MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT MEETING OF THE
COMMITTEE ON JUDICIARY,
JOINT SUBCOMMITTEE ON INSTITUTIONS & CULTURAL EDUCATION
AND
JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN BOB CLARK**, on January 27, 1995, at 9:10 a.m.

ROLL CALL

Committee on Judiciary
Members Present:

Rep. Robert C. Clark, Chairman (R)
Rep. Shiell Anderson, Vice Chairman (Majority) (R)
Rep. Diana E. Wyatt, Vice Chairman (Minority) (D)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. William E. Boharski (R)
Rep. Bill Carey (D)
Rep. Aubyn A. Curtiss (R)
Rep. Duane Grimes (R)
Rep. Joan Hurdle (D)
Rep. Deb Kottel (D)
Rep. Linda McCulloch (D)
Rep. Daniel W. McGee (R)
Rep. Brad Molnar (R)
Rep. Debbie Shea (D)
Rep. Liz Smith (R)
Rep. Loren L. Soft (R)
Rep. Bill Tash (R)
Rep. Cliff Trexler (R)

Members Excused: None

Members Absent: None

Subcommittee on Institutions & Cultural Education
Members Present:

Rep. Marjorie I. Fisher, Chairman (R)
Sen. Larry J. Tveit, Vice Chairman (R)
Sen. Gary C. Aklestad (R)
Rep. William T. "Red" Menahan (D)
Rep. Steve Vick (D)
Sen. Mignon Waterman (D)

Staff Present: Lisa Smith, Legislative Fiscal Analyst
Shirley Benson, Office of Budget & Program Planning
Mary LaFond, Office of Budget & Program Planning
John Patrick, Office of Budget & Program Planning
Brandee Decrevel, Committee Secretary

ROLL CALL
Continued

Subcommittee on Human Services & Aging
Members Present:

Rep. John Cobb, Chairman (R)
Sen. Charles "Chuck" Swysgood, Vice Chairman (R)
Rep. Beverly Barnhart (D)
Sen. James H. "Jim" Burnett (R)
Rep. Betty Lou Kasten (R)
Sen. John "J.D." Lynch (D)

Staff Present: Lois Steinbeck, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
Douglas Schmitz, Office of Budget & Program Planning

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: Hearing on HB 65 - Proposed closure of Eastmont Human Services Center
Executive Action: None

{Tape: 1; Side: A}

HEARING ON HOUSE BILL 65
PROPOSED CLOSURE OF EASTMONT HUMAN SERVICES CENTER

CHAIRMAN BOB CLARK opened the hearing on the Eastmont closure. Testimony was limited to 40 minutes for each side. He announced **REP. BILL BOHARSKI** was in attendance via an active telephone conference line. He appointed **REP. MARJORIE FISHER** to act as chairperson when he leaves the hearing at 10:00 a.m. for another hearing.

Opening Statement by Sponsor:

REP. JEANETTE MCKEE, HD 60, presented testimony in favor of HB 65. **REP. MCKEE** showed a seven-minute video on the Eastmont facility. **EXHIBITS 1, 2 and 3**

Proponents' Testimony:

Rick Day, Director, Department of Corrections and Human Services (DCHS), testified in favor of the closure of Eastmont as presented in HB 65. **EXHIBITS 4 and 5**

Peter Blouke, Director, Department of Social and Rehabilitation Services (SRS), spoke in favor of HB 65. He supports the institution at Warm Springs and the Montana Developmental Center

(MDC) but believes at this time institutionalization is not the solution for services to the developmentally disabled (DD) in Montana's future.

Robert Anderson, Administrator, Special Services Division, (DCHS) and Chairman, Governor's Human Services Subcabinet's Interagency Task Force on Developmental Disabilities, gave an overview of the task force's development of the plan to close Eastmont. **EXHIBITS 6 and 7**

Sylvia Danforth, Director, DEEP, explained DEEP is a not-for profit agency providing a variety of services in eastern Montana to DD children and their families. **Ms. Danforth** spoke as a representative of the Montana Association of Disability Services which includes 43 not-for-profit organizations.

(Tape: 2; Side: A)

Currently in Montana there are no children receiving services in institutions. There are many children with severe disabilities living at home with their families and receiving intensive support services through the specialized family care program. These families are provided with an array of services including physical, occupational and speech therapy, respite care and habilitation services. Parents continue to raise their children in their homes and strongly support services that provide opportunities for their children to transition into a variety of community-based adult services that meet their needs. Most adults with disabilities in Montana are already receiving services in community programs. Adult services like intensive group homes and day services have the same needs as Eastmont. Individuals need to have the opportunity to decide where, how and with whom they want to live. There is increasing demand for community services with waiting lists for both adult and children services. There is no waiting list for Eastmont. Eastmont provides good services to adults with disabilities, but the state needs to support community services as a choice for the developmentally disabled. The Montana Association of Disability services supports HB 65 and community services throughout Montana.

Judith Oberst, parent of a DD child, testified on behalf of Parents, Let's Unite for Kids (PLUK). **EXHIBIT 8**

Charlene Lindberg, Billings, sister of Lyle, an Eastmont resident. Lyle has been in an institution for 25 years. At Eastmont he has accomplished things not thought possible. His family believes this is because of the smaller size of Eastmont as compared to MDC. The family panicked when they heard of the proposal to close Eastmont, but after a review of group homes in Billings, became convinced the community setting would be best for Lyle. The community facilities of 1 staff person to every 4 clients is beneficial, however the waiting list is several years

long. The money available for DD services should be used to develop community services.

Carol Lodee, Helena, mother of a severely DD daughter, Sierra. Sierra is an 11-year-old, 5th grader who is quadriplegic and non-verbal due to cerebral palsy. Despite her impairments she lives at home and has as normal a life as possible. Her normal lifestyle is accomplished by means of a well maintained network of support services - her close family home, the school system, home health care, Girl Scouts and caring friends. Because these support systems are in place, Sierra has the crucial independence of the mind and of the spirit. As an adult Sierra should have the freedom to be as independent as possible, to have lifestyle choices that all adults have. There is no reason these goals cannot be obtained if the same type of support services stay in place - supported employment, community based adult services, technology based support services. Community services is not only the best alternative for the individual but also is more cost effective then institutionalization.

Jessie Schliner, Kalispell, mother of 10 year old DD son, Joey. It is very important for Joey to be with the people he loves and it's important to the people who love him. All DD children need to be with the people who really love them. This is important to remember when setting up any kind of an establishment for these kids - they need to be close to the people who love them because that is their only security system.

Betty Jo Mahen, Missoula, mother of 14-year-old Cathy Jo who has several developmental disabilities. Cathy Jo is currently in a foster home because of **Ms. Mahen's** inability to care for her after she became a working, single mother. "I am on record in support of HB 65 for the redirection of funds into the community based programs." Cathy Jo has a loving foster home in Missoula, but they will not be able to care for her forever. When Cathy Jo transfers into adult services it is important that she stay near her family and foster family. It is inhumane to move her half-way across the state to start over again with strangers, but she and others like her face that possibility in the future if community services aren't available. "Let's keep our kids, and adult kids, close to home where we can continue to participate in their care."

Gail Peterson, Miles City, mother of 13-year-old son Seth, who is mentally and physically handicapped. When Seth is an adult, he will like other adults, want more independence than living with his parents. He won't be able to live completely independently, he'll always need someone to help with his personal care needs and to help him make the right choices. It is the family's hope that Seth will be able to live in a home environment in his community that supplies as much independence as possible with the support he needs.

The following proponents voiced their support of HB 65 and/or left written testimony:

Joe Roberts, Advocacy Group for Developmental Disabilities; Andree Larose, Montana Advocacy Program. EXHIBIT 9

Allen Hartman, M.D., Member, Developmental Disabilities Planning and Advisory Council. EXHIBITS 10 and 11

Martha Huber, mother of Lyle Huber. EXHIBIT 12

Kelly Moorse, Executive Director, Board of Visitors. EXHIBIT 13

Dawn DeVor, Advocacy Specialist, Montana Advocacy Program. EXHIBIT 14

Chris Valenkity, Western Montana Developmental Center.

Kate Cholewa, Human Services Foundation.

Mike Hanshew, Administrator, Developmental Disabilities Division, SRS.

Connye Hager, Developmental Disabilities Planning and Advisory Council. EXHIBIT 15

Clergy of Glendive. EXHIBIT 16

{Tape: 1; Side: B; Approx. Counter: 840}

Opponents' Testimony:

REP. JOHN JOHNSON, HD 2, opposed the sections of HB 65 which would close Eastmont. Eastmont is considered to be a community-based facility. With its 49 residents it is not a large institution. It is located in a residential area, is part of the community, and provides community based services and community activities. The federal House of Representatives Developmental Disabilities Assistance and Bill of Rights Act recognizes and supports that each individual and each family has different goals and needs. The findings, purposes and policies of this Act should not be read to support one kind of residential program over another. The goals expressed in this Act to promote the greatest possible liberation and independence for some individuals should not be read as a federal policy supporting the closure of residential institutions.

{Tape: 2; Side: A}

REP. JOHNSON distributed something to the committee members. **EXHIBIT 17**

Steve Colbo, Eastmont Retention Committee, said Eastmont Community Services Center is not commonly understood as an

institution as much as it is a community facility. The Eastmont Retention Committee does not oppose group homes, they are a necessary part of the system. The proponents of HB 65 have spoken eloquently and convincingly regarding community care, which the Eastmont Retention Committee supports. The issues that need to be addressed in making these decisions include the level of care, which is near total care at Eastmont. The question is will Eastmont residents receive equal care, or better care, if they are moved to other facilities. Another issue is what alternatives will be available if closure is effected. Is the population going to remain at MDC in light of legislative intent to downsize that institution. Is there enough known about the future availability of services to make these decisions today. "I am opposing the language in the bill that would remove Eastmont."

Candace Idey, Member, Eastmont Retention Committee, said Eastmont is a community-based facility providing a wide array of services. Eastmont is welcome in the community and accepted as a neighbor. She opposes the closure of Eastmont.

Rex Kinnick, recreation therapist at Eastmont for nine years, said he takes Eastmont residents into the community frequently for swimming, bowling, movies, ball games, etc. HB 65 is a good bill but should not include the closure of Eastmont.

Dan Schmidt, physical therapist at Eastmont for eight years, expressed concern that if residents are moved from Eastmont and put in community group homes they would not have access to the five day a week physical therapy which helps keep them mobile. He opposes the closure of Eastmont.

SEN. RIC HOLDEN, SD 1, said although the Montana Advocacy Group supports the closure of Eastmont, literature they distributed in 1994 does not advocate the closure and in fact supports the services at Eastmont. In the Executive budget the narrative notes that the SRS costs are approximately $1.6 million more during the 1997 biennium to close Eastmont and establish group homes. The narrative also says "... while the 1999 data shows a general fund savings, the Executive anticipates that over time the cost of operating group homes will be the same as operating Eastmont with general fund ... The Executive budget provides $2,000 for employee assistance, training and relocation programs, however the Executive does not provide the cost of termination payouts ... the Executive does not provide an estimate of the costs ... the Executive does not anticipate whether additional funding will be required in future biennium to maintain Medicaid certification." On the fiscal note there is an assumption that it will take an additional $100,000 of general fund money to close Eastmont. There are many unanswered questions regarding the closure of Eastmont. Closing Eastmont does not provide services to one more resident.

Kevin Dorwat, Glendive, presented written testimony opposing HB 65. **EXHIBIT 18**

Pat Mischel, Glendive, testified in opposition to the closing of Eastmont as proposed in HB 65. **EXHIBIT 19**

Nancy Hafle, Glendive, opposes the closure of Eastmont.

SEN. LARRY TVEIT, SD 50, opposes closing Eastmont. Eastmont patients are not children, as they get older their families die off and there is no family available to care for them. Many of the patients in Eastmont aren't group home material. The quality of care at Eastmont is outstanding, and that should be considered a vital part of the program.

Linda Hickman, Harlowtown, sister of Eastmont client, Caryn, said that Caryn was transferred to Eastmont after living at MDC for many years. She made tremendous progress at Eastmont, becoming more open and receptive to her surroundings and people around her. Caryn was non-verbal but at Eastmont learned to communicate her needs. "I truly believe Caryn would not have thrived in a group home environment, she would have failed." Although Eastmont was a long drive for the family to make to visit Caryn, the progress she made at Eastmont made the inconvenience of the distance insignificant. This is a well run facility that meets needs. The doors should be kept open. **EXHIBITS 20 and 21**

Jane Skartved, Glendive, mother of son, Dean, at Eastmont, testified in opposition to closing Eastmont. **EXHIBIT 22**

Art Zoddey, Glendive, presented a letter of testimony from parents of a Eastmont client and asked that Eastmont remain open. **EXHIBIT 23**

{Tape: 2; Side: B}

Questions from Committee Members and Responses:

SEN. TVEIT commented that many of the proponents for closing Eastmont were speaking of their young children while the residents of Eastmont are adults. He asked if there are records of visitations or contacts with family members of Eastmont patients. **Sylvia Hammer, Superintendent, Eastmont,** answered there are 49 residents, 33 of whom have family in Montana. Of those eight families are in eastern Montana, 11 in central Montana, and 14 in western Montana. Of the 49 residents, 10 have families living out of state and six people have no known family members. Fifteen people have had no contact with family in the past year; 22 have had under five contacts; 12 have had six or more contacts in the past year. Two residents go home regularly to their families. Of the 12 persons with six or more contacts, five families live in eastern Montana, three in central Montana and four in western Montana.

REP. BETTY LOU KASTEN asked for an explanation of the votes taken by the DD task force in reference to closing Eastmont. **Dr. Hartman** reported the first vote was taken at August 1994 meeting with an 8-8 tie, broken by the chair (Dr. Hartman) in favor of closing Eastmont. Two members abstained and six were absent. After further information was provided the task force members, the re-vote in October 1994 was unanimous in favor of closing Eastmont.

REP. JOAN HURDLE asked **Mr. Anderson** a series of questions concerning the ability of MDC to take Eastmont patients if Eastmont were closed. **Mr. Anderson** responded that MDC has 110 beds which is deemed adequate for the need in Montana. It is estimated that 19 of the Eastmont patients would be placed at MDC. There is no waiting list at MDC.

{Tape: 3; Side: A; Comments: This portion of the meeting was recorded following a break at 10:50 a.m. in which the subcommittee members were on the floor. Due to the secretary's absence, no notes were taken so the time of convening and adjournment was not recorded.}

CHAIRMAN FISHER asked how many vacancies are in group homes at this time. **Mike Hanshew, Administrator, Developmental Disabilities division, SRS,** answered the competition for intensive group homes is very fierce now so there are no openings.

REP. AUBYN CURTISS asked if there is a possibility that some of the residents of Eastmont might be moved into a community nursing home. **Mr. Hanshew** explained the recent changes in federal law make it very difficult for a DD person to get into a nursing home. The only way a DD person can get into a community nursing home is if their medical needs are so great they outweigh the need for the active treatment services at Eastmont/MDC. Or an elderly DD person can waive their rights to DD treatment and in effect say "I just want to be an old person now and be in a nursing home." Those are the only two instances in which a DD person can get into a nursing home.

REP. CURTISS asked why Eastmont is not running at full capacity of 55 when there is fierce competition to get into group homes. **Mr. Hanshew** said the admissions process to Eastmont or MDC is through commitment by the courts. If a DD client wants to go into either institution they must petition the court and meet the criteria for admission. Currently no one is petitioning the court, so there are no new placements in Eastmont or MDC. The kind of person who seeks admission to the state institutions tends to be younger adults who may have behavior issues that make them a risk to the community.

REP. CURTISS asked what will become of the facility at Eastmont if the center closes. **Mr. Anderson** replied there is the possibility of using it to house other state services and

interest has been expressed from a private corporation to use it as a nursing home.

REP. BILL TASH asked if a level of care comparable to Eastmont for patients with high physical needs would be available at group homes. **Mr. Hanshew** answered the group home shave a minimum of three staff people in the house (which has a maximum of six clients) during waking hours. At night there is a minimum of one staff person, although many homes have two night staff if there are clients with special needs. As far as physical and occupational therapy, group homes are run similarly to Eastmont. A professional, usually contracted, provides treatment plans and overseeing and training of staff. Most of the day-to-day therapy is performed by the staff members.

REP. DEBBIE SHEA asked if there is currently any consideration of expanding the services at MDC. **Mr. Anderson** answered the current construction project occurring at MDC is going to consolidate to a smaller campus and provide service to 110 residents, which is a decrease in the number of clients currently served. The new campus will reduce the staff by 18 FTE's - mainly maintenance and custodial. The facility should be completed in 1996 at a construction cost $10.3 million.

REP. SHEA asked why some of the $10.3 million wasn't spent on group homes. **Mr. Anderson** said the decision to build the new facilities for MDC was based on the DD task force recommendations to the 1991 session. It was demonstrated through rebasing rates and construction costs the construction of the new facility would cost no extra general fund dollars.

REP. LIZ SMITH asked if the eligibility requirements for a Medicaid certified facility is the same for group homes as for institutions. **Mr. Hanshew** answered the criteria are different. Both are funded under the Medicaid program but in different areas; group homes are in the Medicaid waiver program which allows states to provide alternatives to institutional care; Eastmont and MDC are under Intermediate Care Facility for Mentally Retarded (ICFMR) funding, which is an extension of the nursing home program.

REP. SMITH asked what are the eligibility criteria differences between group homes and institutions. **Mr. Hanshew** answered the criteria are about the same, a client eligible for ICFMR is also eligible for Medicaid waiver programs. In Montana, state law restricts who can go in an ICFMR program, it is a more stringent criteria than required by federal guidelines.

REP. SMITH asked who would be the professional oversight of group home programs. **Mr. Hanshew** explained the group homes are operated by not-for-profit groups which contract with the state. They are subject to annual licensing examinations from SRS as well as certification inspections from one of two national organizations. On a client basis, each home has case managers to

oversee care plans, in some cases these case managers are SRS employees. DFS investigates any complaints of abuse or neglect.

REP. SMITH asked if people who are served in Eastmont would be eligible for service in group homes given that Eastmont criteria requires the client have limited mobility, limited intellectual ability and an inability to verbalize. **Mr. Hanshew** said the Eastmont criteria are not specifically referenced in the law. The law references "total care" and "near total care" without a precise definition. Community group homes do serve people who meet the same criteria as Eastmont. 200 of the 3,300 served in community programs are profoundly retarded, such as the level of "total care" served in Eastmont. 600 have some kind of seizure disorders, more than 100 are in wheelchairs. The group homes have the experience to serve this kind of population because most of the people who meet these definitions are already in community services.

REP. STEVE VICK asked if the state would build or rent the proposed eight new group homes. **Mr. Hanshew** explained the new homes will be built by the private non-profit organizations that will run the programs. The state gives start-up grants for the cost of construction with the agreement that the state retains the right to take over the building or demand repayment if the organization pulls out of the group home service.

REP. VICK asked how these new group homes address the problem of waiting lists, particularly with the planned downsizing of MDC. **Mr. Hanshew** said it is important to understand that the plan to develop alternatives for Eastmont requires $1.3 million of state appropriated new money for this biennium then will require no more money in the future than the regular operating costs of Eastmont. The group homes provide basically the same level of care, but now it's being provided in the community instead of in the institution. To address the needs of the waiting list it would mean committing $1.3 million every biennium into perpetuity because the need for services will never go away.

SEN. CHUCK SWYSGOOD asked if the Iowa decision that caused the closure of Galen plays into the Eastmont closure decision. **Mr. Anderson** said the Iowa decision was a mental health issue, not a DD issue. There has been indication from the Montana Advocacy Program that if the state doesn't take action to try to get some of these individuals out of the institutions, they may take legal action against the state to force the move into the communities. In 1989 a class action law suit forced the move of six out of MDC, which also drove the plans to downsize MDC. The Eastmont closure decision was not based on what may or may not occur in the courts in the future.

SEN. TVEIT asked how there will be room for new patients at MDC since the proposal is to move 19 Eastmont patients to MDC but then reduce the MDC from 119 to 110 beds. **Mr. Anderson** said it is estimated a total of 66 individuals will be placed in

community group homes. The fiscal note for new proposals indicates eight group homes and an additional three group homes is being requested under present law adjustments. Even if Eastmont does not close, there needs to be 18 clients moved from MDC to make the new facility workable.

REP. DANIEL MCGEE commented that the director of Eastmont testified only one family has asked to have their family member moved to a community group home. "If that's the case, whose best interests are being served by the closure of Eastmont and the removal of those clients?" **Mr. Anderson** responded that the best interests of the clients and their families are being addressed in this new proposal. Many of the individuals served at Eastmont and MDC have very close ties with their families, many of whom live far away. Expanding community services and allowing services to be closer to home serves families and the clients.

REP. CURTISS questioned if the Eastmont clients would lose some of their progress due to the trauma of being moved from Eastmont. **Mr. Anderson** replied that in the past four years 85 clients have been moved from institutions to group homes and only five have been returned to institutional care because of major behavior issues. **Mr. Hanshew** said regardless of whether a client is transferring from an institution or a home, there is always a difficult adjustment period. It is part of the adjustment process.

Closing by Sponsor:

REP. MCKEE said change is often frightening, usually unsettling, and more often than not is resisted. Change is probably what is making a lot of people reticent to leave Eastmont. The legislature is here to do what is best for all of Montana's citizens - the young, the elderly, the disabled, the workers, the families. HB 65 is a plan to keep families more intact. She said that HB 65 is a fiscally, morally and well-thought out responsible bill. "I believe future placements of the developmentally disabled lies in community based services. And I submit to the members of the committee, that future is now. Please support HB 65. Thank you very much."

ADJOURNMENT

Adjournment: 10:50 a.m. (for the original meeting)

BOB CLARK, Chairman
Judiciary Committee

MARJORIE I. FISHER, Chairman
Institutions and
Cultural Education Subcommittee

JOHN COBB, Chairman
Human Services & Aging Subcommittee

PAULA CLAWSON, Recording Secretary

BC/MF/JC/pc

HOUSE OF REPRESENTATIVES

Judiciary

ROLL CALL DATE 1/27/95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Bob Clark, Chairman	✓		
Rep. Shiell Anderson, Vice Chair, Majority	✓		
Rep. Diana Wyatt, Vice Chairman, Minority	✓		
Rep. Chris Ahner	✓		
Rep. Ellen Bergman	✓		
Rep. Bill Boharski	✓		
Rep. Bill Carey	✓		
Rep. Aubyn Curtiss	✓		
Rep. Duane Grimes	✓		
Rep. Joan Hurdle	✓		
Rep. Deb Kottel	✓		
Rep. Linda McCulloch	✓		
Rep. Daniel McGee	✓		
Rep. Brad Molnar	✓		
Rep. Debbie Shea	✓	✓	
Rep. Liz Smith	✓		
Rep. Loren Soft	✓		
Rep. Bill Tash	✓		
Rep. Cliff Trexler	✓		

INSTITUTIONS

ROLL CALL VOTE

Joint Appropriations Subcommittee

DATE _____ BILL NO. _____ NUMBER _____

MOTION: _____

_____

_____

NAME	AYE	NO
Rep. Marj Fisher, Chairman ✓		
Rep. Red Menahan ✓		
Rep. Steve Vick ✓		
Sen. Larry Tveit, Vice Chairman ✓		
Sen. Gary Aklestad ✓		
Sen. Mignon Waterman ✓		

HUMAN SERVICES & AGING

ROLL CALL VOTE

Joint Appropriations Subcommittee

DATE _____ BILL NO. _____ NUMBER _____

MOTION: _____

_____

_____

NAME	AYE	NO
Rep. John Cobb, Chairman ✓		
Rep. Beverly Barnhart ✓		
Rep. Betty Lou Kasten ✓		
Sen. Chuck Swysgood, Vice Chairman ✓		
Sen. J.D. Lynch ✓		
Sen. Jim Burnett ✓		

EXHIBIT 1
DATE 1/27/95
HB 65

HB 65

HB 65 was recommended by the Governor's Human Services Subcabinet's Interagency Task Force on Developmental Disabilities. The bill accomplishes two major goals:

1. Revises current commitment laws to clarify language and definitions, improve the commitment process, and eliminate current sunset provisions.

2. Discontinues Eastmont Human Services Center's function as a residential facility for the developmentally disabled.

Note: Changes in item 1. are needed even if Eastmont is not discontinued.

Over the past two decades Montana has faced increasing pressure to reorganize its services for individuals with developmental disabilities. In 1989 the Governor's Human Service Sub-cabinet appointed an Interagency Task Force on Developmental Disabilities including representatives from the five human services departments, advocates, family members, institutional and community service providers. Over the last four years the task force has recommended and implemented major initiatives that have substantially reduced and enhanced institutional services while also expanding and improving community services for the developmentally disabled. HB 65 reflects the task force's continuing effort to improve services for indivividuals with developmental disabilities now and in the future.

Through its ongoing review and evaluation of Montana's Developmental Disabilities Service System, it was determined by the task force that many of the individuals currently being served at both Eastmont and the Montana Developmental Center (MDC) could and should be served in less restrictive community services. From this evaluation the task force developed a specific plan to expand community services for approximately 66 individuals in FY 96-97, and for an additional 12 individuals in FY 98-99. These 78 individuals would come from both Eastmont and MDC, with Eastmont discontinuing as a residential facility effective **January 1, 1997**. Also, as part of this plan, revisions in the commitment laws were recommended. Passage of HB 65 is needed to carry out this plan.

HB 65 is not being presented as a criticism of Eastmont's facility, services or staff; and it is <u>not</u> being presented as a cost savings measure. The bill proposes to reallocate current level resources from institutional services to community services, and is being recommended for the following reasons:

1. <u>Philosophy of Normalization</u> - Making available to persons with developmental disabilities the patterns of everyday life which are as close as possible to regular circumstances and normal ways of life and society. Community services can better provide this normal environment than institutions.

2. State and Federal Laws - State law and federal regulations require individuals with a developmental disability be committed to institutional facilities only when they cannot be safely and effectively treated in community based programs. Assessments on 173 individuals committed to institutions indicate that approximately 70 could be served in current types of community based programs.

3. Eastmont Mission - Over the last five years there have been no new commitments to MDC or Eastmont of the types of individuals resembling those being considered for community placement under this proposal. Also the majority of clients being served at Eastmont could be moved to community services. This calls into question "what is the current or future mission of Eastmont?"

4. Reallocation of Resources - When possible, the reallocation of resources from institutional services to community services expands our ability and capacity to provide services.

5. Future - Future needs for institutions is diminishing. Parents of kids with developmental disabilities tell us they will not accept institutional placement as an option for their children.

As part of this plan, the Department Corrections Human Services (DCHS) has recommended funding for an employee transition and benefit package for affected Eastmont employees, and is also researching alternative uses for the Eastmont facility. It is imperative that local officials, labor organizations and legislators also assist in the effort to find an alternative use for the facility.

HB 65 is drafted rather unusual as it requires 3 effective dates. Refer to Section 27:

1. The first effective date is the date of passage and will implement all the commitment language changes but leaves Eastmont and the definition of seriously developmentally disabled alone.

2. January 1, 1997 - keeps in all of the commitment language changes and also eliminates Eastmont.

3. January 1, 1998 - keeps in all commitment language changes, eliminates Eastmont, and changes the definition of seriously developmentally disabled.

The bill was drafted in this manner so effective dates correspond to dates of patient transfers. It also allows for changes in the commitment language to be implemented even if Eastmont is not discontinued, simply by amending out items 2. and 3. from Section 27.

COMMUNITY SERVICE ALTERNATIVES TO EASTMONT(HB65)

Proposal: House Bill 65 and the Executive Budget both contain parts of a proposal to close Eastmont Human Services Center(EHSC) and re-allocate the funding to develop community based programs for 48 current residents of state operated institutions for people with developmental disabilities. The plan is based on the recommendation of the Interagency Task Force on Developmental Disabilities, a group made up of parents, services providers, advocates and state agency personnel.

The following are the questions that are most often asked regrading the proposal:

1. What community services will be developed?

Answer: The plan calls for developing up to eight new six-person intensive group homes and accompanying day services in communities across the state. Fewer homes may be constructed if current group home residents who are seeking other service alternatives are enabled to move into more integrated living situations such as supported apartments. People from the institutions would then be able to move into the openings created in existing homes. This kind of approach would allow more people to immediately benefit from the Eastmont initiative and reduce the need for new home construction.

2. What will the group homes be like?

Answer: The homes are specially constructed to meet the needs of people with disabilities in accordance with nationally recognized health and safety standards. Homes are totally physically accessible and barrier free and include built-in fire sprinkler systems. Great care is taken to ensure that the homes are attractive and that they blend into the neighborhoods in which they are located. The cost of construction is between $250,000 and $300,000 per home.

3. How will the homes be staffed?

Answer: During the hours that people are awake and in the home a minimum of three staff persons will be on duty. At night there will be at least one staff person who is awake and working in the home. Staff receive training in all areas of working with people with disabilities, including, but not limited to: first aid, CPR, supervising the administration of medications, infection control and other health care procedures, and behavior management and other teaching techniques.

4. What will people do during the day?

Answer: People who live in group homes leave the home during the day in order to attend a day program. The activities at the day program are based on the needs and desires of the persons served. Some people work or receive training at the day program; others may receive the assistance and support they need to find and keep a job, if that is possible.

5. Who will operate the services?

Answer: Services are delivered by private not-for-profit corporations under contract with the Department of Social and Rehabilitation Services(SRS). Each corporation is governed by a board of directors made up of citizens with an interest in services to people with disabilities. SRS currently contracts with 52 agencies to provide services to almost 3,300 people with developmental disabilities and their families.

6. Will specialized health related services such as nursing or occupational and physical therapy be available?

Answer: In order to deliver services, the intensive group home provider agency must demonstrate that all the needs of the people they will be asked to serve can be met, including needs for specialized services. Some community agencies directly employ therapists and nurses. Most agencies contract with private providers or home health agencies to deliver these services based on individual need(Eastmont also contracts with private providers for some of these services). No one will move to a place that does not have the resources readily available to meet their specific needs, including specialized therapies.

7. What will the proposal cost?

Answer: When fully implemented the annual cost of the new community services is virtually the same as the cost of operating EHSC, with a small projected general fund savings of about $50,000 per year. There is a one time cost to make the transition to community services during the 1997 biennium of about $1.3 million in state general fund. The one-time funding covers start-up costs for new group homes, costs in phasing out the EHSC facility and employee assistance costs for EHSC staff.

8. Why not spend the money on people waiting for community services?

Answer: Since the proposal re-allocates money that the state is already spending on one type of service to another more appropriate type of service, using the money to address the needs of people on the waiting list is not an option. Addressing the immediate needs of the waiting list would require an ongoing appropriation of additional funding, this proposal does not require any more money once it is fully implemented. The Eastmont closure will, however, have a dramatic impact on the people who will need services in the future. If implemented, the plan will re-allocate over $3.0 million from a service without a waiting list to a set of services that many Montanans are seeking out and waiting for.

9. What's wrong with Eastmont?

Answer: The plan to develop community services is not intended as an indictment of the way Eastmont provides treatment. Eastmont does a good job of providing residential services within the framework of an institutional model of service. The institutional model is the issue. For some extremely aggressive people and some people who require total care and/or are medically fragile, institutions are an appropriate service option. The vast majority of the people with developmental disabilities who live at Eastmont do not have these kinds of needs. Even the most caring and dedicated professionals can't overcome the built-in limitations that are part of serving large numbers of people living in an big residential facility. Because of the limitations of the service model, only folks who really need to be there should be placed in institutions; that's what this discussion is all about.

10. What about the Montana Developmental Center?

Answer: Some states have taken the position that institutions have no role to play in services. Montana's plan for developmental disabilities services has, however, defined a specific role for state operated institutions and assigned that role to Montana Developmental Center(MDC). The mission of MDC has two distinct parts: 1) the treatment of people with severe behavior problems that present a significant danger to themselves and others. 2) services for some people who require total care and may have severe medical conditions. Some of the long term residents of MDC do not meet either of the criteria described above; they will be considered for placement in the community if the plan is approved. All of the people admitted to the institution since the state commitment

law was revised in 1991 fit the new MDC mission. In addition to the Eastmont proposal, the Executive Budget also contains funding to reduce the population at MDC by 18 people. Six of the people will be placed into community services this year, the remainder will be placed in Fy 97. These placements are necessary in order to accommodate the MDC remodeled campus and will go forward regardless of whether or not Eastmont is closed.

11. What do the people in Eastmont look like?

Answer: The average age of the forty-nine people who live at Eastmont is 45 years old. The oldest person is 72, the youngest is 25. The average resident of Eastmont has lived there for a little over 9 years. Seven of the people are from communities east of Billings. Assessments done within the last year indicate that the "typical" Eastmont resident requires a good deal of personal assistance due to their limited ability to meet their own basic self-care needs(feeding, dressing, bathing, toileting etc.). Some residents engage in behaviors that are a challenge for staff to deal with, but few if any present a significant danger to themselves or others. A number of people receive occupational, physical and speech therapy, but the majority of the services are delivered by EHSC direct care staff under the periodic supervision of the contracted professionals. On-site nursing is a need for a very limited number of people.

12. Can community programs really serve the kind of people who live at Eastmont?

Answer: The majority of people with developmental disabilities in Montana who have needs similar to the Eastmont population are already served in community programs. Many of the adults served in intensive group homes and day services have the same needs as the Eastmont group. Since there is no one under the age of 18 in either EHSC or MDC, all of the kids with similar needs are in the community. A survey of parents and advocates of people placed from MDC and EHSC over the last four years revealed that while they were generally satisfied with services at the institutions, having experienced both institution and community services, they prefer the community service model.

13. Who will be placed into community services?

Answer: Assessments done within the last year indicate that at least 70 residents of EHSC and MDC could be served in community programs. If the proposal to close Eastmont is approved, the needs of all of the residents of the two institutions will be re-assessed. The only people who

will be considered for placement will be the individuals from MDC and EHSC who have been determined to be ready after the re-assessment of their needs is complete. Eastmont residents who do not go to community programs will be transferred to MDC.

14. Where will the services be located?

Answer: Efforts will be made to accommodate the desires of the individuals who will be placed. If, for example, a resident has a brother or sister in Butte who would like them closer to home, we will try to develop the services in Butte. Additional criteria that will come into play when making the decision on where to develop services will be the availability of the necessary specialized support services and the long term demand for the group home services in that location.

15. What is the impact on the Glendive community if HB 65 is passed?

Answer: Currently Eastmont has 105.12 positions (fte) and employs approximately 115-120 people. These state jobs would be eliminated under this proposal. The Task Force was unable to identify an alternative mission for EHSC in the developmental disabilities service system. DCHS is currently looking into alternative uses for the Eastmont facility outside of developmental disabilities. The development of an alternative program or use for the Eastmont facility will require assistance from the local community leaders and legislators, and would help mitigate job loses and impact on the community. Also, the Eastern Montana Veterans Home will soon be providing an additional 70-80 jobs and SRS will be looking at developing at least one or even two group homes in Glendive.

16. What is being done to assist the Eastmont employees if this proposal goes forward?

Answer: The Executive Budget includes an Eastmont employee assistance package. This package calls for the continuation of the current state reduction in force (RIF) registry, state employee insurance participation for six months after layoff, moving assistance, and a severance/incentive payment of $650 for every year of state service. Also the Department of Labor will provide training and layoff assistance to Eastmont employees under Title III of the Job Training Partnership Act.

17. Why are we doing this?

Answer: For more than twenty years Montanans have engaged in an ongoing, sometimes lively and contentious, discussion regarding the best ways for the state to assist and support its citizens with developmental disabilities. The place where Montana has drawn the line separating those who can best be served in the state's institutions from the people who can and should live in the community has changed over the two decades. Part of the change is a product of the maturation of community programs. Playing an even larger part in the move towards community services are the changing expectations of parents, advocates and the people with disabilities themselves. The Eastmont proposal represents the latest chapter in the ongoing discussion. **It's a fairly straight forward policy question: What is the highest and best use of the money the state has chosen to spend on developmental disabilities services.**

Some facts are clear:

1) There is no waiting list to get into Eastmont;

2) The only admissions to Eastmont over the past five years have been people transferred from MDC;

3) People are waiting in line for community services;

4) Because of special education and supports for families, no kids are in state operated institutions;

5) The families of the kids with disabilities who have kept their children at home are telling us they do not want institutional services in the future.

Boiled down to its simplest form, the proposal to close Eastmont is an attempt to listen to the customer and re-allocate scarce resources away from a service where demand is decreasing to the services people are telling us they want in the future.

Eastmont

HB 65

HB 65 was recommended by the Governor's Human Services Subcabinet's Interagency Task Force on Developmental Disabilities. The bill accomplishes two major goals:

1. Revises current commitment laws to clarify language and definitions, improve the commitment process, and eliminate current sunset provisions.

2. Discontinues Eastmont Human Services Center's function as a residential facility for the developmentally disabled.

Note: Changes in item 1. are needed even if Eastmont is not discontinued.

Over the past two decades Montana has faced increasing pressure to reorganize its services for individuals with developmental disabilities. In 1989 the Governor's Human Service Sub-cabinet appointed an Interagency Task Force on Developmental Disabilities including representatives from the five human services departments, advocates, family members, institutional and community service providers. Over the last four years the task force has recommended and implemented major initiatives that have substantially reduced and enhanced institutional services while also expanding and improving community services for the developmentally disabled. HB 65 reflects the task force's continuing effort to improve services for indivividuals with developmental disabilities now and in the future.

Through its ongoing review and evaluation of Montana's Developmental Disabilities Service System, it was determined by the task force that many of the individuals currently being served at both Eastmont and the Montana Developmental Center (MDC) could and should be served in less restrictive community services. From this evaluation the task force developed a specific plan to expand community services for approximately 66 individuals in FY 96-97, and for an additional 12 individuals in FY 98-99. These 78 individuals would come from both Eastmont and MDC, with Eastmont discontinuing as a residential facility effective **January 1, 1997**. Also, as part of this plan, revisions in the commitment laws were recommended. Passage of HB 65 is needed to carry out this plan.

HB 65 is not being presented as a criticism of Eastmont's facility, services or staff; and it is <u>not</u> being presented as a cost savings measure. The bill proposes to reallocate current level resources from institutional services to community services, and is being recommended for the following reasons:

1. <u>Philosophy of Normalization</u> - Making available to persons with developmental disabilities the patterns of everyday life which are as close as possible to regular circumstances and normal ways of life and society. Community services can better provide this normal environment than institutions.

2. State and Federal Laws - State law and federal regulations require individuals with a developmental disability be committed to institutional facilities only when they cannot be safely and effectively treated in community based programs. Assessments on 173 individuals committed to institutions indicate that approximately 70 could be served in current types of community based programs.

3. Eastmont Mission - Over the last five years there have been no new commitments to MDC or Eastmont of the types of individuals resembling those being considered for community placement under this proposal. Also the majority of clients being served at Eastmont could be moved to community services. This calls into question "what is the current or future mission of Eastmont?"

4. Reallocation of Resources - When possible, the reallocation of resources from institutional services to community services expands our ability and capacity to provide services.

5. Future - Future needs for institutions is diminishing. Parents of kids with developmental disabilities tell us they will not accept institutional placement as an option for their children.

As part of this plan, the Department Corrections Human Services (DCHS) has recommended funding for an employee transition and benefit package for affected Eastmont employees, and is also researching alternative uses for the Eastmont facility. It is imperative that local officials, labor organizations and legislators also assist in the effort to find an alternative use for the facility.

HB 65 is drafted rather unusual as it requires 3 effective dates. Refer to Section 27:

1. The first effective date is the date of passage and will implement all the commitment language changes but leaves Eastmont and the definition of seriously developmentally disabled alone.

2. January 1, 1997 - keeps in all of the commitment language changes and also eliminates Eastmont.

3. January 1, 1998 - keeps in all commitment language changes, eliminates Eastmont, and changes the definition of seriously developmentally disabled.

The bill was drafted in this manner so effective dates correspond to dates of patient transfers. It also allows for changes in the commitment language to be implemented even if Eastmont is not discontinued, simply by amending out items 2. and 3. from Section 27.

COMMUNITY SERVICE ALTERNATIVES TO EASTMONT(HB65)

Proposal: House Bill 65 and the Executive Budget both contain parts of a proposal to close Eastmont Human Services Center(EHSC) and re-allocate the funding to develop community based programs for 48 current residents of state operated institutions for people with developmental disabilities. The plan is based on the recommendation of the Interagency Task Force on Developmental Disabilities, a group made up of parents, services providers, advocates and state agency personnel.

The following are the questions that are most often asked regrading the proposal:

1. **What community services will be developed?**

Answer: The plan calls for developing up to eight new six-person intensive group homes and accompanying day services in communities across the state. Fewer homes may be constructed if current group home residents who are seeking other service alternatives are enabled to move into more integrated living situations such as supported apartments. People from the institutions would then be able to move into the openings created in existing homes. This kind of approach would allow more people to immediately benefit from the Eastmont initiative and reduce the need for new home construction.

2. **What will the group homes be like?**

Answer: The homes are specially constructed to meet the needs of people with disabilities in accordance with nationally recognized health and safety standards. Homes are totally physically accessible and barrier free and include built-in fire sprinkler systems. Great care is taken to ensure that the homes are attractive and that they blend into the neighborhoods in which they are located. The cost of construction is between $250,000 and $300,000 per home.

3. **How will the homes be staffed?**

Answer: During the hours that people are awake and in the home a minimum of three staff persons will be on duty. At night there will be at least one staff person who is awake and working in the home. Staff receive training in all areas of working with people with disabilities, including, but not limited to: first aid, CPR, supervising the administration of medications, infection control and other health care procedures, and behavior management and other teaching techniques.

4. What will people do during the day?

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7. What will the proposal cost?

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EXHIBIT 2
DATE 1/27/95
HB 65

STATE OF MONTANA - FISCAL NOTE

Revised Fiscal Note for HB0065, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill to generally revise the laws governing commitment to residential facilities for people who are developmentally disabled, to discontinue the function of the Eastmont Human Services Center (EHSC) at Glendive, and to set qualifications for a person to be committed to a residential facility.

ASSUMPTIONS:

1. The Executive Budget contains new proposals, which recommend the closure of the Eastmont Human Services Center (EHSC) and expansion of community services to serve developmentally disabled (DD) clients, and which are summarized in assumptions three through 16 below.
2. The Executive Budget **present law base** maintains the operation of EHSC through the end of the 1997 biennium. The present law base contains operating expenses for one new group home (available starting FY95) in FY96 and startup costs and operating for two new group homes in FY97. These would allow community placements to keep the Montana Development Center (MDC) population below 110 clients and EHSC at 50. Medicaid certification for MDC is jeopardized if the population exceeds 110 clients.
3. EHSC would close January 1, 1997, and clients would be moved to community-based services. The Executive Budget reflects six months savings in FY97 under new proposals.
4. Separate **new proposals** are included in the Executive Budget under the Department of Corrections and Human Services (DCHS), the Department of Social and Rehabilitation Services (SRS), and the Department of Family Services (DFS) to reflect the implementation of this bill. This fiscal note primarily details the difference from the present law base as a result of this bill.
5. Services will be provided in several smaller group homes or individualized supported living arrangements rather than in one larger residential facility. A variety of work\day service options will be available. The closure of EHSC will require the movement of approximately 48 clients to community group homes. Eight, 6 person, intensive community group homes would be added in the 1997 biennium to provide for these clients.
6. Group homes will be available in the following schedule: three in August 1996; three in September 1996 and two in October 1996.
7. Start-up costs are $80,000 general fund per group home. There is budgeted in SRS $640,000 general fund in FY96 for eight group homes, including the purchase and equipping of the group homes, and a net $2,458,849 in FY97 comprised of $818,133 general fund and $1,640,716 federal special revenue. The annual cost of group home operation is $342,130 in FY96. Of this amount, $330,130 is funded at the Medicaid match rate and is estimated to increase 3% per year. An additional $12,000 of general fund is used each year for operating each group home.
8. The Medicaid match rate (FMAP) is budgeted as follows: actual FY95 = 29.13% general fund and 70.87% federal special revenue; actual FY96 = 30.26% GF and 69.74% FSR; estimated FY97 = 31.00% GF and 69.00% FSR.
9. There is a Vocational Program expansion new proposal in DCHS, which contains 2.25 FTE and $56,448 in FY96 and $55,624 in FY97 to maintain the program required for Medicaid certification of EHSC.
10. A 3% inflation factor is applied to EHSC budgets for FY97, FY98, and FY99, consistent with inflation in community programs.
11. Included in operating costs for EHSC in FY97 is $2,000 per FTE for an Employee Transition Assistance program for a total of $210,240, including vacation and sick leave payouts. The net reduction of state employees in DCHS would be 52.57 FTE in FY97.
12. There is private revenue shown in the DCHS FY94 base that comes from third-party recovery of costs and is deposited to the general fund, but which would be eliminated for a general fund loss of $106,815 in FY97 and about $212,000 on an annualized basis.

(continued)

Dave Lewis 1-10-95
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Jeanette S. McKee 1/12/95
JEANETTE MCKEE, PRIMARY SPONSOR DATE

13. Federal legislation would require Medicaid to rebase FY96 and FY97 costs at EHSC during shutdown.
14. The cost of DD Case Management is $170 per person per month and is funded at the Medicaid match rate. These amounts are included in the operating costs outlined in number 7 above.
15. The DFS cost for state Supplemental Security Income program (SSI) will be $94 per month per client funded by general fund and held constant over the years. The amount budgeted in new proposals is $45,872 in FY97. Clients previously served at EHSC will become eligible for SSI when moved to community services.
16. **In summary, these new proposals already contained in the Executive Budget in all three state agencies result in a general fund cost of $630,500 in FY96 and $616,720 in FY97.**
17. An additional $100,000 general fund cost needs to be budgeted to provide a staff retention incentive program in order to maintain Medicaid certification at EHSC until closure. Loss of Medicaid certification would result in loss of revenue to the general fund of approximately $208,334 per month.

FISCAL IMPACT:

The only fiscal impact from this bill not already reflected in the executive budget is an additional $100,000 general fund cost in FY97 for the retention incentive program discussed in number 17 above. **The total net impact during the 1997 biennium is a $1,347,220 general fund cost.**

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

1. Disposition of the physical property at EHSC could have one or more of the following effects:
   - o Income to the state from the sale of the physical property, based on PAMS valuation, would be $1,988,966.
   - o Income from leasing the physical property at EHSC would be $156,715 (based upon 43,303 sq. ft. at EHSC x $4.90 provided by Dept. of Administration, General Services = $212,185 less $55,470 utilities based upon FYE94 SBAS for EHSC).
   - o Cost to the state of maintaining the physical property if EHSC is neither sold or leased would be $75,470 (utility costs of $55,470 + $20,000 for a contracted custodian).
2. Additional community services would be developed in the 1999 biennium and two intensive group homes serving six persons each would be available in July, 1998.
3. Not including any assumptions regarding the disposition of the EHSC physical property, the general fund savings will be as follows:

	FY98 Difference	FY99 Difference
DCHS	(1,098,136)	(1,133,071)
SRS	994,938	1,020,995
DFS	54,144	54,144
Total General Fund Savings	(49,054)	(57,932)

EXHIBIT 3
DATE 1/27/95
HB 65

January 24, 1995

To: Representative Jeanette McKee

From: Cary B. Lund
Legal Counsel
Department of Social & Rehabilitation Services

Subject: SUMMARY DESCRIPTION OF PROPOSED CHANGES IN HB 65: AMENDING THE LAWS GOVERNING COMMITMENTS TO RESIDENTIAL FACILITIES

I. PURPOSES

HB 65 serves two general purposes. Most of the amendments are for the purpose of making changes in the current procedures relating to the commitment of persons with developmental disabilities to a state institution. A handful of amendments are for the purpose of accomplishing the closure of the Eastmont Human Services Center.

II. Generally

The language and terms of the provisions proposed for amendment have been changed wherever clarification, consistency, or appropriate usage warranted the changes. Many provisions have been broken into new subsections to provide for better organization and comprehension.

Previously, the terms "respondent", "person", "committed person", and "resident" appeared in the provisions without consistent usage. Proposed changes would provide more consistent and appropriate use of the terms.

Previously, the usage of the terms "admission" and "commitment" was interchangeable. The proposed changes include the removal of the term "admission". That term connotes a voluntary process which is not the circumstance with commitments to the two residential facilities.

Language which is suggestive of stigma has been removed or changed. This includes changing "the developmentally disabled" to "persons with developmental disabilities".

References in various statutes to Eastmont are removed effective January 1, 1997.

III. Sections 3, 4 and 5, Definitional Changes in 53-20-102, MCA.

For purposes of the time lines necessary to achieve closure of Eastmont, the proposed bill contains three separate sections, Sections 3, 4 and 5, which amend Section 53-20-102, Definitions. The amendments in these three separate sections are the same except for the definitions of "residential facility" and "seriously

developmentally disabled".

Under the current law, the definition of "residential facility" includes the Montana Developmental Center and Eastmont. Also under the current law the definition of "seriously developmentally disabled" would revert on July 1, 1995 to the prior definition that was replaced in 1991. That definition did not appropriately address the population of persons who were to be served by the Montana Developmental Center. Each section of definitions, Section 3, 4 and 5, shows the definitions statute with all the material interlined as it would have appeared after July 1, 1995. The interlining along with the inclusion of Section 27, Chapter 381, Laws of 1991 in the repealer section, Section 25, are for the purpose of removing the authority for the repeal of the current definition of "seriously developmentally disabled" in the current definition section.

The Section 3 set of definitions are the current set of definitions that contain the definitions of "residential facility" and "seriously developmentally disabled" that must continue in place until Eastmont is closed. The Section 4 set of definitions are the set of definitions that contain the current definition of "seriously developmentally disabled" that must continue in place until the population of near total care persons are deinstitutionalized from Montana Developmental Center as well as Eastmont. The Section 5 set of definitions are the definitions that will govern when the population of the Montana Developmental Center no longer may include persons who require near total care.

Section 3 removes the authority for the reversion of the definition of "seriously developmentally disabled" to that in effect prior to 1991, leaving the current definition in place. The current definition allows for persons with significant behavior problems and persons in need of total care and near total care to be committed to an institution. The definition of "residential facility" will still include Eastmont for the duration of this set of definitions. The definitions in Section 3 are effective upon enactment of the bill and are no longer of effect on December 31, 1996.

Section 4 is the set of definitions that comes into effect on January 1, 1997 and are no longer of effect on December 31, 1997. The definition of "seriously developmentally disabled" will remain unchanged from Section 3. The effective date of this section coincides with the closure of Eastmont. Consequently, Eastmont does not appear in the definition of "residential facility" in Section 4.

The Section 4 set of definitions are replaced by the Section 5 on January 1, 1998. In the Section 5 set of definitions, "near total care" is removed from "seriously developmentally disabled" and therefore changes the substantive criteria for commitment to an institution. The timing of this change allows for the population of near total care persons to be deinstitutionalized from the

Montana Developmental Center as well as from Eastmont.

The following discussions concern amendments that are the same in Sections 3, 4 and 5.

The listing of specific community services under the definition of "community based facilities" and "community based services" is proposed for deletion because it is unnecessary and outdated in part.

The term "professional person" is to be replaced with the term "developmental disabilities professional" which is more descriptive of the status of this class. This term does not encompass the qualified mental retardation professional who provides certain types of professional oversight in the institutional settings.

The aspects of the definition of "qualified mental retardation professional" which originally related to the community aspects of the professional person role are to be deleted.

The proposed changes to the definition of "resident" include the deletion of the phrase "for a course of evaluation, treatment, or habilitation". The phrase is not necessary for the purpose of defining the term and is redundant within itself in that it includes "treatment" and "habilitation'.

The proposed change to the definition of "residential facility screening team" provides a definitive statement of purpose for the team.

IV. Sections 1, 2, 24 and 25, Proposed changes to 53-1-202, 53-1-402 and 53-20-501, MCA and repeal of 53-20-502, MCA.

The amendments in Sections 1, 2 and 24 and the repeal of 53-20-502, MCA in Section 25, effective on January 1, 1997, remove references and material related to Eastmont.

V. Section 6, Proposed changes to 53-20-104, MCA.

Section 6 contains amendments to 53-20-104, MCA for the purposes of clarification and conformity of language. There are no substantive changes.

VI. Section 7, Proposed changes to 53-20-106, MCA.

Section 7 amends 53-20-106, MCA replacing the term "professional person" with the more appropriate term "developmental disabilities professional". The addition of the language to the provision providing that developmental disability professionals must be certified will allow for the repeal of 53-20-105, MCA provided in Section 25.

VII. Section 8, Proposed changes to 53-20-107, MCA.

The proposed amendments to 53-20-107, MCA remove the requirement that the responsibilities of the developmental disabilities professionals encompass evaluation services in guardianship proceedings.

VIII. Section 9, Proposed changes to 53-20-112, MCA.

The proposed amendments to 53-20-112, MCA remove unnecessary language and conform terminology. There are no substantive changes.

IX. Section 10, Proposed changes to 53-20-113, MCA.

The proposed amendments to 53-20-113, MCA include the removal of procedural requirements relating to the commitment of minors. This language is unnecessary in that 53-20-125(1), MCA will now limit commitments to persons 18 years or older in age.

X. Section 11, Proposed changes to 53-20-114, MCA.

The proposed amendments to 53-20-114, MCA are to provide clarity and conform terminology. There are no substantive changes.

XI. Section 12, Proposed changes to 53-20-116, MCA.

The proposed amendments to 53-20-116, MCA make the provision of testimony by a member of the residential facility screening team permissive rather than required at any commitment hearing. The developmental disabilities professional would no longer be an alternative for the presentation of testimony.

XII. Section 13, Proposed changes to 53-20-118, MCA.

The proposed amendments to 53-20-118, MCA are to provide clarity and conform terminology. There are no substantive changes.

XIII. Section 14, Proposed changes to 53-20-121, MCA.

The proposed amendments to 53-20-121, MCA are to generally provide clarity. The changes include a requirement that a copy of the petition be provided to the residential facility screening team.

XIV. Section 15, Proposed changes to 53-20-125, MCA.

The proposed amendments to 53-20-125, MCA are to generally provide clarity. New subsection (1) prefaces the provision with a definitive statement of the criteria for commitment. Former subsection (2) would be deleted because its language is redundant of language in other provisions. The respondent's advocate, the county attorney, and the residential facility are added to the list of parties that are to receive notice of the determination of the residential facility screening team. The addition of the requirement in new subsection (11), concerning findings of fact, is a matter of placing this requirement that currently occurs only in

53-20-129, MCA in a more appropriate location. The changes include a requirement that a copy of any order entered by the court be provided to the residential facility screening team.

XV. Section 16, Proposed changes to 53-20-126, MCA.

The amendment to delete subsection (1) of 53-20-126, MCA is proposed since the substantive requirements in the language occur in other provisions.

XVI. Section 17, Proposed changes to 53-20-127, MCA.

The language in 53-20-127, MCA, relating to fitness for trial, is proposed for deletion because it is of no relevance in a civil commitment proceeding. Language relating to transfer to another residential facility is proposed for removal since there will be only one institution.

XVII. Section 18, Proposed changes to 53-20-128, MCA.

The amendments proposed to 53-20-128, MCA would extensively reorganize the provision to provide for better comprehension. The substantive changes proposed for this provision provide that: the petition for recommitment, instead of having to be filed 15 days prior to the end of the current term of commitment, could be filed at any time prior to the end of commitment; the necessity for the conduct of a screen, as provided in 53-20-133, MCA, is expressly stated; copies of the petition for recommitment and the accompanying report are to be sent to appropriate parties; and the court may hold a hearing even if a hearing is not requested by an informed party.

XVIII. Section 19, Proposed changes to 53-20-129, MCA.

The amendments proposed to 53-20-129, MCA would extensively reorganize the provision to provide for better comprehension. The substantive changes proposed for this provision provide that: only a developmental disabilities professional may initiate an emergency placement; notice of an emergency placement must be given to the facility and to SRS; an order for emergency placement may be entered without a hearing; the residential facility screening team may recommend extended placement for a person who is placed on an emergency basis; and the residential facility screening team should report to the court on seventh rather than fifth judicial day following the filing of the petition for emergency commitment.

XIX Section 20, Proposed changes to 53-20-130, MCA.

The amendments proposed to 53-20-130, MCA are to provide clarity and conform terminology. There are no substantive changes.

XX. Section 21, Proposed changes to 53-20-133, MCA.

The proposed amendments to 53-20-133, MCA are to generally conform

terminology. The proposed change to include references to 53-20-128 and 53-20-129, MCA clarifies that the screening process is applicable to recommitments and emergency placements.

XXI. Section 22, Proposed changes to 53-20-146, MCA.

The amendments proposed to 53-20-146, MCA are to conform terminology. There are no substantive changes.

XXII. Section 23, Proposed changes to 53-20-161, MCA.

The amendments proposed to 53-20-161, MCA are to conform terminology. Notice of proposed release of confidential information is to be directed at the resident's advocate as well.

XXIII. Section 25, Repealed provisions.

53-20-105, MCA is proposed for repeal in that a separate provision for this requirement was unnecessary when it could be clearly stated in 53-20-106, MCA.

53-20-111, MCA is proposed for repeal in that it is redundant of the criteria specified in the procedures and criteria of 53-20-102, 53-20-121 and 53-20-125, MCA.

53-20-502, MCA is proposed for repeal in that it is a service description for the Eastmont facility.

Section 27, Chapter 381, Laws of 1991 is proposed for repeal in that it provides that the definition of "seriously developmentally disabled" reverts to the definition as it existed prior to 1991.

XXIV. Section 26, Phrase change.

The Code Commissioner is directed to generally conform references to persons with developmental disabilities in statute by use of the term "persons with developmental disabilities.

XXV. Section 27, Effective Dates.

The general effective date for the proposed changes is upon enactment.

The effective date of January 1, 1997 for Sections 1, 2, 4, and 24 provide statutory authority in relation to Eastmont up to the stated closure date.

The effective date of January 1, 1998 for Section 5 provides statutory authority for the continued commitment of persons with near total care needs up to the date by which those persons will have all been placed out of the Montana Developmental Center.

EXHIBIT 4
DATE 1/27/95
HB 65

Comments
Eastmont Hearing
HB 65
January 27, 1995

First I would like to join Rep. McKee in thanking the chairs of Judiciary, and Human Services and Public Safety & Special Services committees for agreeing to consolidate this hearing. I would also like to thank the Education Subcommittee Chair for agreeing to allow us to use this room for the hearing. I think this cooperation demonstrates we are interested in making the process more user friendly.

One part of our job as government officials is to continue to evaluate the demand for our various publicly-funded services. In fact, we are often criticized as not having the courage to make difficult decisions when the facts document a government service we provide has out-lived its usefulness.

HB 65 is not about the quality of care or employees at Eastmont; it is about our responsibility to assess and reallocate resources. This issue is also about time, and as time passes, change becomes not only necessary but the right thing to do.

What are the primary issues that support this change:

1. Normalization or making available to persons with developmental disabilities the patterns of everyday life which are as close as possible to our lifestyle.

I know this can be difficult, especially to a lay person like you and I who are not involved daily with the developmentally disabled. When I first walked into Eastmont, I was convinced that the residents could not successfully function outside the institutional environment. This impression was reinforced by the dedication of the staff and the quality of the facility. I had to see an intensive group home. What I saw were the same types of residents I saw at Eastmont. Although a difficult process, I have come to clearly realize the majority of Eastmont residents can be effectively cared for in smaller group home environments.

2. Our own State Law and Federal law direct us to serve the developmentally disabled in an institution only if they cannot be safely and effectively treated in the community.

Our own professional assessment of the Eastmont and MDC residents document 70 could be served at the community level if resources were available.

3. If we decided that Eastmont should remain, what would be its long-term role or mission when we know there have been no new commitments resembling the types of residents at Eastmont for the last five years.

4. Our obligation to reallocate resources to better serve those who need these services wherever they may reside. Resources are limited. We will most likely debate

something known as the "waiting list" and whether the proposal represents additional cost or savings.

First, if the question is asked, *"Is this a 'savings' proposal in this biennium?"*, the straight answer is no. In fact, due to the transition of staff, residents and development of group homes, it will cost an additional $1.3 million. But more importantly, how much can we afford to spend and can we afford to spend more in the community -- and still spend $3.5 million per year ($2.5 medical / $1 general fund) at an institution when we know we are no longer admitting the type of patients it serves. I submit to you in the long run, this is an efficiency and savings proposal, because it requires us to choose and reinvest our scarce public dollars.

Second, it is not a waiting list issue. Yes, we have a waiting list for services now, and we will most likely have if Eastmont is closed. But if we realize through this proposal we are expanding the base level of community services, we can clearly see a future positive impact on the waiting list.

Third, part of the cost is to help transition and support staff. Good management and common sense dictate we facilitate change and support those impacted to move in a different direction. That is why the Department has included and supports continuation of health insurance, reduction-in-force registry, reallocation funds and retention incentives.

5. Probably most important is the future needs of parents who have cared for their developmentally disabled children and are reaching the point where they need a group home environment for their children. They clearly prefer a smaller group home environment closer to home. And I don't think government should tell parents this service is not available because we have failed to redirect state services.

In addition, we have been working to identify alternative uses which have a future in the Glendive community. We have encountered some positive interest but clearly will be unable to confirm the future until this decision is made.

This a difficult issue. It impacts staff for whom I have a great deal of respect and appreciation for the work they do. It impacts residents who will have to move to new homes; and it impacts a supportive community. But it is not a new position for the Department to face. The Departments involved have a great deal of experience implementing reductions in institutional services and transition to community environments.

What HB 65 and the accompanying budget proposals do is allow us to solve problems and not just shift the burden to the next legislature or the next administration. In addition, this decision removes the doubt about the future that will shadow Eastmont, its staff, residents and the community. Finally, the Department and the Governor support this proposal because it is the right thing to do, and we request your support of this difficult decision.

c:\legis\hb65.tst

EXHIBIT 5
DATE 4/27/95
HB 65

MEMORANDUM

TO Rick Day, Director
Corrections and Human Services

FROM Janie Wunderwald
Agency Contract Manager

DATE January 26, 1995

RE Alternative Use of Eastmont Human Services Center

Research Purpose:

The purpose of this research is to prepare informed recommendations for alternative use of the Eastmont Human Services Center complex in the event the legislature adopts the Governor's proposal to discontinue its current function (HB 65).

Strategy:

Research was conducted through survey document and telephone interviews with public officials and private sector employers.

Economic stabilization of the Glendive community was considered the primary evaluation component when ranking recommendations for alternative use.

Report of findings and recommendations:

A. PRIORITY #1: NURSING HOME USE

Because the facility meets nursing home physical plant standards, preserving that function as well as potential re-employment of current staff, would result in the least negative economic impact to the community and the state.

According to the Department of Health and Environmental Sciences Health Services Division records, Glendive is in need of 32 additional nursing home beds.

- Contact with the Operations Manager of Lantis Enterprises, Inc., an out of state nursing home corporation, resulted in an expression of interest in the property. This corporation has several nursing home operations in Eastern Montana and when purchasing existing properties, it is their

policy to always give hiring preference to current staff. When acquiring properties which have skilled, trained staff and utilizing it as a combined nursing home/assisted living complex, Lantis has a practice of re-hiring the majority of staff positions.

- An executive with Horizon Health Care was contacted. He stated their company was not interested in expanding their operation into Eastern Montana at this time.

- The Glendive Medical Center is not at this time interested in the Eastmont property as their expansion plans include additional construction on property adjoining their current location.

B: CO-LOCATION

A letter and survey document was sent to State Agency Directors listed as having field operations in Glendive. The purpose of the survey was to determine levels of interest in co-locating State offices at the Eastmont property.

SRS, DFS, their Contractor's, and the Job Service

Recognizing the Governor's call for each Director to consider co-location of state/county services in future planning, the possibility of utilizing the Eastmont facility complex for that purpose was upon first impression, a logical consideration. However, resulting research revealed five state, county and local non-profit human service providers are already officed in one building located at 207 West Bell. These are SRS, its contractor - DEAP (Developmental Educational Assistance Program), DFS, its contractor - R&R (Resource and Referral for child care services), and WIC (Women, Infants and Children). Three other human service providers are within one block of that address. They are Job Service, Dawson County Health Department, and "ACTION", the local Human Resource Development Council (HRDC). These eight human service providers work together in varying capacities with like clients in a cooperative, cross-referral environment. Additionally, the U.S. Post Office, used extensively by SRS and DFS as a means of client/family location, is conveniently across the street from the West Bell address. The central, downtown location is seen as key to their combined client focus.

These human service agencies and local non-profits have been pursuing a common "one-stop-shopping" location for quite some time. In response to this effort, the Dawson County Commissioners are currently working on developing a grant request to acquire a building directly behind the U.S. Post Office which has adequate space to support that objective.

The Eastmont complex is approximately 1.5 miles from the downtown district. As an alternative use option, that distance alone could present a disruptive, logistical barrier to clients in need of accessing services. Co-locating human service offices at that facility could also tend to disrupt as well as "commercialize" the residential neighborhood, and would be at cross-purposes with co-location planning currently under way.

TRANSPORTATION - Field Construction Office

Current lease expires 9/30/96 - 1,500 sq. ft. $600 per month - 14 pickups & suburbans: 2 office trailers, 1 lab trailer - 15 personnel. Director believes it could be cost effective to co-locate with other agencies.

REVENUE/Property Assessment Division

Current office space provided free by Dawson County. Only in the event that space was no longer available through the county, would they be interested in co-locating with other state agencies.

REVENUE/Liquor

Leased space is for the operation of a State Retail Liquor Store.

JUSTICE/Motor Vehicle Division

Driver licensing services. Eastmont location and facility is geographically unsuitable.

JUSTICE/Highway Patrol

State owned building.

SUMMARY

A. Nursing Home and/or Assisted Living: A privately owned and operated nursing home best meets the primary evaluation criterion for economic stabilization of the Glendive community. Research verifies potential for sale of the Eastmont property for its continued use as a nursing home or a nursing home/assisted living complex.

B. Co-location of State Offices: Co-locating human service providers at the Eastmont location is likely to be disruptive to clients in need of accessing services. It could also be perceived as being at cross-purposes with the co-location planning currently under way in Glendive and may also tend

to disrupt or "commercialize" Eastmont's residential neighborhood. Other State operations located in Glendive are not considered appropriate to the residential location of the facility.

EXHIBIT 6
DATE 1/27/95
HB

DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

MARC RACICOT, GOVERNOR

1539 11TH AVENUE

STATE OF MONTANA

(406) 444-3930
FAX: (406) 444-4920

PO BOX 201301
HELENA, MONTANA 59620-1301

MEMORANDUM

DATE: April 6, 1994

TO: GOVERNOR'S HUMAN SERVICES SUBCABINET

FROM: ROBERT W. ANDERSON, CHAIRMAN
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

RE: PROPOSED PLAN TO DOWNSIZE/REDUCE RESIDENTIAL FACILITIES POPULATIONS AND EXPAND COMMUNITY SERVICES

Enclosed for your review is a plan outlining options to reduce the developmental disability residential facility populations at the Eastmont Human Services Center (EHSC) and the Montana Developmental Center (MDC); and expand community based developmental disability services. Two of the three options propose the eventual closure of the EHSC in Glendive, Mt.

The plan was developed by the Interagency Task Force on Developmental Disabilities as a result of its planning and coordination efforts over the past four years to modify and improve the Montana Developmental Disabilities Service System (MDDSS). The purpose of this plan is to identify options to resolve current and future problems facing the MDDSS. It is not being recommended as a way to reduce the state budget.

We submit this plan for your review, recommendations and possible submission into the Executive Planning Process.

ACTION PLAN TO MODIFY THE MONTANA DEVELOPMENTAL DISABILITIES SERVICE SYSTEM (MDDSS)

DOWNSIZE/REDUCE RESIDENTIAL FACILITIES (INSTITUTIONAL) POPULATIONS AND EXPAND COMMUNITY SERVICES

FY 1996-1999

submitted to:

The Governor's Human Services Subcabinet

April 7, 1994

prepared by:

The Interagency Task Force on Developmental Disabilities

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EXECUTIVE SUMMARY

The Human Services Subcabinet's Interagency Task Force on Developmental Disabilities (task force) has been evaluating and recommending modifications to the Montana Developmental Disabilities Service System (MDDSS) over the past four years. Between 1990-1993 a four phase Action Plan was developed and implemented that established mission statements for services, expanded community services, downsized both the Montana Developmental Center (MDC) and Eastmont Human Services Center (EHSC), revised the DD commitment laws and called for a MDC campus consolidation construction project.

During implementation of the above plan, the task force had difficulty in developing a new definition of "seriously developmentally disabled" and mission statements to accommodate the residential facilities (institutions) at MDC and EHSC. Because of this, the statute defining "seriously developmentally disabled" was sunset to expire October 1, 1995, forcing the task force to reevaluate the issues and provide further recommendations to the 1995 Legislature.

An unanticipated increase of admissions to MDC and a large community waiting list (CWL) have added major problems for the MDDSS. While MDC is currently staffed and budgeted to handle 110 clients, the current client population is at 116. The new campus which will be operational in late FY 1996, will be licensed for a maximum of 110 clients and physically unable to handle anymore than that capacity.

During FY 1994, assessments were completed on 173 individuals with developmental disabilities being treated in residential facilities at MDC, EHSC and the Montana State Hospital. Section III of this plan demonstrates the results of those assessments and concludes that approximately 70 of those individuals could be treated in current types of community-based services if they were made available. In addition, others currently at MDC and EHSC may no longer be found "seriously developmentally disabled" because of improvements in behaviors, in which case the residential facility cannot legally keep them, and community placement would be needed.

Based on the problems currently facing the MDDSS and the assessment results, the consensus of the task force was that status quo of the current MDDSS is unacceptable. Section IV of this plan presents three prioritized options for change in the MDDSS. These priorities were not arrived at by consensus of the task force, but by majority vote. Each of the options presented will correct the immediate problems facing the MDDSS and move toward reducing long-term problems within different time frames and costs. Advantages and disadvantages of each option are

explained in Section IV, on pages 12-13 for Option I, 14-15 for Option II, and page 16 for Option III.

OPTION I (APPENDIX A1-A2)

PHASE 1 - FY 1996-1997:
This phase would establish community services for an additional 30 individuals - 9 from EHSC, 15 from MDC and 6 from the CWL. During fiscal year 1996 and 1997, community services for 30 individuals would be developed. By June of 1996, 9 residents from EHSC, 3 from MDC would be placed, and between July and August 1996 the additional 18 would be placed from MDC/CWL.

PHASE 2 - FY 1998-1999:
This phase would establish community services for approximately 48 individuals - 40 from EHSC and 8 from MDC or the CWL. During FY 1998, community services would be developed. Between July - October 1998 the 48 individuals would be placed into community programs. EHSC would close completely effective January 1,1999.

OPTION II (APPENDIX B1-B2)

PHASE 1 - FY 1996-1997:
This phase would establish community services for an additional 66 individuals - 49 from EHSC, 11 from MDC, and 6 from the CWL. During fiscal year 1996 community services would be expanded to serve an additional 66 individuals. Between July and November 1996 the 66 individuals would be placed into community programs. By January 1, 1997, EHSC would be completely closed.

PHASE II - FY 1998-1999:
This phase would establish community services for an additional 12 individuals from MDC/CWL. During FY 1998 community services would be expanded. Between July and August 1998 the 12 individuals would be moved into community programs.

OPTION III (APPENDIX A1)

Option III represents Phase I of Option I only, and recommends the development of community services for an additional 30 individuals - 9 from EHSC, 15 from MDC, and 6 from CWL. During FY 96-97, community services would be developed. By June 1996, 9 residents from EHSC, 3 from MDC would be placed, and between July and August 1996 the additional 18 would be placed from MDC/CWL. Further evaluation and study of MDDSS would need to be completed before any future action is taken beyond the 1996-97 biennium.

I
Introduction

Over the past two decades Montana has faced increasing pressure to reorganize its services for individuals with developmental disabilities. In 1989 the Montana Developmental Disabilities Service System (MDDSS) faced the potential loss of federal Medicaid dollars due to major survey deficiencies cited at the Montana Developmental Center (MDC) and the Eastmont Human Services Center (EHSC), and a successful court petition of six MDC clients to be placed in less restrictive community based treatment environments. Along with the six MDC residents, there were an additional 70-100 similar individuals being served at MDC and EHSC.

To facilitate a planning process to address these problems and ensure interagency coordination, the Governor's Human Services Sub-cabinet appointed an Interagency Task Force on Developmental Disabilities. The task force includes representatives from the Departments of Corrections and Human Services (DCHS), Social and Rehabilitation Services (SRS), Family Services (DFS), and Health and Environmental Sciences (DHES), the Governor's Office of Budget and Program Planning (OBPP), the Developmental Disabilities Planning and Advisory Council (DDPAC), the Governor's Board of Visitors (BOV), the Montana Advocacy Program (MAP), Family Members and Community Developmental Disabilities (DD) Service Providers. Between 1990 and 1993 the task force developed and implemented a four phase action plan to modify the MDDSS. The plan established mission statements for both residential facilities and community services, expanded community services, reduced the populations at MDC from 190 to 110 and EHSC from 55 to 50, revised the DD commitment laws and called for a major construction project to enhance and consolidate the MDC facility.

While working on the four phase plan, the task force had difficulty in developing appropriate mission statements for the residential facilities which include both MDC and EHSC, and in redefining "seriously developmentally disabled". The task force thought that even after implementing the four phase plan, many individuals would remain committed to the residential facilities who could be served in less restrictive current types of community based programs, if those services were available. However, because of the major undertaking to implement the four phase plan within the required time frames, the task force decided to develop MDC and EHSC mission statements and a definition of "seriously developmentally disabled" that would still include those individuals. Because of the above, it was the consensus of the task force members to sunset the legislation and re-evaluate the mission statements of the residential treatment

facilities and the definition of "seriously developmentally disabled" for reconsideration by the 1995 Legislature.
During FY 1993 and 1994, the task force continued to meet and evaluate the overall MDDSS system including: the development of an overall MDDSS mission statement, the current and future missions of community and residential facility services, the definition of "seriously developmentally disabled", and resolve the unanticipated increase of admissions to MDC. It was the consensus of the task force to move toward redefining "seriously developmentally disabled" to include only those individuals who needed to be served in residential facilities (MDC and EHSC) and to develop a plan to further reduce the numbers of individuals presently served in residential facilities by expanding community-based services.

In July 1993 the task force decided to evaluate the feasibility of closing the EHSC, and reallocating those resources to expand current types of community-based services to meet the needs of not only individuals being served at EHSC, but also some at the MDC and on the community waiting lists (CWL) to alleviate the current MDC overcrowding. Although this plan uses the term "close EHSC", it means to discontinue its use as a residential facility (institution) for developmentally disabled (ICF/MR). Alternative uses of the facility by either the state, county, city or private sector should be investigated. If possible, an alternative use should be developed and ready for implementation prior to any recommended closure of the institution. In October 1993 the task force expanded its membership to include the EHSC Superintendent and a family member of a EHSC resident from eastern Montana.

The following is the overall MDDSS mission statement developed by the task force:

> "Through leadership, the Montana Developmental Disabilities Service System plans, implements, coordinates, evaluates and strengthens service systems that assure opportunities for a good life to all Montanans who have, or are at risk of having a developmental disability. Services are provided through a partnership of skilled, dedicated and innovative individuals making a positive difference in the lives of those they serve."

The following plan is a continuation of the 1990 Action Plan to modify the MDDSS and carry out the above mission. This plan represents an ongoing commitment by the state of Montana to continually modify the MDDSS by reducing the number of individuals served in residential facilities (institutions) and where appropriate expanding community-based services. Without such a commitment, the state of Montana will continue to face future legal action from family members and advocates of individuals with developmental disabilities. The plan also represents a consensus of the task force that the MDDSS status

quo is unacceptable due to major problems currently facing the system. The plan identifies the problems and presents three options and time tables for resolution by:

- Providing more services to individuals in a less restrictive environment by reducing the current over- crowding at MDC, providing additional services to individuals on the CWL, and downsizing or eventually closing EHSC.
- Continuing to ensure interagency coordination and planning of services.
- Clarifying and/or beginning a process to clarify the mission statements for residential services.
- Extending and/or changing the current definition of "seriously developmentally disabled".
- Minimizing costs as much as possible through reallocation of resources.

The plan is presented to the Governor's Human Services Subcabinet for review, evaluation and possible consideration in the Executive Planning Process.

II
CURRENT PROBLEMS WITH MONTANA LAW AND MISSION STATEMENTS FOR THE MONTANA DEVELOPMENTAL DISABILITIES SERVICE SYSTEM (MDDSS)

CURRENT MONTANA LAWS

Montana laws covering the treatment of the developmentally disabled are found primarily in Title 53, Chapter 20, MCA. Section 53-20-101 specifies the purpose of treating the developmentally disabled as follows:

1) secure for each person who may be developmentally disabled such treatment and habilitation as will be suited to the needs of the person and to ensure that such treatment and habilitation are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

2) accomplish this goal whenever possible in a community-based setting;

3) accomplish this goal in an institutional setting only when less restrictive alternatives are unavailable or inadequate and only when a person is so severely disabled as to require institutionalized care; and

4) assure that due process is accorded any person coming under the provisions of this part.

PROBLEM: Residential facilities (institutions) at EHSC and MDC continue to serve many individuals who could be served in community-based services if services were available. (See Section III. Assessments). Until this is resolved the state will continue to face potential litigation from families and advocates.

Under Section 53-20-102 (15) the law defines "seriously developmentally disabled" as a person who:

> (a) is developmentally disabled;
> (b) is impaired in cognitive functioning; and
> (c) has behaviors that pose an imminent risk of harm to self or others or self-help deficits so severe as to require total or near total care and because of those behaviors or deficits, cannot be safely and effectively habilitated in community-based services.

Only an individual meeting the above definition can be admitted to a residential facility which includes the Montana Developmental Center and Eastmont Human Services Center.

PROBLEM: The above definition will sunset on October 1, 1995. As explained in the introduction, the task force purposely sunset this definition because they thought it was too broad and still included individuals whose needs could be served by community-based services rather than residential facilities (institutions). The major area of concern is the term "or near total care", which depicts those individuals. Any of the options addressed in this

plan must extend and/or change the above definition through legislative action.

CURRENT COMMUNITY SERVICES AND SPECIALIZED RESIDENTIAL PROGRAMS

The following presents the mission statements of community-based services and residential facilities (MDC/EHSC) as they appeared in the 1990 MDDSS Action Plan and the problems associated with each.

Community Services:

Community-based services should provide persons with developmental disabilities and their families the training and support necessary to allow the individual to achieve the greatest degree of independence possible. Community services extend into natural living and learning environments in both rural and urban areas. Among the available community service options are:

1) Residential services such as group homes for adults, children, seniors and adults with intensive needs, or less structured residential options such as transitional, independent, and supported living services;
2) Vocational services such as supported employment, work activities and sheltered employment;
3) Non-vocational day services such as senior or intensive day programs; and
4) Family support services such as family training, specialized family care, respite care and adaptive equipment.
5) Case Management.

Specialized Residential Facility Services:

MDC

MDC will provide comprehensive residential training and treatment services to:

1) Persons with developmental disabilities whose behavior problems at this time are so severe that they cannot safely and effectively be served in community-based settings. This group includes, but is not limited to, people with dual diagnoses of mental illness and mental retardation who also have severe behavior problems. Services for these individuals include:
   a. intensive time limited and transitional services for persons with severe behavior problems who respond to treatment and have the ability to care for themselves such that community placement will be feasible and appropriate; and,
   b. long term residential treatment and care for those with severe behavior problems who do not respond well to treatment; and
   c. court ordered diagnostic and evaluation services, not to exceed 30 days.
2. Persons with developmental disabilities who have no severe behavior problems, but who have major self-help deficiencies which cause them to require:

a. immediate emergency nursing or medical intervention; or
b. total, or nearly total, assistance in caring for themselves.

EHSC

EHSC will provide comprehensive residential, training, and treatment services to persons with developmental disabilities who:

1) have severe self-care deficits;
2) as a group are predominantly ambulatory;
3) do not have severe behavior problems; and,
4) do not have severe nursing or medical problems.

PROBLEM: In the 1990 MDDSS Plan the above mission statements for community-based services and residential programs were defined. Those statements are still appropriate for community-based services, but as with the definition of "seriously developmentally disabled", the mission statements for the residential facilities at MDC and EHSC are too broad. This includes the overall EHSC mission statement and 2.b. of the MDC mission statement depicting "total or nearly total assistance". Also, under the 1990 Action Plan, MDC developed plans to serve individuals whose disabilities as described above have led to or are complicated by severe social/sexual deficiencies. These deficiencies have led to a crisis in their living situation and/or brushes with the law enforcement/criminal justice system.

The options outlined in this plan would allow the MDDSS system to move continually toward developing more appropriate mission statements for residential services that fit into the overall MDDSS mission, to comply with the intent of Montana law, federal statutes and national trends in serving individuals with developmental disabilities.

MDC Overcrowding - Based on the 1990-1993 MDDSS Plan, the population at MDC was established at 100-110. The current budget and staffing levels have also been established at that level. These levels are based on a client to staff ratio which allows MDC to continue to meet the increasingly demanding federal certification standards required for Medicaid reimbursement. The new MDC campus consolidation construction project currently in progress is designed and will be licensed to handle a maximum of 110 clients.

PROBLEM: Even with the new commitment process, it has been very difficult to maintain the MDC population at or below 110. The current population at MDC is 116 and has been averaging 113 over the last year. From July 1, 1991 to date, there have been 37 new admissions and 25 readmissions. All admissions require extensive assessment, team planning, and program development. For the most part the new and readmissions are higher skilled individuals with severe behavior problems, and therefore they are mainly served by

the same treatment team. While they require close supervision, these individuals also have many independent skills and are very demanding of staff time on a one-to-one basis. Approximately one-third of the new admissions have social/sexual problems and require a secure environment. MDC is attempting to provide specialized training for staff to deal with the unique problems and needs of these individuals. The constant influx requires shifting clients into various living units in order to keep populations at or near licensed (and licensable due to square footage requirements) capacity, and therefore impacts all of the treatment teams to some extent. This constant movement allows neither clients nor staff to fully adjust before the next change, and seriously impacts the facility's ability to continue to meet the active treatment mandate of the certification standards.

The MDC mission statement includes those individuals needing high levels of care due to lack of basic skills, high level medical/health needs, and often severe physical handicaps such as blindness, deafness, and little or no independent mobility. Although the intensive levels of service these clients require are not available in every community, individuals with similar needs are being successfully served in some communities. Historically, clients requiring this level of service do not return to a residential facility setting once placed; clients with higher level skills and severe behavior problems are often readmitted when their behaviors threaten the safety of themselves or others. Placement of these individuals from the residential facility setting to the community has sometimes been only short term and therefore only temporarily decreased the residential facility population. This is a major problem and will soon be a major crisis, if not resolved. The options outlined in this plan must address this situation, as the new MDC campus will be physically unable to handle more than 110 individuals.

Community Waiting List (CWL) - There are over 1300 persons on the CWL who are in need of services. Of these over 450 receive no services through agencies contracting with the Developmental Disabilities Division (DDD), while over 850 are underserved individuals needing additional or different services than those they currently receive through the DDD. Four hundred of the persons on the CWL are requesting services similar to those which would be needed by the individuals proposed to be moved from residential facilities. Of this group 300 receive some DDD funded services, while over 100 receive no services.

PROBLEM: Without the development of additional, intensive services, some individuals on the waiting list will become "seriously developmentally disabled" and seek admission to the residential facility.

There may be other individuals for whom commitment will be necessary regardless of the additional services. These generally

are individuals who have inappropriate social/sexual or sex offending behaviors and probably have been involved with the criminal justice system. These individuals need a facility which meets their security and safety needs as well as those of others. Currently, MDC is the MDDSS designated agency to develop and provide treatment for these persons.

It is important to develop services in the community that can prevent persons from being unnecessarily labeled "seriously developmentally disabled". This would limit the number of admissions to the residential facility so space will be available for those for whom no services currently exist within the MDDSS. Unless there are services developed to address these intensive service needs, overcrowding at MDC will continue.

In addition, there are individuals currently meeting the definition of seriously developmentally disabled whose behaviors were severe when they were first admitted and who have responded well to treatment provided at the residential facilities. Some of these individuals are likely to no longer be found seriously developmentally disabled, when they are considered annually for recommitment. In those cases they cannot be recommended for further commitment, and the residential facility cannot legally keep them and community placement may be needed for those individuals at that time.

III

ASSESSMENTS OF CURRENT RESIDENTIAL (INSTITUTIONAL) POPULATIONS:

The following is a summary of the information compiled during the recent assessment of each individual with a developmental disability at EHSC, MDC and Montana State Hospital(MSH). Some individuals suffering from dual diagnosis of developmental disability and a mental illness have been committed to MSH.

The project involved the completion of assessment documents for each person, which noted their self-help skills, medical needs, and any behavior problems requiring intervention. These documents were completed by staff who work directly with the individuals at each of the three institutions. The documents were reviewed by a team which included staff from the residential facilities, the Developmental Disabilities Division, and a staff person from the Department of Family Services. These teams reached consensus decisions regarding the area of primary need for each person, whether self-help activities, medical intervention, or intervention with maladaptive behaviors.

The teams noted the degree of intervention needed by each individual through ratings of 1 - 4 for each area. A rating of 1 - is extremely intense; 2 - is intense to serious; 3 - is serious, but less intense; and 4 - is not serious.

A total of 173 individuals were assessed (113 MDC, 49 EHSC, and 11 MSH). Of those, 23 received a rating of #1 (the most severe) for serious behaviors, 54 received a rating of #1 for substantial assistance with self-help needs, and 27 received a rating of #1 for serious medical needs. The total number of people who had a rating of #1 in any of these three primary categories was 81.

The numbers with a rating of #2 were: 70 for behavior, 27 for self-help, and 43 for medical.

A rating of #3 was given as follows: 24 for behavior, 41 for self-help, and 90 for medical.

The #4 ratings were: 56 for behavior, 51 for self-help, and 13 for medical.

One group for whom community-based services do not generally exist is the one including individuals who have engaged in sexually offending behavior. As explained in Section II, the MDDSS, specifically MDC, is seeing a major increase in these individuals. There are approximately 13 individuals in this category in the institutions right now. Their ratings fall in both high and low categories. Because most of the offenses that resulted in commitment occurred with children, and since they do not have access to children now, their current behavior does not

rate as intense. This will be an issue during any discussions regarding overall placement from the institutions into communities.

There are two other groups for whom services do not exist generally in community-based group homes. One group includes those who are fed through gastrostomy or jejunostomy tubes, as nurses must provide these services, and few group homes have nurses available. The second group includes those individuals who first came through the criminal justice system, were convicted of crimes, and for whom sentences were deferred, with commitment to MDC then pursued and accomplished. The status of their criminal sentences then comes into question, as they cannot be sentenced to MDC or EHSC, and they come up annually for review and possible change of their commitment status, regardless of whether their criminal sentence was for longer than one year or not.

To summarize these outcomes, assuming that ratings of #1 identify individuals who most need the level of care provided in institutions, and allowing for the fact that some individuals with lower ratings fall into one of the three categories for whom services do not generally exist in the community, the number of individuals who would be more appropriately served in community-based service is 70.

IV

OPTIONS TO REDUCE RESIDENTIAL SERVICES AND EXPAND COMMUNITY-BASED SERVICES

Over the last twenty years Montana has made significant strides in reducing its institutional populations for the developmentally disabled and in developing community-based services. This effort has been guided by the philosophy of normalization and the implementation of effective federal and state laws. Normalization means making available to all persons with developmental disabilities the patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life and society.

The problems identified in Section II, specifically the overcrowding at MDC documents the need for immediate action. In addition, the assessment results provided in Section III, further supports a continuing effort by the state of Montana to reduce the numbers of individuals currently served in residential (institutional) facilities by approximately 70. The State must also expand current types of community-based services to meet the needs of those and other individuals who are without services. This will result in further downsizing of MDC and EHSC with the possible closure of EHSC. The downsizing and proposed closure of an institution, such as EHSC, is, especially difficult to the clients, the employees, and the communities affected. The options must be carefully evaluated to ensure minimal impact and disruption to clients, employees, and the community by providing the following:

TO CLIENTS

- Community services that meet individual needs are in place before downsizing or closure begins.
- Clients are provided adequate orientation and familiarization to prepare them for their new surroundings. Staff must be trained in advanced to provide the above.
- Every possible effort is made to ensure placements are close to family members or significant others.
- Effective communication of client information and treatment needs between the residential facility and the community programs is essential.

TO EMPLOYEES

- Development or support for job retraining programs.
- Referral and priorities developed for other state or local jobs.
- Incentive programs for employees who stay until closure occurs.
- Reduction in force programs developed.

TO COMMUNITY

- Assistance in the creation and development of alternative programs for the developmentally disabled.
- Assistance in finding alternative programs or uses for the facility.

OPTIONS TO REDUCE RESIDENTIAL SERVICES AND EXPAND COMMUNITY-BASED SERVICES

The following represents a prioritized list of options to reduce residential services and expand community-based services. The options will not only alleviate problems facing the MDDSS, but will begin to address long-term goals and reduce future problems. These priorities do not represent a consensus of the task force but were arrived at by majority vote.

OPTION I (APPENDIX A1-A2)

Expand community services in FY 1996, downsize MDC and EHSC in FY 1997, further expand community services in FY 1998 and close EHSC in FY 1999.

PHASE 1 - FY 1996-1997:
This phase would establish community services for an additional 30 individuals - 9 EHSC, 15 MDC, and 6 from the CWL. During fiscal year 1996 and 1997, community services for 30 individuals would be developed. By June of 1996, 9 residents from EHSC, 3 from MDC or CWL would be placed, and between July and August 1996 the additional 18 would be placed from MDC/CWL.

PHASE 2 - FY 1998-1999:
This phase would establish community services for approximately 48 individuals - 40 EHSC and 8 MDC or CWL. During FY 1998 community services would be developed. Between July - October 1998 the 48 individuals would be placed into community programs. EHSC would close completely effective January 1, 1999.

OPTION I - ADVANTAGES AND DISADVANTAGES

Advantages

- The movement of resources from state institutions into community service programs will result in more potential service opportunities for children with significant disabilities who have remained at home over the last fifteen years under their parents care. These clients will need adult services similar to those that will be developed in their communities under Option I of this plan in the future.
- As required by state law, a group of almost 70 current residents of the state's two residential facilities

(institutions) who are appropriate for placement will enter community services developed specifically to meet their needs.
- Addresses the immediate and long term problem of MDC overcrowding and decreases the CWL which can lessen the stresses that could lead to more admissions.
- Slower process means less disruption to EHSC clients, staff and the community involved.
- Begins the process of reducing residential populations and moving toward the intent of the mission and mission statements.
- Allows reasonable time to develop programs to minimize the impact and to prepare clients, employees, and the community.
- Allows more time to work with the community to develop alternative uses for the facility.
- Less costly in FY 1996-1997.

Disadvantages
- Extends the EHSC closure into next biennium and could create staffing, morale, and recruiting problems.
- May still face litigation from advocates for moving too slowly.
- Although less costly the first biennium, it's more costly overall as it drags out start-up costs over the next four years.
- The "seriously developmentally disabled" definition and the residential mission statement problems would continue for the next four years.

SEE APPENDIX A1-A2 FOR FISCAL IMPACT OF OPTION I

LEGAL IMPACT OF OPTION I:
Legislation would be needed to extend the current definition until December 31, 1998. Beginning January 1, 1999 the term "near total care" would be eliminated. No further sunset clause would be recommended.

This assumes that individuals moving from EHSC and MDC will number 24 by June 1997 and 40 by January 1999 which totals 64 individuals. Six individuals will come from CWL by June 1997. Eight individuals will come from CWL or MDC by January 1999. Based on 70 individuals needing to move to impact the definition, 6 of these 8 individuals will need to come from MDC.
If any of these 70 "near total care" individuals are moved to community services through usual placement activities or die then more of the 8 individuals will come from the CWL.

FY	EHSC/MDC	MDC/CWL	CWL
96-97	24		6
98-99	40	8	
Total	64	8*	6

*Six of these individuals will need to come from MDC to reach the 70 "near total care" individuals.

OPTION II (APPENDIX (B1-B2)

Expand community services in FY 1996, downsize MDC, close EHSC in FY 1997 and further expand community services in FY 1998.

PHASE 1 - FY 1996-1997:
This phase would establish community services for an additional 66 individuals - 49 EHSC, 11 MDC and 6 CWL. During fiscal year 1996 community services would be expanded to serve an additional 66 individuals. Between July and November 1996 the 66 individuals would be placed into community programs. By January 1, 1997, EHSC would be completely closed.

PHASE II - FY 1998-1999:
This phase would establish community services for an additional 12 individuals - MDC/CWL. During FY 1998 community services would be expanded. Between July and August 1998 the 12 individuals would be moved into community programs.

OPTION II - ADVANTAGES AND DISADVANTAGES
Advantages

- The movement of resources from state institutions into community service programs will result in more potential service opportunities for children with significant disabilities who have remained at home over the last fifteen years under their parents care, but who in the future will need adult services similar to those that will be developed in their communities under option one of this plan.
- As required by state law a group of almost 70 current residents of the state's two residential facilities who are appropriate for placement will enter community services developed specifically to meet their needs.
- Moves faster in addressing the mission, mission statements, and legal definition of "seriously developmentally disabled".
- Addresses more quickly the MDC overcrowding and the large numbers of individuals on the CWL.

- Although more costly in FY 1996-1997, it will be less costly overall and reallocates resources to meet long-term needs.
- Does not prolong the EHSC closure and may have less impact on EHSC staffing/morale problems.
- May reduce significantly any chances of litigation.

Disadvantages

- Less time to develop more community services and to place a larger number of individuals.
- Less time to develop programs to minimize impact and prepare clients, employees, and the community.
- Less time to develop alternative uses of the facility.

SEE APPENDIX B1-B2 FOR FISCAL IMPACT OF OPTION II

LEGAL IMPACT OF OPTION II:
Legislation would be needed to extend the current definition until September 30, 1998. Beginning October 1, 1998 the term "near total care" would be eliminated. No further sunset clause would be recommended.

This assumes that individuals moving from EHSC and MDC will number 60 by January 1997. Six individuals will come from CWL by January 1997. Twelve individuals will come from CWL or MDC by July or August 1998. Based on 70 individuals needing to move to impact the definition, 10 of these 12 individuals will need to come from MDC. If any of the 70 "near total care" individuals are moved to community services through usual placement activities or die then more of the 12 individuals will come from the CWL.

FY	EHSC/MDC	MDC/CWL	CWL
96-97	60		6
98-99		12	
Total	60	12*	6

*Ten of these individuals will need to come from MDC to reach the 70 "near total care" individuals.

OPTION III (APPENDIX A1)

Option III represents Phase I of Option I only, and recommends the development of community services for an additional 30 individuals - 9 from EHSC, 15 from MDC and 6 from CWL. During FY 96-97, community services would be developed. By June 1996, 9 residents from EHSC, 3 from MDC or CWL would be placed, and between July and August 1996, the additional 18 would be placed from MDC/CWL. Further evaluation and study of MDDSS would need

to be completed before any future action is taken beyond the 1996-97 biennium.

SEE APPENDIX A1 FOR FISCAL IMPACT OF OPTION III

ADVANTAGES AND DISADVANTAGES OF OPTION III

Advantages

- The development of services addresses the problem of overcrowding at MDC once the new construction is completed and provides sufficient services to meet the needs of the "seriously developmentally disabled" who might be referred to MDC for commitment during the next biennium.
- The plan provides some opportunity for movement into the community for a portion of the people identified as appropriate for such services.
- The plan shows a good faith commitment towards developing community services to the consumer, advocacy, and provider interest groups.
- No closure of EHSC proposed, less disruptive to clients, facility, community, and less political problems.
- Less costly in FY 1996-97.

Disadvantages:

- While this option is less costly than the others, there will be little in the way of savings at the institutions to provide the necessary funding.
- May face litigation from advocates for moving too slowly.
- Although it's a start, this approach doesn't eliminate the problems identified with the definition of "seriously developmentally disabled" and the residential facilities mission statements.

LEGAL IMPACT OF OPTION III
The definition would remain the same with the term "near total care" included. A sunset date of September 30, 1997 would be recommended.

This assumes that individuals moving from EHSC and MDC will number 24 by June 1997. Six individuals will come from CWL by June 1997.

FY	EHSC/MDC	MDC/CWL	CWL
96-97	24		6
Total	24	0	6

Appendix A

Option I. Phase I FY96-97 Develop Community Services for 66 clients (EHSC 49, MDC 11, Community 6). (11 six-person group homes)
Phase II FY98-99 Develop Community Services for 12 clients (MDC 6, Community 6) (2 six-person group homes)
Eleven, 6 person, intensive group homes would be added in the community to provide for the clients.

2. Group Homes would be available as follows: three in Jul. 1996; three in Aug. 1996; three in Sep 1996 and two in Oct 1996. (FY97)
3. Start up costs are $80,000 general fund per group home, which would be available July 1, 1995 budgeted in FY96
4. EHSC would close January 1, 1997 and reflect 1/2 year savings in FY97.
5. Annual cost of group home operation is $330,130 in FY96 and estimated to increase 3% per year, at the medicaid match rate, plus $12,000 per year general fund.
6. Acutal FMAP FY95 = 29.13% GF and 70.87% FF; Estimated FY96 = 29.50% GF and 70.50% FF; FY97 = 29.75% GF and 70.25% FF. Estimated FY98 and FY99 FMAP = 30.00% GF and 70.00% FF.
7. DFS cost for SSI @ $94 per month per client funded by general fund and held constant over the years.
8. Cost of DD Case Management is $170 per person per month at the medicaid match rate.
9. Expenditures and Revenues under current law would increase 3% each year after FY95.
10. Legislation would require medicaid to rebase FY96 and FY97 costs at Eastmont during shutdown.

	FY96			FY97		
Expenditures:	Current Law	Option I Phase I	Cost/(Saving) Difference	Current Law	Option I Phase I	Cost/(Saving) Difference
Department of Corrections & Human Services						
FTE	105.12	105.12	0.00	105.12	52.56	(52.56)
Personal Services	3,367,895	3,367,895	0	3,468,932	1,734,466	(1,734,466)
Operating	372,414	372,414	0	383,586	191,793	(191,793)
Equipment	10,587	10,587	0	10,905	5,452	(5,452)
Transfers	4,815	4,815	0	4,960	2,480	(2,480)
	3,755,712	3,755,712	0	3,868,383	1,934,192	(1,934,192)
Funding						
General Fund	3,755,334	3,755,334	0	3,868,005	1,933,814	(1,934,192)
State Special	378	378	0	378	378	0
Federal Revenue	0	0	0	0	0	0
	3,755,712	3,755,712	0	3,868,383	1,934,192	(1,934,192)
Department of Social & Rehabilitation Services						
Operating Start-Up	0	880,000	880,000	0	0	0
Benefits TCM	0	0	0	0	119,340	119,340
Benefits GP Home Oper	0	0	0	0	3,532,756	3,532,756
	0	880,000	880,000	0	3,652,096	3,652,096
Funding						
General Fund	0	880,000	880,000	0	1,168,691	1,168,691
Federal Revenue	0	0	0	0	2,483,405	2,483,405
	0	880,000	880,000	0	3,652,096	3,652,096
Department of Family Services						
Operating	0	0	0	0	0	0
Benefits	0	0	0	0	131,976	131,976
	0	0	0	0	131,976	131,976
Funding						
General Fund	0	0	0	0	131,976	131,976
Federal Revenue	0	0	0	0	0	0
	0	0	0	0	131,976	131,976
Total All Departments						
FTE	105.12	105.12	0.00	105.12	52.56	(52.56)
Personal Services	3,367,895	3,367,895	0	3,468,932	1,734,466	(1,734,466)
Operating	372,414	1,252,414	880,000	383,586	191,793	(191,793)
Equipment	10,587	10,587	0	10,905	5,452	(5,452)
Benefits	0	0	0	0	3,784,072	3,784,072
Transfers	4,815	4,815	0	4,960	2,480	(2,480)
	3,755,712	4,635,712	880,000	3,868,383	5,718,264	1,849,880
Funding						
General Fund	3,755,334	4,635,334	880,000	3,868,005	3,234,481	(633,525)
State Special Revenue	378	378	0	378	378	0
Federal Revenue	0	0	0	0	2,483,405	2,483,405
	3,755,712	4,635,712	880,000	3,868,383	5,718,264	1,849,880
Revenue:						
Medicaid Revenue to GF	2,411,223	2,411,223	0	2,483,560	1,241,780	(1,241,780)
Private	194,774	194,774	0	200,617	100,309	(100,309)
	2,605,997	2,605,997	0	2,684,177	1,342,088	(1,342,088)
Sale Income to GF	0	0	0	0	0	0
Total GF Cost	$1,149,337	$2,029,337	$880,000	$1,183,828	$1,892,392	$708,564

1,588,564

Option II: 66 clients in Community Cost/Client during the FY96-97 biennium: $24,069

Appendix E

Option II. Phase I. FY96-97 Develop Community Services for 30 clients (EHSC 9, MDC 15, Community 6). (5 six-person group homes).
Phase II. FY98-99 Develop Community Services for 48 clients (EHSC 40, Community 8) (8 six-person group homes).
Five, 6 person, intensive group homes would be added in the community to provide for the current clients.

2. Group Homes would be available as follows: two in Jun. 1996; two in Jul. 1996; one in Aug 1996. (2 in FY96, 3 in FY97).
3. Start up costs are $80,000 general fund per group home, which would be available July 1, 1995 budgeted in FY96
4. EHSC would close cottage II by July 1, 1996, reflecting the 9 clients moved to group homes.
Savings at EHSC from this closure are estimated at $0 in FY96 and $218,504 in FY97. Revenue reduced 8% in FY97.
5. Annual cost of group home operation is $330,130 in FY96 and estimated to increase 3% per year,
at the medicaid match rate, plus $12,000 per year general fund.
6. Acutal FMAP FY95 = 29.13% GF and 70.87% FF; Estimated FY96 = 29.50% GF and 70.50% FF; FY97 = 29.75% GF and 70.25% FF.
7. DFS cost for SSI @ $94 per month per client funded by general fund and held constant over the years.
8. Cost of DD Case Management is $170 per person per month at the medicaid match rate.
9. Expenditures and Revenues under current law would increase 3% each year after FY95.
10. Legislation would require medicaid to rebase FY96 and FY97 costs at Eastmont during shutdown.

	FY96			FY97		
Expenditures:	Current Law	Option II Phase I	Difference	Current Law	Option II Phase I	Cost/(Saving) Difference
Department of Corrections & Human Services						
FTE	105.12	105.12	0.00	105.12	98.12	(7.00)
Personal Services	3,367,895	3,367,895	0	3,468,932	3,287,678	(181,254)
Operating	372,414	372,414	0	383,586	346,336	(37,250)
Equipment	10,587	10,587	0	10,905	10,905	0
Transfers	4,815	4,815	0	4,960	4,960	0
	3,755,712	3,755,712	0	3,868,383	3,649,879	(218,504)
Funding						
General Fund	3,755,334	3,755,334	0	3,868,005	3,649,501	(218,504)
State Special	378	378	0	378	378	0
Federal Revenue	0	0	0	0	0	0
	3,755,712	3,755,712	0	3,868,383	3,649,879	(218,504)
Department of Social & Rehabilitation Services						
Operating Start-Up	0	400,000	400,000	0	0	0
Benefits TCM	0	2,040	2,040	0	60,180	60,180
Benefits GP Home Oper	0	57,022	57,022	0	1,730,834	1,730,834
	0	459,062	459,062	0	1,791,014	1,791,014
Funding						
General Fund	0	418,833	418,833	0	574,274	574,274
Federal Revenue	0	40,229	40,229	0	1,216,740	1,216,740
	0	459,062	459,062	0	1,791,014	1,791,014
Department of Family Services						
Operating	0	0	0	0	0	0
Benefits	0	1,128	1,128	0	33,276	33,276
	0	1,128	1,128	0	33,276	33,276
Funding						
General Fund	0	1,128	1,128	0	33,276	33,276
Federal Revenue	0	0	0	0	0	0
	0	1,128	1,128	0	33,276	33,276
Total All Departments						
FTE	105.12	105.12	0.00	105.12	98.12	(7.00)
Personal Services	3,367,895	3,367,895	0	3,468,932	3,287,678	(181,254)
Operating	372,414	772,414	400,000	383,586	346,336	(37,250)
Equipment	10,587	10,587	0	10,905	10,905	0
Benefits	0	60,190	60,190	0	1,824,290	1,824,290
Transfers	4,815	4,815	0	4,960	4,960	0
	3,755,712	4,215,902	460,190	3,868,383	5,474,169	1,605,786
Funding						
General Fund	3,755,334	4,175,295	419,961	3,868,005	4,257,051	389,046
State Special Revenue	378	378	0	378	378	0
Federal Revenue	0	40,229	40,229	0	1,216,740	1,216,740
	3,755,712	4,215,902	460,190	3,868,383	5,474,169	1,605,786
Revenue:						
Medicaid Revenue to GF	2,411,223	2,411,223	0	2,483,559	2,284,874	(198,685)
Private	194,774	194,774	0	200,617	184,568	(16,049)
	2,605,997	2,605,997	0	2,684,176	2,469,442	(214,734)
Sale Income to GF	0	0	0	0	0	0
Total GF Cost	$1,149,337	$1,569,298	$419,961	$1,183,829	$1,787,609	$603,780

1,023,741

Option II: 30 clients in Community Cost/Client during the FY96-97 biennium: $34,125

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Updated: 14-Mar-94

Appendix A1

Option I. Phase I. FY96-97 Develop Community Services for 30 clients (EHSC 9, MDC 15, Community 6). (5 six-person group homes).
Phase II. FY98-99 Develop Community Services for 48 clients (EHSC 40, Community 8) (8 six-person group homes).

1. Five, 6 person, intensive group homes would be added in the community to provide for the current clients.
2. Group Homes would be available as follows: two in Jun. 1996; two in Jul. 1996; one in Aug 1996. (2 in FY96, 3 in FY97).
3. Start up costs are $80,000 general fund per group home, which would be available July 1, 1995 budgeted in FY96
4. EHSC would close cottage II by July 1, 1996, reflecting the 9 clients moved to group homes.
   Savings at EHSC from this closure are estimated at $0 in FY96 and $218,504 in FY97. Revenue reduced 8% in FY97.
5. Annual cost of group home operation is $330,130 in FY96 and estimated to increase 3% per year,
   at the medicaid match rate, plus $12,000 per year general fund.
6. Acutal FMAP FY95 = 29.13% GF and 70.87% FF; Estimated FY96 = 29.50% GF and 70.50% FF; FY97 = 29.75% GF and 70.25% FF.
7. DFS cost for SSI @ $94 per month per client funded by general fund and held constant over the years.
8. Cost of DD Case Management is $170 per person per month at the medicaid match rate.
9. Expenditures and Revenues under current law would increase 3% each year after FY95.
10. Legislation would require medicaid to rebase FY96 and FY97 costs at Eastmont during shutdown.

NO CHANGE IN CURRENT PROGRAMS OR SERVICES ESTIMATE

	FY96			FY97		
Expenditures:	Current Law	No Change	Difference	Current Law	No Change	Cost/(Saving) Difference
Department of Corrections & Human Services						
FTE	105.12	105.12	0.00	105.12	105.12	0.00
Personal Services	3,367,895	3,367,895	0	3,468,932	3,468,932	0
Operating	372,414	372,414	0	383,586	383,586	0
Equipment	10,587	10,587	0	10,905	10,905	0
Transfers	4,815	4,815	0	4,960	4,960	0
	3,755,712	3,755,712	0	3,868,383	3,868,383	0
Funding						
General Fund	3,755,334	3,755,334	0	3,868,005	3,868,005	0
State Special	378	378	0	378	378	0
Federal Revenue	0	0	0	0	0	0
	3,755,712	3,755,712	0	3,868,383	3,868,383	0
Department of Social & Rehabilitation Services						
Operating Start-Up	0	0	0	0	0	0
Benefits TCM	0	0	0	0	0	0
Benefits GP Home Oper	0	0	0	0	0	0
	0	0	0	0	0	0
Funding						
General Fund	0	0	0	0	0	0
Federal Revenue	0	0	0	0	0	0
	0	0	0	0	0	0
Department of Family Services						
Operating	0	0	0	0	0	0
Benefits	0	0	0	0	0	0
	0	0	0	0	0	0
Funding						
General Fund	0	0	0	0	0	0
Federal Revenue	0	0	0	0	0	0
	0	0	0	0	0	0
Total All Departments						
FTE	105.12	105.12	0.00	105.12	105.12	0.00
Personal Services	3,367,895	3,367,895	0	3,468,932	3,468,932	0
Operating	372,414	372,414	0	383,586	383,586	0
Equipment	10,587	10,587	0	10,905	10,905	0
Benefits	0	0	0	0	0	0
Transfers	4,815	4,815	0	4,960	4,960	0
	3,755,712	3,755,712	0	3,868,383	3,868,383	0
Funding						
General Fund	3,755,334	3,755,334	0	3,868,005	3,868,005	0
State Special Revenue	378	378	0	378	378	0
Federal Revenue	0	0	0	0	0	0
	3,755,712	3,755,712	0	3,868,383	3,868,383	0
Revenue:						
Medicaid Revenue to GF	2,411,223	2,411,223	0	2,483,560	2,483,560	0
Private	194,774	194,774	0	200,617	200,617	0
	2,605,997	2,605,997	0	2,684,177	2,684,177	0
Sale Income to GF	0	0	0	0	0	0
Total GF Cost	$1,149,337	$1,149,337	$0	$1,183,828	$1,183,828	$0

0

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Updated: 14-Mar-94

Appendix A2

Option I. Phase I. FY96-97 Develop Community Services for 30 clients (EHSC 9, MDC 15, Community 6). (5 six-person group homes)
Phase II. FY98-99 Develop Community Services for 48 clients (EHSC 40, Community 8) (8 six-person group homes).

1. Eight, 6 person, intensive group homes would be added in the community to provide for the current clients.
2. Group Homes would be available as follows: two in Sep. 1997; two in Oct. 1997; two in Nov 1997 and two in Dec 1997. (8 in FY98).
3. Start up costs are $80,000 general fund per group home, which would be available July 1, 1997 budgeted in FY98
4. EHSC would close by Mar. 31, 1998 (1/4 FY98 and all of FY99 closed)

5. Annual cost of group home operation is $330,130 in FY96 and estimated to increase 3% per year, at the medicaid match rate, plus $12,000 per year general fund.
6. Acutal FMAP FY95 = 29.13% GF and 70.87% FF; Estimated FY98 = 30.00% GF and 70.00% FF; FY99 = 30.00% GF and 70.00% FF.
7. DFS cost for SSI @ $94 per month per client funded by general fund and held constant over the years.
8. Cost of DD Case Management is $170 per person per month at the medicaid match rate.
9. Expenditures and Revenues under current law would increase 3% each year after FY95.
10. Legislation would require medicaid to rebase FY96, FY97 and FY98 costs at Eastmont during shutdown.

NO CHANGE IN CURRENT PROGRAMS OR SERVICES ESTIMATE

	FY98			FY99		
Expenditures:	Current Law	Option I Phase II	Difference	Current Law	Option I Phase II	Cost/(Saving) Difference
Department of Corrections & Human Services						
FTE	105.12	105.12	0.00	105.12	105.12	0.00
Personal Services	3,573,000	3,573,000	0	3,680,190	3,680,190	0
Operating	395,094	395,094	0	406,947	406,947	0
Equipment	11,232	11,232	0	11,569	11,569	0
Transfers	5,108	5,108	0	5,262	5,262	0
	3,984,435	3,984,435	0	4,103,968	4,103,968	0
Funding						
General Fund	3,984,057	3,984,057	0	4,103,590	4,103,590	0
State Special	378	378	0	378	378	0
Federal Revenue	0	0	0	0	0	0
	3,984,435	3,984,435	0	4,103,968	4,103,968	0
Department of Social & Rehabilitation Services						
Operating Start-Up	0	0	0	0	0	0
Benefits TCM	0	0	0	0	0	0
Benefits GP Home Oper	0	0	0	0	0	0
	0	0	0	0	0	0
Funding						
General Fund	0	0	0	0	0	0
Federal Revenue	0	0	0	0	0	0
	0	0	0	0	0	0
Department of Family Services						
Operating	0	0	0	0	0	0
Benefits	0	0	0	0	0	0
	0	0	0	0	0	0
Funding						
General Fund	0	0	0	0	0	0
Federal Revenue	0	0	0	0	0	0
	0	0	0	0	0	0
Total All Departments						
FTE	105.12	105.12	0.00	105.12	105.12	0.00
Personal Services	3,573,000	3,573,000	0	3,680,190	3,680,190	0
Operating	395,094	395,094	0	406,947	406,947	0
Equipment	11,232	11,232	0	11,569	11,569	0
Benefits	0	0	0	0	0	0
Transfers	5,108	5,108	0	5,262	5,262	0
	3,984,435	3,984,435	0	4,103,968	4,103,968	0
Funding						
General Fund	3,984,057	3,984,057	0	4,103,590	4,103,590	0
State Special Revenue	378	378	0	378	378	0
Federal Revenue	0	0	0	0	0	0
	3,984,435	3,984,435	0	4,103,968	4,103,968	0
Revenue:						
Medicaid Revenue to GF	2,558,066	2,558,066	0	2,634,808	2,634,808	0
Private	206,636	206,636	0	212,835	212,835	0
	2,764,702	2,764,702	0	2,847,643	2,847,643	0
Sale Income to GF	0	0	0	0	0	0
Total GF Cost	$1,219,354	$1,219,354	$0	$1,255,946	$1,255,946	$0

0

EXHIBIT 8.
DATE 1/27/95
HB

LEGISLATIVE TESTIMONY
PARENTS, LET'S UNITE FOR KIDS
1500 N. 30th St.
Billings, MT 59101
406-657-2055

Mr. Chairman, Members of the Committee,

My name is Jude Oberst and I am here today to read testimony from Parents, Let's Unite for Kids (PLUK), a statewide organization serving over 3,900 families of children with disabilities. Our organization is in strong support of closure of EastMont Human Services Center. We have no objection to the work that EastMont has done in the past, but we see this service model as "antiquated." Younger parents who have children with more severe disabilities have kept their children at home. These young parents expect their children to remain in the community when they are adults. Very few parents favor an institutional placement for their children.

PLUK interacts with hundreds of parents annually. Most of them have strongly internalized the concepts of least restrictive environment and inclusion. They want their children to grow up and become part of the community--live in regular neighborhoods, interact with both disabled and nondisabled individuals. Even parents of children with severe disabilities like me do not see their children as needing segregated placements in separate facilities. No matter how loving and appropriate the care in an institution, institutional settings are inherently separate and different from family living. Children with disabilities who have always been raised in a home-like environment are prepared for life in the community, not for segregated placements.

We urge the Legislature to think of the East Mont issue as part of long-term planning for the Developmental Disabilities Division. We do not need institutional placements; rather the future lies in community-based services which have been so successful in this state. Parent support in the future will come for expansion of community-based, close-to-home options for their adult children with disabilities.

EXHIBIT 7
DATE 1/27/95
HB

DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

MARC RACICOT, GOVERNOR
1539 11TH AVENUE
STATE OF MONTANA
(406) 444-3930
FAX: (406) 444-4920
PO BOX 201301
HELENA, MONTANA 59620-1301

MEMORANDUM

DATE: September 19, 1994

TO: GOVERNOR'S HUMAN SERVICES SUBCABINET

FROM: ROBERT ANDERSON AND MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

RE: FURTHER EVALUATION OF THE EASTMONT HUMAN SERVICES CENTER (EHSC) CLOSURE - OPTION II

Enclosed, as you requested, is the Evaluation Report on Option II which proposes the closure of EHSC by January 1, 1997. This report includes additional information regarding the impact such a closure would have on clients, families, EHSC staff and the community of Glendive. The following is a brief summary of that information.

* Further evaluation of Option II did not produce any recommended changes in projected time lines or costs. Initially the transition to community services will cost an additional $1.5 million during the 1997 biennium, but will be cost neutral when completed. Other costs associated with the closure of EHSC not reflected in the Option II projections are employee termination payout and other employee incentive and benefits programs. These programs could range from $250,000 to $450,000 of additional general fund costs during the 1997 biennium depending on the type and number implemented.

* Status quo is not an option. Reductions in the MDC population must occur. If no action is taken EHSC will remain at 49 - 50 clients, the overcrowding at MDC will continue and there will be no impact on the community waiting list. MDC/EHSC population projections estimate by FY 2001 EHSC will continue to have 49 - 50 clients and MDC could reach 136. At a minimum, community services will have to be expanded for 18 MDC residents in FY 1997 and 12 in FY 1999 to keep MDC below its new facility capacity of 110.

* Current EHSC/MDC client demographic information indicates that a majority of clients currently being served came from western or central Montana. From a total of 160 clients, 31 (19%) indicate home of origin in eastern Montana. Of that 31, 15 are at EHSC (30.5 % of EHSC total) and 16 are at MDC (14 % of MDC total).

* Almost all admissions to EHSC over the last four years came as transfers from MDC. Of the 63 admissions (commitments) to MDC over the same time period, only 6 (9.5%) came from eastern Montana. Also, none of the individuals recently committed to MDC over the last four years resemble the types of individuals that are being considered for placement under Option II. This demonstrates that community services have matured and are currently able to handle these types of individuals.

* Results of the surveys indicated that current types of community services would meet the needs of those individuals to be placed under Option II and most parents and families, with the exception of families of current EHSC residents, favor community services over institutional services.

- Surveys of community and institutional services indicated that appropriate community services can be developed for the people under consideration for placement, and many of the same types of individuals are currently being served in community programs.

- Currently there are no children (under eighteen) being served in MDC or EHSC. A survey of parents of children currently served at home or in communities demonstrated a preference for community services over institutional services when their children reach adulthood.

- Survey of relatives or guardians of individuals currently residing at EHSC indicated they do not want EHSC closed nor their relatives placed in community programs.

- Survey of families of former institutional clients who have recently (4 years) been transferred to community services indicated that many were initially satisfied with institutional services and opposed community placement, but after experiencing the placement and both services, now prefer community services.

* It's imperative that if Option II is adopted and EHSC closes, programs be implemented to reduce the impact on EHSC employees and alternative uses for the EHSC facility be developed to reduce the impact on the community.

* Option II, represents one plan for resolving the current problems facing Montana's developmental service system. It redirects resources from institutional services to community services, allows us to manage projected MDC populations under 110 through 2001 and will have a long term positive impact on managing the community waiting list. New language under the proposed legislative changes to Title 53, Chapter 20, MCA may also have a positive impact on reducing commitments to MDC.

* The task force was again unable to find an alternative long term mission for EHSC that is appropriate and would benefit the future needs of Montana's developmental disabilities service system. Absent an appropriate mission for EHSC, this issue probably will not go away.

* There will be little visible political support for Option II. Also failure to act may result in a class action lawsuit.

INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES
OPTION II EVALUATION REPORT AND FINDINGS
SEPTEMBER 19, 1994

I. INTRODUCTION

On April 7, 1994 the Interagency Task Force on Developmental Disabilities presented to the Governors Human Services Subcabinet a proposed plan to downsize/reduce the populations in residential (institutional) facilities for individuals with developmental disabilities and expand community services.

Briefly, that plan included the following three options:

Option I would expand community services for 30 individuals in FY 96-97, for an additional 48 individuals in FY 98-99, and close Eastmont by January 1, 1999.

Option II would expand community services for 66 individuals in FY 96-97, for an additional 12 individuals in FY 98-99, and close Eastmont by January 1, 1997.

Option III would expand community services for 30 individuals in FY 96-97, reduces Eastmont population to 40, and requires further evaluation of the Developmental Disabilities Service System in FY 98-99.

In addition, overcrowding at the Montana Developmental Center (MDC) would have to be addressed. MDC had a population of 116 which is one under the maximum licensed bed capacity for the current facility and 6 over the proposed capacity of the new facility. As of the date of this report, MDC has 118 clients.

After discussing and reviewing the plan, other possible options, letters from concerned organizations and individuals, you requested additional information regarding Option II. This information was to include greater detail regarding the time lines, costs, capabilities of community services, impact on the clients, family members, Eastmont staff and the Glendive Community.

The following report includes the information, surveys and the results gathered by the Task Force in regards to your request.

II. OPTION II OVERVIEW

PHASE 1 - FY 1996 -1997:
This phase would establish community services for an additional 66 individuals - 49 from EHSC, 17 from MDC or the community waiting list (CWL). During fiscal year 1996, community services would be expanded to serve an additional 66 individuals. Between July and November 1996 the 66 individuals would be placed into community programs. By January 1, 1997, EHSC would no longer serve as a state operated residential facility for the developmentally disabled (ICF/MR).

COSTS:	FY 1996	FY 1997	BIENNIUM TOTAL
	+ $880,000	+ $642,764	+ $1,522,764

PHASE 2 - FY 1998 - 1999:
This phase would establish community services for an additional 12 individuals from MDC/CWL. During FY 1998 community services would be expanded. Between July and August 1998 the 12 individuals would be moved into community programs.

COSTS:	FY 1998	FY 1999	BIENNIUM TOTAL
	+ $160,000	+ $261,325	+ $421,325

III. OPTION II EVALUATION FINDINGS

A. TIME LINES

After further review of the time lines planned in Option II, they appear to be realistic and appropriate. They will provide adequate time to ensure more detailed planning and coordination in determining individuals to be placed, in developing appropriate community services, and ensure effective coordination and orientation of client placements. The time lines also provide adequate flexibility to allow for any unexpected delays in construction, program development or other unanticipated problems.

B. COSTS

The costs outlined in Option II appear to represent an accurate estimate. Initially the transition to community services will cost an additional $1.5 million in general fund dollars, but will be almost cost neutral when completed. It must be noted these projections represent our best estimates at this time and will most likely change.

Also, other costs associated with closing a facility, which are very difficult to project, are not included in the estimate. These are costs associated with any reduction in

force programs, vacation and sick leave pay outs, severance pay, or other incentive programs such as: additional staff training or counseling, extension of health insurance benefits, early retirement, or bonuses for those who remain until closure. These types of programs are explained in more detail below, under "Impact on EHSC Staff". Based on the Galen closure and depending on what is approved, these costs could range anywhere from $2,000 to $4,000 per employee or an additional $250,000 to $450,000.

C. EHSC/MDC CLIENT DEMOGRAPHIC AND POPULATION DATA

Population projections at EHSC and MDC verify that maintaining the current status quo is no option. Projections indicate that while EHSC would remain at 49-50 clients, MDC would continue to increase at about 4 clients per year, putting its population at 136 by 2001. Maintaining the status quo would also have no positive impact on the community waiting list (CWL). See Attachment 1, MDC Population Projections.

Option II not only closes EHSC, but will allow us to manage projected MDC populations below 110 through the year 2001 and would have a long term positive impact on the CWL. Any expansion of community services whether through downsize efforts as Option II, or by other means, gives us the ability to offer more community services and better meet future demands for services.

EHSC/MDC demographic information over the last four years indicate discharge destinations to eastern Montana represented 8 out of 27 (30%) of EHSC discharges and 23 out of 104 (22%) of MDC discharges. Of the 23 referred to eastern Montana from MDC 20 (87%) represent transfers to EHSC. This destination data really only demonstrates where group homes were developed during the last downsizing efforts. Since almost all admissions to EHSC over the last four years were transfers from MDC, only MDC admission data was gathered. Of the 63 admissions to MDC 6 (9.5%) came from eastern Montana.

It should be noted here that none of the individuals admitted (committed) to MDC over the last four years resemble the types of individuals that are being considered for placement under Option II. These individuals generally have low skills, mild behaviors, limited medical needs and, once placed in community programs, historically do not return to the institutions. This demonstrates that community services are able to care for these types of individuals and institutionalization is no longer necessary. See Attachment 2, Summary of MDC and EHSC Data.

D. COMMUNITY AND INSTITUTIONAL SERVICES

Service Needs of Institutional Residents and DD Community Service Provider Surveys - The results of these surveys demonstrate that current types and levels of community services are appropriate and could meet the needs of those individuals who would be transferred from EHSC or MDC. Many similar types of individuals are currently being served in community services. See Attachment 3 and 4, Summaries of Survey Results.

E. IMPACT ON CLIENTS AND FAMILIES

1. Satisfaction Survey of Families of Former Institutional Clients - This survey of family members of individuals who have recently (within 4 years) moved from institutional services to community based services demonstrates satisfaction with community services over institutional services. Although many were satisfied with institutional services and did not initially support a move to community services, they now appear to prefer community placement after experiencing both services. See Attachment 5, Summary of Survey Results.

2. Survey of Relatives/Guardians of EHSC Residents. The results of this survey clearly demonstrate that most relatives or guardians of individuals currently served at EHSC are pleased with EHSC, do not want to see EHSC closed and do not want their relatives moved to community programs. See Attachment 6, Summary of Survey Results.

3. Parent Planning Survey. This survey asked parents of children with a developmental disability to rank their preference for residential settings, locations and services when their children reach adulthood. Results demonstrate that families prefer smaller residences (2-6 people) located close to family with safe and secure settings. Those responding consider institutional housing and settings to be the least favorable of all options. See Attachment 7, Summary of Survey Results.

F. IMPACT ON EHSC STAFF

The closure of EHSC will eliminate 105 state jobs and would have a major impact on those employees. The State of Montana should do what it can to reduce the impact on employees affected by implementing programs that would reduce employee anxiety, maintain job interest, and provide additional benefits and incentives. Through meetings with EHSC staff and review of information on state and private closures or reduction in force efforts, the following ideas could be considered to reduce impact on staff:

1. Ensure Communication To Reduce Employee Anxiety

a. The Department of Corrections and Human Services (DCHS) Director, Division Administrator and other central office staff should continue to meet with EHSC employees on an ongoing basis to keep them informed on the proposal for closure and the pending legislation. DCHS should ensure a continuing flow of information to EHSC employees by means of letters, meetings and other appropriate communication as the process changes or develops. Individual letters should be sent to each employee as soon as possible explaining management intent with regard to closure and impact on facility and employees.

b. Through Job Service or other agencies, have classes available for employees on how to deal with stress and the possibility of changing employment. Participate to the extent possible by allowing release time, paid time and other accommodations to permit training and counseling on stress management and coping.

c. Initiate the Department of Labor Rapid Response effort as soon as possible.

d. Provide a means to access a state long distance line to DCHS Central Office, Reduction in Force (RIF) Registry Staff and PERS staff, to enable EHSC employees an opportunity for personal response to questions or problems.

e. Labor and Union officials representing employees need to be involved from the very beginning on any closure proposal. They will need to be continually updated when information becomes available. Also, management and labor will have to negotiate closure of existing contracts at EHSC.

f. Prepare official layoff notices with at least 60 day notice to correspond with the placement of clients out of the facility and closure timelines.

2. Consider Implementation of Employee Benefit Programs

a. Consider legislation to prevent the sunset of HB 522 on June 30, 1995. Decide what date EHSC employees could be registered on the HB 522 RIF registry as potentially laid off employees.

b. Determine when EHSC employees would be eligible for six months of salary protection for demotion due to a potential layoff.

c. Consider developing early retirement legislation for those long term employees affected by layoff at EHSC.

d. Development of a DCHS transfer list for potential vacancies at other facilities within the Department for qualified EHSC employees. Also provide moving costs to those who are willing to transfer.

e. Provide additional salary or bonuses to selected EHSC employees to work until the final day of closure to avoid leaving clients without the best care possible.

f. Develop hiring preferences with state contracted private corporations such as those who would develop group homes in eastern Montana or the Glendive Medical Center who will operate the Eastern Montana Veterans Home.

g. Provide additional bonuses for retraining of EHSC employees, similar to what the Department of Administration did with custodial workers.

h. Consider allowing employees paid time to interview for other jobs and also providing clerical help in typing and preparing resumes.

i. Consider subscribing to newspapers throughout the State and allow time for employees to scan help wanted ads.

j. Consider purchasing the "Surviving a Layoff" book for each employee. The cost is $4.00 per book.

3. Implement Programs To Maintain Job Interest

a. Increase the scrutiny of Industrial Accident claims and Sick Leave requests for possible rejection. Advise Worker's Compensation of concerns. Provide employees with training and advice that may impact their future employability.

b. Budget for and provide assistance in the evaluation of reasons, causes and validity of accidents.

F. IMPACT ON GLENDIVE COMMUNITY

As with any closure or reduction in force efforts occurring at a large employer in any small community, there is major impact. The only way to offset community impact is to find alternatives or other opportunities which create additional jobs in the community. At this point, it is difficult for the Task Force to provide more detailed information

regarding this issue, however the following represents some general ideas and information:

1. Ask the Department of Commerce to prepare an Economic Impact Study.

2. Community leaders need to be involved in the Rapid Response Committee with the DCHS and the Department of Labor to assist in the planning for proposed closure.

3. Although the opening of the Eastern Montana Veterans Home (EMVH) in January 1995 will offset about 80 jobs in the community, it may also create a staffing problem at EHSC if employees leave early to work at EMVH. DCHS should work with Glendive Medical Center to develop a hiring priority for qualified EHSC employees affected by the closure and seeking employment at the EMVH.

4. It is very likely that 1 and probably 2 intensive group homes could be developed in Glendive which would mean an additional 15 to 30 jobs. Also priorities for hiring former EHSC employees could be developed.

5. The EHSC facility is a nice facility and could be used for a number of alternative services. It is imperative that the community of Glendive work with state agencies, legislators, union officials and private businesses to find alternative uses for the facility and maintain jobs for the community. If no alternatives are found for the facility, a physical plant closure analysis needs to be done with regard to state obligations and plans for the campus. This should include environmental considerations.

ATTACHMENT #1

DATE: September 14, 1994

TO: RICK DAY, DIRECTOR, DCHS

FROM: ROBERT W. ANDERSON and TED CLACK

RE: MDC POPULATION PROJECTIONS

The following are MDC projections based on Status Quo, Option II, and Option II with adjustments. These "projections" are limited by the availability of appropriate data. We conclude that the 1991 changes in the commitment statute invalidate the use of admissions data from earlier years as bases for projections. Further, the number of discharges from MDC in FY 1991-92 are distorted by decisions to "downsize" and are similarly inappropriate bases for projections. We computed estimated annual discharges as an average of the 1993-1994 data. Based on this information MDC can continue to experience a net increase of 4 clients per year

MDC ADMISSIONS/REDUCTIONS DATA					
	FY 91	FY 92	FY 93	FY 94	4 YR AVG
ADMISSIONS	19	18	11	16	16
REDUCTIONS*	55*	41*	13	12	12
ANNUAL NET INCREASE/DECREASE					+4

* REDUCTIONS INCLUDE: DISCHARGES, TRANSFERS AND DEATHS. DISCHARGES IN FY 91 & 92 ARE DISTORTED DUE TO DOWNSIZE AND COMMUNITY PLACEMENT EFFORTS AND NOT COMPUTED IN AVERAGE.

MDC POPULATION PROJECTIONS							
		STATUS QUO EHSC REMAINS AT 49		OPTION II (AS STATED)*		OPTION II (ADJUSTED)**	
FY END	CAPACITY	PROJECTION	# PLACED	PROJECTION	# PLACED	PROJECTION	# PLACED
94	117	114		114		114	
95	117	112	6	112	6	112	6
96	117	116		116		116	
97	110	120		109	11	103	17
98	110	124		113		107	
99	110	128		105	12	99	12
00	110	132		109		103	
01	110	136		113		107	

*OPTION II (as stated) includes moving 49 patients from EHSC, 11 from MDC and from CWL in FY 97, and 12 from MDC/CWL in FY 99.

** OPTION II (adjusted) includes moving all 17 patients from MDC in FY 97, and all 12 clients from MDC in FY 99. Zero clients would be moved from the CWL.

TO: BOB ANDERSON, MIKE HANSHEW

FROM: TED CLACK Ted

RE: SUMMARY OF MDC AND EHSC DATA

DATE: 31 MAY 1994

According to DCHS data, there have been 27 discharges from EHSC since July 1990. The destinations of those discharges, the related number of clients and the region of each destination are listed below:

Destination	Number	Region
Anaconda	2	west
Billings	6	central
Bozeman	1	central
Great Falls	1	central
Havre	2	east
Miles City	5	east
Missoula	8	west
MDC	1	west
Sidney	1	east
Total	27	

Adding the destinations by region...

Region	Number	Percent
East	8	29.6
Central	8	29.6
West	11	40.7

Destinations outside Eastern Montana accounted for 70.3 percent of discharges reported since July 1990.

Assuming that the addresses of the discharges' primary correspondents are related to the area of origin of each discharge, those discharged from EHSC in the period were from...

Region	Number	Percent
East	9	33.3
Central	8	29.6
West	6	22.2
Other State	3	11.1
Unknown	1	3.7

(I will identify the specific cities/towns if you wish)

MDC discharges since July 1990 totaled 104 and were distributed among 21 destinations. Those destinations were...

Destination	Number	Region
Anaconda	3	west
Billings	7	central
Bozeman	1	west
Butte	7	west

Dillon	1	west
EHSC	10	east
Emigrant	1	central
Glendive	10	east
Great Falls	5	central
Hamilton	6	west
Harlem	3	central
Havre	4	central
Helena	9	west
Kalispell	3	west
Lewistown	1	central
Libby	1	west
Livingston	4	central
Miles City	2	east
Missoula	22	west
Poplar	1	east
Ronan	3	west

Regional totals and percentages come to...

Region	Number	Percent
East	23	22.1 (87% in Glendive)
Central	25	24.0
West	56	53.8 (39.3% in Missoula)

Note that destinations outside Eastern Montana have accounted for 77.8 percent of total MDC discharges since July 1990.

MDC discharges were distributed among six types of placement, as follows:

Type	Number	Percent
D/B	1	1.0
FHP	2	1.9
GHP	73	70.2
HP	7	6.7
NHP	1	1.0
IP	20	19.2

MDC admissions from July 1, 1990 through May 31, 1994 were distributed among the three regions as follows:

Region	Number	Percent
East	6	9.5
Central	31	49.2
West	26	41.3

The reported counties of origin of the present MDC population are distributed among the regions as follows:

Region	Number	Percent
East	16	14.4
Central	46	41.4
West	49	44.1

ATTACHMENT #3

TO: BOB ANDERSON, MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: TED CLACK Ted

RE: SUMMARY OF RESULTS: DD COMMUNITY SERVICE PROVIDER SURVEY

DATE: 18 AUGUST 1994

The following conclusions were drawn from the results of survey forms completed for 10 community service provider programs.

* All or the vast majority of community service programs provide all but three of the service types listed in the survey.

* In no case do fewer than one-half the programs provide all the services listed.

* Those programs not providing some services indicated that those services are available should they be needed or required.

* Most programs stated that there are no limits to the services they provide. Where limits were noted, most had to do with inconvenience rather than absence of service. The most frequent response regarding limitations had to do with the difficulty faced in finding service professionals willing to work for Medicare/Medicaid rates and under the rules of those agencies. This problem can be no surprise to state agencies experiencing recruitment and contracting problems on a regular basis.

* All programs serve clients with behavior problems; all provide special equipment as needed. Other special needs clients also are served by community programs. None of the programs indicated that they had particular problems acquiring special equipment when it is needed.

* All programs provide vocational activities; 90 percent pay the clients. All provide in-house and community recreational activities.

These results indicate that the community based programs surveyed appear to provide a full range of services in response to demand posed by their clients, that they experience no insurmountable difficulty locating necessary services and that they serve a broad range of special needs clients.

A summary of the results of the 10 completed Community Service Provider Survey forms I received follows.

1. Number of programs providing visual services 10
   a) Services provided by:
      * optometrists 9
      * opthamologists 5
      * other 0
      * more than one professional type 5
   b) Limitations on visual services?
      * yes 2
      * no 7

2. Number of programs providing dietetic services 8
   (two programs do not; one program can acquire this service in the community if necessary)
   a) Services provided by:
      * dietitians 5
      * others (consultants, dietetic assistants, nurse practitioner) 3
   b) Limitations on dietetic services?
      * yes 2
      * no 8

3. Number of programs providing occupational therapy services (two programs not providing this service can obtain it in the community if necessary) 5
   a) Services provided by:
      * licensed occupational therapist 5
      * certified OT assistant 2
      * rehabilitation aide 1
      * more than one professional type 2
   b) Limitations on occupational therapy services?
      * yes 4
      * no 2

4. Number of programs providing physical therapy services 6
   (two programs not providing this service can obtain it in the community if necessary)
   a) Services provided by:
      * licensed physical therapist 6
      * certified PT assistant 2
      * more than one professional type 2
   b) Limitations on physical therapy services?
      * yes 2
      * no 5

5. Number of programs providing nursing services (the program not providing this service can obtain it in the community if necessary) 9
      * on site 1
   a) Services provided by:

* registered nurse 8
* licensed practical nurse 4
* more than one professional type 2

b) Limitations on nursing services?
* yes 4
* no 5

c) Do nurses supervise others in service delivery?
* yes 4
* no 5

6. Number of programs providing medical specialist services. 10
a) Services provided by:
* physician 10
* registered nurse 4
* more than one professional type 4

b) Limitations on medical specialist services?
* yes 1
* no 9

7. Number of programs providing general physician services (one program contracts with a local physician on demand) 10
a) Services provided by:
* physician 8
* Doctor of Podiatry 1

b) Limitations on general physician services?
* yes 3
* no 7

c) Do physicians supervise others in service delivery?
* yes 3
* no 6

(Two Registered Nurses and one LPN were listed as supervised by a physician)

8. Number of programs providing counselling. 8
a) Services provided by:
* doctor 5
* nurse 1
* psychologist 7
* others (MSW) 2
* more than one type of professional 5

b) Limitations on counselling services?
* yes 4
* no 5

c) Do professionals supervise others in service delivery?
* yes 2

* no 6

9. Number of programs providing psychiatric consultations. 10
   a) Limitations on psychiatric consultations?
      * yes 5
      * no 4

10. Number of programs providing blood screening services. 10
    a) Limitations on blood screening services?
       * yes 0
       * no 9

11. Number of programs providing nurses to administer injections. 5
    (One program not providing this service can obtain it in the community if necessary)

Where respondents indicated that limitations to services exist, their responses fell into the following categories:

A. Medicare/Medicaid rates and allowances limit access to services and the number of providers who will participate. 6
B. Availability of the specific service in the community. 5
C. Limited to appointment schedules only. 3
D. Contract provisions. 1
E. Cost 1
F. Agency barriers. 1

12. Number of programs providing barrier free settings. 10

13. Number of programs providing special equipment. 10
    a) Special equipment provided:
       * special beds 6
       * adaptive chairs 5
       * adaptive eating equipment 5
       * feeding tubes 2
       * special bathing equipment 5
       * a van with a lift 3
       * communication equipment 6
    b) Difficulties acquiring special equipment?
       * yes 2
       * no 7

14. Number of programs by staffing ratios.
    a) Day staff ratios:
       * 1:2 9
       * 2:3 1
    b) Night staff ratios:

	* 1:3	2
	* 1:4	2
	* 1:6	6
c)	Awake night staff available?	
	* yes	10
d)	24-hr supervision available?	
	* yes	10
15.	Number of programs serving special needs clients:	
	* Prader-Willi clients	2
	* Oxygen needed by client	1
	* Special diet for clients	8
	* Hearing impaired clients	3
	* Visually impaired clients	3
	* Clients with communication needs	7
	* Epileptic clients	7
	> with seizures	7
	> seizure frequency	
	1) 1-2 per month	3
	2) 4 per year	1
	3) variable	1
	4) unknown	1
	* Drug sensitive clients	4
	* Food sensitive clients	3
	* Clients with Medicaid eligibility problems	1
	* Clients with behavior problems:	10
	> physical aggression	5
	> property destructive	3
	> verbal aggression	2
	> self-injurious behaviors	2
	> explosive/violent behavior	2
	> aggression	1
	> OBRA clients	1
	> incontinent	1
	> screaming	1
16.	Number of programs providing vocational activities	10
a)	frequency of activity	
	> 6 days a week	6
	> 5 days a week	1
	> 9 days a month	1
	> variable	1
b)	clients paid for activities	9
c)	types of activity:	
	> industries programs	4
	> recycling	3
	> "community work"	3
	> janitorial/maintenance work	3
	> special vocational/academic programs	3
	> furniture construction	2
	> agricultural work	1
	> self-help training	1

	> IDP	1
17.	Number of programs providing recreational activities	9
	a) types of activity	
	> "normal community" activities	7
	> movies	5
	> dining	5
	> shopping	5
	> swimming	4
	> bowling	4
	> fishing	4
	> camping	3
	> ballgames and the like	3
	> picnics	2
	> riding	2
	> skiing/boating/cooking/arts&crafts	1ea.
18.	Number of programs providing activities with non-disabled people in the community.	10
	a) frequency of activity	
	> daily	3
	> 3 times a week	1
	> twice a week	1
	> once a week	3
	> once or twice a month	2
	b) types of activity	
	> dining	5
	> "normal community activities"	5
	> shopping	3
	> "same as above" (Item 17)	2
	> swimming/bowling/games	2ea.
	> movies/camp/community work/classes/ arts&crafts/"advocacy"/Senior Volunteers	1ea.

ATTACHMENT #4

DATE: SEPTEMBER 16, 1994

TO: BOB ANDERSON AND MIKE HANSHEW

FROM: TED CLACK

RE: SUMMARY OF IDENTIFIED SERVICE NEEDS OF EHSC AND MDC RESIDENTS BEING CONSIDERED FOR COMUNITY PLACEMENT.

The following table summarizes the count of residents at each institutuion who reportedly now receive the services or programs listed. I was unable to acquire these data in a form suitable from computer storage and processing. The services or programs listed correspond to the items contained in the earlier survey of the Community Based Programs.

SUMMARY OF SERVICES/PROGRAMS NOW RECEIVED BY EHSC AND MDC CLIENTS CONSIDERED FOR COMMUNITY PLACEMENT

SERVICES/PROGRAMS	EHSC - 30			MDC - 43		
VISUAL SERVICES	ANNUAL EXAM - 30			ANNUAL EXAM - 43		
DIETITCIAN SERVICES	1HR/YR 28	1HR/MO 1	1HR/WK 1	1 HR/YR 37	1 HR/MO 5	1HR/WK 1
OT THERAPIST	1HR/YR 28	1HR/2-3YRS 2		1HR/YR 21	1HR/2-3YRS 22	
OT FROM "OTHER"	1-2HR/WK N/A	2+ HR/WK 4		1-2HR/WK 1	2+HR/WK 1	
PT THERAPIST	1HR/YR 30	1HR/2-3YR N/A	WEEKLY+ N/A	1HR/YR 16	1HR/2-3YR 8	WEKLY+ 12
PT FROM "OTHER"	1-2HR/WK 3	2+HR/WK 7		1-2HR/WK 0		2+HR/WK 7
NURSE SERVICES	DAILY 1			DAILY 41		
MEDICAL SPECIALIST	AS NEEDED 2			AS NEEDED 10		

SUMMARY OF SERVICES/PROGRAMS NOW RECEIVED BY EHSC AND MDC CLIENTS CONSIDERED FOR COMMUNITY PLACEMENT

SERVICES/PROGRAMS	EHSC - 30			MDC - 43		
GENERAL PHYSICIAN	²1/OTR 1		1-2/YR 28	1/OTR 43		1-2/YR N/A
SPEECH THERAPY	ASSESSMENT N/A	1+/YR 29	1/3YRS 0	ASSESSMENT 43	1+/YR 22	1/3YRS 21
SPEECH FROM "OTHER"	1-2HRS/WK 3	>2HRS/WK 5		1-2HRS/WK 9	>2HRS/WK 5	
PSYCH EVALUATION	ANNUAL 30			ANNUAL 43*		
COUNSELING	DAILY 0	1/WK 0	>/WK 0	DAILY 2	1/WK 2	>1/WK 1
PSYCHOTROPIC MEDS	NO. RECEIVING 5			NO. RECEIVING 31		
PSYCH CONSULTS	NO. RECEIVING 0			NO. RECEIVING 35		
BLOOD SCREENS	NO. RECEIVING 29			NO. RECEIVING 35		
OTHER MEDS	NO. RECEIVING 30			NO. RECEIVING 39		
WHEELCHAIRS	NO. USING 6			NO. USING 8		
AMBULANCE AIDS	NO. USING 8			NO. USING 0		
SPECIAL BEDS	NO. USING 0			NO. USING 3		
SPECIAL CHAIRS	NO. USING 3			NO. USING 3		
SPECIAL EATING AIDS	NO. USING 27			NO. USING 3		
FEEDING TUBE	NO. USING 0			NO. USING 1		
SPECIAL BATHING AIDS	NO. USING 3			NO. USING 1		
LIFT VAN	NO. USING 10			NO. USING 7		

SUMMARY OF SERVICES/PROGRAMS NOW RECEIVED BY EHSC AND MDC CLIENTS CONSIDERED FOR COMMUNITY PLACEMENT

SERVICES/PROGRAMS	EHSC - 30			MDC - 43		
SPECIAL COMMUNICATION AIDS	NO. USING 3			NO. USING 2		
STAFFING RATIOS AM	1/4	1/5 15	1/6 14	1/4 43	1/5 0	1/6 0
STAFFING RATIOS PM	1/8	1/10 14	1/15 15	1/8 43	1/10 0	1/15 0
NEED AWAKE STAFF PM	Y 24	N 6		Y 38	N 5	
NEED 24HR SUPERVISION	Y 28	N 2		Y 42	N 1	
SPECIAL DIETS	Y 26			Y 19		
HEARING IMPAIRED	Y 0			Y 5		
VISUALLY IMPAIRED	Y 5			Y 8		
EPILEPSY	Y 15			Y 29		
SEIZURES	Y 10			Y 29		
SEIZURE FREQUENCY	≥1/MO 3	≥1/YR 5	1/YR N/A	≤1/YR N/A	≥1/MO 6	≥1/YR 7	1/YR 0	≤1/YR 1
DRUG SENSITIVE	Y 9			Y 14		
FOOD SENSITIVE	Y 7			Y 3		
NEED BEHAVIOR MOD PGMS	Y 10			Y 22		
USE VOCATIONAL PGMS	Y 4			Y 27		
USE RECREATIONAL PGMS	Y 30			Y 43		

TO: BOB ANDERSON, MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: TED CLACK Ted

RE: SUMMARY OF RESULTS: SATISFACTION SURVEY OF FAMILIES OF FORMER INSTITUTIONAL CLIENTS

DATE: 18 AUGUST 1994

The following conclusions were drawn from the results of 36 of 39 surveys returned by or for families of former institutional clients. Three of the 39 survey forms were blank.

* I used cumulative totals of ratings of the various items included in this survey because the data represent ordinal level measurement. That is, one can say one response indicates more of some characteristic than another but cannot say how much more or how many times more. I did not use average ratings because averages would be illegitimate with these data. Averages require ratio levels of measurement. Comparisons of cumulative ratings accomplish the same purposes without stretching the data more than is justifiable. Each cumulative total is based on paired responses - I did not include data from respondents who did not provide ratings for the same service in each service setting.

* Respondents expressed higher levels of satisfaction with community-based services than with institutional services on **every** item.

* The results of responses to open-ended questions also indicate greater satisfaction with community-based than with institutional services.

* Data from this survey do **not** paint a damning picture of the institutional programs, overall, they merely indicate what I would call a strong preference for services in the community setting.

The results of the family satisfaction survey indicate that those surveyed are satisfied with the services provided by the community-based programs and prefer them to institutional services.

A summary of the results of those 36 surveys follows.

1. Years in institutional setting:

AVERAGE YEARS	MAXIMUM	MINIMUM	NO ANSWER
18.7	36	0.6	11

2. Tally of responses favoring and opposing movement to the community.

		NUMBER RESPONDING
AGAINST	(1)	7
	(2)	2
	(3)	8
	(4)	10
FOR	(5)	8
CUMULATIVE TOTAL		115

3. Tally of responses expressing satisfaction with transfers to community programs.

		NUMBER RESPONDING
DISSATISFIED	(1)	0
	(2)	1
	(3)	2
	(4)	13
SATISFIED	(5)	19
CUMULATIVE TOTAL		155

4. Respondent comments about the quality of institutional care received by their family member.

RESPONSE	NUMBER RESPONDING
Pleased with the care	6
Care was poor	6
Too much staff turnover	3
Staff tried but situation was poor	3
Needed more normal environment	2
Matters improved over time	1
Daughter sexually molested	1
Client was unhappy there	1
Family was not kept informed	1
Institution was poorly run	1

5. Respondent comments about the quality of care provided in community programs.

RESPONSE	NUMBER RESPONDING
Very pleased with the services	3
Client has improved	2
Family wants more feedback	2

Client is receiving good care 1

6. Community program changes suggested by respondents

RESPONSE	NUMBER RESPONDING
Programs closer to family home	7
Would make no changes	5
Programs doing wonderful job	3
Continue to develop training programs	2
Better pay for staff	1
No response	22

7. General comments about community programs

RESPONSE	NUMBER RESPONDING
Programs are doing a great job	12
Approve of work for those who can work	2
Client is doing well in the community	2
Don't close EHSC	2
Client should never have been in MDC/EHSC	1
Community program has attractive setting	1
Need more advocacy	1
No response	21

8. Comparison of "satisfaction" ratings for institutional and community programs.

A. LIVING AREA

	NUMBER RESPONDING	
RATING	**INSTITUTIONAL**	**COMMUNITY**
1 (UNSATISFIED)	4	0
2	5	0
3	6	2
4	11	8
5 (SATISFIED)	8	21
NO ANSWER	2	5
CUMULATIVE TOTAL	**116**	**143**

B. SUPPORT SERVICES

1 (UNSATISFIED)	5	0
2	2	0
3	10	3
4	9	11
5 (SATISFIED)	7	16
NO ANSWER	3	6
CUMULATIVE TOTAL	**110**	**133**

C. MEDICAL CARE

1 (UNSATISFIED)	1	0
2	8	2
3	5	5
4	11	8
5 (SATISFIED)	9	18
NO ANSWER	2	3
CUMULATIVE TOTAL	121	141

D. SKILL TRAINING

1 (UNSATISFIED)	3	0
2	6	0
3	4	3
4	12	9
5 (SATISFIED)	9	20
NO ANSWER	2	4
CUMULATIVE TOTAL	120	145

E. SATISFACTION WITH STAFF

1 (UNSATISFIED)	3	0
2	8	0
3	7	2
4	8	11
5 (SATISFIED)	7	17
NO ANSWER	3	6
CUMULATIVE TOTAL	107	135

F. SATISFACTION WITH ACTIVITIES

1 (UNSATISFIED)	2	0
2	4	0
3	8	2
4	7	8
5 (SATISFIED)	10	20
NO ANSWER	5	6
CUMULATIVE TOTAL	112	138

CUMULATIVE TOTAL OF SATISFACTION SCORES - ALL ITEMS	686	835

ATTACHMENT #6

TO: BOB ANDERSON, MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: TED CLACK Ted

RE: SUMMARY OF THE SURVEY OF RELATIVES/GUARDIANS OF EHSC RESIDENTS

DATE: 13 SEPTEMBER 1994

A total of 26 surveys was returned by 12 September 1994. The results summarized below were drawn from those surveys.

* The weighted average reported amount of time in residency at EHSC or in the institutional system was 12.8 years, with three respondents uncertain. The reported maximum residency was 38 years; the minimum was 2 years.

* 20 of 26 respondents were strongly opposed to community placement, three were neutral, two strongly supported the idea and one wanted more information.

* The vast majority of respondents were very satisfied with the institutional services provided at EHSC. More respondents failed to address this series of items than expressed less than maximum satisfaction with those services. I will provide more specific response tallies if you want them.

* 22 of 26 respondents do **not** attend Individual Plan meetings. The most common reason cited for nonattendance was distance from EHSC.

* 18 of 26 respondents stated that their relative was farther from them now than when in the previous service setting. Six respondents indicated that their relative was closer now than previously.

* 12 of 26 respondents see their relatives about as often as before they were housed at EHSC; six see their relatives more often while five see them less often. Two respondents never see their relative; one respondent failed to respond.

* Most respondents (17 of 26) provided no suggestions regarding change in the services their relatives receive. Five respondents stated that EHSC is a wonderful facility and should be left intact, two

requested larger budgets for EHSC and one suggested that another institution be built elsewhere. One respondent wanted appropriate services available closer to the family residence.

* 13 respondents stated their satisfaction with EHSC and their opposition to its closure; 12 respondents provided no further comments. One respondent requested development of proper alternative services.

ATTACHMENT #7

TO: BOB ANDERSON, MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: TED CLACK Ted

RE: SUMMARY OF RESULTS: PARENT PLANNING SURVEY

DATE: 31 AUGUST 1994

The results presented below were drawn from the 54 returns of a reported total of 150 surveys mailed to parents of children with developmental disabilities. The data are presented in total and by DD Planning Region. The data from each return were placed in a computer database for summary. Weighted ranks were computed for each item listed on the survey; ranks were computed separately for each region and for the statewide total. A summary table, presenting service options in descending order of respondent preference, the distribution of respondents by city and region and other data is attached.

Overall, the survey results indicate:

* Those responding most prefer two-person or six-person housing for their children when they have reached adulthood.

* Those responding consider institutional housing to be least favorable of all options; five respondents considered that form of housing unacceptable.

* Respondents favored location of their childrens' residences in their own or nearby communities to other location alternatives.

* Respondents were most concerned that basic life support services and family contact would be available to their children when they reach adulthood. The availability of outside monitoring of services and work and recreational opportunities were of little **relative** concern to respondents. The availability of caring staff and homelike environments were given mid-range ranks by respondents. Several respondents indicated that they considered **all** items to be important.

* Although the relative ranks of items varied somewhat by DD Planning Region, those results were generally consistent with the statewide total results.

RELATIVE RANKS OF RESPONDENT PREFERENCES FOR PARENT PLANING SURVEY ITEMS. TOTAL AND BY PLANNING REGIONS.

SERVICE OPTIONS	STATE TOTAL	REG 1	REG 2	REG 3	REG 4	REG 5
RESIDENTIAL SETTINGS						
ROOMMATE W/ SUPPORT	1	1	1	2	3	2
6 PERSON GROUP HOME	2	2	3	3	1	4
PARENT'S HOME	3	4	2	1	4	3
ALONE W/ SUPPORT	4	3	4	4	5	1
8 PERSON GROUP HOME	5	5	5	5	2	5
UNKNOWN	6	6	6	7	6	7
50-100 PERSON INSTITUTION	7	7	*	6	7	6
RESIDENTIAL LOCATION						
OUTSIDE HOME, SAME TOWN	1	1	1	1	1	1
OUTSIDE HOME, CLOSE TOWN	2	2	4	3	3	2
IN PARENTS' HOME	3	3	2	2	2	3
OUTSIDE HOME, OTHER TOWN	4	4	3	5	4	4
UNKNOWN	5	5	*	4	5	5
SERVICE FEATURES						
SECURITY AND SAFETY	1	1	2	2	1	1
FAMILY CONTACT	2	3	1	1	2	2
LIFE SUPPORTS	3	4	5	3	3	4
HOMELIKE ENVIRONMENT	4	5	3	5	4	5
TRAINED STAFF WHO CARE	5	2	4	4	5	7

SOCIAL INTERACTION	6	7	6	8	7	3
SPECIAL SERVICES (OT,PT)	7	8	9	6	6	9
RECREATIONAL ACTIVITIES	8	9	8	9	8	8
EMPLOYMENT OPPORTUNITY	9	6	7	7	10	6
FREQUENT MONITORING	10	10	10	10	9	10

NUMBER OF RESPONDENTS LABELLING SELECTED OPTIONS AS UNACCEPTABLE

OPTION	NUMBER
* LIVING ALONE WITH SUPPORT	2
* LIVING IN 50-100 CLIENT INSTITUTION	5
* OUTSIDE PARENTS' HOME, OTHER TOWN	2
* EMPLOYMENT OPPORTUNITIES	1

DISTRIBUTION OF RESPONDENTS BY DD PLANNING REGION

REGION 1	REGION 2	REGION 3	REGION 4	REGION 5
8	10	9	17	7

THREE RESPONDENTS DID NOT IDENTIFY THEIR TOWNS OF RESIDENCE

COUNT OF RESPONDENTS BY COMMUNITY

ANACONDA	1	DAWSON	1	MANHATTAN	1
BILLINGS	5	FORSYTH	1	MILES CITY	1
BOZEMAN	4	GLENDIVE	3	MISSOULA	5
BUTTE	6	GREAT FALLS	4	ROSEBUD	1
CHESTER	1	HAMILTON	1	SHELBY	1
CHOTEAU	2	HELENA	4	VAUGHN	1
COLSTRIP	1	LAUREL	2	WHITEHALL	1
CUT BANK	1	LIBBY	1	WINNETT	1
		YELLOWSTONE	1		

EXHIBIT 9
DATE 1/27/95
HB

MONTANA ADVOCACY PROGRAM, Inc.
316 North Park, Room 211
P.O. Box 1680
Helena, Montana 59624

(406)444-3889
1-800-245-4743
(VOICE - TDD)
Fax #: (406)444-0261

January 27, 1995

Representative John Cobb, Chairperson
Human Services Joint Appropriations Subcommittee

Representative Marge Fisher
Institutions Joint Appropriations Subcommittee
State Capitol
Helena, Montana 59620

Re: Eastmont Closure

Mr. Chairman, Madame Chair and Members of the Committee:

For the record, my name is Andree Larose and I am a staff attorney for the Montana Advocacy Program. Montana Advocacy Program is a non-profit organization which advocates the rights of individuals with disabilities. We are here to testify in support of the closure of Eastmont because we feel very strongly that it is the right thing to do. It is the humane thing to do, it is the ethical thing to do, it is the fiscally responsible thing to do and it is the legally appropriate thing to do.

I come before you as an attorney with the branch of MAP which provides protection and advocacy for persons with developmental disabilities. In seven years with the PADD program, I have represented many individuals being committed to institutions serving persons with developmental disabilities. I speak from my personal experiences, I speak from my frustrations, and I speak for many of my clients who are not here today.

You must decide whether we, as a State, are going to continue to involuntarily commit to institutions people who do not need to be there, or whether we are going to give these people an opportunity to live in a more normal setting which allows them greater access to the community and greater normal social interactions.

The Department has presented a proposal which makes good use of scarce resources in a manner which meets each individual's treatment needs and respects each person's legal rights. The cost of operating an institution such as Eastmont far exceeds the cost of providing community based services. Once the transition is made and Eastmont is closed, the funds which had been used to operate Eastmont can be redirected into providing more appropriate services for more individuals at the same cost. This is not only what is right for the individuals involved; it makes good fiscal sense. And it is a good plan in the long term. Eventually, the community services created to meet the needs of those Eastmont residents will be available for others on the waiting list. This plan

shows foresight for the future of developmentally disabled Montanans.

Legal Reasons for Closing Eastmont: An Individual Has a Constitutional Right to be Free from Unnecessary Confinement in an Institution

Montana law requires that a person be institutionalized "only when a person is so severely disabled as to require institutionalized care." 53-20-101, MCA. Instead of institutionalization, Montana law requires treatment and habilitation be accomplished in community based setting whenever possible.

The Montana legislature established the community group home program in recognition of "desirability of meeting their needs on a community level to the fullest extent possible and in order to reduce the need for care in existing state institutions." 53-20-301, MCA.

Each person has a fundamental liberty interest under the 14th Amendment of the U.S. Constitution and under the Montana Constitution to not be involuntarily confined in an institution unless certain legal criteria are met.

Even then, institutionalization is not meant to be the permanent, long term placement for people with disabilities. It is well established in Supreme Court cases that the committed individual is entitled to habilitation to enable him or her to leave his commitment.

Developmentally Disabled Individuals Are Denied the Right to Treatment in the Least Restrictive Environment

Whenever I go to MDC, at least one or two residents approach me and say "Please get me out of here. I want to live in the group home." I tell them I will try. But I know their chances are slim.

I have represented many individuals over the years who have objected to continued involuntary commitment and whose treatment team agrees can be safely and effectively habilitated in the community. The type of services they need exist in the state, other people with similar disabilities and needs are served in community based services.

There is no reason to keep them in an institution. Yet they continue to be recommitted for one reason - there are not enough community services. As openings arise in community services, the person in the institution is a lower priority than an individual in an abusive or crisis situation in the community. A vicious cycle begins. At the recommitment, the judge typically agrees that the person could be habilitated in the community, but finds that since he or she has not been placed in any of the openings, they are recommitted for another year. And so long as they are committed, they remain a lower priority and don't get placed. The vicious cycle continues, year after year after year.

I want to quote from an order in one case of an individual who has been in an institution for **15 years.** Last year the judge said: "Moreover, the record reflects that the Court has **always** recommended community placement and that the Department has in good faith attempted to do so, but without success due to unavailability of qualified community based facilities." The court then ordered recommitment to MDC. For 15 years this court has found that this resident could be served

appropriately in community services, but each year he has been recommitted solely because the State has not selected him for placement in community based services.

He is not the only person who is inappropriately institutionalized. People are institutionalized at both Eastmont and MDC who do not need to be there, who are not so severely disabled as to require institutionalized treatment. The Department has identified at least 70 individuals in this situation; this includes most residents at Eastmont and several at MDC. In a recommitment proceeding held last year, a district court judge recognized that there are 80 or so individuals in this situation.

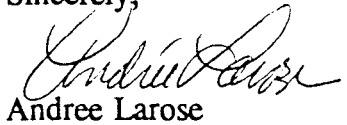
This is tragic. This is a violation of these individuals' constitutional rights. This must be stopped.

The idea that persons should be institutionalized as little as possible and treated in community-based services as much as possible is the philosophical and legal underpinning of Montana's service system. If we approach this whole situation from that point first, the closure of Eastmont is inevitable. As long as it is open, there will be efforts to fill the beds whether the people truly need to be there or not. Under the criteria for commitment, there is no need for two institutions serving persons with developmental disabilities in Montana. We should not be looking for ways to fill an institution and keep it open, even though keeping Eastmont open provides many jobs for the Glendive community. We know there are dedicated, caring staff at Eastmont and that residents receive quality care there. We are saddened people may lose their jobs. Hopefully, many of those same staff will seek employment in community based services. It is fiscally irresponsible to keep open an institution that is not needed, even where it preserves jobs in a community. Let's remember the most important right involved here. It is the fundamental constitutional right to liberty. No matter how good the care, please remember that "commitment for any purpose constitutes a significant deprivation of liberty..." Addington v. Texas, 441 U.S. 418, 99 S.Ct. 1804, 1809 (1979). (emphasis added). This is true no matter how benevolent or well intentioned the state's purpose may be. O'Conner v. Donaldson, 422 U.S. 563, 95 S.Ct. 2486, 2494.

Most of the residents at Eastmont are not so severely disabled as to require institutionalization. Several years ago Montana Advocacy Program represented six individuals from MDC who were in this same situation. We raised constitutional issues of liberty and due process. After an initial order in which the district court recognized the viability of our constitutional arguments, the case was settled and those six residents were placed in community services. Those same constitutional issues exist again with most of the Eastmont residents and many MDC residents.

The Department has come to you now with a plan that is proactive, rather than reactive. You have the opportunity to do the right thing - in a thoughtful, comprehensive manner. Monies can be expended on direct care services, rather than on costly litigation. Please take advantage of this opportunity. We urge you to close Eastmont and redirect those funds into the development of appropriate community based services. Thank you for your time.

Sincerely,



Andree Larose

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Sincerely,

Andree Larose

EXHIBIT 10
DATE 1/27/95
HB

TESTIMONY BEFORE THE HOUSE JUDICIARY, AND HOUSE APPROPRIATIONS JOINT SUBCOMMITTEES ON HUMAN SERVICES AND INSTITUTIONS

January 27th, 1995

Mr. Chairman, committee members. For the record my name is Dr. Allen Hartman. I am a pediatrician at the Billings Clinic and have been a practicing physician in Montana since 1961.

I am also a member of the Developmental Disabilities Planning and Advisory Council and have served on the Council since it's formation in 1971. I am the current Chairperson of the Council and have been asked to give the opinion of the Council regarding the future of Eastmont.

The Council is a 25 member federally funded advisory body mandated in both federal and state law (PL 104-230, 2-15-2204 MCA and 53-20-206 MCA). Members of the Council include representatives of SRS, DFS, OPI, Corrections and Health, an attorney, physician, social worker, two members of the Legislature, advocacy and provider agencies and twelve parent or consumer members. All members are appointed by the Governor. They represent all geographical areas of the state from Eureka to Sidney to Billings to Missoula.

The Council has several purposes. Most importantly is the responsibility to advise the Governor and various state and local agencies involved in the provision of services to persons with developmental disabilities.

Well over a year ago, the Council began looking at the future of Eastmont with an understanding that we would be asked for an opinion. During that time, Council members visited Eastmont, toured the Montana Developmental Center and looked at community based intensive group homes. These are the types of homes that would provide services to the people who currently live at Eastmont if they are moved into the community. In addition, over the year, all of the issues surrounding the controversy were discussed.

At our August 1994 meeting in Helena, the Council narrowly voted to

recommend closure to the Governor. The vote was 9 to 8 with two abstentions. Six members of the Council were not present.

It is interesting to review this vote.

There are a variety of reasons why one more member of the Council voted for closure than against it. You have heard all of those reasons expressed by a variety of persons this morning. I will not list them again. Instead, I would rather review the reasons for members voting no. We understand that much has been made of the closeness of the vote. We do not find that the closeness is surprising. We feel that the closeness represents a microcosm of the issues involved in the proposed closure.

Analyzing the vote, we find that three "no" votes are members from eastern Montana who justifiably support the community of Glendive and eastern Montana issues in general. They would hate to see this area lose any kind of services. They are justifiably proud of the services delivered at Eastmont. We agree with them that Eastmont is a fine facility. We do not wish to see the Glendive area harmed economically and would hope that one or possibly two group homes related to this project could be located there. Similarly, we would like to see some economically valuable use of the facility if closure occurs.

At least two of the "no" votes resulted from a fear of the loss of service capacity that Eastmont represents. In fact there will be no loss of capacity. The addition of services for another 50 - 60 persons in the community will create even more capacity by increasing available options.

At least one member voted no as a function of concern over the waiting list. It has already been explained that adoption of this measure will have no impact on the waiting list issue. If Eastmont is closed, no more people from the community will be served. Similarly, if Eastmont remains open, no more people will be served.

At least one member voted "no", feeling that the persons served in Eastmont could not be served successfully in the community. This person was not present during our tours of intensive group homes here in Helena that provide services to exactly the same kinds of people who now live at Eastmont. Some of these homes have been in service since 1978 and statewide there are 37 homes of this type serving a population of 240 persons. Additionally, there are 138 children receiving services in their own homes through the Specialized

Family Care Program, who 20 years ago would have been institutionalized because they have similar needs to those persons in MDC and Eastmont.

In October, because of the closeness of the vote, the Council was asked for direction regarding speaking to the Legislature regarding the closure. The vote of the Council to support the previous decision was unanimous.

Finally, since the time that the Council voted in August, two members have made statements that given the opportunity to vote again, they would change their vote from against closure to favoring closure. Similarly, of the six members who were absent and the two who abstained for the August vote, six have expressed that they would have voted for closure if they were given that option. One is likely to have voted against and another is unknown. As a result, what appears to have been a very close vote may not have been so.

Of course, the voting of the Council was completed in August and speculation as to another vote has little or no value. In the end, the fact remains that regardless of the closeness of the vote, the Council voted in favor of recommending closure and stands, as a body, with that decision today.

Thank you.

EXHIBIT 11
DATE 1/27/95
HB

The following members of the State of Montana Developmental Disabilities Planning and Advisory Council voted in favor of Option II as presented by the Interagency Task Force on Developmental Disabilities:

NAME	AFFILIATION
Robert Runkel	Office of Public Instruction
Randy Cochran	Consumer Member
Dr. Allen Hartman	Physician
Kristin Bakula	Montana Advocacy Program
Cary B. Lund	Department of Social and Rehabilitation Services
Robert J. Tallon	Montana Association of Independent Disability Services
Judy Rolfe	Parent/Consumer Member
J. Cort Harrington	Attorney
Florence Massey	Parent/Consumer Member

The following members of the State of Montana Developmental Disabilities Planning and Advisory Council voted in opposition to Option II as presented by the Interagency Task Force on Developmental Disabilities:

NAME	AFFILIATION	
Betty Lou Kasten	Legislative Representative	NO CHANGE
Harold Lorenz	Consumer Representative	NO CHANGE
Ken Kronebusch	Consumer Representative	NO CHANGE
Connye Hager	Legislative Representative	CHANGE
Othelia Schulz	Consumer Representative	NO CHANGE
Vonnie Koenig	Consumer Representative	CHANGE
Tom Price	Consumer Representative	NO CHANGE
Peyton Terry	Consumer Representative	NO CHANGE

The following members of the State of Montana Developmental Disabilities Planning and Advisory Council abstained from voting voted on Option II as presented by the Interagency Task Force on Developmental Disabilities:

NAME	AFFILIATION	
Don Sekora	DFS	WOULD VOTE YES
Bob Anderson	DCHS	WOULD VOTE YES

The following members of the State of Montana Developmental Disabilities Planning and Advisory Council were not present for the vote:

NAME	AFFILIATION	
Steve Clincher	Consumer Member	MIGHT VOTE NO
Wallace Melcher	Consumer Member	WOULD VOTE YES
Tom Seekins	MUARID	WOULD VOTE YES
Marylynn Donnelly	DHES	WOULD VOTE YES
Frank Clark	Social Work	WOULD VOTE YES
Joyce Curtis	Consumer Member	UNKNOWN

EXHIBIT 12
DATE 1/27/95
HB

Mr. Chairman and Committee Members

My name is Martha Huber and I am from Billings MT. I am speaking on behalf of our son, Lyle Huber a resident of Eastmont Human Services. My husband Ervin and I are here to speak in favor of House Bill 65.

Our son Lyle lived in our home until it became impossible for us to care for him. We were forced to place him at Boulder River School and Hospital in Boulder Mt. In 1969 there was no place else to go, he was 20 years old. Because we lived in the far eastern part of the state our visits were limited to only about 2-3 times per year. Lyle is one of 5 children and he was very much missed.

When Lyle left Boulder in 1979 and eventually ended up in Eastmont, we were thrilled to have him living in Glendive at last, where we lived. Soon however, Ervins job took us to Billings and once again we left Lyle behind and visits became minimal. Even though we tried to see Lyle as often as possible we were left with the same problem as before. We missed him.

Soon after Ervins retirement we began to have health problems which made the travel even harder and visits farther apart. As we approach our 80's we have become entirely dependent upon our other children to take us to visit **our** son. Upon our death the responsibility for Lyle's care will be placed in our daughter, Charlene's charge. She and two brothers also live in Billings. This is something we **can not ignore** and is a very important part of our whole families future.

We, too, have checked into the available services in Billings and were truly excited about the possibilities. We were not only impressed with the care given to the residents, but that Lyle could at last live in a nice, new environment **close to home.**

This fact alone has made us decide that available money should be spent for community based services, close to family and friends.

I hope you will remember this in your decision making.
I pray that God will lead all of you to the right choice.

Thank you for your time.

EXHIBIT 13
DATE 1/27/95
HB

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS

MARC RACICOT, GOVERNOR

PO BOX 200804

STATE OF MONTANA

(406) 444-3955
TOLL FREE 1-(800) 332-2272

HELENA, MONTANA 59620-0804
FAX 406-444-3543

January 27, 1995

Appropriations Subcommittees:
Human Services and Institutions
House Judiciary Committee
State Capitol
Helena, MT 59620

Committee Members:

For the record, my name is Kelly Moorse and I am the Executive Director of the Board of Visitors. The Board reviews patient care and treatment at Eastmont Human Services Center (EHSC) and Montana Developmental Center.

Our Board members (who include families with developmentally disabled individuals) have reviewed and support the changes proposed by House Bill 65. When we look at the history and development of services for persons with developmental disabilities over the past 25 years, it's truly incredible. When first begun in 1967-69 EHSC provided a new concept in training individuals with developmental disabilities between the ages of 4-21, in establishing a five day program. At that time we had no community based programs (no group homes, no day programs etc.) In 1979, 29 individuals were transferred from Boulder and the seven day program was a reality. By 1983 the five day program was eliminated because of the expansion of school and community based services. Soon after, we had no children in any either of our state institutions for persons with developmental disabilities and no community admissions to EHSC. In 1988, in response to the Medicaid active treatment requirements, Eastmont reorganized their treatment programs to provide more functional and age appropriate training. Moreover, the census was reduced to 50 in order to meet the active treatment mandates. EHSC Staff addressed "What do we provide to promote independence for the residents?" Program development, although slow at times, began addressing prevocational training, community outings, recreation, functional living skills etc. During this same time, intensive community based services, with group homes and day services were developed.

The population at EHSC is no different than those individuals from MDC who are served by the intensive models established in the early 1990's. Over the past 25 years EHSC role and mission has changed to meet consumer needs and requirements of funding sources. Given this progression and the ongoing expansion of community services, the Board supports the closure of EHSC.

The Board support of closing Eastmont is not a reflection on the quality of care provided by the staff at the facility. As any facility goes through the turmoil and the upheaval over its pending future, the staff have remained focused and dedicated to providing quality services.

Let us not forget that we could not take this step in the developmental disability service system if it were not for those who saw a need to create a service where there was none. We owe those who pioneered the cause of EHSC a debt of gratitude. They helped move our system forward and we must continue to do so. The closure of Eastmont is the end of chapter in our service delivery system, but it will open new pages, greater opportunities in the lives of persons with developmental disabilities.

We urge the committee's support of House Bill 65.

Sincerely,

Kelly Moorse
Executive Director

SOCIAL INTERACTION	6	7	6	8	7	3
SPECIAL SERVICES (OT,PT)	7	8	9	6	6	9
RECREATIONAL ACTIVITIES	8	9	8	9	8	8
EMPLOYMENT OPPORTUNITY	9	6	7	7	10	6
FREQUENT MONITORING	10	10	10	10	9	10

NUMBER OF RESPONDENTS LABELLING SELECTED OPTIONS AS UNACCEPTABLE

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RELATIVE RANKS OF RESPONDENT PREFERENCES FOR PARENT PLANING SURVEY ITEMS. TOTAL AND BY PLANNING REGIONS.

SERVICE OPTIONS	STATE TOTAL	REG 1	REG 2	REG 3	REG 4	REG 5
RESIDENTIAL SETTINGS						
ROOMMATE W/ SUPPORT	1	1	1	2	3	2
6 PERSON GROUP HOME	2	2	3	3	1	4
PARENT'S HOME	3	4	2	1	4	3
ALONE W/ SUPPORT	4	3	4	4	5	1
8 PERSON GROUP HOME	5	5	5	5	2	5
UNKNOWN	6	6	6	7	6	7
50-100 PERSON INSTITUTION	7	7	*	6	7	6
RESIDENTIAL LOCATION						
OUTSIDE HOME, SAME TOWN	1	1	1	1	1	1
OUTSIDE HOME, CLOSE TOWN	2	2	4	3	3	2
IN PARENTS' HOME	3	3	2	2	2	3
OUTSIDE HOME, OTHER TOWN	4	4	3	5	4	4
UNKNOWN	5	5	*	4	5	5
SERVICE FEATURES						
SECURITY AND SAFETY	1	1	2	2	1	1
FAMILY CONTACT	2	3	1	1	2	2
LIFE SUPPORTS	3	4	5	3	3	4
HOMELIKE ENVIRONMENT	4	5	3	5	4	5
TRAINED STAFF WHO CARE	5	2	4	4	5	7

TO: **BOB ANDERSON, MIKE HANSHEW**
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: **TED CLACK** Ted

RE: **SUMMARY OF RESULTS: PARENT PLANNING SURVEY**

DATE: **31 AUGUST 1994**

The results presented below were drawn from the 54 returns of a reported total of 150 surveys mailed to parents of children with developmental disabilities. The data are presented in total and by DD Planning Region. The data from each return were placed in a computer database for summary. Weighted ranks were computed for each item listed on the survey; ranks were computed separately for each region and for the statewide total. A summary table, presenting service options in descending order of respondent preference, the distribution of respondents by city and region and other data is attached.

Overall, the survey results indicate:

* Those responding most prefer two-person or six-person housing for their children when they have reached adulthood.

* Those responding consider institutional housing to be least favorable of all options; five respondents considered that form of housing unacceptable.

* Respondents favored location of their childrens' residences in their own or nearby communities to other location alternatives.

* Respondents were most concerned that basic life support services and family contact would be available to their children when they reach adulthood. The availability of outside monitoring of services and work and recreational opportunities were of little **relative** concern to respondents. The availability of caring staff and homelike environments were given mid-range ranks by respondents. Several respondents indicated that they considered **all** items to be important.

* Although the relative ranks of items varied somewhat by DD Planning Region, those results were generally consistent with the statewide total results.

requested larger budgets for EHSC and one suggested that another institution be built elsewhere. One respondent wanted appropriate services available closer to the family residence.

* 13 respondents stated their satisfaction with EHSC and their opposition to its closure; 12 respondents provided no further comments. One respondent requested development of proper alternative services.

ATTACHMENT #6

TO: **BOB ANDERSON, MIKE HANSHEW**
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: **TED CLACK** Ted

RE: **SUMMARY OF THE SURVEY OF RELATIVES/GUARDIANS OF EHSC RESIDENTS**

DATE: **13 SEPTEMBER 1994**

A total of 26 surveys was returned by 12 September 1994. The results summarized below were drawn from those surveys.

* The weighted average reported amount of time in residency at EHSC or in the institutional system was 12.8 years, with three respondents uncertain. The reported maximum residency was 38 years; the minimum was 2 years.

* 20 of 26 respondents were strongly opposed to community placement, three were neutral, two strongly supported the idea and one wanted more information.

* The vast majority of respondents were very satisfied with the institutional services provided at EHSC. More respondents failed to address this series of items than expressed less than maximum satisfaction with those services. I will provide more specific response tallies if you want them.

* 22 of 26 respondents do **not** attend Individual Plan meetings. The most common reason cited for nonattendance was distance from EHSC.

* 18 of 26 respondents stated that their relative was farther from them now than when in the previous service setting. Six respondents indicated that their relative was closer now than previously.

* 12 of 26 respondents see their relatives about as often as before they were housed at EHSC; six see their relatives more often while five see them less often. Two respondents never see their relative; one respondent failed to respond.

* Most respondents (17 of 26) provided no suggestions regarding change in the services their relatives receive. Five respondents stated that EHSC is a wonderful facility and should be left intact, two

C. MEDICAL CARE

1 (UNSATISFIED)	1	0
2	8	2
3	5	5
4	11	8
5 (SATISFIED)	9	18
NO ANSWER	2	3
CUMULATIVE TOTAL	121	141

D. SKILL TRAINING

1 (UNSATISFIED)	3	0
2	6	0
3	4	3
4	12	9
5 (SATISFIED)	9	20
NO ANSWER	2	4
CUMULATIVE TOTAL	120	145

E. SATISFACTION WITH STAFF

1 (UNSATISFIED)	3	0
2	8	0
3	7	2
4	8	11
5 (SATISFIED)	7	17
NO ANSWER	3	6
CUMULATIVE TOTAL	107	135

F. SATISFACTION WITH ACTIVITIES

1 (UNSATISFIED)	2	0
2	4	0
3	8	2
4	7	8
5 (SATISFIED)	10	20
NO ANSWER	5	6
CUMULATIVE TOTAL	112	138

CUMULATIVE TOTAL OF SATISFACTION SCORES - ALL ITEMS

686	835

Client is receiving good care 1

6. Community program changes suggested by respondents

RESPONSE	NUMBER RESPONDING
Programs closer to family home	7
Would make no changes	5
Programs doing wonderful job	3
Continue to develop training programs	2
Better pay for staff	1
No response	22

7. General comments about community programs

RESPONSE	NUMBER RESPONDING
Programs are doing a great job	12
Approve of work for those who can work	2
Client is doing well in the community	2
Don't close EHSC	2
Client should never have been in MDC/EHSC	1
Community program has attractive setting	1
Need more advocacy	1
No response	21

8. Comparison of "satisfaction" ratings for institutional and community programs.

A. LIVING AREA

	NUMBER RESPONDING	
RATING	**INSTITUTIONAL**	**COMMUNITY**
1 (UNSATISFIED)	4	0
2	5	0
3	6	2
4	11	8
5 (SATISFIED)	8	21
NO ANSWER	2	5
CUMULATIVE TOTAL	**116**	**143**

B. SUPPORT SERVICES

1 (UNSATISFIED)	5	0
2	2	0
3	10	3
4	9	11
5 (SATISFIED)	7	16
NO ANSWER	3	6
CUMULATIVE TOTAL	**110**	**133**

1. Years in institutional setting:

AVERAGE YEARS	MAXIMUM	MINIMUM	NO ANSWER
18.7	36	0.6	11

2. Tally of responses favoring and opposing movement to the community.

		NUMBER RESPONDING
AGAINST	(1)	7
	(2)	2
	(3)	8
	(4)	10
FOR	(5)	8
CUMULATIVE TOTAL		115

3. Tally of responses expressing satisfaction with transfers to community programs.

		NUMBER RESPONDING
DISSATISFIED	(1)	0
	(2)	1
	(3)	2
	(4)	13
SATISFIED	(5)	19
CUMULATIVE TOTAL		155

4. Respondent comments about the quality of institutional care received by their family member.

RESPONSE	NUMBER RESPONDING
Pleased with the care	6
Care was poor	6
Too much staff turnover	3
Staff tried but situation was poor	3
Needed more normal environment	2
Matters improved over time	1
Daughter sexually molested	1
Client was unhappy there	1
Family was not kept informed	1
Institution was poorly run	1

5. Respondent comments about the quality of care provided in community programs.

RESPONSE	NUMBER RESPONDING
Very pleased with the services	3
Client has improved	2
Family wants more feedback	2

TO: BOB ANDERSON, MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: TED CLACK Ted

RE: SUMMARY OF RESULTS: SATISFACTION SURVEY OF FAMILIES OF FORMER INSTITUTIONAL CLIENTS

DATE: 18 AUGUST 1994

The following conclusions were drawn from the results of 36 of 39 surveys returned by or for families of former institutional clients. Three of the 39 survey forms were blank.

* I used cumulative totals of ratings of the various items included in this survey because the data represent ordinal level measurement. That is, one can say one response indicates more of some characteristic than another but cannot say how much more or how many times more. I did not use average ratings because averages would be illegitimate with these data. Averages require ratio levels of measurement. Comparisons of cumulative ratings accomplish the same purposes without stretching the data more than is justifiable. Each cumulative total is based on paired responses - I did not include data from respondents who did not provide ratings for the same service in each service setting.

* Respondents expressed higher levels of satisfaction with community-based services than with institutional services on **every** item.

* The results of responses to open-ended questions also indicate greater satisfaction with community-based than with institutional services.

* Data from this survey do **not** paint a damning picture of the institutional programs, overall, they merely indicate what I would call a strong preference for services in the community setting.

The results of the family satisfaction survey indicate that those surveyed are satisfied with the services provided by the community-based programs and prefer them to institutional services.

A summary of the results of those 36 surveys follows.

SUMMARY OF SERVICES/PROGRAMS NOW RECEIVED BY EHSC AND MDC CLIENTS CONSIDERED FOR COMMUNITY PLACEMENT

SERVICES/PROGRAMS	EHSC - 30			MDC - 43		
SPECIAL COMMUNICATION AIDS	NO. USING 3			NO. USING 2		
STAFFING RATIOS AM	1/4	1/5 15	1/6 14	1/4 43	1/5 0	1/6 0
STAFFING RATIOS PM	1/8	1/10 14	1/15 15	1/8 43	1/10 0	1/15 0
NEED AWAKE STAFF PM	Y 24	N 6		Y 38	N 5	
NEED 24HR SUPERVISION	Y 28	N 2		Y 42	N 1	
SPECIAL DIETS	Y 26			Y 19		
HEARING IMPAIRED	Y 0			Y 5		
VISUALLY IMPAIRED	Y 5			Y 8		
EPILEPSY	Y 15			Y 29		
SEIZURES	Y 10			Y 29		
SEIZURE FREQUENCY	≥1/MO 3	≥1/YR 5	1/YR N/A	≤1/YR N/A	≥1/MO 6	≥1/YR 7	1/YR 0	≤1/YR 1
DRUG SENSITIVE	Y 9			Y 14		
FOOD SENSITIVE	Y 7			Y 3		
NEED BEHAVIOR MOD PGMS	Y 10			Y 22		
USE VOCATIONAL PGMS	Y 4			Y 27		
USE RECREATIONAL PGMS	Y 30			Y 43		

SUMMARY OF SERVICES/PROGRAMS NOW RECEIVED BY EHSC AND MDC CLIENTS CONSIDERED FOR COMMUNITY PLACEMENT

SERVICES/PROGRAMS	EHSC - 30			MDC - 43		
GENERAL PHYSICIAN	≥1/QTR 1		1-2/YR 28	1/QTR 43		1-2/YR N/A
SPEECH THERAPY	ASSESSMENT N/A	1+/YR 29	1/3YRS 0	ASSESSMENT 43	1+/YR 22	1/3YRS 21
SPEECH FROM "OTHER"	1-2HRS/WK 3	>2HRS/WK 5		1-2HRS/WK 9	>2HRS/WK 5	
PSYCH EVALUATION	ANNUAL 30			ANNUAL 43*		
COUNSELING	DAILY 0	1/WK 0	>/WK 0	DAILY 2	1/WK 2	>1/WK 1
PSYCHOTROPIC MEDS	NO. RECEIVING 5			NO. RECEIVING 31		
PSYCH CONSULTS	NO. RECEIVING 0			NO. RECEIVING 35		
BLOOD SCREENS	NO. RECEIVING 29			NO. RECEIVING 35		
OTHER MEDS	NO. RECEIVING 30			NO. RECEIVING 39		
WHEELCHAIRS	NO. USING 6			NO. USING 8		
AMBULANCE AIDS	NO. USING 8			NO. USING 0		
SPECIAL BEDS	NO. USING 0			NO. USING 3		
SPECIAL CHAIRS	NO. USING 3			NO. USING 3		
SPECIAL EATING AIDS	NO. USING 27			NO. USING 3		
FEEDING TUBE	NO. USING 0			NO. USING 1		
SPECIAL BATHING AIDS	NO. USING 3			NO. USING 1		
LIFT VAN	NO. USING 10			NO. USING 7		

ATTACHMENT #4

DATE: SEPTEMBER 16, 1994

TO: BOB ANDERSON AND MIKE HANSHEW

FROM: TED CLACK

RE: SUMMARY OF IDENTIFIED SERVICE NEEDS OF EHSC AND MDC RESIDENTS BEING CONSIDERED FOR COMUNITY PLACEMENT.

The following table summarizes the count of residents at each institutuion who reportedly now receive the services or programs listed. I was unable to acquire these data in a form suitable from computer storage and processing. The services or programs listed correspond to the items contained in the earlier survey of the Communïty Based Programs.

SUMMARY OF SERVICES/PROGRAMS NOW RECEIVED BY EHSC AND MDC CLIENTS CONSIDERED FOR COMMUNITY PLACEMENT

SERVICES/PROGRAMS	EHSC - 30			MDC - 43		
VISUAL SERVICES	ANNUAL EXAM - 30			ANNUAL EXAM - 43		
DIETITCIAN SERVICES	1HR/YR 28	1HR/MO 1	1HR/WK 1	1 HR/YR 37	1 HR/MO 5	1HR/WK 1
OT THERAPIST	1HR/YR 28	1HR/2-3YRS 2		1HR/YR 21	1HR/2-3YRS 22	
OT FROM "OTHER"	1-2HR/WK N/A	2+ HR/WK 4		1-2HR/WK 1	2+HR/WK 1	
PT THERAPIST	1HR/YR 30	1HR/2-3YR N/A	WEEKLY+ N/A	1HR/YR 16	1HR/2-3YR 8	WEKLY+ 12
PT FROM "OTHER"	1-2HR/WK 3	2+HR/WK 7		1-2HR/WK 0		2+HR/WK 7
NURSE SERVICES	DAILY 1			DAILY 41		
MEDICAL SPECIALIST	AS NEEDED 2			AS NEEDED 10		

	> IDP	1
17.	Number of programs providing recreational activities	9
	a) types of activity	
	> "normal community" activities	7
	> movies	5
	> dining	5
	> shopping	5
	> swimming	4
	> bowling	4
	> fishing	4
	> camping	3
	> ballgames and the like	3
	> picnics	2
	> riding	2
	> skiing/boating/cooking/arts&crafts	1ea.
18.	Number of programs providing activities with non-disabled people in the community.	10
	a) frequency of activity	
	> daily	3
	> 3 times a week	1
	> twice a week	1
	> once a week	3
	> once or twice a month	2
	b) types of activity	
	> dining	5
	> "normal community activities"	5
	> shopping	3
	> "same as above" (Item 17)	2
	> swimming/bowling/games	2ea.
	> movies/camp/community work/classes/ arts&crafts/"advocacy"/Senior Volunteers	1ea.

	* 1:3	2
	* 1:4	2
	* 1:6	6
c)	Awake night staff available?	
	* yes	10
d)	24-hr supervision available?	
	* yes	10
15.	Number of programs serving special needs clients:	
	* Prader-Willi clients	2
	* Oxygen needed by client	1
	* Special diet for clients	8
	* Hearing impaired clients	3
	* Visually impaired clients	3
	* Clients with communication needs	7
	* Epileptic clients	7
	> with seizures	7
	> seizure frequency	
	1) 1-2 per month	3
	2) 4 per year	1
	3) variable	1
	4) unknown	1
	* Drug sensitive clients	4
	* Food sensitive clients	3
	* Clients with Medicaid eligibility problems	1
	* Clients with behavior problems:	10
	> physical aggression	5
	> property destructive	3
	> verbal aggression	2
	> self-injurious behaviors	2
	> explosive/violent behavior	2
	> aggression	1
	> OBRA clients	1
	> incontinent	1
	> screaming	1
16.	Number of programs providing vocational activities	10
a)	frequency of activity	
	> 6 days a week	6
	> 5 days a week	1
	> 9 days a month	1
	> variable	1
b)	clients paid for activities	9
c)	types of activity:	
	> industries programs	4
	> recycling	3
	> "community work"	3
	> janitorial/maintenance work	3
	> special vocational/academic programs	3
	> furniture construction	2
	> agricultural work	1
	> self-help training	1

* no 6

9. Number of programs providing psychiatric consultations. 10
   a) Limitations on psychiatric consultations?
      * yes 5
      * no 4

10. Number of programs providing blood screening services. 10
    a) Limitations on blood screening services?
       * yes 0
       * no 9

11. Number of programs providing nurses to administer injections. 5
    (One program not providing this service can obtain it in the community if necessary)

Where respondents indicated that limitations to services exist, their responses fell into the following categories:

A. Medicare/Medicaid rates and allowances limit access to services and the number of providers who will participate. 6
B. Availability of the specific service in the community. 5
C. Limited to appointment schedules only. 3
D. Contract provisions. 1
E. Cost 1
F. Agency barriers. 1

12. Number of programs providing barrier free settings. 10

13. Number of programs providing special equipment. 10
    a) Special equipment provided:
       * special beds 6
       * adaptive chairs 5
       * adaptive eating equipment 5
       * feeding tubes 2
       * special bathing equipment 5
       * a van with a lift 3
       * communication equipment 6
    b) Difficulties acquiring special equipment?
       * yes 2
       * no 7

14. Number of programs by staffing ratios.
    a) Day staff ratios:
       * 1:2 9
       * 2:3 1
    b) Night staff ratios:

* registered nurse 8
* licensed practical nurse 4
* more than one professional type 2

b) Limitations on nursing services?
* yes 4
* no 5

c) Do nurses supervise others in service delivery?
* yes 4
* no 5

6. Number of programs providing medical specialist services. 10
a) Services provided by:
* physician 10
* registered nurse 4
* more than one professional type 4

b) Limitations on medical specialist services?
* yes 1
* no 9

7. Number of programs providing general physician services (one program contracts with a local physician on demand) 10
a) Services provided by:
* physician 8
* Doctor of Podiatry 1

b) Limitations on general physician services?
* yes 3
* no 7

c) Do physicians supervise others in service delivery?
* yes 3
* no 6

(Two Registered Nurses and one LPN were listed as supervised by a physician)

8. Number of programs providing counselling. 8
a) Services provided by:
* doctor 5
* nurse 1
* psychologist 7
* others (MSW) 2
* more than one type of professional 5

b) Limitations on counselling services?
* yes 4
* no 5

c) Do professionals supervise others in service delivery?
* yes 2

A summary of the results of the 10 completed Community Service Provider Survey forms I received follows.

1. Number of programs providing visual services — 10
   a) Services provided by:
      * optometrists — 9
      * opthamologists — 5
      * other — 0
      * more than one professional type — 5
   b) Limitations on visual services?
      * yes — 2
      * no — 7

2. Number of programs providing dietetic services — 8
   (two programs do not; one program can acquire this service in the community if necessary)
   a) Services provided by:
      * dietitians — 5
      * others (consultants, dietetic assistants, nurse practitioner) — 3
   b) Limitations on dietetic services?
      * yes — 2
      * no — 8

3. Number of programs providing occupational therapy services — 5
   (two programs not providing this service can obtain it in the community if necessary)
   a) Services provided by:
      * licensed occupational therapist — 5
      * certified OT assistant — 2
      * rehabilitation aide — 1
      * more than one professional type — 2
   b) Limitations on occupational therapy services?
      * yes — 4
      * no — 2

4. Number of programs providing physical therapy services — 6
   (two programs not providing this service can obtain it in the community if necessary)
   a) Services provided by:
      * licensed physical therapist — 6
      * certified PT assistant — 2
      * more than one professional type — 2
   b) Limitations on physical therapy services?
      * yes — 2
      * no — 5

5. Number of programs providing nursing services (the program not providing this service can obtain it in the community if necessary) — 9
      * on site — 1
   a) Services provided by:

ATTACHMENT #3

TO: BOB ANDERSON, MIKE HANSHEW
INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES

FROM: TED CLACK Ted

RE: SUMMARY OF RESULTS: DD COMMUNITY SERVICE PROVIDER SURVEY

DATE: 18 AUGUST 1994

The following conclusions were drawn from the results of survey forms completed for 10 community service provider programs.

* All or the vast majority of community service programs provide all but three of the service types listed in the survey.

* In no case do fewer than one-half the programs provide all the services listed.

* Those programs not providing some services indicated that those services are available should they be needed or required.

* Most programs stated that there are no limits to the services they provide. Where limits were noted, most had to do with inconvenience rather than absence of service. The most frequent response regarding limitations had to do with the difficulty faced in finding service professionals willing to work for Medicare/Medicaid rates and under the rules of those agencies. This problem can be no surprise to state agencies experiencing recruitment and contracting problems on a regular basis.

* All programs serve clients with behavior problems; all provide special equipment as needed. Other special needs clients also are served by community programs. None of the programs indicated that they had particular problems acquiring special equipment when it is needed.

* All programs provide vocational activities; 90 percent pay the clients. All provide in-house and community recreational activities.

These results indicate that the community based programs surveyed appear to provide a full range of services in response to demand posed by their clients, that they experience no insurmountable difficulty locating necessary services and that they serve a broad range of special needs clients.

Dillon	1	west
EHSC	10	east
Emigrant	1	central
Glendive	10	east
Great Falls	5	central
Hamilton	6	west
Harlem	3	central
Havre	4	central
Helena	9	west
Kalispell	3	west
Lewistown	1	central
Libby	1	west
Livingston	4	central
Miles City	2	east
Missoula	22	west
Poplar	1	east
Ronan	3	west

Regional totals and percentages come to...

Region	Number	Percent
East	23	22.1 (87% in Glendive)
Central	25	24.0
West	56	53.8 (39.3% in Missoula)

Note that destinations outside Eastern Montana have accounted for 77.8 percent of total MDC discharges since July 1990.

MDC discharges were distributed among six types of placement, as follows:

Type	Number	Percent
D/B	1	1.0
FHP	2	1.9
GHP	73	70.2
HP	7	6.7
NHP	1	1.0
IP	20	19.2

MDC admissions from July 1, 1990 through May 31, 1994 were distributed among the three regions as follows:

Region	Number	Percent
East	6	9.5
Central	31	49.2
West	26	41.3

The reported counties of origin of the present MDC population are distributed among the regions as follows:

Region	Number	Percent
East	16	14.4
Central	46	41.4
West	49	44.1

TO: BOB ANDERSON, MIKE HANSHEW

FROM: TED CLACK Ted

RE: SUMMARY OF MDC AND EHSC DATA

DATE: 31 MAY 1994

According to DCHS data, there have been 27 discharges from EHSC since July 1990. The destinations of those discharges, the related number of clients and the region of each destination are listed below:

Destination	Number	Region
Anaconda	2	west
Billings	6	central
Bozeman	1	central
Great Falls	1	central
Havre	2	east
Miles City	5	east
Missoula	8	west
MDC	1	west
Sidney	1	east
Total	27	

Adding the destinations by region...

Region	Number	Percent
East	8	29.6
Central	8	29.6
West	11	40.7

Destinations outside Eastern Montana accounted for 70.3 percent of discharges reported since July 1990.

Assuming that the addresses of the discharges' primary correspondents are related to the area of origin of each discharge, those discharged from EHSC in the period were from...

Region	Number	Percent
East	9	33.3
Central	8	29.6
West	6	22.2
Other State	3	11.1
Unknown	1	3.7

(I will identify the specific cities/towns if you wish)

MDC discharges since July 1990 totaled 104 and were distributed among 21 destinations. Those destinations were...

Destination	Number	Region
Anaconda	3	west
Billings	7	central
Bozeman	1	west
Butte	7	west

ATTACHMENT #1

DATE: September 14, 1994

TO: RICK DAY, DIRECTOR, DCHS

FROM: ROBERT W. ANDERSON and TED CLACK

RE: MDC POPULATION PROJECTIONS

The following are MDC projections based on Status Quo, Option II, and Option II with adjustments. These "projections" are limited by the availability of appropriate data. We conclude that the 1991 changes in the commitment statute invalidate the use of admissions data from earlier years as bases for projections. Further, the number of discharges from MDC in FY 1991-92 are distorted by decisions to "downsize" and are similarly inappropriate bases for projections. We computed estimated annual discharges as an average of the 1993-1994 data. Based on this information MDC can continue to experience a net increase of 4 clients per year

MDC ADMISSIONS/REDUCTIONS DATA

	FY 91	FY 92	FY 93	FY 94	4 YR AVG
ADMISSIONS	19	18	11	16	16
REDUCTIONS*	55*	41*	13	12	12
ANNUAL NET INCREASE/DECREASE					+4

* REDUCTIONS INCLUDE: DISCHARGES, TRANSFERS AND DEATHS. DISCHARGES IN FY 91 & 92 ARE DISTORTED DUE TO DOWNSIZE AND COMMUNITY PLACEMENT EFFORTS AND NOT COMPUTED IN AVERAGE.

MDC POPULATION PROJECTIONS

		STATUS QUO EHSC REMAINS AT 49		OPTION II (AS STATED)*		OPTION II (ADJUSTED)**	
FY END	CAPACITY	PROJECTION	# PLACED	PROJECTION	# PLACED	PROJECTION	# PLACED
94	117	114		114		114	
95	117	112	6	112	6	112	6
96	117	116		116		116	
97	110	120		109	11	103	17
98	110	124		113		107	
99	110	128		105	12	99	12
00	110	132		109		103	
01	110	136		113		107	

*OPTION II (as stated) includes moving 49 patients from EHSC, 11 from MDC and 6 from CWL in FY 97, and 12 from MDC/CWL in FY 99.

* OPTION II (adjusted) includes moving all 17 patients from MDC in FY 97, and all 12 clients from MDC in FY 99. Zero clients would be moved from the CWL.

regarding this issue, however the following represents some general ideas and information:

1. Ask the Department of Commerce to prepare an Economic Impact Study.

2. Community leaders need to be involved in the Rapid Response Committee with the DCHS and the Department of Labor to assist in the planning for proposed closure.

3. Although the opening of the Eastern Montana Veterans Home (EMVH) in January 1995 will offset about 80 jobs in the community, it may also create a staffing problem at EHSC if employees leave early to work at EMVH. DCHS should work with Glendive Medical Center to develop a hiring priority for qualified EHSC employees affected by the closure and seeking employment at the EMVH.

4. It is very likely that 1 and probably 2 intensive group homes could be developed in Glendive which would mean an additional 15 to 30 jobs. Also priorities for hiring former EHSC employees could be developed.

5. The EHSC facility is a nice facility and could be used for a number of alternative services. It is imperative that the community of Glendive work with state agencies, legislators, union officials and private businesses to find alternative uses for the facility and maintain jobs for the community. If no alternatives are found for the facility, a physical plant closure analysis needs to be done with regard to state obligations and plans for the campus. This should include environmental considerations.

c. Consider developing early retirement legislation for those long term employees affected by layoff at EHSC.

d. Development of a DCHS transfer list for potential vacancies at other facilities within the Department for qualified EHSC employees. Also provide moving costs to those who are willing to transfer.

e. Provide additional salary or bonuses to selected EHSC employees to work until the final day of closure to avoid leaving clients without the best care possible.

f. Develop hiring preferences with state contracted private corporations such as those who would develop group homes in eastern Montana or the Glendive Medical Center who will operate the Eastern Montana Veterans Home.

g. Provide additional bonuses for retraining of EHSC employees, similar to what the Department of Administration did with custodial workers.

h. Consider allowing employees paid time to interview for other jobs and also providing clerical help in typing and preparing resumes.

i. Consider subscribing to newspapers throughout the State and allow time for employees to scan help wanted ads.

j. Consider purchasing the "Surviving a Layoff" book for each employee. The cost is $4.00 per book.

3. Implement Programs To Maintain Job Interest

a. Increase the scrutiny of Industrial Accident claims and Sick Leave requests for possible rejection. Advise Worker's Compensation of concerns. Provide employees with training and advice that may impact their future employability.

b. Budget for and provide assistance in the evaluation of reasons, causes and validity of accidents.

F. IMPACT ON GLENDIVE COMMUNITY

As with any closure or reduction in force efforts occurring at a large employer in any small community, there is major impact. The only way to offset community impact is to find alternatives or other opportunities which create additional jobs in the community. At this point, it is difficult for the Task Force to provide more detailed information

1. Ensure Communication To Reduce Employee Anxiety

a. The Department of Corrections and Human Services (DCHS) Director, Division Administrator and other central office staff should continue to meet with EHSC employees on an ongoing basis to keep them informed on the proposal for closure and the pending legislation. DCHS should ensure a continuing flow of information to EHSC employees by means of letters, meetings and other appropriate communication as the process changes or develops. Individual letters should be sent to each employee as soon as possible explaining management intent with regard to closure and impact on facility and employees.

b. Through Job Service or other agencies, have classes available for employees on how to deal with stress and the possibility of changing employment. Participate to the extent possible by allowing release time, paid time and other accommodations to permit training and counseling on stress management and coping.

c. Initiate the Department of Labor Rapid Response effort as soon as possible.

d. Provide a means to access a state long distance line to DCHS Central Office, Reduction in Force (RIF) Registry Staff and PERS staff, to enable EHSC employees an opportunity for personal response to questions or problems.

e. Labor and Union officials representing employees need to be involved from the very beginning on any closure proposal. They will need to be continually updated when information becomes available. Also, management and labor will have to negotiate closure of existing contracts at EHSC.

f. Prepare official layoff notices with at least 60 day notice to correspond with the placement of clients out of the facility and closure timelines.

2. Consider Implementation of Employee Benefit Programs

a. Consider legislation to prevent the sunset of HB 522 on June 30, 1995. Decide what date EHSC employees could be registered on the HB 522 RIF registry as potentially laid off employees.

b. Determine when EHSC employees would be eligible for six months of salary protection for demotion due to a potential layoff.

D. COMMUNITY AND INSTITUTIONAL SERVICES

Service Needs of Institutional Residents and DD Community Service Provider Surveys - The results of these surveys demonstrate that current types and levels of community services are appropriate and could meet the needs of those individuals who would be transferred from EHSC or MDC. Many similar types of individuals are currently being served in community services. See Attachment 3 and 4, Summaries of Survey Results.

E. IMPACT ON CLIENTS AND FAMILIES

1. Satisfaction Survey of Families of Former Institutional Clients - This survey of family members of individuals who have recently (within 4 years) moved from institutional services to community based services demonstrates satisfaction with community services over institutional services. Although many were satisfied with institutional services and did not initially support a move to community services, they now appear to prefer community placement after experiencing both services. See Attachment 5, Summary of Survey Results.

2. Survey of Relatives/Guardians of EHSC Residents. The results of this survey clearly demonstrate that most relatives or guardians of individuals currently served at EHSC are pleased with EHSC, do not want to see EHSC closed and do not want their relatives moved to community programs. See Attachment 6, Summary of Survey Results.

3. Parent Planning Survey. This survey asked parents of children with a developmental disability to rank their preference for residential settings, locations and services when their children reach adulthood. Results demonstrate that families prefer smaller residences (2-6 people) located close to family with safe and secure settings. Those responding consider institutional housing and settings to be the least favorable of all options. See Attachment 7, Summary of Survey Results.

F. IMPACT ON EHSC STAFF

The closure of EHSC will eliminate 105 state jobs and would have a major impact on those employees. The State of Montana should do what it can to reduce the impact on employees affected by implementing programs that would reduce employee anxiety, maintain job interest, and provide additional benefits and incentives. Through meetings with EHSC staff and review of information on state and private closures or reduction in force efforts, the following ideas could be considered to reduce impact on staff:

force programs, vacation and sick leave pay outs, severance pay, or other incentive programs such as: additional staff training or counseling, extension of health insurance benefits, early retirement, or bonuses for those who remain until closure. These types of programs are explained in more detail below, under "Impact on EHSC Staff". Based on the Galen closure and depending on what is approved, these costs could range anywhere from $2,000 to $4,000 per employee or an additional $250,000 to $450,000.

C. EHSC/MDC CLIENT DEMOGRAPHIC AND POPULATION DATA

Population projections at EHSC and MDC verify that maintaining the current status quo is no option. Projections indicate that while EHSC would remain at 49-50 clients, MDC would continue to increase at about 4 clients per year, putting its population at 136 by 2001. Maintaining the status quo would also have no positive impact on the community waiting list (CWL). See Attachment 1, MDC Population Projections.

Option II not only closes EHSC, but will allow us to manage projected MDC populations below 110 through the year 2001 and would have a long term positive impact on the CWL. Any expansion of community services whether through downsize efforts as Option II, or by other means, gives us the ability to offer more community services and better meet future demands for services.

EHSC/MDC demographic information over the last four years indicate discharge destinations to eastern Montana represented 8 out of 27 (30%) of EHSC discharges and 23 out of 104 (22%) of MDC discharges. Of the 23 referred to eastern Montana from MDC 20 (87%) represent transfers to EHSC. This destination data really only demonstrates where group homes were developed during the last downsizing efforts. Since almost all admissions to EHSC over the last four years were transfers from MDC, only MDC admission data was gathered. Of the 63 admissions to MDC 6 (9.5%) came from eastern Montana.

It should be noted here that none of the individuals admitted (committed) to MDC over the last four years resemble the types of individuals that are being considered for placement under Option II. These individuals generally have low skills, mild behaviors, limited medical needs and, once placed in community programs, historically do not return to the institutions. This demonstrates that community services are able to care for these types of individuals and institutionalization is no longer necessary. See Attachment 2, Summary of MDC and EHSC Data.

II. OPTION II OVERVIEW

PHASE 1 - FY 1996 -1997:
This phase would establish community services for an additional 66 individuals - 49 from EHSC, 17 from MDC or the community waiting list (CWL). During fiscal year 1996, community services would be expanded to serve an additional 66 individuals. Between July and November 1996 the 66 individuals would be placed into community programs. By January 1, 1997, EHSC would no longer serve as a state operated residential facility for the developmentally disabled (ICF/MR).

COSTS:	FY 1996	FY 1997	BIENNIUM TOTAL
	+ $880,000	+ $642,764	+ $1,522,764

PHASE 2 - FY 1998 - 1999:
This phase would establish community services for an additional 12 individuals from MDC/CWL. During FY 1998 community services would be expanded. Between July and August 1998 the 12 individuals would be moved into community programs.

COSTS:	FY 1998	FY 1999	BIENNIUM TOTAL
	+ $160,000	+ $261,325	+ $421,325

III. OPTION II EVALUATION FINDINGS

A. TIME LINES

After further review of the time lines planned in Option II, they appear to be realistic and appropriate. They will provide adequate time to ensure more detailed planning and coordination in determining individuals to be placed, in developing appropriate community services, and ensure effective coordination and orientation of client placements. The time lines also provide adequate flexibility to allow for any unexpected delays in construction, program development or other unanticipated problems.

B. COSTS

The costs outlined in Option II appear to represent an accurate estimate. Initially the transition to community services will cost an additional $1.5 million in general fund dollars, but will be almost cost neutral when completed. It must be noted these projections represent our best estimates at this time and will most likely change.

Also, other costs associated with closing a facility, which are very difficult to project, are not included in the estimate. These are costs associated with any reduction in

INTERAGENCY TASK FORCE ON DEVELOPMENTAL DISABILITIES
OPTION II EVALUATION REPORT AND FINDINGS
SEPTEMBER 19, 1994

I. INTRODUCTION

On April 7, 1994 the Interagency Task Force on Developmental Disabilities presented to the Governors Human Services Subcabinet a proposed plan to downsize/reduce the populations in residential (institutional) facilities for individuals with developmental disabilities and expand community services.

Briefly, that plan included the following three options:

Option I would expand community services for 30 individuals in FY 96-97, for an additional 48 individuals in FY 98-99, and close Eastmont by January 1, 1999.

Option II would expand community services for 66 individuals in FY 96-97, for an additional 12 individuals in FY 98-99, and close Eastmont by January 1, 1997.

Option III would expand community services for 30 individuals in FY 96-97, reduces Eastmont population to 40, and requires further evaluation of the Developmental Disabilities Service System in FY 98-99.

In addition, overcrowding at the Montana Developmental Center (MDC) would have to be addressed. MDC had a population of 116 which is one under the maximum licensed bed capacity for the current facility and 6 over the proposed capacity of the new facility. As of the date of this report, MDC has 118 clients.

After discussing and reviewing the plan, other possible options, letters from concerned organizations and individuals, you requested additional information regarding Option II. This information was to include greater detail regarding the time lines, costs, capabilities of community services, impact on the clients, family members, Eastmont staff and the Glendive Community.

The following report includes the information, surveys and the results gathered by the Task Force in regards to your request.

* Option II, represents one plan for resolving the current problems facing Montana's developmental service system. It redirects resources from institutional services to community services, allows us to manage projected MDC populations under 110 through 2001 and will have a long term positive impact on managing the community waiting list. New language under the proposed legislative changes to Title 53, Chapter 20, MCA may also have a positive impact on reducing commitments to MDC.

* The task force was again unable to find an alternative long term mission for EHSC that is appropriate and would benefit the future needs of Montana's developmental disabilities service system. Absent an appropriate mission for EHSC, this issue probably will not go away.

* There will be little visible political support for Option II. Also failure to act may result in a class action lawsuit.

EXHIBIT 14
DATE 1/27/95
HB 65

MONTANA ADVOCACY PROGRAM
100 North 27th Street, Suite 330
Billings, Montana 59101

(406) 256-3889
1-800-245-4743
(Voice/TDD)

TO: Members of the Joint Committee on HB 65
FROM: Dawn DeVor, Advocacy Specialist, Montana Advocacy Program
DATE: 1-30-95
RE: Support for passage of HB 65

I have worked as an advocate for people with developmental disabilities throughout eastern Montana for the past two years. In this capacity, I have visited Eastmont on three separate occasions. Prior to my work in advocacy, I was employed for five and a half years in a community-based vocational program that served adults with severe and multiple disabilities, whose impairments were very similar to those experienced by the individuals at Eastmont.

When Eastmont came into being twenty-five years ago, communities, for the most part, did not have the expertise to serve individuals with intensive-level needs. Such is no longer the case. A generation of Montana citizens with severe disabilities are growing up without wanting or needing institutional care. In addition, of the hundreds of adults on waiting lists for services, all are requesting community-based services; none are petitioning to be committed to Eastmont. It is clear, then, that Eastmont does not have a future.

However, Eastmont does have a present, as evidenced by the forty-nine people who call the institution home. Why should they make the often disruptive transition to community-based services when they are receiving good care at Eastmont? The reasons, in my opinion, are two-fold: Community-based services can provide the same level of care and safety as Eastmont, and they offer the additional benefits of greater freedom, individual expression, and integration.

Community-based, intensive-level group homes and vocational day programs are licensed and accredited. Each individual has a case manager to coordinate his/her services, which certainly include physical therapy, occupational therapy, and other medically-related services as needed. Also, each individual has a written plan of services that is developed and monitored by a multidisciplinary team called an Individual Planning team. Thus, care and safety issues are being well provided in community settings across Montana, in both large and small communities.

But care and safety, vitally important as they are, are not all there is to life. In a six-person intensive group home, individuals with severe disabilities not only learn eating skills, they help to prepare meals on a daily basis according to their abilities. They also help to do housework and yardwork as they are able because all

of us learn best by experience. In terms of social and recreational opportunities, it is much easier to plan and individualize meaningful activities for six people then it is for forty-nine people. And, community participation by individuals or small groups allows for more interaction and involvement than does large-group activity.

When individuals leave the group home each week day to attend a vocational day program, they have the opportunity not only to learn new skills but also to interact with a different group of people than those with whom they live. They also have the opportunity to earn money for their labor. Eastmont residents, too, can earn money by doing such tasks as folding towels or making beds; the difference is that, in community-based services, individuals can work on off-site crews, meaning that the towels are folded and the beds are made, etc., in actual businesses. These practices may sound idealistic, but they are happening right now.

Yes, transitions can often be difficult, but Montana has twenty years' experience in facilitating successful community placements for people with developmental disabilities. For Eastmont residents who truly require institutional care, the Montana Developmental Center at Boulder will be available for them. However, the majority of Eastmont residents, from those aged in their 20s to those in their 60s, could be served in community settings. The world is a much wider, infinitely more fascinating place than these individuals have ever had the opportunity to experience. HB 65 offers them these opportunities; I hope that you will support it.

EXHIBIT 14
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EXHIBIT 15
DATE 1/27/95
HB

TESTIMONY BEFORE THE HOUSE JUDICIARY, AND
HOUSE APPROPRIATIONS JOINT SUBCOMMITTEES
ON HUMAN SERVICES AND INSTITUTIONS

January 27, 1995

Mr. Chairman, members of the committee. For the record my name is Connye Hager, former Senator from Senate District 6. I was a member of the Developmental Disabilities Planning and Advisory Council (DDPAC) at the time the Council voted on the future of Eastmont.

At the August meeting of the DDPAC, I voted against the recommendation for closure of Eastmont. I did so because issues concerning a facility closure were new to all the members of the Council. It was difficult reaching a conclusion. People's lives at the institution were involved as well as the jobs of employees of the institution.

I have since received additional information regarding this proposal. I fully believe the Council's initial vote to recommend closure is completed and should stand without further comment. At the October meeting, I made the motion to support the Committee's decision of closure. The motion received unanimous approval from the Council.

People with disabilities need to live in the community, the same as you and I. While I found Eastmont to be an excellent facility, I also believe there are likely to be more opportunities for a normal life living in the community versus an institution. For 12 years Representative Soft and I have lived next door and across the street from a Developmental Disabilities home. We found them to be good neighbors and certainly not a threat to the neighborhood.

The people living at Eastmont do not need to live in a facility of this type. They can reside in homes in communities and still receive the services available to them at Eastmont. I know of more than 200 persons who have the same needs as the persons at Eastmont who currently live in various communities across the state.

The Council has been told by the parents of children with disabilities they do not want their kids to live in an institution as adults. For 20 years Montana has told parents the best place for their children was at home. As a result, there are no children with developmental disabilities in Eastmont or the MDC (Montana Development Council) and we do not need to place them there is the future.

Closing the facility is a vote for the future of Montanans with developmental disabilities. There is only so much money to go around for services of this type and it needs to be spent in the places that will have the best long term effect.

Sincerely,

Connye Hager

EXHIBIT 14
DATE 1/27/95
HB

zmm 207-f

Glendive United Methodist Church

Towne and Kendrick
Box 200
GLENDIVE, MONTANA 59330

January 23, 1995

The Honorable Members of the Institutions Committee
Montana State Legislature
Helena, Montana

Representative Marge Fisher, Chair
Representative Steve Vick
Representative William Menahan

Senator Larry Tveit, Vice Chair
Senator Gary Aklestad
Senator Mignon Waterman

Dear Friends,

We, the undersigned clergy of Glendive, write with enthusiastic support for the excellent, caring services provided by the Eastmont Human Services to its residents in a homelike atmosphere. Dispersing most of the residents to Group Homes and the remainder to Montana Development Center at Boulder will change forever the life these residents have come to know.

What is the quality of life at Eastmont in which these residents thrive?

1. A large number and variety of staff who are familiar with each resident, who can quickly step in for emergencies or when residents have a special need situation.

2. Annual progress in achieving personal goals. Staff members tell of the steady and marked progressive changes residents have made since moving to Eastmont as seen from their many and various perspectives.

3. Professional physical therapy supervised in large, cheerful, well equipped areas.

4. Professional occupational therapy that addresses a resident's capacity to work within Eastmont and other possible settings.

5. Professional educational organization of the residents into 5 units of 10 each, who are similar in need and aptitude, with personalized plans for the group and individuals.

6. Trained staff persons, with the necessary knowledge and comprehensive experience to quickly procure from Medicaid and Medicare the prescribed treatment needs as ordered by physicians, physical therapy and occupational therapy. (No simple task!)

7. Twenty-four hour a day special needs professional and nursing care that is so vital to the quickly changing conditions and needs of the residents.

8. A comprehensive, multi professional Personal Annual Evaluation of each resident's self help skills, social and recreational skills, physical and occupational therapy progress, communication skills and progress with behavior.

9. Professional Dietician services that ensure the quality and correctness of the necessary therapeutic and modified diets required by the residents.

Providing the above tangible quality of life assets in the required most intensive level group home settings CANNOT BE DONE IN SOME INSTANCES (Items 1-5), AND CANNOT BE DONE IN OTHERS WITHOUT COSTLY DUPLICATION OF FACILITIES, EQUIPMENT AND TRAINING.

The Federal Medicaid requirement for serving Eastmont's residents mandates "A continuous, aggressive active treatment program" carried on through twenty four hours a day. Can a series of group homes do that as professionally and efficiently as Eastmont can considering the level of functioning of the residents?

Today's challenging, honorable belief is that everyone is entitled to live in the least restricted environment possible. Sometimes this has achieved positive results. Other times it has not and has created serious problems. (The homeless in our streets for example). Who best determines what the "least restrictive environment" is for persons who require 24 hour a day active attention in order to function? Who knows the issues better than those with the "hands on" practical experience?

We know of no resident's family who has complained or requested this change. We wonder why the legislature would want to take its valuable time.....and spend precious tax funds.....to try to fix something that isn't broken.

We respectfully ask that Eastmont Human Services Center remain intact and funded to continue its excellent care and services. We see and hear about Eastmont's high quality work daily! It is a witness to the intangibles of love, dedication, spirit and reverence that radiate among the Eastmont staff and the Glendive community and which make Eastmont's residents thrive!

Sincerely yours,
Members of the Glendive Ministeral Association

Pastor Dennis Franklin – Assembly of God
Pastor Kenneth Bjerke – Zion Lutheran
Pastor Jimmie Harrold United Methodist
Pastor Allen Solheim – Evangelical Church
Pastor James Sinclair – First Baptist church
Pastor Gary J. Lozier – Christian & Missionary Alliance Church
Pastor Arlin D. Rausch – Community Bible Church

EXHIBIT 17
DATE 1/27/95
HB

Amendments to House Bill No. 65
First Reading Copy

Requested by Rep. John Johnson

Prepared by Susan Byorth Fox
January 24, 1995

1. Title, lines 7 and 8.
Strike: "DISCONTINUING" on line 7 through "DISABILITIES;" on line 8

2. Title, lines 9 and 10.
Strike: "53-1-202," on line 9 through "53-1-402," on line 10

3. Title, line 12.
Following: "53-20-146,"
Insert: "AND"
Following: "53-20-161,"
Strike: "AND 53-20-501,"
Following: "53-20-105"
Strike: ","
Insert: "AND"

4. Title, line 13.
Strike: "AND 53-20-502,"

5. Page 1, line 18 through page 3, line 2.
Strike: Sections 1 and 2 in their entirety
Renumber: subsequent sections

6. Page 7, line 1 through page 10, line 26.
Strike: Section 4 in its entirety
Renumber: subsequent sections

7. Page 30, lines 13 through 17.
Strike: Section 24 in its entirety

8. Page 30, line 19.
Following: "53-20-105"
Strike: ","
Insert: "and"
Strike: "53-20-502,"

9. Page 30, line 28.
Strike: "3, 6 through 23, 25, 26"
Insert: "1, 3 through 22"

10. Page 30, line 30 through page 31, line 1.
Following: "(2)"
Strike: the remainder of line 30 through "(3)" on page 31, line 1
Strike: "5" on page 31, line 1
Insert: "2"

EXHIBIT 18
DATE 1/27/95
HB

Dear Committee Member,

Enclosed are excerpts from the "Interagency Task Force On Developmental Disabilities", rough draft plan. As evidenced in this document the Montana Developmental Center (MDC) is experiencing problems keeping it's population at or below 110.It also states that from July 1, 1991 to date there have been 37 new admissions and 25 readmissions. Approximately one-third of the new admissions have social/sexual problems and require a secure environment. The document also states that MDC is seeing a major increase in the individuals who have engaged in sexually offending behavior. This is one group for whom community based services do not generally exist.

The task force also had assessments of each person at MDC, EHSC, and MSH completed to evaluate their skills, needs, and problems. The outcome of these assessments was that of a total of 173 individuals the number of individuals who would be more appropriately served in community based placement is 70.

If indeed 70 individuals out of the existing population would be more appropriately served in community based services, 103 individuals of the existing population are more appropriately served at MDC, EHSC, and MSH. The point being that we are talking about the existing population.

In a period of just under three years there were 37 new admissions and 25 readmissions to MDC. Of the new admissions approximately one-third have social/sexual problems requiring a secure environment. If this trend continues, it will take less than 3 years and MDC will once again be over capacity. In addition, the report is silent concerning the remainder of the new admissions. It may be presumed that some of these individuals require services which cannot be provided in a community based setting.

At previous task force meetings it was stated that some individuals do well in the community based setting while others do not. This can be evidenced by the 25 readmissions in approximately three years. Of the 70 determined to be more appropriately served in the community, how many will not do well and need readmittance?

MDC will be able to accommodate 110 individuals, with 103 of these being in the current population. If Eastmont is closed where will the individuals who would require readmission go? Where will the new admissions requiring a secure environment go? Where will the new admissions requiring the services of a residential facility go? We are not opposed to community based service but feel that by closing Eastmont a large gap in services will occur. It appears that the task force figures will cut the availability of residential facility services too close.

The need for residential facility services will be larger than the 110 allowed for at MDC. If Eastmont is closed it is probable that such services will need to be provided in the future and at additional cost to the State. Eastmont has provided quality care for those in need for over twenty years. There is a need for this facility and to close it will just create additional problems in the future.

Sincerely,

Kevin Dorwart
Glendive

statutes and national trends in serving individuals with developmental disabilities.

MDC Overcrowding - Based on the 1990-1993 MDDSS Plan, the population at MDC was established at 100-110. The current budget and staffing levels have also been established at that level. These levels are based on a client to staff ratio which allows MDC to continue to meet the increasingly demanding federal certification standards required for Medicaid reimbursement. The new MDC campus consolidation construction project currently in progress, is designed and will be licensed to handle a maximum 110 clients.

PROBLEM: Even with the new commitment process, it has been very difficult to maintain MDC population at or below 110. The current population at MDC is 117 and has been averaging 113 over the last year. From July 1, 1991 to date, there have been 37 new admissions and 25 readmissions. All admissions require extensive assessment, team planning, and program development. For the most part the new and readmissions are higher skilled individuals with severe behavior problems, and therefore they are mainly served by the same treatment team. While they require close supervision, these individuals also have many independent skills and are very demanding of staff time on a one-to-one basis. Approximately one-third of the new admissions have social/sexual problems and

therefore require a secure environment. The facility is attempting to provide specialized training for staff to deal with the unique problems and needs these individuals present. The constant influx requires shifting clients into various living units in order to keep populations at or near licensed (and licensable due to square footage requirements) capacity, and therefore impacts all of the treatment teams to some extent. This constant movement allows neither clients nor staff to fully adjust before the next change, and seriously impacts the facility's ability to continue to meet the active treatment mandate of the certification standards.

Section 2.b. of the MDC mission statement addresses those individuals needing high levels of care due to lack of basic skills, high level medical/health needs, and often severe physical handicaps such as blindness, deafness, and little or no independent mobility. Although the intensive levels of service these clients require are available only on a limited basis in the community, individuals with similar needs are being successfully served in communities throughout the state. Historically, clients requiring this level of service do not return to an institutional setting once placed; while clients with higher level skills, but severe behavior problems are often readmitted when their behaviors threaten the safety of others. Placement of these individuals from the institutional setting to the community has

sometimes been only short term and therefore only temporarily decreased the institutional population. This is currently a crisis and will soon be a major crisis, if not resolved. The options outlined in this plan must address this situation, as the new MDC campus will be physically unable to handle more than 110 individuals.

Community Waiting List - Currently, there are over 1300 persons on the CWL who are in need of services. Of these over 450 receive no services through agencies contracting with the Developmental Disabilities Division (DDD), while over 850 are underserved individuals needing additional or different services than those they currently receive through the DDD. Four hundred of the persons on the CWL are requesting services similar to those which would be needed by the individuals proposed to be moved from residential facilities. Of this group, over 100 receive no DDD funded services while almost 300 do.

PROBLEM: Without the development of additional, intensive services, some individuals on the waiting list will become "seriously developmentally disabled" and seek admission to the residential facility.

There may be other individuals for whom commitment will be necessary regardless of the additional services. These generally are individuals who have sex offending behaviors and probably

have been involved with the criminal system. These individuals need a facility which meets their security and safety needs as well as those of others. Currently, MDC is the MDDSS designated agency to develop and provide treatment for these persons.

It is important to prevent persons from becoming "seriously developmentally disabled" in order to limit the number of admissions to the residential facility so space will be available for those for whom no other option exists within the MDDSS. Unless there are services developed to address these intensive service needs, overcrowding at MDC will continue.

A total of 173 individuals were assessed (113 MDC, 49 EHSC, and 11 MSH). Of those, 23 received a rating of #1 (the most severe) for serious behaviors, 54 received a rating of #1 for substantial assistance with self-help needs, and 27 received a rating of #1 for serious medical needs. The total number of people who had a rating of #1 in any of these three primary categories was 81.

The numbers with a rating of #2 were: 70 for behavior, 27 for self-help, and 43 for medical.

A rating of #3 was given as follows: 24 for behavior, 41 for self-help, and 90 for medical.

The #4 ratings were: 56 for behavior, 51 for self-help, and 13 for medical.

One group for whom community-based services do not generally exist is the one including individuals who have engaged in sexually offending behavior. As explained in Section II, the MDDSS, specifically MDC is seeing a major increase in these individuals. There are approximately 13 individuals in this category in the institutions right now. Their ratings fall in both high and low categories, because most of the offenses that resulted in commitment occurred with children, and since they do not have access to children now, their current behavior does not

rate as intense. This will be an issue during any discussions regarding overall placement from the institutions into communities.

There are two other groups for whom services do not exist generally in community-based group homes. One group includes those who are fed through gastrostomy tubes or who have jejunostomy tubes, as nurses must provide these services, and few group homes have nurses available to do this.

Another group for whom placement would be a concern includes those individuals who first came through the criminal justice system, were convicted of crimes, and for whom sentences were deferred, with commitment to MDC then pursued and accomplished.

To summarize these outcomes, assuming that ratings of #1 identify individuals who most need the level of care provided in institutions, and allowing for the fact that some individuals with lower ratings fall into one of the three categories for whom services do not generally exist in the community, the number of individuals who would be more appropriately served in community-based placement is 70.

EXHIBIT 19
DATE 1/27/95
HB

January 27,1995

Chairpersons Fisher, Cobb, and Chairman Clark
Members of the Committees:

My name is Pat A. Mischel- My adress is 47 RD 261 Glendive.

Thank you for allowing me the opportunity to address some of the proposals in HB 65.

The removal of Eastmont as a component of the Developmentally Disabled system is unwarrented, and not in the best interest of the residents or the State of Montana.

The 49 residents of Eastmont are provided with the best care in a residental Campus style facility. The individuals at Eastmont reside at 700 Little St. in Glendive, Mt. Although having disabilities, thay are very much an active part of our community.

The residents of 700 Little St. share the same City Pool, Bowling Alley, and Restaurants as myself and my children.

The residents at Eastmont will probably never run a marathon or win the Nobel Prize, but because of the oustanding care provided, these people will live life to their fullest potential and always be treated with dignity.

The Governors task force found the care at Eastmont to be without criticism Medicaid who employs National Experts on the Developmentally Disabled, has recommended and inspected the changes Eastmont has made to the building and to the care of persons, over the past 20 years. Medicaids opinion of Eastmonts 15 and 35 residental cottages is one of a modern,and quality care facility.

Some of the people in this room seem to be stuck on the word "Residental'', when we should be stuck on the word "CARE", Quality Care, Diginfied Care, Care: to feel interest in, bother about, to be concerned about, having the wish to care for, to look after, to like, to enjoy.
Care is what all Montanan's who cannot help themselves deserve, the Residents at Eastmont are provided with the best care available under any NAME.

My suggestion to you is take the 1.4 million dollars that it would take to close Eastmont and construct an additional 12-15 person Residential Cottage This solution would make it possible in the near future to have 3 - 12-15 Residental Style Facilities with Campus Style Activites.
The final result would be Retaining Eastmont as one of the many choices for the care of the Developmentally Disabled.

Once again I ask you to Ammend HB 65 to Retain Eastmont Human Services at Glendive.

Thank You!

Pat A. Mischel
47 Road 261
Glendive, Mt. 59330
365-6690

EXHIBIT 20
DATE 1/27/95
HB

GORDON R. HICKMAN
ATTORNEY AT LAW
20 S. Central Avenue
HARLOWTON, MONTANA 59036
(406) 632-5651

April 25, 1989

Mr. John P. Berry
Social Worker
Eastmont Human Services Center
East Little Street
Glendive, Mt. 59330

Re: Caryn Rae Hickman

Dear Mr. Berry:

Thank you for your letter of April 24, 1989. Linda and I did enjoy our visit to your establishment and we were impressed with the friendliness and co-operation of your staff members. They were unfailingly courteous, friendly and helpful.

Caryn is making progress. Some progress is great progress.

We do not delude ourselves that she will ever be normal, but she seems more content and has developed an interest in her surroundings and the activities she observes. I know that her condition is unalterable, but, if she can improve so that she has an awareness of things that are going on around her, she will, I believe, be a happier person.

I hope that we did not entirely deplete the Glendive supply of chocolate sundaes.

Thank you and the staff for helping make our visit as enjoyable as possible.

I am enclosing a check to be used as you and Mrs. Hammer see fit to help brighten a day or time for the children.

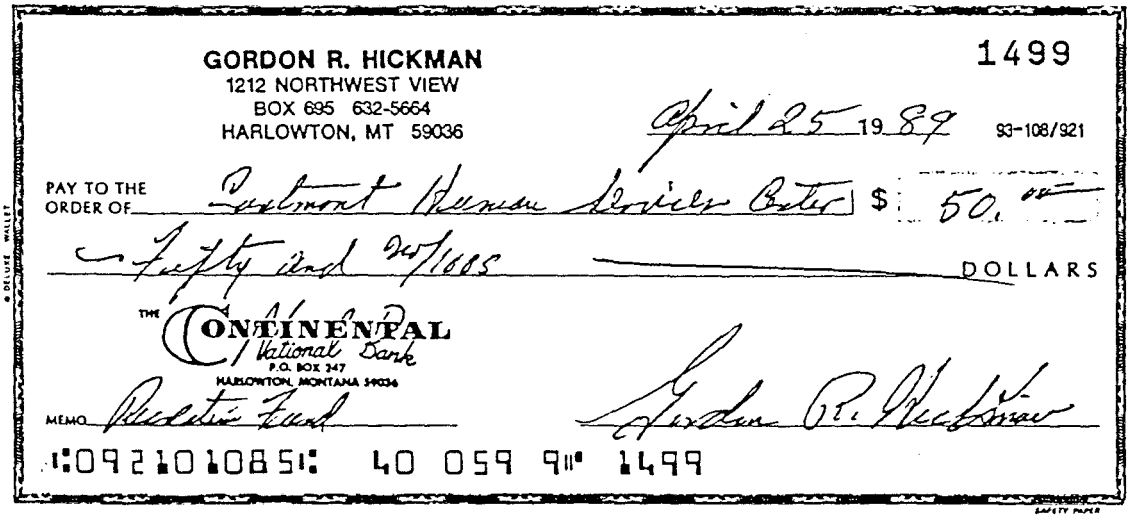
Please give Mrs. Hammer my very best regards and again, Thank you and all of the staff for the many courtesies. We do appreciate the treatment we received.

Very truly yours,

Gordon R. Hickman

GRH/sg

Encls.



GORDON R. HICKMAN
1212 NORTHWEST VIEW
BOX 695 632-5664
HARLOWTON, MT 59036

1499

April 25 19 89 93-108/321

PAY TO THE ORDER OF Fortmont Human Service Center $ 50.00

Fifty and 00/100 DOLLARS

THE CONTINENTAL National Bank
P.O. BOX 247
HARLOWTON, MONTANA 59036

MEMO Recreation Fund

Gordon R. Hickman

⑆092101085⑆ 40 059 9⑈ 1499

EXHIBIT 21
DATE 1/27/95
HB

HOUSEHOLD INTERNATIONAL

Margo J. Hickman, CPCU
Director of Risk Management

January 25, 1995

State of Montana Legislature
c/o Linda Hickman
Harlowton, Montana 59036

RE: Eastmont Facility

To Whom It May Concern:

I am writing in support of keeping the Eastmont facility open and operational. My sister, Caryn Hickman, was a resident of the facility for several years prior to her death. She was transferred from Boulder where she lived most of her life. Both facilities provided excellent care and we were grateful that the State of Montana operated such excellent facilities for the care of its residents with special needs.

However, during Caryn's years at Eastmont, she blossomed to her full potential due to the care and expertise of its staff. She was taught to take care of herself and was given duties and jobs to perform for her fellow residents. She seemed very happy while there and made tremendous progress.

While this is a personal testimonial on behalf of my family's observations, please also consider other practical aspects of this decision. Due to Montana's size, the ability of families living in eastern Montana to visit the Boulder facility would be severely hampered. Each facility has its own distinct atmosphere and it is reasonable to determine that different people will respond better in one place or the other. You have a dedicated staff and adequate facilities and are caring for people who, in many cases, rely solely on the state for their care and whose lives and routines would be seriously upset by a move across the state into a different facility with different caregivers.

Thank you for your consideration of a matter which will truly impact, in a very direct way, the lives of the residents and the staff of an effective facility.

Sincerely,

Margo J. Hickman

Margo J. Hickman

EXHIBIT 22
DATE 1/27/95
HB

Jane Startved
Parent. Glendive MT

Page 1 of 2

I REALIZE THAT I SHOULD HAVE HOUSED HIM THERE SOONER. BUT NOW I CANNOT JUSTIFY TAKING HIM OUT OF THIS ENVIRONMENT, HIS HOME, AND PLACING HIM INTO AN INAPPROPRIATE GROUP HOME WHERE HE WILL INEVITABLY BACKSLIDE.

EASTMONT IS ALSO VERY IMPORTANT TO THE COMMUNITY. THE RESIDENTS SWIM, BOWL, PATRONIZE RESTAURANTS, AND SHOP JUST LIKE THE REST OF THE GLENDIVE COMMUNITY. THEY ENJOY SCHOOL PLAYS, FAIRS AND CIRCUSES JUST LIKE EVERYONE ELSE. AND MOST OF ALL, THEIR REVENUE STAYS IN GLENDIVE! THE RESIDENTS AREN'T TAKEN TO BILLINGS TO DO THEIR SHOPPING, THEY DO IT RIGHT IN GLENDIVE.

ALTHOUGH IT HAS BEEN SUGGESTED THAT THE RESIDENTS SHOULD BE ABLE TO GO TO TOWN ALONE WITH MONEY IN THEIR POCKETS TO DO WHAT THEY WISH, WE ALL REALIZE THAT THESE RESIDENTS CAN'T MAKE THAT KIND OF A DECISION ON THEIR OWN. IF THEY COULD MAKE SUCH DECISIONS, A TRAINING CENTER SUCH AS EASTMONT OR A GROUP HOME WOULD NOT BE NECESSARY AT ALL.

WE TALK OF RIGHTS. I BELIEVE THAT THEIR RIGHTS WOULD BE VIOLATED IF THEY WERE FORCED TO LEAVE THEIR HOME IN ORDER TO DO WHAT OTHERS THINK IS THE RIGHT THING. THEY HAVE RIGHTS TO BE WHERE THEY CAN RECEIVE THE PROPER CARE AND AFFECTION THAT THEY DESERVE: EASTMONT!

MOST OF THE RESIDENTS IN EASTMONT HAVE VERY SPECIAL MEDICAL NEEDS AND THAT MAKES HAVING ONE DOCTOR A PLUS! HAVING NURSES ON DUTY AT ALL TIMES IS A PLUS! WE'VE DONE ALL THE FIGURING AND THERE ARE NO NEGATIVES TO KEEPING EASTMONT OPEN!

MY FAMILY AND I ASK THAT YOU CONSIDER THE RESIDENTS AT EASTMONT AND HELP US TO RETAIN THIS FINE FACILITY.

Jane Skaltved
Parent

Page 2

MY SON LIVED AT HOME UNTIL HE WAS TWENTY YEARS OLD. DUE TO MY HEART CONDITION HE BECAME A RESIDENT AT EASTMONT. WE, HIS LOVING FAMILY, FEEL GRATIFIED THAT HE HAD SUCH A PLACE TO LIVE WHERE HE COULD ALSO BE CLOSE TO HOME. HE HAS HAD EXTENSIVE THERAPY ON HIS LEGS AND BACK AND HAS BEEN GIVEN THE TREATMENT THAT ANY PROFOUNDLY HANDICAPPED YET WONDERFUL HUMAN BEING DESERVES.

LET ME TELL YOU A LITTLE ABOUT DEAN. HE HAS CEREBRAL PALSY AND IT HAS LEFT HIM UTTERLY HELPLESS. HE HAS NO SELF HELP SKILLS AND IS WHEELCHAIR BOUND. DEAN SUFFERS FROM OCCASIONAL SEIZURES AND HAS ~~RECENTLY DEVELOPED~~ some mild SCOLIOSIS. BUT THESE OBSTACLES ARE NOTHING TO THE QUALIFIED STAFF AT EASTMONT. THERE IS ALWAYS A NURSE ON DUTY AND THE AIDES ARE WELL TRAINED TO HANDLE ANY EMERGENCIES THAT MIGHT ARISE. A DIETICIAN WORKS WITH THE VARIOUS INDIVIDUALS THERE TO COORDINATE MEALS FOR THE SPECIAL NEEDS OF THE RESIDENTS. ONE DOCTOR SEES TO THE WELFARE OF THE RESIDENTS AND HE IS AWARE OF ALL THEIR MEDICAL NEEDS. IN SOME GROUP HOME CASES, THE CARE IS NOT AS SPECIALIZED OR BASED ON INDIVIDUAL NEEDS AS IT IS IN EASTMONT. FOR EXAMPLE, THE RESIDENTS' DIETS ARE UPDATED YEARLY IN MOST GROUP HOMES. RESIDENTS WITH UNSTABLE DIGESTIVE SYSTEMS LIKE DEAN WOULD OFTEN BE SICK AND WOULD NOT HAVE HIS NEEDS SUITED.

DEAN CONTINUES TO MAKE EXCEPTIONAL PROGRESS AT EASTMONT. I BELIEVE THAT THIS IS DUE TO THE FACT THAT HE IS LIVING NEAR HIS FAMILY. WE HAVE FREQUENT CONTACT WITH HIM AND WE ARE VERY PLEASED WITH HIS "HOME AWAY FROM HOME." I THINK THAT IT WOULD BE CRUEL TO UPROOT THESE PEOPLE WHEN THEY ARE GETTING THE KIND OF CARE AND PROTECTION THAT THEY NEED AND DESERVE AT EASTMONT.

ALTHOUGH IT WAS HARD FOR ME TO ACCEPT THE FACT THAT I COULD NO LONGER CARE FOR DEAN THE WAY A MOTHER OUGHT, I NOW KNOW THAT EASTMONT WAS THE BEST PLACE FOR HIM.

Jan 17, 95

EXHIBIT 23
DATE 1/27/95
HB

To Whom it May Concern,

I Am Writing this in regards to House Bill 65. Where they Want to Close Down Eastmont Human Service Center.

We have a Son there. We are Pleased the way they are running Eastmont. We really don't Want to see you Close it as Our Son is a person which Needs 24 hr Care. He was Moved from Boulder to Eastmont And it took him a longtime to Get adjusted to Eastmont as he had friends there. Now you are talking about Closing it. He is doing Good there. They take him Bowling, Swiming etc which he really enjays. You have a Place Now for Ones like him Why Change Something that Works Good for Something you're not Sure of. Please Keep it Open!

Bob & Marcella Elfring

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE 1-27-95

BILL NO. HB 65 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRIN

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Dawn Sess	Montana Advocacy	✓	
Charlene Lindberg	Lyle Huber	✓	
Martha Huber	Lyle Huber	✓	
Kate Cholewa	Human Services Found.	✓	
Sen. Ric Holden	SD 1		✓
Rep K Kimble			✓
Nancy Hoyle			✓
DAN Schmidt			✓
Sandra Lemon	CDC - Kalispell	✓	
MARK HAWTHORN	SRS	✓	
JOE ROBERTS	System Adv for Dev. Dis.	✓	
Wallace Melcher	" " " "	✓	
Curt B Hunt	SRS/Legal	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HR:1993
wp:vissbcom.man
CS-14

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE

BILL NO. SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Greg A. Olsen	DDPAC	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HR:1993
wp:vissbcom.man
CS-14