CHAPTER 5

TASK FORCE RECOMMENDATIONS

Deinstitutionalization is much more than moving people from one place to another. A major portion of the efforts of the Residential Services Task Force were focused on ways of making the community service system stronger. Without a strong community service system with a full array of services, deinstitutionalization cannot take place. In order to reach this goal, the Residential Services Task Force makes the following recommendations:

1. The five year plan for the development of community-based alternatives to institutional care is the most feasible.

2. Funding should follow the individual, not the program. Greater flexibility is needed to meet the needs of individuals.

3. Anyone eligible for services through the DMHDD should receive individual/family management and support (independent case management) services.

4. Programs should be regionalized so that people who need services can maintain contact with their families and culture.

5. Regional Client Program Managers should be placed in Juneau, Anchorage and Fairbanks.

6. A system of independent case management through individual/family management and support services should be established for all those eligible for DMHDD services.

7. The State's definition of "developmental disability" should be the same as the federal definition.

8. The State should promulgate comprehensive administrative regulations which include program standards.

9. The State should develop a complete service array, including community services for people who are non-ambulatory, have low self-help skills or behavior problems.

SERVICE PRINCIPLES

In developing this implementation plan and planning for services for people with developmental disabilities, the following service principles were used. These principles are consistent with federal developmental disabilities and special education legislation and the principle of normalization. The planning principles are:

1. Services must be dispersed geographically within the state.

2. Services for people with developmental disabilities should be specialized or specially adapted services which are available to the general public.

3. Services must be designed to maximize individual potential.

4. Services must be designed to minimize institutionalization.

5. Services must be provided in the least restrictive setting, enabling a person to live as normally as possible.

6. Services should be provided by the generic agencies which provide such services or similar services to the general public.

7. Services should be directed toward the social, personal, physical, or economic habilitation of individuals with disabilities.

POLICIES AND IMPLEMENTATION STRATEGIES

The policy recommendations set forth by the Task Force provide a framework for implementation of services in accordance with these statutory principles. Specific policies must be developed or adopted by the Department of Health and Social Services' Developmental Disabilities Program in the areas of:

1. FUNDING
2. REGIONALIZATION
3. CASE MANAGEMENT
4. ELIGIBILITY
5. QUALITY ASSURANCE

Policv Recommendation #1: FUNDING

Policy 1 .a. Funding should entitle all individuals who are developmentally disabled and their families to receive special services.

Policy I .b. Funding should follow the client on a per client basis.

Policy 1 .c. Funding should empower individuals and families.

Policy 1 .d. Funding should provide for independence and for choice.

Policy 1 .e. Funding should promote diversification and individualization of services.

Pol icy 1 . f. Funding should encourage innovation and adaptation of generic services.

Rationale:

Current funding policy is tied to programs rather than individuals. If a person who is developmentally disabled does not fit into an existing program, he/she is not provided services. All people with substantial disabilities should be entitled to receive State services once they have been determined to meet eligibility criteria. With flexibility in funding policy, services could be developed based on the needs of individuals.

A major concern of parents is the lack of assessment and monitoring of community based programs. Currently, programs funded by the Division of Mental Health and Developmental Disabilities receive a site review annually. These reviews are generally paper audits designed to measure grant or contract compliance, not program quality. By designating 2% of the developmental disabilities budget for monitoring, quality assurance, and related activities (an additional 2% over program budget), the non-profit service providers could form a partnership with the State in improving program quality . If the State cannot employ personnel to carry out program monitoring and quality assurance, then the state should contract for these services. This approach has been successful in other states. Programs cannot be held accountable for higher standards if they are not supported in their efforts to attain those standards.

If this plan is accepted and implemented, there will be a more diverse and regionalized service system than there is at the present. However, the State could sponsor people will still need very specialized services. By designating 2% of the developmental disabilities budget for growth and development (an additional 2% over program budget), pilot programs to provide community based service to people who previously were denied services or were served without success.

Imblementation Strategies:

1. The State could provide individual and family subsidies for basic needs, such as, health and support services and material support. A program should be established as a pilot project in one Level II community and one Level I I I community. Level II and Level I I I communities have less access to services than do people in larger communities, such as Anchorage and Fairbanks. The Regional Developmental Disabilities Coordinators would be responsible for intake and eligibility screening. Initially, 50 - 100 individuals and their families would be served. Eventually, 400 - 500 people would be served statewide.

2. The State could provide $2000/year for each person eligible for developmental disabilities services for individual/family management and support services (independent case management).

3. The State could establish regional RFPs for new services. Service needs should also be determined and prioritized on a regional basis.

4. Grants should specify increments of service of 5, 10, and 20 individuals.

5. Residential program guidelines should specify "not more than 5 people per residence”.

6. Vocational program guidelines should specify "not more than 8 per setting”.

7. Educational (adult/continuing education) guidelines should be developed specifying maximum number of people per environmental setting.

8. Initially, Level II and Level I II regional centers should be targeted for service development.

9. Existing providers should be encouraged to form joint cooperative ventures with rural, regional corporations to bid for transitional or interim start-up grants.

10 As services develop in Level I I and Level I I I regional centers, people currently receiving services in Anchorage or Valdez can move closer to their community of meaningful tie. On a long-term basis this means Anchorage agencies will serve Anchorage residents to a much greater extent than is presently possible.

11. The State should earmark a fixed percentage (2%) of the DMHDD community services budget for monitoring, quality assurance, technical assistance, and other related activities.

12. The State should fund existing non-profit programs and services that meet grant requirements, program standards, licensure laws/regulations, compliance reports and audit reviews.

13. A percentage (2%) of the DMHDD community services budget should be earmarked for pilot programs, demonstration and training projects.

14. A budget planning process should be instituted that includes a pre-planned budgetary cycle, the development of an actual "needs oriented" budget, and a hearing/appeals process based on programmatic need.

15. Guidelines should be designed for legitimate, allowable costs, or, a "pass-through" process.

Policy Recommendation #2: REGIONALIZATION

Policy 2 .a. Before program development is undertaken in any region, potential service providers will be required to present, as part of the grant process, a report that details: 1) the services available in the region; 2) the existing organizational infrastructure; and 3) the readiness of communities within the region for the proposed services.

Policy 2. b. In program development, partnerships will be formed with the regional health corporations and/or other local agencies currently providing services in the region. Program development will be based on the needs and wants of the people in the region and in individual communities. Programs will be administered by organizations located within the region.

Policy 2 .c. The initial focus of program development in rural regions will be programs for children and families.

Policy 2.d. People living in residential programs outside their home region will have the option return to their home region on an individual basis after a support system is established.

Policy 2 .e. Program development will follow the levels of care construct found in the Governor's Council for the Handicapped and Gifted State Plan of Services. This constant represents the minimum service array recommended for each level of community. (See Appendix H)

Rationale:

Many successful programs and service providers now operate in rural regions. The Regional Health Corporations have provided primary health care to people in rural regions for many years. The Indian Child Welfare Act, which is administered by Alaska Native social service agencies, had the effect of empowering tribes in providing Alaska Native children with foster and adoptive Alaska Native families. It has led to issues regarding children and family problems being discussed at the village level. The villages make decisions about the well being of individual children and children as a group. The Indian Child Welfare Act has led to Village Councils directing their non-profit associations to direct their resources toward advocacy, training and child welfare services. These include the development of child foster care and adoptive homes.

In working cooperatively with these programs, service providers for people with developmental disabilities could learn about effective service delivery and be identified with programs that are accepted. A service system designed around the needs of children can grow into a system serving people of all ages.

People with disabilities living in rural areas generally have to leave their home regions when they need residential or vocational services. Many of the people living at Harborview or in nursing homes left their village or community as children and have grown up in institutions. In order to stop the flow of children and young adults from rural areas, programs that provide support to families and residential alternatives need to be established. These programs include family subsidies, case management, respite, specialized foster care, shared care and other residential alternatives.

The levels of care construct provides, a reasonable framework for service development. A service system based on the levels of care concept would provide people with services in their home communities or in subregional or regional centers. People with developmental disabilities could maintain contact with their culture, family and community.

Program development in rural areas must come from within each community. In the past, many programs developed for urban populations were imposed on the people of rural regions. Often people were not asked if they wanted or needed the services. A result in some cases was unacceptable services which were not used or were used inappropriately and which were resented by the local people.

If programs for people with developmental disabilities are to be provided in the state's rural regions, it is essential that they be developed when communities are ready for and want them.

Implementation Strategies:

1. Prior to the implementation of any of the recommendations in this plan, the local program and funding agency will ascertain the readiness of each region for the recommended services. If there is any indication that the services are not appropriate at that time, the possibility of alternate services will be discussed

2. Specialized Foster Care and Shared Care Programs should be associated with Indian Child Welfare Act agencies.

3. Initial focus for service development in the North, Northwest, West and Southwest regions should be respite services, individual case management, and specialized foster care and shared care.

4. Program development will take place with the guidance and concurrence of local decision makers, including regional health corporations, local service providers and village councils and elders.

5. Grants should be reviewed by regional Proposal Evaluation Committees (PECs).

Policy Recommendation #3: CASE MANAGEMENT

Policy 3.a. The State is responsible for directly providing case management as it relates to determining eligibility for services, referral to appropriate programs and determining the service array required to meet the needs of those eligible for service. Case management should include individuals involved in generic services who meet eligibility criteria for developmental disability services, especially infants and young children living in nursing homes, the Neonatal Intensive Care Unit at Providence Hospital, and the Alaska Native Medical Center and "high risk" newborns identified by other providers.

Policy 3.b. The State is responsible for developing individual/family management and support services, through grant, contract or purchase of service agreement. Any person who is eligible for services for people with developmental disabilities is entitled to individual/family management and support services.

Rationale:

The State's responsibility for case management should include determining eligibility, referring to appropriate services and determining the service array required to meet the needs of people eligible for services. Currently, the single Client Program Manager is little more than an official gatekeeper, determining eligibility for programs often on the basis of information provided by the potential service provider. Little information is collected on individuals who have not yet entered the service system, therefore making it extremely difficult to plan for needed services.

With the growth in the system of services for people with developmental disabilities, it is clearly impossible for one centrally located person to perform all of the functions of a Client Program Manager. Regionalization of this function makes sense in light of the increasing regionalization of services.

In addition, the Division of Mental Health and Developmental Disabilities should develop a management information system in order to adequately handle program grant information, client information and more complete information on people on the Division's waiting lists and/or eligible for services.

Individual/Family Management and Support (IFMS) workers will act as the individual's advocate in acquiring services. The IFMS services will be independent. That means they will not be associated with a service provider or the State in order to avoid conflict situations and to insure that all services available to the general public are utilized to the maximum extent possible. These services should be available to all those eligible for Division services and will be required under the "Medicaid Home and Community Quality Services Act".

Implementation Strateqies:

(1) Regional Client Program Managers should be located in Juneau, Anchorage and Fairbanks.

(2) The State should develop a client information system that includes information on all people deemed eligible for services.

(3) The State should initially provide $2000 for each person on the waiting list for individual/family management and support (independent case management) services. These funds can be contracted out to IFMS workers who are not employed by the State or any service provider.

Policy Recommendation #4: ELIGIBILITY

Policy: The State's definition of "developmental disability" should be the same as the current federal definition.

Rationale:

The State definition of a developmental disability (A.S. 47.80) is considered "categorical". In order to qualify for services, a person must have mental retardation, autism, cerebral palsy, or epilepsy and be substantially handicapped in terms of functioning normally in society. It is also required that the impairment originate during childhood, prior to the age of 22.

The federal definition is "functional" in nature. A person must have substantial functional limitations in three or more major life activities, including: 1) self-care; 2) receptive and expressive language; 3) learning; 4) mobility; 5) self-direction; 6) capacity for independent living; and 7) economic self-sufficiency. This is generally a larger group than those qualifying under the "categorial" definition. Individuals who are deaf or have impairments due to muscular dystrophy or cystic fibrosis would be eligible under the federal definition as long as they have substantial functional limitations. The impairment is required to have originated prior to the person's twenty-second birthday.

The change would alleviate problems encountered by programs and the State when applying for federal monies for services. Non-profits applying for federal funds must prove that they will provide services to all people who are eligible under the federal definition.

Implementation Strateqy:

The Alaska State Legislature should amend A.S. 47.80.900(7) to the definition of developmental disabilities found in P. L. 100-l 46.

Policy Recommendation #5: QUALITY ASSURANCE

Policy 5.a. The State should promulgate comprehensive administrative regulations which include program standards for programs funded by the Division of Mental Health and Developmental Disabilities.

Policy 5. b. Requests for Proposals for services funded by the Division of Mental Health and Developmental Disabilities should include descriptions of the services required and be accompanied by a copy of the Division of Mental Health and Developmental Disabilities administrative regulations as a reference to program standards.

Policy 5 .c. Licensure standards for Adult Residential Care Facilities should be revised to incorporate program standards included in administrative regulations for programs funded by the Division of Mental Health and Developmental Disabilities.

Policy 5.d. Licensure of Adult Residential Care Facilities should take into consideration individual habilitation planning requirements.

Rationale:

Administrative regulations are needed that set forth program standards for all services funded by the Division at Mental Health and Developmental Disabilities. Currently, there are no such regulations.

Minimum standards should be established for even the least restrictive settings (specialized foster care/shared care, apartment programs, independent living support services) funded by the Division. Boarding homes must be included in the development of program standards. They are home for a substantial number of people who have developmental disabilities and are the least monitored part of the service system.

Licensure regulations as administered by the Division of Family and Youth Services (DFYS) must be linked to the program standards,especially those relating to habilitation planning, developed for programs funded by the Division of Mental Health and Developmental Disabilities. Current licensure standards require that residents of group home facilities be supervised at all times. For individuals who are preparing for semi-independent or apartment living, it is important that they learn how to spend time alone prior to their placement in the more independent setting. This preparation is not possible with the current regulations.

Implementation Strategies:

Regulations should be promulgated and include the following:

1. Individual client rights
2. Program standards for:
   a. Case Management
   b. Respite

c. Specialized Foster Care
d. Shared Care
e. Boarding Homes
f. Group Homes
g. Apartment/ Independent Living
h. Vocational Support Services
3. Accessibility of Program Facilities
4. Eligibility for services
5. Appeals Process
6. Program review process
a. Internal audit
b. Site review
c. Financial audit
d. Peer review
7. Sanctions for Programs Not Meeting Standards
8. Standardized Habilitation Plan Requirements

Also, the State should amend DFYS regulations to incorporate standards developed for developmental disabilities programs, especially those relating to individual habilitation planning requirements.

COMMUNITY SERVICES

In order provide comprehensive residential and day services to people with developmental disabilities, the Residential Services Task Force recommends that the following service array be developed. These services are based on the service array in the Council's State Plan of Services. The services listed below are those needed by people living in institutions and on the DMHDD waiting list and not the complete array developed for the plan.

CASE MANAGEMENT SERVICES

Individual/ Family Management and Support Services - Advocacy, counseling and crisis intervention provided by someone not associated with the state funding agency or a service provider. The purpose of IFMS is to ensure that individuals receive needed services and that there is accountability and continuity. The State may wish to provide for these services through regionalized Requests for Proposals or through small contracts administered by the Regional Client Program Managers.

RESIDENTIAL PROGRAMS

Supported Living Services - Independent living assistance with on-going support and training; services to increase community participation with intermittent training to accommodate changing life circumstances. Programs included are apartment or semi-independent living programs, follow-along services, personal care attendant services and family subsidy programs. Staff require formal training.

Supported Board and Care - Board and care with targeted training. One or two people live with an individual or family or in a boarding home and receive training from outside program staff. Board and care family or staff do not require special training.

Specialized Foster Care/Shared Care - One or two people with developmental disabilities living with a family in which the parents provide the training and care with periodic support from outside program staff. Foster families require some formal training.

Group Homes - Family-like setting providing supported community living for children and adults. Staff may live in or be employed on a shift basis. Program depends on the mobility, medical and behavioral programming needs of the people living in the residence. Types of group homes, based on focus of services, are:

1. Developmental Learning Services - Support and training for children, youth and adults. Structured training and supervision with emphasis on life skills development and refinement. From one to five individuals live with one or two (couple) people and relief staff. Staff require some formal training.

2. Developmental Learning/ Intensive Care Services - Environments with high staff/client ratio to accommodate individuals who are non-ambulatory, non-verbal or who need significant assistance with daily living activities. Behavioral programming, as needed. One to five people live with staff trained in working with people with physical disabilities and behavioral management techniques.

3. Intensive Training/ Behavioral Programming Services - Structured environment with a high staff/client ratio and high level of intensity for individuals with extraordinary behavior problems. Management of every interaction, contingency management, heroic and explicit intervention. One to five people live with staff who are highly trained in behavior management.

4. Intensive Training/Medical Programming - Medical model program organized by health care professionals. Program eligible for Intermediate Care Facility for the Mentally Retarded (ICF/MR) funding. Ideal size of program is five people. Clear developmental training programs primarily directed at self-care and social skills. Because of the extent of the personal care and health maintenance needs of the residents, most services are brought to the facility rather than taking place in the community.

5. Intermediate Care Facility (ICF) - Nursing home care for people requiring regular medical/physical services and monitoring, 24-hour nursing care and therapy services. The emphasis of intermediate care is to prevent deterioration and maintain maximum functioning level.

6. Psychiatric or Correctional Facility - Psychiatric or correctional facility care for individuals whose primary problems are mental illness or criminal offenses and who require specialized care and treatment because they are a danger to themselves or others.

DAY PROGRAMS

Infant Learning Programs - Early identification, intervention and training using the family as the primary teacher and provider. Services designed to encourage the mental and physical development of infants and toddlers in order to reduce the long-term effects of handicapping conditions.

Public School/Special Education - Public education geared to the special needs of exceptional children between the ages of 3 and 22. An Individualized Education Plan (IEP) based on the recommendations of people involved with the child (teachers, parents, therapists, and, if possible, the child), is mandated by P.L. 94-142.

Vocational Support Services - Supported employment is paid employment, Integrated rn the community , for which a person receives initial and on-going support and training to gain and/or maintain that employment. Support can be provided in any of the following ways:

1. Individual Placement - Employment with public or private employers.

2. Enclave - A group of eight or fewer people with developmental disabilities trained and supervised within a business, working among non-handicapped workers.

3. Mobile Work Crew - A group of eight or fewer people with developmental disabilities performing service jobs at sites throughout the community. Staff for enclaves and work crews are similar and depend on the location and type of job.

4. Benchwork - Paid employment in a service agency which also functions as a business enterprise. Work is performed in the program's own workspace. Generally more intensely staffed than other vocational training programs.

Day Program - A program for those not ready for, or unable to benefit from, vocational training. Day Activity Programs also serve people who are older and retired from normal vocational activities. Structured activities are aimed at engaging the person's attention and maximizing potential developmental gains. Programs provide developmental and experiential activities not normally available in the home.

COSTS OF SERVICES (Cost/Year)

Annual costs of the following service components are based on the costs of current community based services. Client payments to programs, through Social Security or Aid to the Disabled, are not included in the annualized costs. Figures for Medicaid eligible service models (ICF, API, ICF/MR) represent only the cost to the State. The federal share is not included.

Service	Cost/Year
Individual/Family Management and Support (IFMS)	$2,000
Residential Services	
Supported Living	
Apartments	10,000
Independent Living	10,000
Follow-along	2,000
In-home Training	4,000
Supported Board and Care	6,200 - $12,775
Individualized Program (AY I Model)	47,000
Specialized Foster Care/Shared Care	
Specialized Foster Care	10,000 - 25,000
Shared Care	14,500
Group Homes	
Developmental Learning Services	
Adults	$22,000 - $35,000
Children	25,000 - 38,000
Developmental Learning/ Intensive Care	
Adults	45,000
Children	48,000
Intensive Training / Behavioral Programming	
Adults	45,000
Children	48,000
Intensive Training/Medical Programming	55,000
Intermediate Care Facility (ICF)	52,200
Psychiatric or Correctional Facility	46,050
Day Services	
Infant Learning Services	$3,000
Special Education	10,000
Vocational Support Services	
Individual Placement	5,000
Enclaves/Work Crews	10,000
Benchwork	10,000
Day Program	10,000

ONE, THREE AND FIVE YEAR PLANS

This section examines a one, three and five year approaches to deinstitutionalization for people with developmental disabilities. These plans are based on the needs of individuals living in institutions and on the DMHDD waiting list. Each person is identifiable by name.

1. Individual/Family Management and Support is the necessary first component of the transition from institutional to community-based services. IFMS workers will advocate for the individual, work as liaison between the institution and the community-based service provider and insure that the recommended placement is in the best interest of the individual.

2. Residential settings that are less restrictive (specialized foster care/shared care, supported living) can be put into place more quickly than more intensive, facility-based programs (group homes).

3. Programs can be established in areas where there are currently similar programs more quickly than in communities where there are no programs.

4. START-UP COSTS are necessary to insure high quality programs. Costs are calculated at one month of program costs in communities where there are currently programs and two months of program costs in communities where there are no programs. In addition, each group home will require approximately $20,000 for furniture, linens, kitchen equipment and other household goods.

5. PROGRAM COSTS are directly related to the costs of staffing each residential setting. Programs with higher costs have higher staff/client ratios. Costs were based on actual program costs for similar programs in Alaska and represent the average cost of the service statewide.

6. FUNDS FOR TRANSITION will be used to allow a person living in an institution to visit the community placement at least once prior to transfer. If this visitation is not possible, transition monies can be used to fund the travel of a staff member from the community program to visit the person in the institution prior to discharge.

7. TRANSPORTATION COSTS are for travel from the institution to a community program. Figures represent travel costs for the person moving to the community program and for a staff member to assist during the trip.

8. GROUP HOME CONSTRUCTION COSTS are based on plans for an accessible group home, including site costs, in Anchorage. Construction costs in rural areas and for ICF/MR style group homes are estimated at 50% over the base design costs ($400,000). Group homes will be single family type residences which are fully accessible, have sprinkler systems and meet licensing standards.

9. It is recommended that the State build and own the group home facilities and lease them to non-profit service providers. However, other options may be available in larger communities. Programs may be able to lease or purchase single-family houses which can be renovated to be accessible and to meet State licensing codes.

10. Emergency placement beds are provided in community service programs and will be contracted for by the state. These will be no-reject beds, meaning the program can not refuse to admit the person. The state will provide additional funds to the program to meet the habilitation or treatment needs of the individual. Initially, the State may choose to operate some of the programs. The State could run one program in each region, to assure that "0-reject" beds are available throughout the state and to smooth the transition for Harborview employees by making similar positions available in the State employment system.

ONE YEAR PLAN

If it were necessary, due to a fire, earthquake or flooding, to move people with developmental disabilities from Harborview Developmental Center to community based placements in one year, the following schedule could be expected for the development of programs and services. Recommended services also include placements for the nine children living in nursing homes.

The following plan assumes a standard Request for Proposals process, allowing potential grantees to organize and plan for services. it is essential that there be Regional Client Program Managers (3) in place to assist grantees in developing services and insuring that placements are appropriate and that the rights of individuals moving to community program are protected.

If program development were to take place in one year, it would not be possible to construct new facilities for group homes. Single family residences in the community would be used, primarily on a lease basis.

The Task Force includes this scenario as a one-year crisis plan. A one year transition from institutional to community based services would put great stress on already existing services in the community. It is not recommended that this plan be implemented unless it is absolutely necessary.

ONE YEAR PLAN COSTS

Costs of transition to community based programs. These totals represent new state monies and do not include institutional costs for the same period. The one-year plan includes residential and day services for 58 people currently living at Harborview and nine children living in nursing homes. Program costs include funds for staff orientation and training, group home start-up, transition and transportation. These are one-time expenditures .

Program Costs	$ 2,332,260
Resident Transition Costs $500/resident x 67 residents	$ 33,500
Resident Transportation $1 OOO/ resident x 67 residents	$ 67,000
TOTAL ONE YEAR PROGRAM COSTS	$ 2,432,760

THREE YEAR PLAN

This plan represents the community services needed for 89 people currently living in institutions and 133 people on the Division of Mental Health and Developmental Disabilities waiting list for residential and vocational services.

A three-year phase-in of community services begins with the development of Individual/Family Management and Support services for 83 people on the Division of Mental Health and Developmental Disabilities waiting list who currently are not receiving any service from the Division. Other programs recommended for the first year are specialized foster care/shared care services throughout the state, supported living services in Kenai, Valdez and Ketchikan, individually designed programs (using the Alaska Youth Initiative model) in Barrow and Dillingham and educational and vocational day programs.

During the second year, group home programs will begin in communities which currently have residential or vocational programs for people with developmental disabilities. Vocational and day programs will be needed in these same communities for people placed in new group home. Individual/Family Management and Support services will also begin for 139 people currently living in institutions or receiving DMHDD services.

The last year of the plan recommends that group home programs be established in the Nome/ Kotzebue area and in Bethel. Vocational and day programs are planned for these same communities for people placed in new group homes.

The three-year plan includes the costs of state-built group homes. Programs in larger urban areas may be able to lease of purchase single family homes which can be renovated to meet program needs and licensure standards.

A summary of the costs associated with the three year plan for the development of community services can be found on the next page.

THREE YEAR PLAN COSTS

Costs of transition to community based programs. These totals represent new state monies and do not include institutional costs for the same period.

FIRST YEAR COSTS FOR PROGRAMS

	New Program Costs	Continuing Costs
Prog ram Costs	$ 1,084,780	
Resident Transition Costs $500/resident x 21 residents	$ 10,500	
Resident Transportation $1000 / resident x 2 1 residents	$ 21,000	
FIRST YEAR PROGRAM COSTS	$ 1,116,280	
Group Home Construction 22-26 Facilities @ $400,000 each 2 Facilities @ $600,000	 $10,400,000 $ 1,200,000	
FIRST YEAR CAPITAL COSTS	$11,600,000	
SECOND YEAR COSTS PROGRAM COSTS		
Program Costs	$7,513,010	$1,125,000
Programmatic Support for Back-up Beds Back-up Beds	$ 300,000	
Resident Transition Costs $1 500/resident x 47 residents	$ 70,500	
Resident Transportation $1 500/resident x 47 residents	$ 70,500	
SECOND YEAR PROGRAM COSTS	$ 7,954,010	$1,125,000
Group Home Construction 2 - 4 Facilities @ $600,000 each	 $ 2,400,000	
SECOND YEAR CAPITAL COSTS	$ 2,400,000	
THIRD YEAR COSTS FOR PROGRAMS		
Program Costs	$ 970,000	$8,018,000
Resident Transition Costs $1 500/resident x 11 residents	$ 16,500	
Resident Transportation $1 500/resident x 11 residents	$ 16,500	
TOTAL THIRD YEAR PLAN PROGRAM COSTS	$ 1,003,000	$8,018,000

FIVE YEAR PLAN

The Residential Services Task Force recommends the five year plan as the most feasible means of developing community services as alternatives to institutional care for people with developmental disabilities. This plan represents the community services needed for 89 people currently living in institutions and 133 people on the Division of Mental Health and Developmental Disabilities waiting list for residential and vocational services.

During the first year of the five year plan, Individual/Family Management and Support services begin for 83 people on the DMHDD waiting list who are currently receiving no services and vocational support services begin for 13 individuals in Anchorage currently without day programs. Supported living and specialized foster care/shared care services. Adults in these settings will require vocational support or day program services.

The second year of the plan calls for individually designed programs (AYI Model) and specialized foster care/shared care in communities which currently don't have residential services of any kind for people with developmental disabilities.

Developmental learning services group homes are scheduled to open during the third year. Educational day programs for those placed in these settings will also be needed at this time.

During the fourth year, more intensely staffed group homes will be developed in communities that currently have residential programs. These include group homes designed for people with more intense care needs, behavioral problems and medical concerns. Educational and day programs for people placed in these programs will also be needed at this time. Regional back-up beds will be located in these programs. In order to support the individual service needs of people placed in back-up beds, the DMHDD will need $300,000 to provide programmatic support for these placements.

Intensely staffed group homes will open in the Nome/Kotzebue area and Bethel during the fifth year. Educational and day programs are scheduled to begin also.

The five year plan includes the costs of state-built group homes. Programs in larger urban areas may be able to lease or purchase single family homes which can be renovated to meet program needs and licensure standards.

A summary of the costs associated with the five year plan for the development of community services can be found on the next page.