STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION

DMR

LOWELL P. WEICKER JR
GOVERNOR

OFFICE OF THE
COMMISSIONER

March 2, 1994

Honorable Lowell P. Weicker, Jr.
Governor
State of Connecticut
State Capital
Hartford, CT 06106

Dear Governor Weicker:

I am forwarding to you with this letter a copy of the **Southbury Training School Planning Committee Report.** This report, together with the **Planning Report to Eliminate the DMR Waiting Lists** submitted to you earlier with my recommendations, completes the study phase of these two major challenges facing DMR.

After careful review of **The Southbury Training School Planning Committee Report,** I recommend the following action plan:

- placing 75 people in the community in FY '95, contingent on approval of your proposed budget amendment
- developing a revised plan to place the remaining 825 people in community settings over a five year time span, beginning in FY '96
- identifying and setting aside appropriate residential space at Southbury Training School for as many as 100 individuals and maintaining that space as a safeguard against any problems or delays that might occur in the placement process.

As you know, the Southbury Training School Committee was designed to include representatives of constituencies with widely differing views. In spite of this, the committee has produced an enormously valuable document. Both the majority and minority opinions included in this report will inform all of the detailed planning that must follow as we move toward a goal of closing Southbury Training School.

Sincerely yours,

Toni Richardson
Commissioner

TR:eac R03024a
Enclosure

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THE SOUTHBURY TRAINING SCHOOL TASK FORCE

FINAL REPORT

JANUARY 1, 1995

I. Acknowledgement

There has been a great deal of hard work and effort put into this committee by its members and staff. It would be appropriate at this time to recognize the members and staff who spent many hours putting together this report.

Rep. Barbara M. Ireland (Chair), 111th District

Rep. Arthur J. O'Neill (Chair), 69th District

Rep. John W. Betkoski, III, 105th District

Rep. J. Vincent Chase, 120th District

Sen. Joseph J. Crisco, Jr., 17th District

Sen. Louis C. DeLuca, 32nd District

Rep. Lucien A. Dimeo, 103rd District

Sen. Judith G. Freedman, 26th District

Rep. Josephine S. Fuchs, 136th District

Rep. Bob Godfrey, 110th District

Rep. Marilyn Hess, 150th District

Rep. Thomas S. Luby, 82nd District

Sen. James H. Maloney, 24th District

Rep. James A. Tavegia, 83rd District

Rep. Christel H. Truglia, 145th District

Rep. Peter F. Villano, 91st District

Carol Bison, House Legislative Staff

Pamela Booth, House Legislative Staff

Gail Hensley, House Legislative Staff

John Titsworth, House Legislative Staff

Pamela Young, House legislative Staff

EXECUTIVE SUMMARY

DMR proposes to close STS within five years. Based on the experience of closure the Mansfield Training School, closure of STS would take at least ten years. Because the closure cannot be done within the five years, the estimated financial savings cannot be achieved. Therefore, the transfer of resources to community programs to alleviate the waiting list cannot occur as scheduled.

It was apparent that DMR's ability to monitor or supervise existing group homes or other community placements needed major improvement. Because the financial savings based on the closure of STS within five years cannot be achieved, adequate community support services cannot be created.

It was evident that the projections for placements of 10% of STS's residents in supported living and 10% in community training homes were arbitrarily arrived at. Many residents of STS are benefitting from their present placement and appear unlikely to benefit from community placement.

We recommend the following. Change the name and mission of Southbury Training School to reflect its evolution into an improved life care community. Establish criteria to evaluate current population for community placement. Over a period of at least ten years, expand the life care community at STS. Develop programs at STS to provide support for the life care community and for other communities throughout the state. Create a funding mechanism for the creation of group homes. We did conclude that sheltered workshops can continue to perform an important function in providing work experience and day program opportunities. Individuals on the waiting list should be evaluated and surveyed as to their program needs. Individuals residing in community settings, whether or not on the waiting list may desire or need to be placed in the STS life care community. Criteria for placement at STS life care community should be developed. An independent oversight committee should be created and appointed to develop a plan of implementation which shall include the development of a comprehensive site plan for STS.

C. Letter and Reports from U.S. Justice Dept. and Copy of Consent Decree and Subsequent Modification.

D. Cost Analysis Presented Nov. 12, 1994

E. Questions and Answers dated Oct. 12, 1994

F. Copy of Complaint by CARC in Federal Court

G. A Profile of Quality of Life Outcomes and Trends

H. California Position Statement

I. U.S. Policy regarding Disabilities

J. Names of Witnesses of the June 27th public Hearing

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II. HOW WE GOT HERE

1) In the Spring of 1993 the Mansfield Training School was closed. Governor Weicker was reported to have made statements indicating the desire to close the Southbury Training School.

2) Thereafter Department of Mental Retardation Commissioner Toni Richardson announced the formation of a committee to study and plan the actions that would be needed to close the Southbury Training School and move its residents into community placement within five years.

3) During the following months many letters were received regarding the closure report of the Southbury facility, many of those coming from parents and guardians of clients at STS.

4) In December 1993, Legislators requested the formation of a bi-partisan legislative task force to look at the situation which was unfolding.

5) In February 1994, a fact finding committee was formed to conduct a thorough review of the proposed closing of the Southbury Training School and submit a report to legislative leadership by January 1, 1995.

6) The Southbury Training School Planning Committee Report was released in March of 1994 by DMR Commissioner Toni Richardson. The plan called for:

a. The closure of STS over five years.

b. Place every resident living at STS into the community at the rate of 160 per year.

c. An increase of nearly $9 million more than current operating expenditures over the first three years of the closure of STS.

State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

TO: Representative Arthur O'Neill

FROM: Senator John B. Larson, President Pro Tem of the Senate JBL
Representative Thomas D. Ritter, Speaker of the House T.R.

RE: Southbury Training School

FROM: February 8, 1994

As you are probably aware, the planned closing of the Southbury Training School has been announced. As a result of this we have received several inquiries from concerned constituents regarding this matter. Some of these contacts express a desire to keep the school open, while others support the closing.

Prior to leadership suggesting any legislative action, we have elected to form a fact finding committee. This committee will be chaired by Representative Barbara Ireland and Representative Arthur O'Neill.

We are appointing you as a member of that committee. We expect the committee to conduct a thorough review of the proposed closing of Southbury and submit a report to our offices by January 1, 1995. Thank you for your willingness to sit on this important committee.

IV. OPENING STATEMENT

It should be the policy of the State of Connecticut that people with developmental disabilities and their families have the opportunity to make choices. Several states that have led efforts to de-institutionalize, have started to rethink what these policies should be. We, the task force of the Southbury Training School, are supportive of concepts expressed in the March 12, 1994 ARC-California Inclusion Position Paper. In particular, we support, "Inclusion as on option in an array of services and support options which may include the opportunity to be integrated into the community or congregate with peers... There is a wide array of abilities and disabilities among California's citizens of mental retardation for services and supports under California's regional center system. We advocate for a wide range of choices which embrace congregate as well as fully inclusive options within school settings, training and support services, employment settings, living situations, health services, and leisure activities. The decision making process relating to the identification, planning and implementation of the appropriate services and supports should be a shared responsibility between the individual with mental retardation, parents/family members, guardians, conservators, and professionals. This shared decision making-process is essential to an effective individual program planning process."[1]

In addition, we are cognizant of and agree with the Development Disabilities Assistance and Bill of Rights Act Amendments of 1994 which state, "Individuals with developmental disabilities and their families are the primary decisionmakers regarding the services and supports such individuals and their families receive and play decisionmaking roles in policies and programs that affect the lives of such individuals and their families."[2]

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[1]California News Magazine, 1994 Summer Edition, newsletter of the Association for Retarded Citizens-California, pp. 1-2.

[2]Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1994, Section 101, subsection c, number 3.

V. The Activities of the Task Force Include:

Feb. 8, 1994, letter creating the Task Force was distributed

March 1, 1994, an organizational meeting with committee members was formed to set up a plan of action.

March 1-25, 1994, written questions were prepared and submitted to Commissioner Richardson and Director Howley of the Southbury Training School.

April 18, 1994, public hearing was held with DMR Comm. Richardson and Dir. Howley at the Legislative office building in Hartford.

May 16, 1994, public hearing was held with Commissioner Richardson and Director Howley at the Legislative Office Building in Hartford.

May 16, 1994, public forum at Kennedy High School was held in Waterbury.

June 27, 1994, speakers were invited to testify representing various groups at the Legislative Office Building in Hartford.[3]

August 17th 1994, the Task Force toured the Southbury Training School at STS.

Sept. 26, 1994, public hearing at STS was held, testimony included parents, clients, staff from STS. About 65 witnesses testified.

Oct. 12, 1994, additional questions for Commissioner Richardson were prepared and sent.

Oct. 13, 1994, the task force toured VARCA in Derby, CT.

Nov. 14, 1994, meeting with Dep. Comm. of DMR Linda Goldfarb was held, supplemental questions for Comm. Richardson were presented.

Nov. 29, 1994, the discussion draft was presented and approved.

*In addition there were various informal meetings with state officials regarding finances and legal issues, as well as informal meetings and visits at STS involving members of the task force.

There were two important events which occurred related to STS during the work period of the task force: 1)U.S. Justice Dept. Report, June 27, 1994, 2)Messier et al. v. Southbury Training School was fileed on Oct. 5, 1994.

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[3]Names of the participants of the June 27th hearing are found in the appendix.

VI. Findings of Fact Based on Testimony and Other Evidence

In addition to the testimony presented at the public hearings, the Task Force reviewed a wide array of documents including, but not limited to, those documents found in the appendix.[4] Based on the evidence presented, the Task Force has reached the following conclusions.

A. The Task Force has evaluated DMR's five year plan of closure.

1. We find that the closure plan is too optimistic.

a. By DMR's own admission closure cannot take place within five years unless all state agencies (DMR, DPW, DOH etc.) involved make closure their top priority.[5] There was no evidence presented that would indicate that these state agencies would make it a top priority during the next five year period. In the absence of such a commitment it is our judgment based on years of experience (as legislators), that the plan cannot be accomplished.

b. DMR's major prior experience was the closure of Mansfield: it took eight years to reduce the population from 669 to zero. In only one year (1988) did DMR attain the planned rate of community placement (the rate needed to close STS within the five year time frame is even higher than either the planned Mansfield rate or the actual rate for any year other than 1988).[6] Because of the geographic nexus the Mansfield placements were mostly in eastern Connecticut where housing costs are much lower than in western Connecticut. Based on nexus, most STS placements would be in western Connecticut.[7]

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[4]See appendix

[5]Testimony from Deputy Commissioner Linda Goldfarb to the task force, Nov. 14, 1994.

[6]Answers to supplemental questions from Comm. Richardson, Nov. 14, 1994.

[7]Testimony from Dep. Comm. Goldfarb/DMR staff, Nov. 14, 1994.

(A.1.) c. Based on the Mansfield experience we estimate closure would take at least 10 years: actual Mansfield rate = 83.625 placements per year, current population of STS as of 11/30/94 = 872. 872/83.625 = 10.42 years. We also note that at best, two of the STS placements planned for the current year have occurred to date despite full funding of DMR's request for placements.[8]

(A.) 2. Because the closure cannot be done within the five years the estimated financial savings cannot be achieved. In fact the cost to DMR and other state agencies will be higher in 2001 not lower since savings can occur only near the end of the program when STS is substantially closed.[9] In addition, DMR's projected savings through the closure of STS is not credible because to date, DMR has been unable to provide an answer to the following question related to the closure of Mansfield Training School.

Q:"What was our experience (in terms of time frame and cost) with the closure of Mansfield Training School?"

A:"We were unable to differentiate costs that are attributed only to MTS residents. Most private sector homes that opened in 1985-1990 were not specific to MTS residents or even to a class members. Many providers opened homes to serve some class members and some others from the community. We do not have the data that attributes specific costs of ten years ago to specific clients."[10]

(A.) 3. Because the financial savings cannot be achieved as planned, the transfer of resources to community programs to alleviate the waiting list cannot occur as scheduled.

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[8]Put together from answers to supplemental questions from Comm. Richardson, Nov. 14, 1994.

[9]DMR's, Southbury Training School Planning Committee Report, March 1, 1994.

[10]Answers to written questions prepared by task force for comm. Richardson, Oct. 12, 1994.

SOUTHBURY TRAINING SCHOOL PLANNING COMMITTEE REPORT

A study of and recommendations for what it would take to close Southbury Training School and move its 900 residents into community placements within five years.

Submitted to:
Toni Richardson, Commissioner
Department of Mental Retardation

March 1, 1994

LIST OF APPENDICES

It is essential to understand that an individual's participation on this planning committee and even his or her willingness to reach consensus on various committee recommendations does not imply support for the closure of STS. In fact, several committee members openly opposed the concept of closure (see **Appendix A** for these committee members' names) but participated in formulating this plan for the commissioner within the prescribed framework of "what it would take to close STS in five years." The concern was also expressed that facilitating a move by residents of STS to the community not be viewed as a higher priority in terms of Connecticut's community residential planning, but that the needs of those now living with their families and people on DMR's waiting list be carefully balanced with the needs of STS residents.

Why Plan for the Closure of STS?

The commissioner spoke to the committee at its first meeting about why she found it necessary to ask for a plan to close STS. The complete text of her September 23, 1993 statement is presented in **Appendix B**. The main points she made were as follows:

- There is a national trend toward reducing the population of institutions for people with mental retardation.
- Civil rights litigation has confirmed the right of people to make choices about how they should live. This includes the right to live in the community.
- The residents of STS are aging and the population is shrinking. As a result, some time in the near future it will no longer be economical to continue to maintain STS.
- STS facilities are inappropriate for the aging population and it would be too costly to undertake renovations.
- People newly approaching the DMR system want comprehensive community services and reject institutional living arrangements for their sons and daughters with disabilities.
- Federal reimbursement is more generous at present for people living in the community than for those who live in large institutions.
- DMR has had extensive experience in closing other large facilities and so can proceed expeditiously.
- Parents are getting older and won't be here to help with transition if we wait too long. We need their active participation in planning for any moves.

STS Background Information

The Southbury Training School opened in 1940. The institution spans 1,600 acres in the town of Southbury. The facility consists of 125 separate buildings, most of which were built in the 1930s. It was the demand for increased capacity at the Mansfield Training School which opened in 1917 in the

The Probate Court has approved full guardianship for 88 percent of STS residents and limited guardianship for another eight percent. Only four percent of the residents are considered legally competent.

Residences

The residents live in 39 cottages, with 10 to 35 adults living together in each building. A number of the cottages are overcrowded and need major renovation. Two cottages have been modernized recently and provide small attractive modern apartments for four residents each. Thirty residents live in three-person ranch-type homes on the grounds of STS. Currently 240 residents at STS, or 27 percent, live in buildings that are ICF/MR certified and receive 50 percent federal reimbursement for all costs.

Day Programs

The STS administration has been working hard to provide day programs for all residents. At present, 658 have full-time programs. Because of budgetary constraints, 175 residents have only part-time programs. Sixty-seven people have no day programs; 30 residents prefer not to attend day programs or are too fragile medically to be able to take advantage of them.

On campus day programs are provided to 618 residents: 39 percent in Adult Day Treatment, 23 percent in Opportunities for Older Adults and 19 percent in Sheltered Workshops or enclaves. The majority of workers earn below minimum wage. Off campus programs are provided to 215 residents. Of these, 125 work; 90 percent of them in sheltered workshops or enclave situations.

Interest in Moving into the Community

STS Director, Dr. Thomas Howley, has said he has a list of 58 residents for whom community placement is being actively sought. A number of STS families have indicated that they are willing to look at community settings for their relatives, but in a recent questionnaire sent out by the Home and School Association, 568 of 591 returns stated a preference for remaining at STS.

When STS residents move from the training school, they usually return to their "nexus." Nexus refers to the DMR region from which the person came or where his or her relatives continue to reside. A map of the DMR regions is included in **Appendix C**. Community moves to nexus locations would result in people returning to regions in the following proportions:

Region 1	283	31.3%
Region 2	19	2.1%
Region 3	7	0.7%
Region 4	403	44.6%
Region 5	186	20.6%
Region 6	6	0.6%

Workers

At the end of December 1993, STS had 1,806 staff working at the school (Full-Time Equivalents). Direct care workers totaled 1,413. Six unions represent most of the employees at STS. They are:

Families and Guardians
Family members and guardians are encouraged to participate in making plans for their children's programs and services by attending the annual Overall Plan of Service (OPS) meetings and by joining in cottage parent groups.

Four protective organizations specific to STS help maintain standards:

- The Board of Trustees of STS meets nine times a year. It visits cottages, investigates support services (e.g., medical, dental, fiscal) and advises the Director about administrative and financial problems. It sends an annual written report on the state of the School to the Governor's Council on Mental Retardation. One of its members is a member of that council.

- The STS Home and School Association (H&S) watches activities at the training school and brings incidents that need investigation to the attention of the director. It holds open meetings to inform parents of what is going on at the school and what is planned, and about the rights and options of residents, families and guardians. H&S has also donated funds to STS to provide a wheelchair van and scholarships to help recruit occupational or physical therapists for STS.

- The STS Foundation is a non-profit fund-raising organization that funds a guardianship program, which acts as court-appointed guardian for about 225 people who live at STS and 59 former STS residents who now live in the community. It has also donated a swimming pool, picnic pavilions, an ambulance and a wheelchair van to STS.

- The Western Connecticut Association for Human Rights (WeCAHR), under a contract from the Office of Protection and Advocacy, supervises a self-advocacy program on campus. About 25 to 35 residents meet weekly to learn about self-advocacy. They have established and support a chapter of People First. WeCAHR has two full time staff assigned to STS and provides advocacy services to 115 individuals.

There are other volunteers on campus. In the year ending June, 1993, 330 volunteers contributed over 31,000 hours of service to the training school in a number of different capacities. One of the most important of these is the Thrift Shop, which raised over $80,000 for STS in 1993.

- There is an ambulance on campus in case of emergency.

- STS has its own police and fire departments.

- The adaptive devices required for residents' welfare is maintained by specially trained workers on the premises.

- The residents enjoy special amenities donated by volunteer groups, such as a swimming pool, fitness center, picnic pavilions and a rustic Adventure Area.

4. WHAT IS WORKING WELL IN THE COMMUNITY

The following observations were generated during a brainstorming session of the full committee and were the perceptions of one or more committee members. The validity of these perceptions was not discussed. The purpose of this session was to focus the attention of the committee on subjects and issues that might later be addressed in the work of the subcommittees as a prelude to writing the recommendations. A copy of the brainstorming list can be found in **Appendix E.**

- People who move into the community have the opportunity to live close to their family and friends. They can choose among several types of living arrangements. They live in home-like settings with access to the resources of town life. Persons who live in the community have more freedom and can exercise more choice and control in all aspects of their lives, including selecting activities in which they wish to participate.

- Public transportation, though limited and in need of improvement, provides access to community resources. All private group homes have vehicles which give residents access to activities occurring in their surroundings.

- DMR and private agencies are working hard to support people without dominating their lives. Almost everyone has some kind of day program. Some people have real jobs, with real fringe benefits, and are able to become less dependent on or even independent of the state.

- A variety of physicians and dentists take care of people living in the community who are supported by DMR. The department has been actively seeking effective ways to recruit more and better clinical services in community settings.

- The private sector can develop community placements faster than the state. The small autonomous boards of directors in the private sector can establish and oversee innovative programs. Communities have a wide array of resources which the private agencies are learning to tap for the benefit of their residents. These agencies can build on ties to the community and thus increase opportunities for community acceptance.

- Union representatives are concerned about the viability of community services for the residents with whom they work. They care deeply for the STS residents and are concerned about the disruption a transition to community services would create. They are very concerned about the future security of their jobs, both as they know them today and what impact work in community settings would have on the need to acquire new skills and define new roles. Work schedules, benefits, and career ladders could be at risk with community-based services and people in this group feel they must assertively protect the interests of their fellow workers.

These discussions and their emotional nature strengthened the committee's commitment to rely on data and facts to develop its recommendations. Despite these often opposing viewpoints, the committee members were in agreement about some fundamental principles, although not necessarily about how or where to obtain or achieve them:

- ✦ The residents of STS must have the best possible care and support in secure, safe environments with as little disruption as possible in the relationships and attachments they have developed at STS.

- ✦ People living at STS must have the supports and services they need and those supports and services must be equal in quality or better than those now available at STS.

- ✦ Residents must have environments where they are free from abuse and safe from crime, and have their personal and financial interests protected.

- ✦ Dependable quality assurance is an essential service feature in the detection of problems.

- ✦ Medical and dental services must be of the highest quality and provided by practitioners who have experience and competence to treat this population and its particular medical needs.

- ✦ Choice in where you live, who the staff are who support you, what you do during the day and with whom you spend it, are basic rights that must be honored. Everyday choices to increase the control you have over your own life, like what to eat or wear, are equally important.

- ✦ People must have sufficient opportunities to do things with people they enjoy so they are not bored, socially isolated, or lonely.

- ✦ Transportation is key to successful integration in the community. Resources must be adequate to meet the needs of the residents.

- ✦ Careful and objective review of the shortcomings in community services must occur in order to ensure that the principles identified above are fully addressed.

4. Data from DMR indicate that community programs serving people with challenging behaviors or specialized medical and physical needs have between 30 and 100 percent more staff on duty, per client, than comparable programs at STS. This richer staffing level must be established and maintained for STS residents with the same needs when they move into the community.

5. Consideration must be given to the needs of Southbury's older residents (38 percent are over age 50 at present, according to the STS administration), with particular concern for the special issues arising from the aging process (e.g., frailty, osteoporosis, Alzheimer's).

6. As people reach an age at which they become medically fragile, they must move into a DMR licensed group home or an Intermediate Care Facility for Mentally Retarded (ICF/MR) rather than a Long Term Care Facility (LTC) or nursing home. Placement into LTC facilities should be avoided, if possible. However, if placement into an LTC becomes necessary, the criteria established by the Mansfield Consent Decree will apply. In any event, DMR case managers must continue monitoring these individuals after they are placed in an long term care facility (LTC).

7. STS residents must be tested to determine their potential capacity for alternative communication through technology. Requisite technology must be provided, utilized and maintained whether people live at STS or move into the community.

8. DMR must guarantee that medical and dental care in the community is as good or better than it now is at STS (see section 3: *Things That Are Working At STS And Must Be Carried Forward Into The Community* of this report for additional details).

9. All changing medical needs of persons under DMR care must be recognized and accommodated, including funding to provide the licensed nursing and other professional services required.

10. Case management is a strong component of the DMR quality assurance system. The ratio of one DMR case manager for every 40 STS residents must be maintained when these residents move into the community.

The Roles And Rights Of Other Important Players

Parents And Family:

11. Roles and rights of parents and families must be clarified and affirmed according to DMR Policies. Recommendations about their rights regarding placement of their STS family members will be found under: *Planning A Move* in this section of the report. These roles and rights include a continuing function in establishing and evaluating ongoing and proposed programs.

12. Parents, family members, guardians shall always have access to the resident and his or her records consistent with the resident's wishes.

Guardians:

13. Many DMR clients need guardians and advocates but lack them. DMR must therefore explore ways of obtaining independent guardians for those who need such protection. The state must

21. When planning the location of homes and residences, the following considerations shall be taken into account:

    - the residents' needs and interests as well as their roots (nexus)
    - respect for the integrity of existing sibling relationships
    - availability of other group homes in the area, for trading and sharing resources.

22. Every home in the community must meet DMR's licensing standards.

23. When residents move into the community, they must have the opportunity to attend recreational events and meetings of interest to them. The agencies providing their care shall be required to facilitate this kind of participation in community life by accommodating the agency work schedules to achieve this aim.

24. Adequate transportation is essential to effective integration of persons with mental retardation into the community. DMR should work with local governments and communities to expand public transportation in the community for persons with disabilities. In addition, the transportation standards established in private sector homes in the community must be established for DMR-operated residences as well. These standards must be maintained and implemented at all community residences, whether private or public.

Planning A Move

25. DMR must educate residents, parents and staff regarding community placement: what it is and what it means.

26. DMR shall develop guidelines for educating the public and inviting participation and support from the community, and these criteria must be incorporated as requirements in requests for proposals (RFPs) for group homes.

27. DMR shall develop a check list of the issues that need to be addressed in working with each resident in choosing the location, staff, housemates. This check list must focus on personal relationships and needs of the resident.

28. In order to assure continuity and quality of life and maintain relationships, every effort must be made to allow residents to move with people they chose to live with, both staff and other residents. To avoid delays in posting and filling positions, early planning must group residents with the staff who might move with them.

29. All residents, whether they remain at STS or move into the community, must have a day program and recreational opportunities appropriate to their needs and desires, as determined by the residents and their Interdisciplinary Teams.

30. The following steps must be taken before a community placement is made:

    A. In reviewing options and making decisions, the STS resident must be encouraged and supported to participate to the full extent of his or her ability.

- all appropriate staffing and all needed support services
- an active treatment plan, with details in writing
- all medical providers, including any specialists needed for the care of the individual concerned
- a dentist appropriate to the resident's individual needs
- clinical supports noted in the OPS
- any adaptive equipment needed by the resident
- a full-time, appropriate, fully funded day program. The lunch hour and travel time should not be included in counting the hours of the day program.

31. If any resident moves into a community setting which becomes inappropriate, a better placement for the former STS resident must be found within two months or the conditions which rendered the placement inappropriate must be alleviated within two months. It must be recognized that although all residents of a particular community setting have equal rights under the law, the needs of the residents who have lived there longer and have developed a lifestyle and friendships in the area should have priority when the providers make plans to rectify situations listed above. Residents with longer tenure should not be forced to move in order to accommodate the needs of more recent arrivals.

Priority In Moves

32. New placements from STS must be developed first for the STS residents who have been actively seeking community placement (that is, the ones who are on the STS residential waiting list). Within this list, clients with all degrees of handicap must be given an equal opportunity to leave STS.

Community Living Project

33. DMR must seek funding from the legislature for the following project: Develop state-run programs for the placement in the community of individuals who wish to leave or whose guardians, parents or family wish them to leave Southbury Training School. This proposal should not stop any client of STS from going to whatever situation the placement team recommends. This project would mandate a broad based committee to oversee the planning and placement in the community of the above referenced group from STS. Leaders of this project will provide the Governor's Council on Mental Retardation with status reports every six months during the duration of the project.

> **Minority Opinion**: Some members of the committee believed strongly that the initiative to develop community placement programs for individuals at STS who wish to leave should not be limited to state-run programs. (see **Appendix J** for full text by Tom Fanning, Mike Richards, Jean Bowen, Jim McCann, Jim McGaughey, and David Hadden.)

Fiscal Issues

34. DMR must ensure that the 032 (Temporary Support) account is funded adequately in anticipation of possible extra costs associated with the transition of STS residents into the community, and for unexpected situations which might arise later.

authority to be determined by DMR. It should have enough power that it could influence the conduct of care-givers.

43. DMR must re-examine its Policy #8: Case Management, particularly with relation to job specifications and the desirability of emphasizing experience in the selection process. It must consider the selection, training, and role of case managers with the following questions in mind:
    - What is their role as team coordinator?
    - What is their role as problem solver?
    - What is their role as monitor of quality of care?

44. DMR shall examine the Individual Review (IR) items to see how they can be improved to identify medical issues.

45. Since there are questions about whether the "Red Flag" system is being implemented as consistently as intended, DMR must re-examine it. Some way must also be found to alert responsible parties, including families and guardians when there are continuing deficits of programs prescribed in the OPS.

46. DMR shall establish generally accepted standards for medical care. These standards can be based on those published by the Agency for Health Care Policy and Research of the Federal Department of Health and Human Services and on the recommendations of medical groups such as the American Cancer Society, the American Medical Association, the American Colleges of Physicians and of Surgeons, etc. DMR must establish a special committee to examine these standards and decide which are appropriate for its clients.

47. DMR must establish a system for tracking the actual medical/dental services rendered in the community, and not merely the paper statements that a client has been assigned to a doctor or a dentist. This will serve two objectives:

    - It will assure that the required services are actually rendered
    - It will allow DMR to learn whether they are being charged for services never received, or for excessive or unnecessary services.

> **Minority Opinion:** While such a system should be explored, this recommendation is not supported because of doubts about its effectiveness and its efficiency. The cost-benefit of this recommendation is questionable. (See **Appendix K** for full text by Steve Staugaitis)

48. DMR must explore the development of HMOs or other plans for delivering health services specializing in the problems of people with mental retardation. The Health Care unit already in operation at STS might serve as a model for developing this type of service.

49. DMR shall set up a longitudinal study of people who move from STS to the community, using acceptable scientifically valid techniques, to evaluate the frequency of moves within the community, quality of life and how well the individual has adjusted to community living. It must also include as an integral part of the study, statistics on problems with residential placement, day programs, adequate medical/dental care, abuse, etc.

COMMUNITY PLACEMENT PROJECTIONS

Type of Home	Percent	Total
CLA ICF/MR	32	
CLA Waiver (HCBW)	48	80%
CTH	10	
Supported Living	10	20%

- The cost projections for community placements were calculated according to the proportions listed in the table above. Some members of the committee felt that this number is too low and believe that the number of residents needing ICFs/MR may be as high as 50 percent of the total residents at STS. If greater numbers of people require an ICF/MR level of service, the overall cost projections would, by necessity, be higher.

- All of the following rates costs are based on parity between state and private employee wages. The cost projections however, do not recommend a public, private, or blended system. Instead they are simply based on the public pay rate.

- CLA ICF/MR rates ($344.68—first year rate) include direct services, room and board, medical/therapeutic services, current level of transportation, and amortization of capital costs to establish new programs.

- CLA Waiver rates ($290.22—first year rate) include direct services, room and board, medical/therapeutic services, current level of transportation, and amortization of capital costs to establish new programs.

- Supported living rates ($86.22—first year rate) include support services and housing subsidy.

- CTH rates ($44.28—first year rate) include support services and room and board.

- Day service rates ($40.28—first year rate) are calculated separately from the residential rates.

- An inflation rate of 3.43 percent per year pegged to the Consumer Price Index (CPI) is calculated for each of the five years.

Transition Period—Total Costs

When referring to the cost analyses in **Appendices L** and **M** there are costs in addition to the residential and day program rate costs that will be required to implement the committee's recommendations. They are referred to in the analyses as *Other Community Costs*. In all instances, the committee used current information or experience on which to base its cost projections. The

#42	Accreditation Council Training	$20,000 level or variable	cost to train trainers who would train additional people to use the Outcome Measures tool to assess quality of life issues. (one time cost)
#34	Temporary Support (032) Account	$400,000 level $368,750 variable	based on assumption there will be a need for additional supports during transition to the community. Assume need for temporary supports will taper off and plateau. (ongoing cost)
#35 #40	Quality Assurance	$496,000 level $444,333 variable	based on current staff ratios for this purpose (1 QA staff for every 100 living units). (ongoing cost)

TOTAL COST FOR OTHER COMMUNITY COSTS FOR FIVE YEAR PERIOD

Other Community Costs	**$7,788,212**	**level**
	$7,391,109	**variable**

CUMULATIVE COST OF FIVE YEARS

Level Placement Rate

(running a dual system—cost to develop community placements and downsize STS)

Community costs	community costs—gross	$250,357,761
	less reimbursements	(111,194,300)
	total community costs—NET	**139,163,461**
STS costs	STS expenditures—gross	$279,417,930
	less reimbursements	(46,291,037)
	total STS expenditures—NET	**$233,126,893**
Total costs	transitional period cost—gross	$529,775,691
	less all reimbursements	(157,485,337)
	total transitional cost—NET	**$372,290,354**

CAPITAL COSTS
Variable Placement Rate

	Capital Cost Based On Cumulative Cost Of Five Years	Cumulative Cost Of Five Years
STS capital cost	$7,839,849	$302,934,251
CLA/ICF capital cost (8.08%)	$6,275,124	$77,662,429
CLA/Waiver capital cost (9.89%)	**$9,715,668**	$98,237,292

STS—Total Cost

The following table outlines the total cost to operate STS during the same five year period and assumes no people move to the community settings. Renovation costs to operate STS have been included but no new bonding or renovations or additional staffing are assumed for the five year period.

TOTAL COST TO OPERATE STS FOR THE FIVE YEARS
(assume no residents move and STS continues to operate)

STS Operating Costs	STS expenditures—gross	$516,323,852
	less reimbursements	$95,142,385
	Total STS expenditures—NET	$421,181,467

Overall, the projected cost analyses demonstrate that timing affects the cost; the longer the moves into the community take, the greater the cost of running the dual system.

8. AREAS WHERE MORE INFORMATION IS NEEDED

Because of time constraint and the sheer size of the planning task before the committee, there were issues of significance to the committee that were not fully explored.

- Several committee members were particularly concerned about the lack of information about what has happened to the former Mansfield residents after they moved into the community. The Mansfield Panel of Monitors was supervising the moves until December 1990. Since then no specific information about any problems encountered by these individuals has been available.

APPENDICES

APPENDIX B

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL RETARDATION

DMR

LOWELL P. WEICKER JR
GOVERNOR

OFFICE OF THE
COMMISSIONER

WHY WE MUST TALK ABOUT CLOSURE NOW

Toni Richardson, Commissioner
September 23, 1993

On our present path, with no admissions and few placements, the natural process of aging and death will lower the STS population to zero over time. But because that time is hard to predict we don't tend to think of it as a plan to close. BUT STS IS GOING TO CLOSE.

For some of us who have been some part of STS for many years - in my case 25 - the possibility of closing is hard to talk about. And most of us don't want to talk about something painful if the prospects for it happening are very remote.

But here we are - talking about it and I need to tell you why I believe we must have this conversation now. Why I believe the consequences of not doing it now will be worse than the pain, for some, of doing it.

We know that facts and trends lead to the conclusion - THAT STS WILL CLOSE.

- National Trends are that institutions are closing:
  - the population of institutions for people with mental retardation has been cut almost in half over the past ten years
  - New Hampshire and DC are now institution free
  - more and more states have closure plans in place: Massachusetts, New York, Vermont, Oklahoma, New Mexico
  - soon there will be more people served with federal Medicaid dollars in community settings than in institutions.
- And we know that litigation drove trends: and that it was grounded in civil rights, and the notions:
  - that people should not be restricted more than absolutely necessary to receive help
  - that people should have some choices in how they live their lives

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  - decisions about renovation of buildings require 20 year bond commitments
  - and land use decisions must be considered if we are to avoid ungrounded speculation.

- Our planning cycle is upon us. It is time to issue our biennial 5 year plan. We cannot do that properly without addressing STS.
- People who want to leave Southbury haven't been able to. Their agitation is mounting. I can't advocate for their needs without opening up the issue of closing STS.
- Groups like "People First" are calling for change. Closing STS is their top priority.
- Certification efforts are struggling even though people at STS are working hard to keep up.
- Possibilities to capture federal dollars are real and critical in our cash poor time. We get federal help with only 25% of STS costs. We could get federal match on 100% of community costs.
- Parents - you are getting older and you won't be here to help with transition if we wait too long. We need your active participation.
- I am not willing to risk the future to escape the personal pain of facing the fact that Southbury is going to close.

COMMUNITY SERVICES AREN'T PERFECT

I am not trying to convince anyone that community services are perfect. They are not. As we grow and develop them we uncover issues that make us struggle - serious issues such as:

  - how to train our workers to support individual choice while still acknowledging real needs for help with choice-making
  - how to deal with behavior society is not used to
  - how to meet the need for safety in today's society
  - what to do about medical needs when the right service is not always available at the right time.

We cannot concentrate our energy on solving these issues if our attention is constantly diverted to addressing persistent problems in institutions about capital improvements, accessibility, pollution control, lead paint abatement, asbestos removal as well as the same problems of training, behavior, society and medical needs that keep recurring in institutions as well.

My real education has come not from academic degrees in liberal arts, education and law - but from people like these - who have taught me not how they can change but how I can change and, by doing so, make their world richer. As a mother told me recently

"My child only has this life. I have to make it the best it can be."

Some people have said "yes change but not now." But I was taught to ask, "if not now when and if not us who?"

Some of you have said to me - Toni, you've changed - you believed in STS, you believed it wouldn't close soon, you said you wanted our people to be able to stay until they chose to leave.

That is absolutely true. I did.

But what I couldn't know then is how much change would be accomplished so quickly. When I took office, MTS was not scheduled to close. Hillside Manor housed 60 people with mental retardation. We had more money to spend. We didn't know how many people were on our waiting lists. We had no experience in capturing federal Medicaid dollars for community programs. We carried the burden of active court monitoring, relied on a newborn quality assurance program and had even sketchier data and financial systems. None of that is true today. All these things have changed. No one, certainly not I, could have predicted what we have accomplished together.

But that pace of change shouldn't surprise us given the other massive changes that surround us - whether it be the Middle East peace agreement, the collapse of the Soviet Union, or the very real prospect of national health care.

So we are called to change and we are equipped to do it.

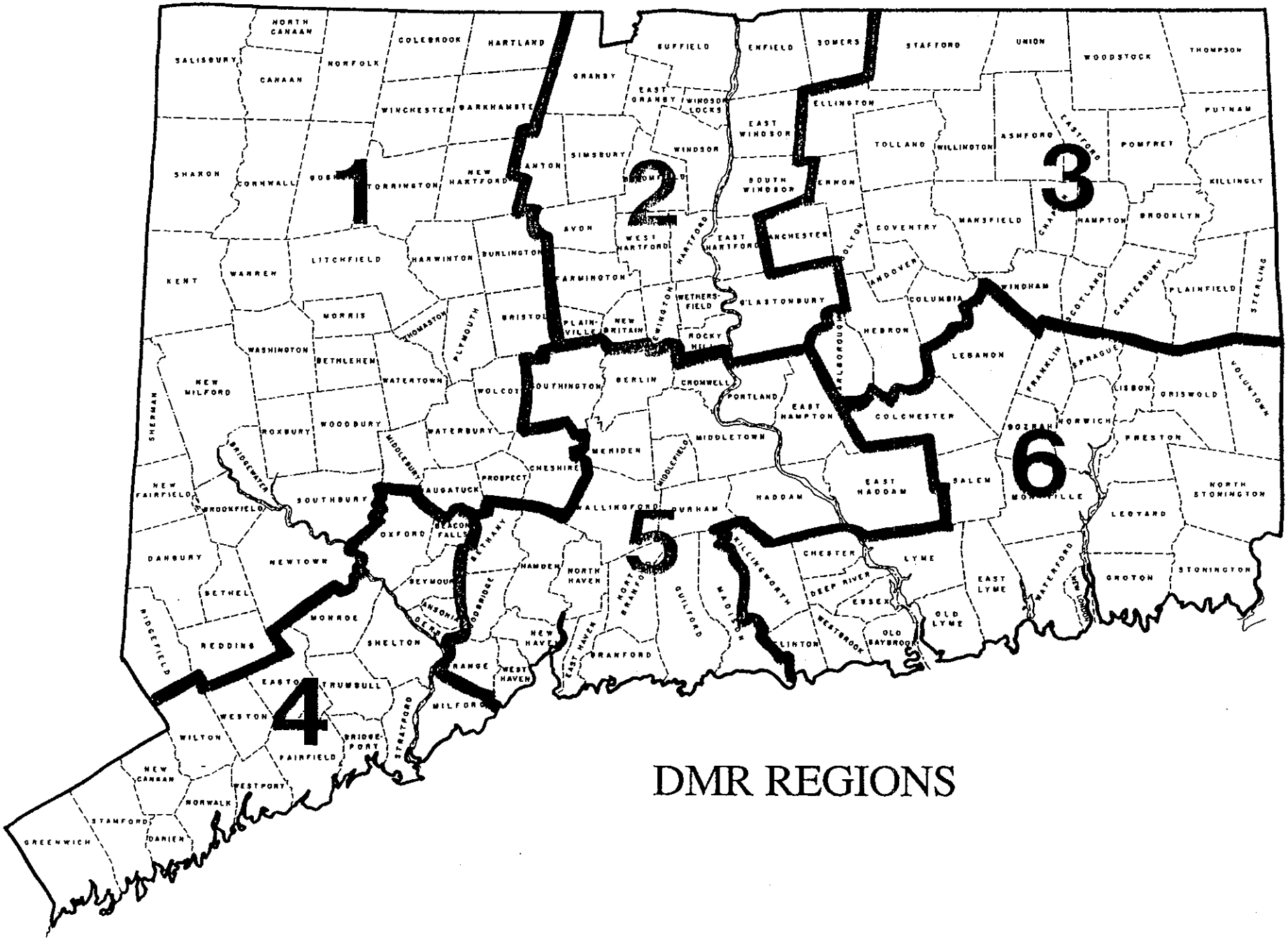
MY COMMITMENT TO PARENTS

I believe I made a commitment to parents:

- to tell you when and if this discussion became necessary. And I believe it is now necessary
- to include you in this process; to not make decisions about you without you
- to move people only when we have appropriate alternatives. But I need to know now what it will take to make those alternatives available.

I am not willing to risk:

- that litigation, whether USJD or some individual action, will overtake us. And remember we now have a progressive new federal administration; with appointments of people like Judy Heumann to the Office of Special Education & Rehabilitation Services and Bob Williams, whose parents were once advised to place him at MTS, to the Commission on Developmental Disabilities



DMR REGIONS

APPENDIX C

APPENDIX E
WHAT'S WORKING IN THE COMMUNITY

Community Integration and Participation

- A lot more people are physically present in the community
- Private agencies that are community based bring strong ties to the community (increase chances for community acceptance)
- Immediate access to resources of town life
- In general, communities have a wider array of resources and as we learn how to harness them, can serve people better
- People with disabilities are living everywhere. More independence. Acceptance and inclusion is getting better
- There are people with substantial needs that are being met in the community

Relationships and Personal Issues

- There has been an evolution of how to support people without dominating their lives
- More people are becoming independent from the state
- There are opportunities to live close to family and friends
  - more opportunities to enjoy those relationships
  - enhances the ability of those supporters to monitor care
- A lot of people are happier in the community
- Enhanced personal freedom
- Provides opportunities to go beyond "minimal" standards to more participation, more freedom
- More integration

Staff

- Training for staff is good
- Cadre of very committed workers in both public and private sector
- Enthusiasm among workers

Supports, Services, and Options

- Ability to live in a home-like, family-like setting
- Housing in community (more options)
- Housing could be made available
- Smaller homes **can** be better if appropriate supports are in place
- All community programs (homes) have a vehicle
- People have access to jobs - some with benefits
- Ninety-nine percent of people have day programs
- Availability of Title XIX, social security, jobs, payment for doctors/health benefits
- A diverse group of community medical providers
- Public transportation (where available) is a positive

Private Sector

- Private providers have small autonomous boards of directors that oversee programs
- System of care between state and private group homes is the same (private sector tends to be more innovative)
- Private sector can develop placements faster than state

- Not enough doctors, specialists, dentists
- Difficulty getting doctors to accept Title 19
- Physicians not in place for clients with known needs as they move into community
- Many group homes are "in the woods" (rural areas) making integration difficult
- Lack of adequate access and funding for mental health services
- Not adequate support for individuals who present very significant behavior problems (need expertise to consult with)
- If a client is "difficult" behavior problem, it is very difficult to move the client
- If a dually diagnosed individual needs to be moved out to the community, it is difficult

Financial Concerns

- Rents for houses are too high
- Some agencies merge client funds into one joint account contrary to DMR policy
- "I" don't believe there should be "for profit" group homes
- Funding process may result in reduced client care
- Duplication of services/purchases (salaries of all the directors of group homes)
- C.I.L. making too much money (politicians in the middle)
- Contracting system still does not allow real self-determination (results in too much movement to group homes)
- Financial failures of some group homes

APPENDIX H
Full Text on Clients' Rights for Inclusion in The "Principles" Section

Like all citizens, the residents of Southbury Training School have certain civil and human rights that are implicitly recognized in law. However, because the rights of people who have disabilities have not always been respected to the same extent as those of typical people, specific legal and policy protections have been established which explicitly define particular rights of people who receive services from the Department of Mental Retardation. These rights are principally enumerated in Sections 17a-210(b) through (d), and 17a-238 of the Connecticut General Statutes; and in DMR Policies #1-13. Taken together, the rights declared in these documents describe a resident's entitlement to safe, decent, and fair treatment from the department, and place limits on the degree to which the service system may employ intrusive programming practices or allow administrative exigencies to arbitrarily disrupt individual lives. Just as important, these explicit statements of rights also affirm the individuality and humanity of each resident.

It is axiomatic that all planning for the downsizing and ultimate closing of Southbury must respect both the letter and the spirit of these laws and policies. This means, among other things, that individual identities and needs must drive program development, that residents and their personal representatives must be fully involved in transition planning, and that enhancing and protecting each resident's status as a valued citizen must be understood as a primary planning goal.

Jim McGaughey

APPENDIX J
Minority Opinion Recommendation #41

Some members of the committee believed strongly that the initiative to develop community placement programs for individuals at STS who wish to leave should **not** be limited to state-run programs. In these members' view, programs should be expanded to include privately run programs so that STS residents can have the maximum array of available choices to best address their individual needs. Other members of the committee were willing to support the initiative as drafted, but only if it were explicit that exclusive reliance on state-run programs not be assumed as the model under which all STS residents would receive the opportunity to live in the community.

These members would suggest that the Department of Mental Retardation submit legislation which would:

1. Provide sufficient fiscal resources to allow for community placement, in a combination of state and private operated programs, of individuals currently residing at STS who wish to leave or whose guardians wish them to leave STS.

2. Establish the special Panel of Monitors (recommendation #41) to oversee the planning and placement in the community of the above referenced group from STS.

3. Require a progress report from the Monitors to the commissioner of DMR on a quarterly basis on all aspects of the planning and development of facilities and programs and the moves of the STS residents.

Submitted by Thomas Fanning, Michael Richards, Jean Bowen, James McGaughey, James McCann, and David Hadden

SOUTHBURY TRAINING SCHOOL
COMMUNITY RESIDENTIAL AND DAY SERVICES
COST AND REVENUE PROJECTIONS

LEVEL PLACEMENT RATE

PLANNED NEW PLACEMENTS BY FISCAL YEAR	(1) FY 94		(2) FY 95		(3) FY 96		(4) FY 97		(5) FY 98		(6) FY 99		(7) CUMULATIVE COST OF FIVE YEARS	(8) RECURRING ANNUAL COST	
RESIDENTIAL PROGRAMS			BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	(columns 2–6)		
CLA–ICF			51	$344.88	51	$356.51	51	$368.75	51	$381.41	51	$394.50			
CLA–WAIVER			77	$290.22	77	$300.18	77	$310.49	77	$321.15	77	$332.17			
SUPPORTED LIVING			16	$86.22	16	$89.18	16	$92.24	16	$95.41	16	$98.69			
CTH			16	$44.55	16	$46.08	16	$47.66	16	$49.30	16	$50.99			
TOTAL RESIDENTIAL			160	$262.61	160	$271.63	160	$280.95	160	$290.60	160	$300.57			
DAY PROGRAMS			160	$40.28	160	$41.67	160	$43.10	160	$44.58	160	$46.11			
PLACEMENT COSTS BY YEAR	BEDS	COST	BEDS	COST	BEDS	COST	BEDS	COST	BEDS	COST	BEDS	COST		BEDS	COST
CLA–ICF			51	$3,164,119	102	$9,909,170	153	$17,113,652	204	$24,801,161	255	$32,996,373	$87,984,475	255	$37,979,194
CLA–WAIVER			77	$4,022,408	154	$12,597,103	231	$21,755,851	308	$31,528,651	385	$41,946,871	$111,850,885	385	$46,281,318
SUPPORTED LIVING			16	$248,315	32	$777,655	48	$1,343,050	64	$1,946,353	80	$2,589,499	$6,904,872	80	$2,980,543
CTH			16	$128,312	32	$401,839	48	$693,997	64	$1,005,743	80	$1,338,078	$3,567,970	80	$1,540,142
DAY PROGRAMS			160	$1,160,190	320	$3,633,404	480	$6,275,078	640	$9,093,864	800	$12,098,810	$32,261,347	800	$13,925,869
TOTAL RESIDENTIAL AND DAY				$8,723,344		$27,319,171		$47,181,629		$68,375,773		$90,969,631	$242,569,549		$104,707,062
COSTS OF OTHER RECOMENDATIONS				ANNUAL COST		ANNUAL COST		ANNUAL COST		ANNUAL COST		ANNUAL COST			ANNUAL COST
TRANSPORTATION				$90,830		$281,635		$485,394		$703,021		$935,431	$2,496,312		$1,074,420
ADVOCATES				$252,000		$252,000		$252,000		$252,000		$252,000	$1,260,000		$252,000
GUARDIANSHIP				$188,880		$188,880		$188,880		$188,880		$188,880	$944,400		$188,880
LONGITUDINAL STUDY				$110,000		$110,000		$110,000		$110,000		$110,000	$550,000		$110,000
EXTERNAL MONITOR PANEL				$250,000		$250,000		$250,000		$250,000		$250,000	$1,250,000		$250,000
COMMUNITY PRC				$10,000		$20,000		$30,000		$40,000		$50,000	$150,000		$50,000
COMMUNICATION TECHNOLOGY				$67,500		$4,500		$4,500		$22,500		$22,500	$121,500		$22,500
MEDICAL SERVICES TRACKING				* $0									$0		
HMO CONSULTANT				$100,000		**							$100,000		
ACDD TRAINING				$20,000									$20,000		
TEMPORARY SUPPORT (032) FUNDS				$40,000		$60,000		$80,000		$100,000		$120,000	$400,000		$100,000
QUALITY ASSURANCE				$33,067		$66,133		$99,200		$132,267		$165,333	$496,000		$165,333
TOTAL OTHER COSTS				$1,162,277		$1,233,149		$1,499,974		$1,798,668		$2,094,145	$7,788,212		$2,213,133
TOTAL RESIDENTIAL AND DAY				$8,723,344		$27,319,171		$47,181,629		$68,375,773		$90,969,631	$242,569,549		$104,707,062
OTHER COSTS				$1,162,277		$1,233,149		$1,499,974		$1,798,668		$2,094,145	$7,788,212		$2,213,133
COMMUNITY COSTS–GROSS		$0		$9,885,621		$28,552,320		$48,681,603		$70,174,441		$93,063,775	$250,357,761		$106,920,195
LESS REIMBURSEMENTS		$0		($4,043,698)		($12,526,284)		($21,619,594)		($31,331,001)		($41,673,724)	($111,194,300)		($47,945,027)
TOTAL COMMUNITY COSTS–NET	0	$0	160	$5,841,924	320	$16,026,036	480	$27,062,010	640	$38,843,440	800	$51,390,052	$139,163,461	800	$58,975,169
STS EXPENDITURES–GROSS		$93,222,078		$92,100,862		$76,072,459		$57,482,208		$37,526,310		$16,236,091	$279,417,930		$0
LESS REIMBURSEMENTS		($17,177,922)		($15,990,329)		($12,866,469)		($9,503,286)		($5,897,626)		($2,033,327)	($46,291,037)		$0
TOTAL STS EXPENDITURES–NET	900	$76,044,156	724	$76,110,533	547	$63,205,990	370	$47,978,922	194	$31,628,684	17	$14,202,763	$233,126,893	0	$0
TOTAL COST–GROSS		$93,222,078		$101,986,483		$104,624,779		$106,163,811		$107,700,751		$109,299,866	$529,775,691		$106,920,195
LESS ALL REIMBURSEMENTS		($17,177,922)		($20,034,026)		($25,392,753)		($31,122,880)		($37,228,627)		($43,707,051)	($157,485,337)		($47,945,027)
TOTAL COST–NET	900	$76,044,156	884	$81,952,457	867	$79,232,027	850	$75,040,931	834	$70,472,124	817	$65,592,815	$372,290,354	800	$58,975,169

NOTES: Projected costs for both Southbury and community placements include both current direct operating expenses and capital expenses. Worker's compensation and allocated costs have been removed as they apply equally to either option. Both expense and revenue projections have been adjusted by the projected average increase in the CPI.

* Funding for investigation of possible fraud in medical services delivery was considered outside the scope of this budget.

** The need for funding in subsequent years will be determined by the results of the consultant's study.

Report: STS5YLPP.WK1

APPENDIX L

SOUTHBURY TRAINING SCHOOL
COMMUNITY RESIDENTIAL AND DAY SERVICES
COST AND REVENUE PROJECTIONS

VARIABLE PLACEMENT RATE

PLANNED NEW PLACEMENTS BY FISCAL YEAR	(1) FY 94		(2) FY 95		(3) FY 96		(4) FY 97		(5) FY 98		(6) FY 99		(7) CUMULATIVE COST OF FIVE YEARS (COLUMNS 2–6)	(8) RECURRING ANNUAL COST	
RESIDENTIAL PROGRAMS			BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM	BEDS	AVERAGE PER DIEM			
CLA–ICF			24	$344.68	48	$356.51	64	$368.75	64	$381.41	55	$394.50			
CLA–WAIVER			36	$290.22	72	$300.18	96	$310.49	96	$321.15	85	$332.17			
SUPPORTED LIVING			8	$86.22	15	$89.18	20	$92.24	20	$95.41	17	$98.69			
CTH			7	$44.55	15	$46.08	20	$47.66	20	$49.30	18	$50.99			
TOTAL RESIDENTIAL			75	$262.96	150	$271.70	200	$281.02	200	$290.67	175	$300.16			
DAY PROGRAMS			75	$40.28	150	$41.67	200	$43.10	200	$44.58	175	$46.11			
PLACEMENT COSTS BY YEAR	BEDS	COST	BEDS	COST	BEDS	COST	BEDS	COST	BEDS	COST	BEDS	COST		BEDS	COST
CLA–ICF			24	$1,488,997	72	$6,203,258	136	$13,938,721	200	$23,327,013	255	$32,704,439	$77,662,429	255	$37,979,194
CLA–WAIVER			36	$1,880,606	108	$7,834,728	204	$17,604,635	300	$29,462,067	385	$41,465,255	$98,237,292	385	$48,261,318
SUPPORTED LIVING			8	$124,157	23	$501,195	43	$1,106,448	63	$1,840,926	80	$2,571,243	$6,143,969	80	$2,980,543
CTH			7	$56,137	22	$242,164	42	$554,340	62	$933,271	80	$1,319,210	$3,105,121	80	$1,540,142
DAY PROGRAMS			75	$543,839	225	$2,265,669	425	$5,090,959	625	$8,519,925	800	$11,970,859	$28,391,252	800	$13,925,886
TOTAL RESIDENTIAL AND DAY				$4,093,737		$17,047,014		$38,295,103		$64,083,202		$90,021,006	$213,540,062		$104,707,082
COSTS OF OTHER RECOMENDATIONS				ANNUAL COST		ANNUAL COST		ANNUAL COST		ANNUAL COST		ANNUAL COST			ANNUAL COST
TRANSPORTATION				$42,677		$176,022		$394,383		$659,082		$925,687	$2,197,751		$1,674,420
ADVOCATES				$252,000		$252,000		$252,000		$252,000		$252,000	$1,260,000		$252,000
GUARDIANSHIP				$188,880		$188,880		$188,880		$188,880		$188,880	$944,400		$188,880
LONGITUDINAL STUDY				$110,000		$110,000		$110,000		$110,000		$110,000	$550,000		$110,000
EXTERNAL MONITOR PANEL				$250,000		$250,000		$250,000		$250,000		$250,000	$1,250,000		$250,000
COMMUNITY PRC				$4,688		$14,063		$28,563		$39,063		$50,000	$134,375		$50,000
COMMUNICATION TECHNOLOGY				$67,500		$4,500		$4,500		$22,500		$22,500	$121,500		$22,500
MEDICAL SERVICES TRACKING				* $0									$0		
HMO CONSULTANT				$100,000		**							$100,000		
ACDD TRAINING				$20,000									$20,000		
TEMPORARY SUPPORT (032) FUNDS				$18,750		$46,875		$78,125		$103,125		$121,875	$368,750		$100,000
QUALITY ASSURANCE				$15,500		$46,500		$87,833		$129,167		$165,333	$444,333		$165,333
TOTAL OTHER COSTS				$1,069,894		$1,088,840		$1,392,283		$1,753,817		$2,086,275	$7,391,109		$2,213,133
TOTAL RESIDENTIAL AND DAY				$4,093,737		$17,047,014		$38,295,103		$64,083,202		$90,021,006	$213,540,062		$104,707,082
OTHER COSTS				$1,069,894		$1,088,840		$1,392,283		$1,753,817		$2,086,275	$7,391,109		$2,213,133
COMMUNITY COSTS–GROSS		$0		$5,163,631		$18,135,854		$39,687,387		$65,837,019		$92,107,281	$220,931,171		$106,920,195
LESS REIMBURSEMENTS		$0		($1,915,772)		($7,823,661)		($17,559,205)		($29,377,292)		($41,245,734)	($97,921,664)		($47,945,027)
TOTAL COMMUNITY COSTS–NET	0	$0	75	$3,247,859	225	$10,312,193	425	$22,128,182	625	$36,459,726	800	$50,861,547	$123,009,507	800	$58,975,169
STS EXPENDITURES–GROSS		$93,222,078		$95,899,153		$84,391,788		$64,652,776		$40,987,353		$17,003,181	$302,934,251		$0
LESS REIMBURSEMENTS		($17,177,922)		($16,934,202)		($14,934,294)		($11,285,152)		($6,757,697)		($2,223,952)	($52,135,297)		$0
TOTAL STS EXPENDITURES–NET	900	$76,044,156	809	$78,964,951	642	$69,457,494	425	$53,367,624	209	$34,229,656	17	$14,779,229	$250,798,954	0	$0
TOTAL COST–GROSS		$93,222,078		$101,062,784		$102,527,642		$104,340,163		$106,824,371		$109,110,462	$523,865,423		$106,920,195
LESS ALL REIMBURSEMENTS		($17,177,922)		($18,849,974)		($22,757,956)		($28,844,357)		($36,134,989)		($43,469,686)	($150,056,962)		($47,945,027)
TOTAL COST–NET	900	$76,044,156	884	$82,212,810	867	$79,769,687	850	$75,495,806	834	$70,689,382	817	$65,640,777	$373,808,461	800	$58,975,169

NOTES: Projected costs for both Southbury and community placements include both current direct operating expenses and capital expenses. Worker's compensation and allocated costs have been removed as they apply equally to either option. Both expense and revenue projections have been adjusted by the projected average increase in the CPI.

* Funding for investigation of possible fraud in medical services delivery was considered outside the scope of this budget.

** The need for funding in subsequent years will be determined by the results of the consultant's study.

Report: STS5YVRP.WK1

APPENDIX M

STS PLANNING COMMITTEE MEMBERS

Arc of Connecticut	James McCann, Executive Director, Central Connecticut ARC
Board of Trustees	Dr. Philip Bondy, Board of Trustees member, parent Irving Sloan, Chairman, Board of Trustees, parent
Connecticut Association of Residential Facilities	Michael Richards, Executive Director, Institute for Professional Practice
Connecticut Community Providers Association	Thomas Fanning, Executive Director, DATAHR, Inc.
Connecticut Employee Union Independent	Steven Perruccio, President, CEUI
Connecticut State Employees Association	Doreen DelBianco, staff representative, CSEA
Governor's Council on Mental Retardation	J. C. David Hadden, Esq., parent
FORConn	Louis Richards, FORConn member, parent
District 1199—New England Health Care Employees Union	Ron Dwyer, union delegate, SMRW2 Loretta Ezarsky, union delegate, Case Manager
Home and School Association	Sally Bondy, President, Home and School Association, parent Ann Dougherty, Secretary Pro Tem, sister
Office of Protection & Advocacy for Persons with Disabilities	James McGaughey, Acting Assistant Director, P&A
People First	Kathy Juni, President, People First Ben Paige, Self Advocate
DMR Regional Directors	Steven Staugaitis, Director, Region 1 Linda Underwood, Director, Region 4
STS Director	Thomas Howley, Director, STS
Southbury Foundation	Hilda Sloan, Board member, parent Anne Rotzal, Board member, parent
WeCAHR	Jean Bowen, Executive Director, WeCAHR
Meeting Facilitator	Larry Fox, consultant, Lawrence S. Fox and Associates
Committee Coordinators	Beth McArthur, DMR, Director of Planning and Development Terry Cote, DMR, Director of Program Development John Howard, STS, Director of Residential Programs
OPM Support to the Committee	John Bacewicz, OPM, Fiscal and Program Policy Director Don Perrault, OPM, Associate Budget Specialist