.
2. When asked what RHC’s should look like 10 years from now, this group’s responses were most like the responses of “other interested people” in that the majority (55%) indicated that RHC’s should no longer exist and be replaced by private providers. There was some interest in RHC’s providing emergency and respite services or other community support services, which were also mentioned in the “other” responses.

WHAT SHOULD HAPPEN TO RHC’S? FAMILIES/CONSUMERS IN COMMUNITY SETTINGS RESPONSES	PERCENT RESPONSE
No change from now	15%
RHC’s would no longer exist and be replaced by private community providers	55%
A network of SOLA-like homes would replace the current RHC’s	5%
RHC’s would provide emergency and respite community support service only	7.5%
RHC’s would provide clinical health and behavioral outreach services only	2.5%
Other	15%
Totals	100%

INDIVIDUALS WHO HAVE RECENTLY MOVED FROM AN RHC TO A SOLA OR COMMUNITY SETTING

Since there were only 5 respondents in this category, there was limited data. Based on these individuals' experiences, the top four supports needed for a successful transition from RHC to community were:

- Long term sustainability of the program,
- Living close to family and friends,
- Familiar direct care staff, and
- Quality assurance accountability.

ATTACHMENT #3: DESCRIPTION AND ANALYSIS OF RHC OPTIONS

A description and analysis of each RHC option is presented in this attachment.

Option #1: Maintain current status:

In this option, each of the RHC's remain open and continue to receive short-term emergency and respite admissions only. Clinical outreach to people living at home by RHC staff remains limited. Capital facility costs are focused on minor works repair and maintenance expenses. Growth in community supported living programs is not projected to keep pace with new people waiting to enter the DD system let alone address people wishing to leave the RHCs. The projected impact of this option is three-fold.

First using attrition only, the RHC bed capacity is projected to decrease from the current 2009 capacity of 976 people to a projected capacity of 963 people in 2014 and 950 people in 2019. Primary reductions would occur at Fircrest, Rainier, Yakima, and Lakeland where the population is older. Given the projected decrease, consolidation of FHMC and Lakeland SNF beds could occur at Fircrest and Yakima by 2012.

Second, if Washington does not fill behind attrition-caused vacancies, the annual per capita cost of supporting people in the RHCs will continue to rise significantly. As the RHC capacity decreases, economy-of-scale factors and facility fixed costs will drive per capita cost up. A review of other neighboring states' financial experiences (Idaho and Montana) suggests that per capita costs could rise by 29.6% by 2014 and 67.9% by 2019. These higher per person costs will be offset by the reduction in the number of people served.

Third, if the current practice of admitting new younger people to attrition-caused vacancies is continued, Washington will be creating a new generation of RHC consumers. The current practice of admitting people to the RHC's on a short-term basis has created a defacto long-term admission. A review of recent short-term admissions reveals that people are transitioned to long-term status after an average stay of eleven (11) months at the RHC. In effect, the generation of people who entered the RHCs as children in the 1960's will be replaced by the generation of people entering the RHCs in the 2000's. Without substantial growth in community capacity, RHC's will remain a viable option to people who otherwise would be without services.

This option was considered but not accepted. Specifically, the study team found that quality of care and supports can be equaled or exceeded in community supported living programs and that future people enrolling in state services will want options to live in their communities.

Option #2: Close all RHCs and expand existing community system:

In this option, each of the RHC's close entirely and state-operated residential care is eliminated. This option has the overall impact of reducing approximately 2,720 full-time staff; 62% of the RHC staff are direct care workers and 18 % of the staff are clinicians. The remaining 20% of the staff provide administrative and program supervision, and plant maintenance and housekeeping / laundry supports. The projected impact of this option has two key points.

First, there are insufficient opportunities for re-employment within the field of developmental disabilities. Experience in other states is that an estimated 60% of former RHC professionals and direct care staff leave the field of disabilities for careers in other health care professions. In effect, there is a significant loss of experience and expertise.

Second, other states have aggressively closed their entire state-operated programs and report continued quality of care. There appear to be two keys to success. In some states like Indiana and the District of Columbia, there is an underlying private ICF/MR network which accepts people which otherwise were served by state-operated programs. In effect, private institutions replaced state institutions. Additionally, in states which do not rely on private ICF/MR agencies (such as Arizona), those states have “zero reject” policies which require community providers to offer services to all people referred regardless of the complexity of their needs. In those instances, community providers are required to serve as their own “back up” and cannot discharge people or refuse admission except in those instances when they have no vacancies.

This option was also considered and partially accepted. The study team found that the expertise of state clinical and program staff was critical to both people leaving RHCs as well as people wishing to stay in their communities. Also, the team found that Washington uses its RHCS as the “zero reject” option. Should the “zero reject” option and the clinical /program support not be available through the RHCs, there does not appear to be a ready solution to address that gap.

Option #3: Close SNF program and expand community capacity and diversity:

In this option, the SNF portion of the RHCs is closed and people are moved to alternative programs in the community. Historically, Washington has used intensive tenant support programs or other RHCs to accommodate RHC downsizing. Approximately 60% of the people leaving Interlake School (an RHC for medically-intensive need people) transferred to Lakeland or Fircrest in 1994. The recent legislative initiative to close Yakima Valley and relocate people to local nursing homes revealed that the community SNF agencies were not equipped to support people with developmental disabilities. The primary consideration for this option was Washington’s interest in creating new alternative community nursing programs using the HCBS waiver.

This option was considered and partially accepted. The team found that quality of care could not be consistently maintained or exceeded by the current menu of community options, and that this option did not immediately pass the quality of care test. The team believes that Washington does not have a sufficient range of community-based health options for people wishing to remain in their own neighborhoods, and that the future market for people wishing to age-in-place is increasing. The team recommends that Washington expand and develop community –based residential health options. Because these are new programs and because of perceptions of “transfer trauma”, the team recommends that Washington use state employees to initially open and operate the community health homes. The study team also found that a number of people currently living at Rainier, Fircrest, and Lakeland were admitted to those agencies at a young age and have lived at the RHCs for over 40 years. The team also recommends that Washington respect the choices made by people who entered RHCs some time ago. To accomplish that point,

the team recommends that at small number of SNF beds be retained at Fircrest (for western Washington), Yakima Valley (for central Washington), and Lakeland (for eastern Washington).

Option #4: Close ICF/MR program and expand community capacity and diversity:

In this option, the ICF/MR portion of the RHCs is closed and people are moved to alternative programs in the community. Nationally, ICF/MR programs have proved costly and over regulated. States such as Oregon, Montana, and Arizona have eliminated or never had ICF/MR programs. The District of Columbia and Wisconsin are aggressively transitioning (or have transitioned) their small ICF/MR programs to HCBS waivers. It is the belief in these states that ICF/MR regulations inhibit community inclusion and self-directed choice.

This option was considered and accepted. The team found that RHC ICF/MR quality of care is equally maintained or exceeded by the current community supports system. This option passes the quality of care test. The team believes that Washington should redirect its resources away from the ICF/MR programs and continue its aggressive use of a wide variety of HCBS waivers and associated funding. The team found a substantial market for community supports, and encourages Washington to expand its range of supported living options for people wishing to remain in their own neighborhood. The team recommends that Washington expand and develop community –based residential health options. The study team did however recognize that Washington does not have a “zero reject” system in its community program, and therefore recommends that a small number of beds be retained at Rainier and Lakeland for people with co-existing mental health and disability needs and people who present risks to their communities. The team found that people with these conditions were in most need of fail-safe back-up support.

Option #5: Retain RHC short-term / respite capacity and clinical outreach services and shift RHC resources to state-operated community residential supports

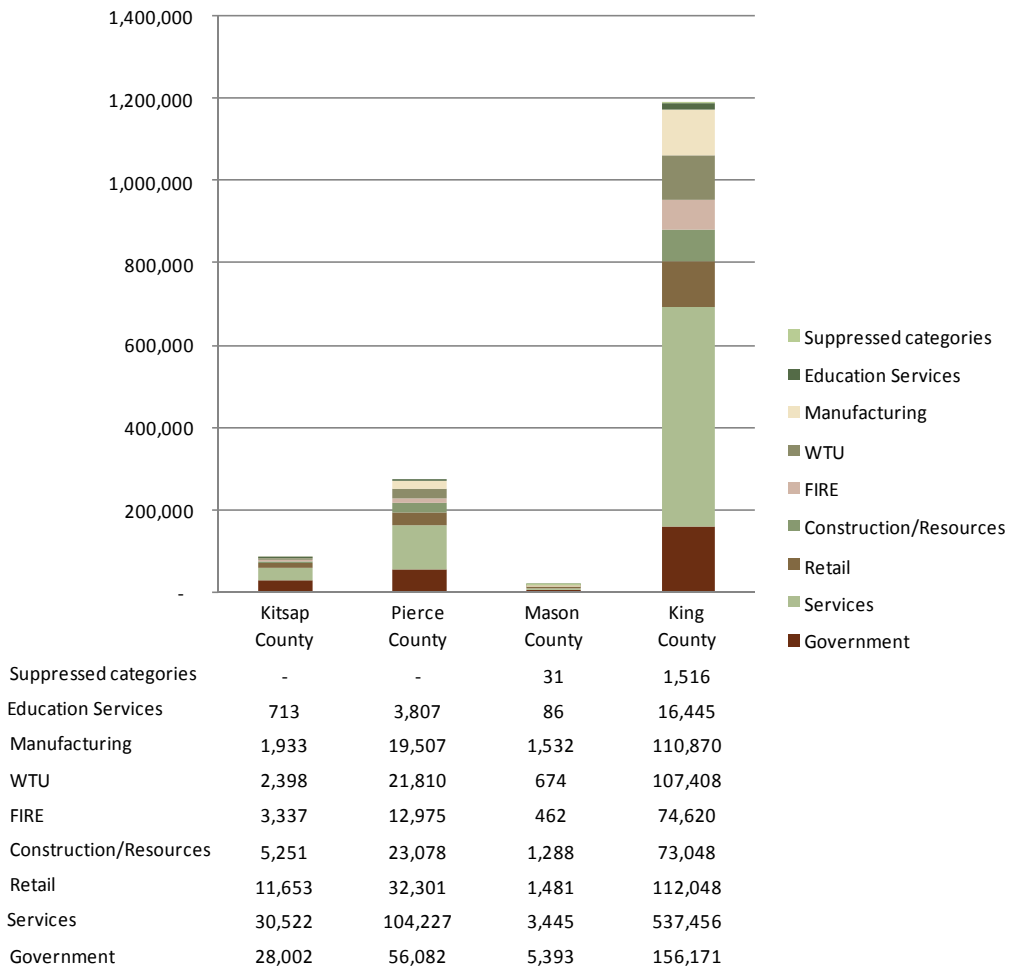
In this option, each RHC is transitioned to a network of clinical and residential services. Each RHC retains on-campus a small number of respite / short-term emergency beds and associated supports. Also, teams of behavior management clinicians and nurses are organized to provide in-home and on-site consultation in community settings. Direct care staff resources are also available to provide home-based support to people and families in those instances where other supports are not available or working correctly. Finally, on-campus medical, dental, and other therapeutic supports are available should people be unable to obtain these supports elsewhere in their immediate communities.

This option was considered and accepted. The study team has had experience in other states with the outreach model and has found services to equal or exceed current community efforts. In addition, the team heard testimony from the focus groups and survey responses that access to behavioral and health expertise varied with each community. Families and staff in eastern and central Washington strongly emphasized the lack of available clinical support. Additionally, the team found that current SOLA programs lacked sufficient “economies of scale” to be cost effective. A review of recent tort claims suggests that added program supervision and clinical supports should be made available from the RHCs.

ATTACHMENT #4: AFFECTED EMPLOYEE & COMMUNITY IMPACT

Facility	Frances Haddon Morgan Center
Street Address	3423 6 th St, Bremerton
Host Jurisdiction	City of Bremerton
City Population	36,620
County Population	247,600 (Kitsap County)
School District	Bremerton School District #100
Affected Counties	Kitsap, King, Pierce, and Mason

Employment Composition



Total Jobs & Percent of Total	Kitsap County	Pierce County	Mason County	King County	WA State
Total Jobs	83,809	273,787	14,393	1,189,582	2,950,824
Suppressed categories	0%	0%	0%	0%	0%
Education Services	1%	1%	1%	1%	1%
Manufacturing	2%	7%	11%	9%	10%
WTU	3%	8%	5%	9%	7%
FIRE	4%	5%	3%	6%	5%
Construction/Resources	6%	8%	9%	6%	9%
Retail	14%	12%	10%	9%	11%
Services	36%	38%	24%	45%	39%
Government	33%	20%	37%	13%	18%
Total	100%	100%	100%	100%	100%

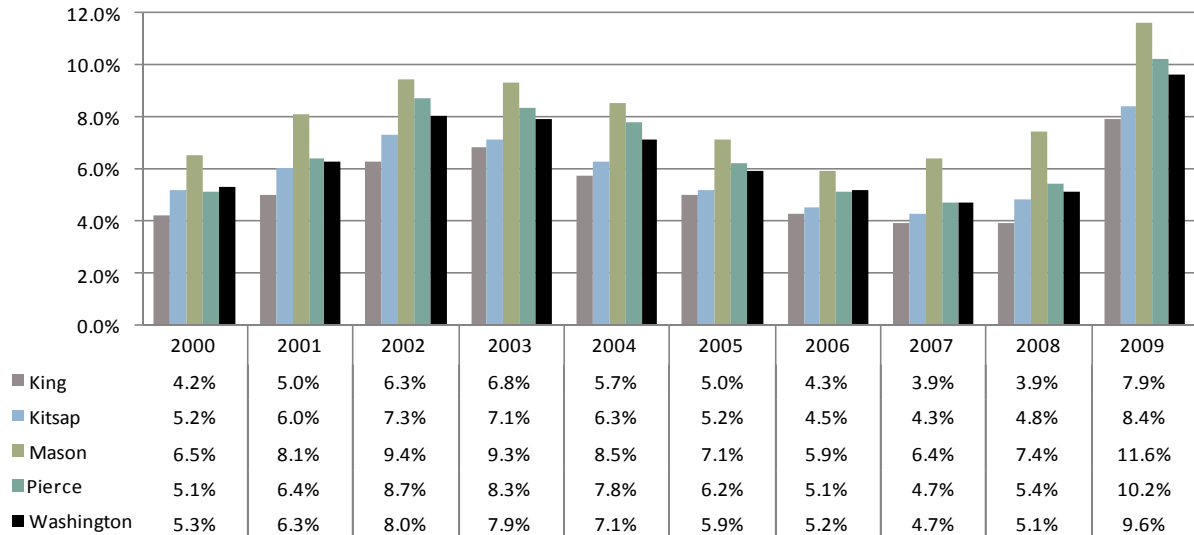
- Source: Washington State Employment Security Department, Covered Employment Classified By Industry, Annual Average 2008 (Preliminary)
- FIRE = Finance, Insurance, and Real Estate; WTU = Wholesale Trade, Transport, Warehousing, and Utilities
- See additional explanatory note on page 30.

Current Unemployment

Affected Counties	Civilian Labor Force			
	March 2008	Unemployment March 2008	Unemployment Rate	
			Mar 2008	Mar 2009
King	1,085,970	42,050	3.9%	7.9%
Kitsap	124,420	5,970	4.8%	8.4%
Mason	25,450	1,900	7.4%	11.6%
Pierce	393,270	21,330	5.4%	10.2%

- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

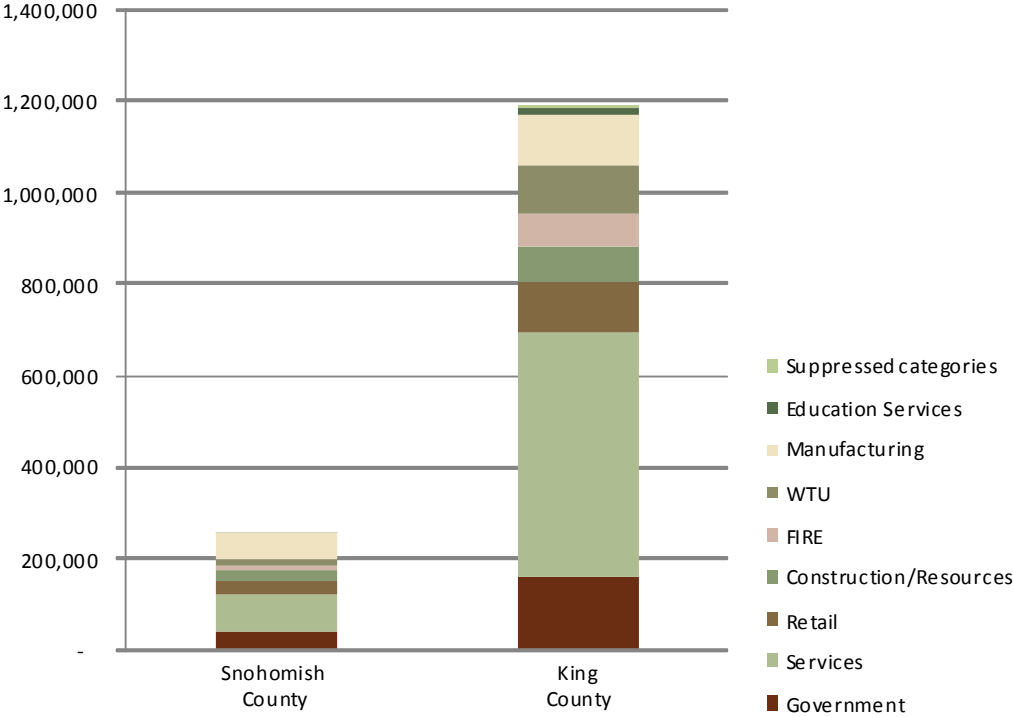
Historical Unemployment



- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Facility	Fircrest School
Street Address	15230 15th NE, Shoreline
Host Jurisdiction	City of Shoreline
City Population	54,320
County Population	704,300 (Snohomish County)
School District	Shoreline School District #412
Affected Counties	King and Snohomish

Employment Composition



Suppressed categories	-	1,516
Education Services	1,392	16,445
Manufacturing	54,953	110,870
WTU	11,815	107,408
FIRE	12,175	74,620
Construction/Resources	21,708	73,048
Retail	32,015	112,048
Services	81,724	537,456
Government	37,911	156,171

Total Jobs & Percent of Total	Snohomish County	King County	WA State
Total Jobs	253,693	1,189,582	2,950,824
Suppressed categories	0%	0%	0%
Education Services	1%	1%	1%
Manufacturing	22%	9%	10%
WTU	5%	9%	7%
FIRE	5%	6%	5%
Construction/Resources	9%	6%	9%
Retail	13%	9%	11%
Services	32%	45%	39%
Government	15%	13%	18%
Total	100%	100%	100%

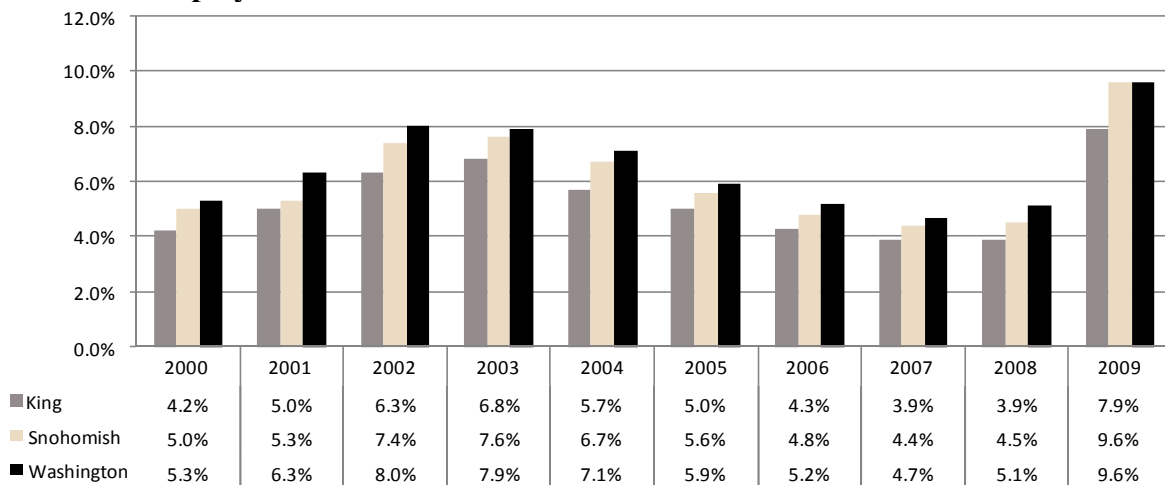
- Source: Washington State Employment Security Department, Covered Employment Classified By Industry, Annual Average 2008 (Preliminary)
- FIRE = Finance, Insurance, and Real Estate; WTU = Wholesale Trade, Transport, Warehousing, and Utilities
- See additional explanatory note on page 30.

Current Unemployment

Affected Counties	Civilian Labor			
	Force March 2008	Unemployment March 2008	Unemployment Rate	
			Mar 2008	Mar 2009
King	1,085,970	42,050	3.9%	7.9%
Snohomish	370,830	16,720	4.5%	9.6%

- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

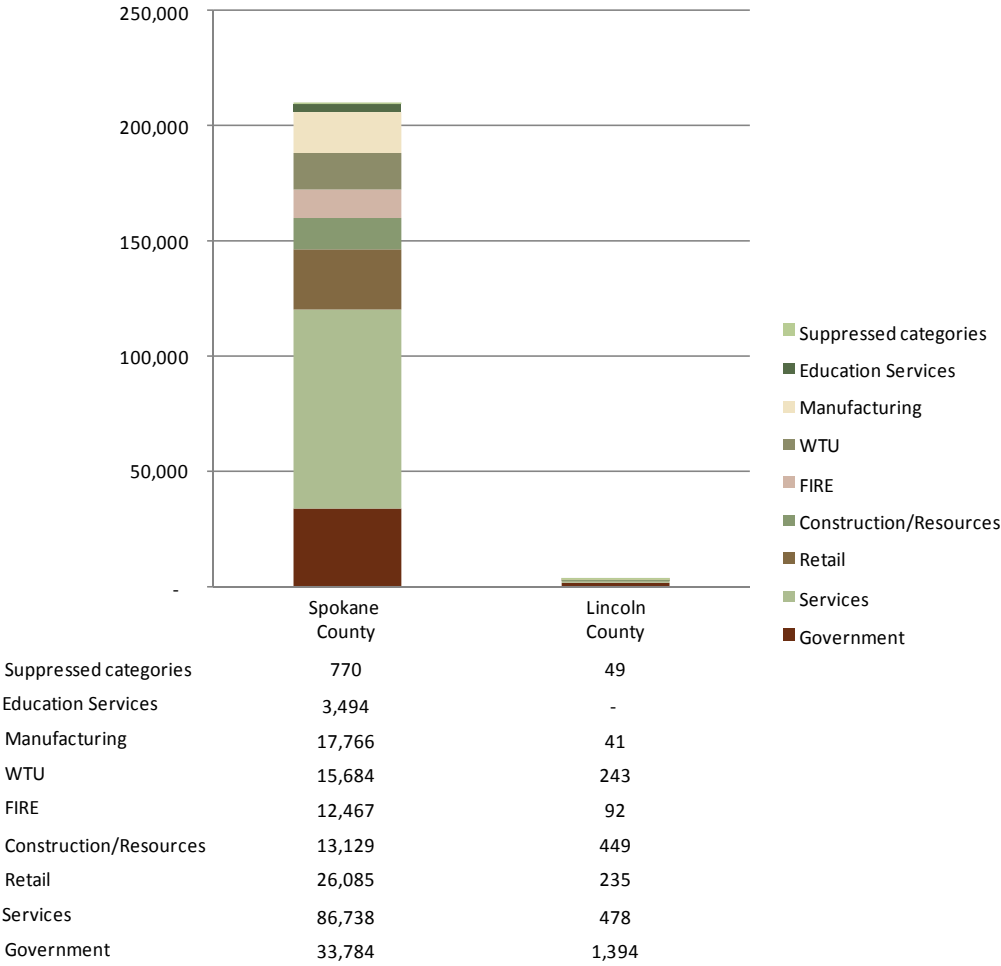
Historical Unemployment



- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Facility	Lakeland Village
Street Address	2320 S Salnave Rd, Medical Lake
Host Jurisdiction	City of Medical Lake
City Population	4,845
County Population	465,500 (Spokane County)
School District	Medical Lake School District
Affected Counties	Spokane and Lincoln

Employment Composition



Total Jobs & Percent of Total	Spokane County	Lincoln County	WA State
Total Jobs	209,916	2,981	2,950,824
Suppressed categories	0%	2%	0%
Education Services	2%	0%	1%
Manufacturing	8%	1%	10%
WTU	7%	8%	7%
FIRE	6%	3%	5%
Construction/Resources	6%	15%	9%
Retail	12%	8%	11%
Services	41%	16%	39%
Government	16%	47%	18%
Total	100%	100%	100%

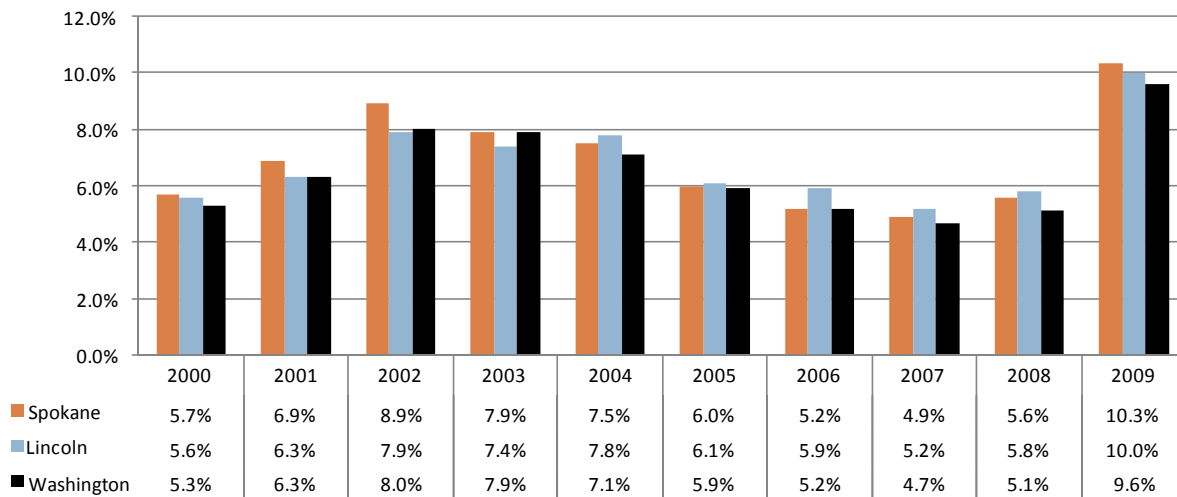
- Source: Washington State Employment Security Department, Covered Employment Classified By Industry, Annual Average 2008 (Preliminary)
- FIRE = Finance, Insurance, and Real Estate; WTU = Wholesale Trade, Transport, Warehousing, and Utilities
- See additional explanatory note on page 30.

Current Unemployment

Affected Counties	Civilian Labor			
	Force March 2008	Unemployment March 2008	Unemployment Rate	
			Mar 2008	Mar 2009
Spokane	239,420	13,460	5.6%	10.3%
Lincoln	4,740	270	5.8%	10.0%

- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Historical Unemployment

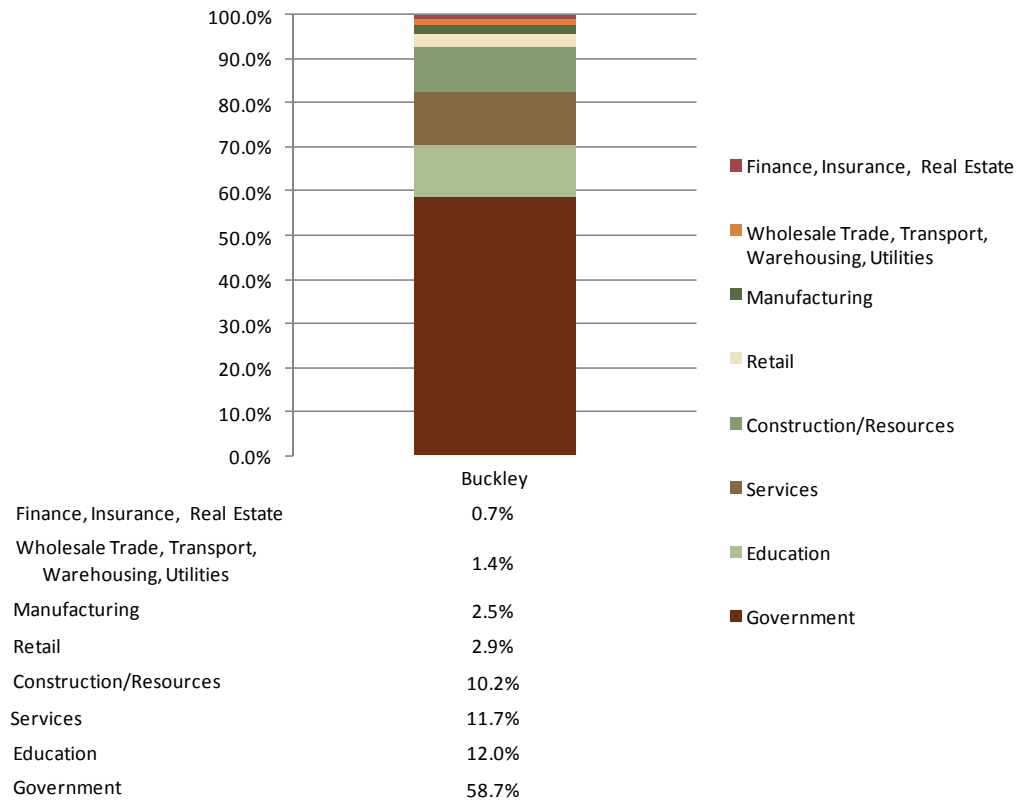


- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Total Jobs & Percent of Total	Pierce County	King County	WA State
Total Jobs	273,787	1,189,582	2,950,824
Suppressed categories	0%	0%	0%
Education Services	1%	1%	1%
Manufacturing	7%	9%	10%
WTU	8%	9%	7%
FIRE	5%	6%	5%
Construction/Resources	8%	6%	9%
Retail	12%	9%	11%
Services	38%	45%	39%
Government	20%	13%	18%
Total	100%	100%	100%

- Source: Washington State Employment Security Department, Covered Employment Classified By Industry, Annual Average 2008 (Preliminary)
- FIRE = Finance, Insurance, and Real Estate; WTU = Wholesale Trade, Transport, Warehousing, and Utilities
- See additional explanatory note on page 30.

Employment Composition within the City of Buckley



Construction/Resources	269
Finance, Insurance, Real Estate	18
Manufacturing	65
Retail	77
Services	308
Wholesale Trade, Transport, Warehousing, Utilities	38
Government	1,551
Education	317
Total	2,643

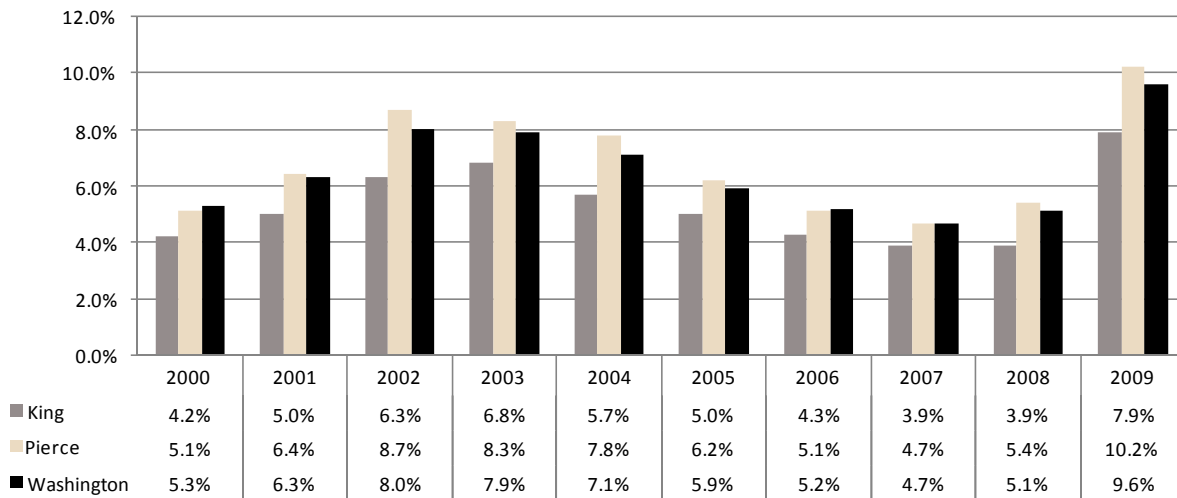
- Source: Puget Sound Regional Council, 2009
- Covered employment for 2008

Current Unemployment

Affected Counties	Civilian Labor Force		Unemployment Rate	
	March 2008	March 2008	Mar 2008	Mar 2009
King	1,085,970	42,050	3.9%	7.9%
Pierce	393,270	21,330	5.4%	10.2%

- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

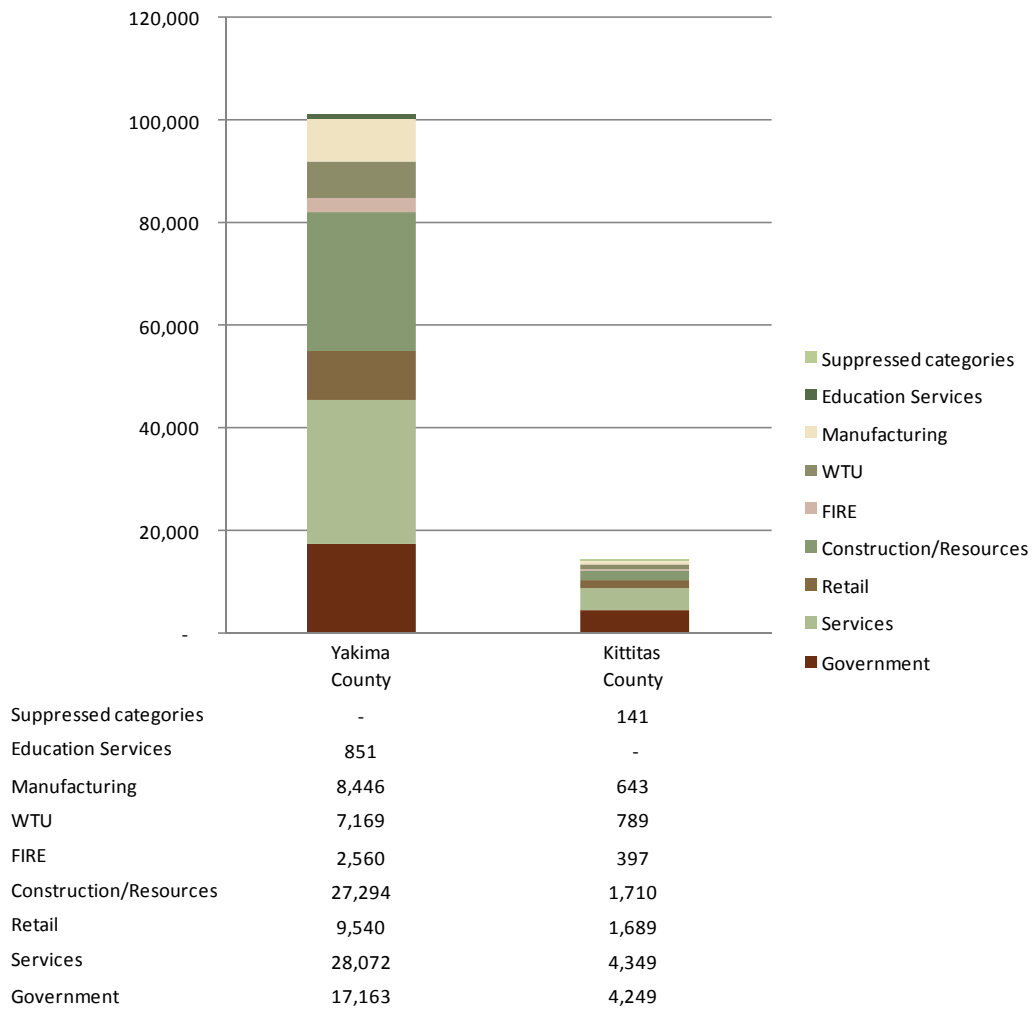
Historical Unemployment



- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Facility	Yakima Valley School
Street Address	609 Speyers Road, Selah
Host Jurisdiction	City of Selah
City Population	7,185
County Population	238,400 (Yakima County)
School District	Selah School District
Affected Counties	Yakima and Kittitas

Employment Composition



Total Jobs & Percent of Total	Yakima County	Kittitas County	WA State
Total Jobs	101,095	13,967	2,950,824
Suppressed categories	0%	1%	0%
Education Services	1%	0%	1%
Manufacturing	8%	5%	10%
WTU	7%	6%	7%
FIRE	3%	3%	5%
Construction/Resources	27%	12%	9%
Retail	9%	12%	11%
Services	28%	31%	39%
Government	17%	30%	18%
Total	100%	100%	100%

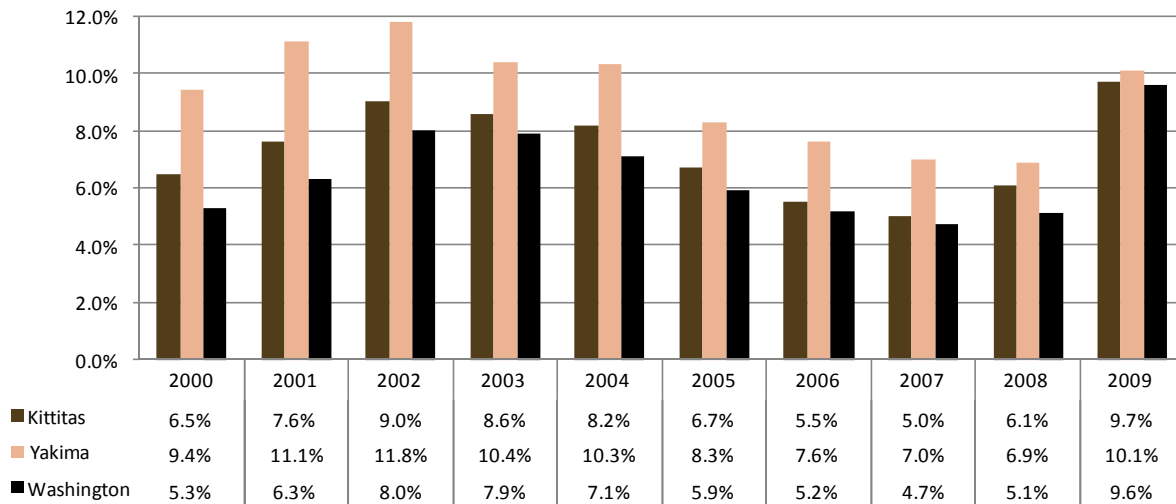
- Source: Washington State Employment Security Department, Covered Employment Classified By Industry, Annual Average 2008 (Preliminary)
- FIRE = Finance, Insurance, and Real Estate; WTU = Wholesale Trade, Transport, Warehousing, and Utilities
- See additional explanatory note on page 30.

Current Unemployment

Civilian Labor				
Affected Counties	Force March 2008	Unemployment March 2008	Unemployment Rate	
			Mar 2008	Mar 2009
Kittitas	21,170	1,290	6.1%	9.7%
Yakima	120,640	8,380	6.9%	10.1%

- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Historical Unemployment



- Source: Washington State Employment Security Department, 2009
- Local Area Unemployment Statistics are not seasonally adjusted, and include both covered and noncovered employment.

Explanatory Note for Employment Composition Charts

- Source: Washington State Employment Security Department, Covered Employment Classified By Industry, Annual Average 2008 (Preliminary)
- Employment categories are combinations of NAICS codes according to the following definitions:
 - Construction and Resources: (NAICS codes 11, 21, and 23). Includes agriculture, forestry, fishing, mining, and construction.
 - Finance, Insurance, Real Estate (FIRE): (NAICS codes 52 and 53).
 - Manufacturing: (NAICS codes 31, 32, and 33).
 - Retail: (NAICS codes 44 and 45).
 - Services: (NAICS codes 54-81). See descriptions of sub-categories in the Services Employment section.
 - Wholesale Trade, Transport, Warehousing, and Utilities (WTU): (NAICS codes 22, 42, 48, and 49).
 - Education: (NAICS code 61). Public education jobs estimated with supplementary data from Washington State Superintendent of Schools Office.
 - Government: (NAICS code 92)
- In some counties, data for particular NAICS codes may be suppressed for confidentiality purposes. Totals for suppressed categories are calculated separately, meaning that totals shown for employment categories with suppressed NAICS counts do not show full employment.

Affected Number of RHC Employees by Option

We examined each option in isolation, but acknowledge these options may be implemented in combination. The five options studied have significant differences in the number of FTE reductions, the total net changes to DDD, and the timeline in which they are implemented. The numbers of FTEs reduced and created under Options 1 through 5 – as well as the net change in FTE count – are summarized in **Exhibit 1**.

Exhibit 1
Summary of Changes in FTE Counts

Option	DDD Staff Reduced at Closed Facility	Demand for Staffing Created Elsewhere in DDD	Net Change in DDD FTE Count
Option 1: Close Frances Haddon Morgan Center	139.2 FTE (between FY11 and FY12)	52.5 FTE	-86.7 FTE
Option 2: Downsize Fircrest School	469.9 FTE (between FY11 and FY16)	240.2 FTE	-229.7 FTE
Option 3: Downsize Lakeland Village RHC	481.0 FTE (between FY13 and FY17)	94.5	-386.5 FTE
Option 4: Close Rainier School RHC	1,154.9 FTE (between FY12 and FY17)	18.0 FTE	-1,136.9 FTE
Option 5: Downsize Yakima Valley School	153.4 FTE (between FY12 and FY16)	181.5 FTE	+28.1 FTE

Source: Davis Deshaies LLC and BERK, 2009

The starting points and duration of each option’s implementation differ. FHMC experiences a quick and immediate closure, beginning in FY11 and ending in FY12. Employees laid off at this time may enter an economy still recovering from the recession, with fewer job opportunities. All other RHCs experience a longer, more gradual closure, lasting between five to six years.

Closure of Rainier School would result in the largest number of net FTE reductions, with about three times as many employees affected as the option to downsize Lakeland Village – the option with the second greatest impact on employees.

Options 2 and 3 (downsizing Fircrest School and Lakeland Village) impact nearly the same number of employees; similarly Options 1 and 5 (closing Frances Haddon Morgan Center and downsizing Yakima Valley School) eliminate approximately the same number of FTEs

The option to downsize Yakima Valley School would result in a net *increase* of approximately 28 DDD FTE.

Exhibit 2 summarizes employment options within and outside of DSHS.

Exhibit 2 – Summary of Employment Options

Within DDD	Outside DDD
DAVIS DESHAIES LLC	NOVEMBER 1, 2009
	3.31

DDD Staff Reduced at Facility	Positions at New SOLAs	Potential Employment Options at RHC or SOLA Facilities	New Positions in Private Facilities*	Other Options
Option 1: Close Frances Haddon Morgan Center				
139.2 FTE (between FY11 and FY12)	SOLAs 51.0 FTE Case Management 1.5 FTE (12 FTE within driving distance)	Rainier is in Region 5 and could present a large pool of employment options, likely requiring relocation Beyond Region 5, Fircrest presents a sizeable pool of employment options, located 40 miles from FHMC Staff is the least senior of the four RHCs, resulting in relatively less bumping system-wide	115 FTEs state-wide	Relatively convenient driving or ferry access to multiple large job markets: Silverdale, Poulsbo, Seattle, Tacoma
Option 2: Downsize Fircrest School				
469.9 FTE (between FY11 and FY16)	SOLAs 232.7 FTE Case Management 7.5 FTE (150 FTE within driving distance)	Employment at FHMC or Rainier may be possible without relocation; other RHCs require relocation New SOLAs provide sizable pool of employment options without relocation Staff is relatively senior (ranked second among the four RHCs), which could result in relatively more bumping system-wide	255.9 FTEs state-wide	Easy access to the largest job market in the State
Option 3: Downsize Lakeland Village RHC				
481.0 FTE (between FY13 and FY17)	SOLAs 85.5 FTE Case Management 9.0 FTE (at least 42 FTE within driving distance)	All RHCs would require relocation New SOLAs provide some employment options without relocation, but additions are significantly less than the reductions Staff is the most senior of the four RHCs, making them relatively more able to bump others; degree of system-wide bumping dependent on staff willingness to relocate	573.8 FTEs state-wide	Relatively few job markets beyond the Spokane; the regional economy has higher unemployment than other areas of the State
Option 4: Close Rainier School				
1,154.9 FTE (between FY12 and FY17)	SOLAs 0.0 FTE Case Management 18.0 FTE	Fircrest and FHMC in Region 5 may present options for some, likely requiring relocation Given the large number of Rainier employees, absorption would be statewide, likely requiring relocation and probably resulting in significant bumping system-wide	1,112.6 FTEs state-wide	Relatively convenient access to moderately sized job markets (Tacoma, Federal Way, Kent, Renton); jobs in Seattle and the Eastside may be within commuting distance for some and might require relocation for others
Option 5: Downsize Yakima Valley School				
153.4 FTE (between FY12 and FY16)	SOLAs 178.5 FTE Case Management 3.0 FTE (130 FTE within driving distance)	All RHCs are located a significant distance from YVS and would require relocation New SOLAs provide sizable pool of employment options without relocation Staff is ranked a close third in seniority of the four RHCs, which could result in bumping; willingness to relocate factors into the degree of system-wide shifts	0 FTEs state-wide	Access to Yakima or Ellensburg; the small size of these job markets plus relatively high regional unemployment may cause difficulties

* Assuming a staffing model of 8.5 Direct Care FTE and 3.0 FTE Administrative and Clinical Care FTE per home
Source: Davis Deshaies LLC and BERK, 2009

ATTACHMENT #5: PRICING ASSUMPTIONS FOR PEOPLE LEAVING RHCs

This attachment outlines both the transition expenses as well as the on-going care expenses for people who are leaving the state residential habilitation centers. There are three sections to this attachment.

1. PLACEMENT TRANSITION AND ONE-TIME EXPENSES

Transition one-time only costs are calculated at \$11,500 per person and are applied equally to people moving to community programs. Expenses cover one-time costs including environmental modifications and associated equipment, rent deposit assistance, modification to a residence, the purchase of furniture and consumable supplies, and moving expenses. The one-time only cost factor is applied at the time of community placement.

2. RENT SUBSIDIES

Recent DSHS data¹ indicates that 16% of the people in current supported living situations receive state-fund rent subsidies. People residing in King and Snohomish Counties are more likely to require rent support due to higher housing costs. For purposes of this study, rent subsidies are estimated to be \$1,700 per year for 100% of 170 people moving into those counties. These costs HAVE NOT BEEN included in the cost of downsizing, but would add \$289,000 per year in state funds should DSHS wish to continue providing rent subsidies.

3. PROVIDER REIMBURSEMENT RATES

Provider reimbursement rates are based upon the most recent RHC data (R. Sherman ADSA – July 2009). Community supported living rates were used for the private provider costs. Region IV SOLA (J. Cordy ADSA – July 2009) rates were used to calculate costs for SOLA and special health care homes (designated as SCNF in this study and associated worksheets). The rates are:

Community Supported Living: ISS Hours / Day	RCL Rates (last 9 people to leave RHC)	Number of people in home
>0 - 1.0	\$0.00	
>1.0 - 2.0	\$0.00	
>2.00 - 4.00	\$0.00	
>4.00 - 6.00	\$0.00	
>6.00 - 8.00	\$0.00	
>8.00 - 10.00	\$0.00	
>10.00 - 12.00	\$203.69	3
>12.00 - 14.00	\$0.00	
>14.00 - 16.00	\$262.02	2
>16.00 - 18.00	\$296.13	1
>18.00 - 20.00	\$343.98	1
>20.00 - 22.00	\$0.00	
>22.00 - 24.00	\$0.00	
>24.00	\$505.24	1

4. NON-CONSUMER EXPENSES

¹ Sherman, Ron, "SL Allowances data", e-mail to N. Davis dated 10/27/2009

Non-consumer expenses are highly important to the continued support of people leaving the RHCs. Services included are on-going case management and program monitoring costs, and placement transition expenses. These costs are projected at the following rates:

- Case management and quality assurance staff costs have been included in the initial budget impact projections. Case management assumes ratios at 1:35 people based upon recent federal Department of Justice settlements. The current cost for one case manager is priced at \$66,750 per year.
-
- Quality assurance ratios are based upon 1 staff per 250 consumers placed. The current cost for one quality review specialist (compensation plus indirect) is \$117,000 per year.
-
- Community resource center costs (emergency crisis response team & ambulatory care / clinical services) are included in the budget projections.
-
- Additional planned and unplanned respite beds are not included in the projections of the cost of placement. Should the state wish to consider expanding this service at the RHCs, additional staff and facilities will need to be added to the cost projections.
-
- State-operated community special health care homes (SCNF) are included as placement options in this study. In addition to the community support center staffing (e.g. emergency crisis support, ambulatory care, and clinical support), a SCNF staffing model and associated administrative costs are also included.

TYPE OF PROGRAM	BUSINESS RULE	# of Staff
Emergency crisis support / ambulatory care / clinical outreach centers	Retain all RHC Clinical Staff & associated pharmacy, lab, and clinical areas	
Clinical Staff	<i>Psychiatrists</i>	0.5
	<i>Physicians</i>	1
	<i>Physician Assistants</i>	1
	<i>Psychologists</i>	2
	<i>Psychologist Associates</i>	2
	<i>Dentists</i>	2
	<i>Dental Hygienist</i>	1
	<i>Dental Assistant</i>	1
	<i>Occupational Therapist</i>	1
	<i>Physical Therapist</i>	1
	<i>Therapy Aides</i>	1
	<i>Registered Nurse 4</i>	1
	<i>Pharmacist / Clinical Pharmacist D</i>	2
	<i>Pharmacy Technician</i>	1
	<i>Dietician</i>	0.5
	Sub-Total per Outreach Clinic	18

Administrative Staff	Retain administrative staff for Clinical Outreach & crisis center management	
	<i>Clinic supervisor</i>	1
	<i>Fiscal Analyst 3</i>	1
	<i>Secretary</i>	1
	<i>Medical Records Technician</i>	1
	Sub-Total per Outreach Clinic	4
TYPE OF PROGRAM	BUSINESS RULE	# of Staff
State Certified Nursing Facility (SCNF)	Staffing is based upon 4 person community home with 1:2 direct care staffing and associated health care management SOLA / SCNF management	
Program Staff	<i>Habilitation Plan Administrator</i>	0.25
	<i>Registered Nurse 3 (Manager)</i>	1
	<i>Registered Nurse 2 (Relief coverage)</i>	1
	<i>LPN 4</i>	2
	<i>Attendant Counselor 2</i>	8.5
	Sub-total per SCNF	12.75
Administrative Staff	<i>Quality assurance director</i>	1
	<i>Residential Services Coordinator</i>	1
	<i>Management Analyst 1</i>	1
	<i>IT Spec 4</i>	1
	<i>Office Assistant</i>	1
	<i>Safety Officer</i>	1
	Sub-Total per Regional SNCF Program	6
DDD Case Management Transition Team	Staffing is based on 1:35 case management; 1:70 resource development	
	<i>DD case manager 2</i>	25
	<i>DD case manager 3</i>	13
	Sub-Total for ALL STATE	38

ATTACHMENT #6 – FISCAL IMPACT STATEMENT FOR RECOMMENDED OPTION

The fiscal impact statements for the recommended options are described in two sections. The first section summarizes the operating budgets for the study team’s recommendation for Recommendation #3: RHC Restructure, and also details the placement schedule and associated cost impact. Also, capital budget savings for Recommendation #1: 250 Bed Reduction is presented. The second section presents a life-cycle cost analysis of both operating and capital costs using net present values.

SUMMARY OF OPERATING & CAPITAL BUDGET SAVINGS

-
- Summary of operating budget savings per State Fiscal Year (SFY) for Recommendation #3: RHC restructure option
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	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Community On-going Expense	\$3,224,030	\$16,703,042	\$28,438,311	\$40,226,270	\$67,282,368	\$92,466,081	\$110,515,415	\$112,838,140
Community One-time Expense	\$736,000	\$1,012,000	\$1,104,000	\$1,288,000	\$2,495,500	\$2,403,500	\$1,092,500	• 0
Increase SOLA Mgt	• 0	• 0	\$595,884	\$1,191,768	\$1,787,652	\$1,787,652	\$1,787,652	\$1,787,652
Clinical Outreach / Crisis Response Teams	• 0	• 0	• 0	• 0	• 0	\$1,645,080	\$1,645,080	\$1,645,080
Placement Transition Teams	\$184,273	\$437,649	\$714,059	\$1,036,538	\$1,661,340	\$2,263,107	\$2,536,636	\$2,536,636
TOTAL EXPENSES	\$4,144,304	\$18,152,692	\$30,852,254	\$43,742,576	\$73,226,860	\$100,565,421	\$117,57,286	\$118,807,511
RHC REVENUE	\$2,328,940	\$19,413,474	\$34,410,694	\$50,120,499	\$80,182,787	\$119,126,848	\$156,833,509	\$160,790,468

BALANCE	(\$1,815,363)	\$1,260,782	\$3,558,440	\$6,377,923	\$6,955,927	\$18,561,427	\$39,256,223	\$41,982,957
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Summary of FHMC Capital Budget (only RHC closure for Recommendation #1: 250 bed reduction option)

State Fiscal Years	SFY 2011/2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Minor Works	\$2,875,000	\$0	\$0	\$0	\$0		
Cold Closure one-time	0	\$90,000	\$0	\$0	\$0		
Cold Closure on-going		\$110,000	\$110,000	\$110,000	\$110,000	\$110,000	\$110,000
TOTAL Minor Works Savings	\$2,875,000	\$0	\$0	\$0	\$0		
Total On-going Cost		\$190,000	\$110,000	\$110,000	\$110,000	\$110,000	\$110,000

Summary of the RHC / Community transition and impact by fiscal year for Recommendation #3: RHC Restructure

STATE FISCAL YEAR (JULY TO JUNE)	RHC ACTION	TOTAL NUMBER OF PEOPLE MOVING FROM RHCs	NUMBER OF PEOPLE MOVING TO PRIVATE COMMUNITY RESIDENTIAL PROGRAMS	NUMBER OF PEOPLE MOVING TO STATE-OPERATED SUPPORTED LIVING PROGRAMS	NET SAVINGS OR (LOSS) FOR BIENNIUM (END OF LAST SFY)
SFY 2011	FHMC: close 2 cottages Fircrest: close 2 cottages	32 32 ²	16 16	16 16	(\$1,815,363)
SFY 2012	FHMC: close facility Rainier: close 3 cottages Yakima: close 1 cottage	24 48 16	24 48 0	0 0 16	\$1,260,782
SFY 2013	Lakeland: close 2 cottages Rainier: close 4 cottages	32 64	16 64	16 0	\$3,558,440
SFY 2014	Fircrest: close 2 cottages Lakeland: close 1 cottage Rainier: close 4 cottages	32 16 64	16 16 64	16 0 0	\$6,377,923
SFY 2015	Fircrest: close 4 cottages Lakeland: close 4 cottages Rainier: close 4 cottages Yakima: close 2 cottages	57 64 64 32	41 64 64 8	16 0 0 24	\$6,955,927
SFY 2016	Fircrest: close 3 cottages Lakeland: close 4 cottages Rainier: close 6 cottages Yakima: close 1 cottage	41 64 88 16	32 64 88 0	9 0 0 16	\$18,561,427
SFY 2017	Lakeland: close 3 cottages Rainier: close 3 cottages	36 59	36 59	0 0	\$39,256,223
SFY 2018	Actions complete				\$41,982,957
TOTAL IMPACT		Remaining RHC Capacity	Total increase in private	Total increase in state-operated	Total Net Savings from

² Fircrest to move all children to state-operated intensive care home in 2011

STATE FISCAL YEAR (JULY TO JUNE)	RHC ACTION	TOTAL NUMBER OF PEOPLE MOVING FROM RHCs	NUMBER OF PEOPLE MOVING TO PRIVATE COMMUNITY RESIDENTIAL PROGRAMS	NUMBER OF PEOPLE MOVING TO STATE-OPERATED SUPPORTED LIVING PROGRAMS	NET SAVINGS OR (LOSS) FOR BIENNIUM (END OF LAST SFY)
			community programs	com. programs	SFY 2010 through SFY 2018
	FHMC: closed facility	0	40	16	
	Fircrest: ICF/MR	0	105	16	
	Fircrest: SNF	48	0	41	
	Lakeland: ICF/MR	0	180	0	
	Lakeland: SNF beds	26	16	16	
	Rainier: closed facility	0	387	0	
	Yakima: SNF	38	8	56	
TOTAL		112	736	145	\$116,138,316

Life Cycle Cost Savings

This section of the fiscal impact analysis assesses the life cycle costs to the state. The goal of lifecycle cost analyses is to offer a measure of each option’s effectiveness in a way that allows direct comparison:

When viewed over a period of years, what overall savings does this option offer?

Stated another way: From where we are standing today, what is the *value* of pursuing a given course of action? How much money would Washington State stand to save over, say, a ten-year time frame? And given that each option envisions different (and varying) cost changes over time, what is the normalized, “present value” of estimated savings?

This measure of effectiveness serves as one piece of data that will compliment all of the other considerations that come into play as State policy makers decide on a course of action.

Methodology and Limitations

To measurement of net savings, BERK compared each contemplated option with a baseline scenario—an assumed state-of-the-world that describes how the system could be expected to operate if none of the contemplated actions was pursued.

For DDD, the baseline scenario assumed that all current facilities would continue to operate, and generally, they would operate as they do now (i.e. they would have similar staffing, similar usage of their facilities, and levels of capital investment that are in line with levels seen in recent years).

Findings Presented in Terms of “Net Present Value”

To offer an apples-to-apples comparison of the savings offered by the five options, the consultant team calculates savings in terms of *net present value* (NPV). The concept of NPV recognizes that, in general, a dollar in my hand today is worth more to me than a dollar in my hand five years from now.

If I have a dollar today, I can put it in the bank and enjoy the interest it generates. Alternatively, if I need a dollar today but don't have one, I can borrow the dollar from a bank, but I have to pay them interest to do so.

The concept of NPV recognizes that money in my hand today is worth more, so it *discounts* expenditures in future years—to describe what those expenditures are worth today. Calculating net present value for a stream of future savings simply means translating each year's savings to describe what those saving are worth in some base year, and then adding them all up.

Division of Developmental Disabilities

From the perspective of operating cost reduction, all options offer significant cost savings, with the two largest facilities: Fircrest School and Rainier School, offering the greatest prospect for savings (Exhibit 3). In present value terms, the five options offer present values of savings ranging from \$10.7 million to \$54.9 million.³

Under a scenario where all five facilities are closed, operating cost savings would be reduced by roughly \$3.4 million (in 2009 dollars). This reduction would come from introduced demand for (1) three SCNF oversight centers (at a cost of \$596,000 per center) and (2) an ambulatory care clinic (at a cost of \$1.645 million). These cost items only become necessary under the close-all-five-facility scenario, therefore, these costs are not reflected in any of the individual closure options.

Exhibit 3

Present Value of 10-Year Operating Savings (in Millions) Relative to Baseline (Savings Presented in Year-of-Expenditure Dollars)

	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	Net Present Value of Savings (2011)
Fircrest School	(\$0.84) M	\$1.03	\$1.06	\$0.23	\$0.41	\$2.98	\$17.42	\$17.84	\$18.27	\$18.71	\$54.9 M
FHMC	(\$1.06) M	\$1.15	\$1.89	\$1.94	\$1.99	\$2.03	\$2.08	\$2.13	\$2.19	\$2.24	\$12.7 M
Lakeland Village	\$0.00 M	\$0.00	(\$0.92)	\$0.20	\$0.71	\$4.51	\$8.98	\$11.39	\$11.67	\$11.95	\$34.4 M
Rainier School	\$0.00 M	(\$1.22)	\$0.20	\$2.87	\$5.29	\$7.60	\$10.65	\$16.28	\$16.67	\$17.07	\$54.3 M
Yakima Valley School	\$0.00 M	(\$0.25)	\$0.80	\$0.82	\$0.02	\$2.04	\$3.29	\$2.56	\$2.62	\$2.68	\$10.7 M
										Sum of NPVs	\$166.8 M

Source: BERK

From a capital investment perspective the principal savings result from avoided investments. Estimates of avoided costs are based on observed levels of capital investment in recent years. Partially offsetting these avoided capital costs are costs associated with “cold closure” of the facility. These cold-closure costs reflect the costs of minimal maintenance of each facility's grounds and buildings.

³ Net Present Values are calculated using a discount rate of 4.2%, a rate that reflects projected future costs of State bonded debt. In effect, this discount rate reflects the cost the State pays to move money forward through time.

Exhibit 4
Present Value of 10-Year Capital Savings (in Millions)
(Savings Presented in Year-of-Expenditure Dollars)

	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	Net Present Value of Savings (2011)
Fircrest School	\$1.40 M	\$1.44	\$1.49	\$1.54	\$1.57	\$1.05	\$1.07	\$1.09	\$1.11	\$1.14	\$10.5 M
FHMC	\$0.68 M	\$0.59	\$0.61	\$0.63	\$0.64	\$0.66	\$0.67	\$0.68	\$0.69	\$0.71	\$5.2 M
Lakeland Village	\$1.32 M	\$1.36	\$1.41	\$1.45	\$1.48	\$1.51	\$1.11	\$1.13	\$1.16	\$1.18	\$10.6 M
Rainier School	\$1.61 M	\$1.66	\$1.72	\$1.77	\$1.81	\$1.85	\$1.35	\$1.37	\$1.40	\$1.43	\$12.9 M
Yakima Valley School	\$0.28 M	\$0.29	\$0.30	\$0.31	\$0.32	\$0.11	\$0.11	\$0.11	\$0.11	\$0.12	\$1.7 M
									Sum of NPVs		\$41.0 M

Source: BERK

Another capital issue (related to the costs of cold closure) is the value of assets that have been freed up in instances where facilities are closed. Under any circumstances, it is appropriate to count the value of assets that are freed up as a result of given option as a contribution to the lifecycle value of pursuing that option.

If the State chose to dispose of (or find alternative uses) for assets that are closed, then exercising those options would generate additional capital value (either in terms of capital revenues, in the case of an outright sale, or in terms of facilitating provision of other public services). If the State chose to simply hold the facility in cold closure (perhaps awaiting a more favorable environment for real estate sale and/or development), one can think of the value of the asset as an asset in holding. The cost of holding the facility in cold closure is reflected in the capital savings estimated in **Error! Reference source not found.** Clearly, if the State chose to dispose of an asset, then the ongoing cold-closure costs would no longer be needed.

DSHS does not have any particularly current estimates of the value of the five facilities examined in this analysis. The most recent assessment was performed in 2003, by Heartland, the presentation of findings for which is entitled *State of Washington DSHS Centers Alternatives Analysis*. Heartland's analysis examines a range of options for using, selling, or leasing properties—each of which would generate income for the State—and it assessed estimated market value of each site. Heartlands analysis found that the Fircrest School was far and away the most valuable facility, with a market value ranging between \$25 million and \$35 million. The remaining facilities had far lower market values—between \$10 million and \$15 million combined—asset values that are certainly real, but that are dwarfed by the present value of the savings (operational and capital) associated with the closure options analyzed above.

If the State were to pursue any of the above closure options, DSHS would need to develop an updated analysis of options for disposition of the sites (or portions of sites that are freed up in the case of partial closure) in question.