WYOMING LIFE RESOURCE CENTER STUDY | FINAL REPORT

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Prepared by

The Wyoming Department of Health

Thomas O. Forslund
Director

Wyoming Department of Health

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SECTION ONE: OVERVIEW OF THE STUDY AND REPORT

Overview of Legislation

During the 2013 General Session, the Wyoming Legislature passed House Bill 0068, Enrolled Act No. 81, House (hereinafter HEA81). HEA81 directed the Wyoming Department of Health (WDH) to conduct a study of the most effective and efficient means of providing care to clients of the Wyoming Life Resource Center (WLRC).

Section 1(a)(i) required the "[d]evelopment of a proposed plan for providing care most effectively and efficiently to the clients of the [WLRC] and, if transition of certain clients of the [WLRC] is recommended, a plan for that transition that meets all legal requirements and considers input from guardians[.]" This provision defines the core of the study.

Ultimately, HEA81 directed the WDH to study (1) whether some or all the WLRC clients should be transitioned out of the WLRC to be served through community based services; and (2) whether there are efficiencies that can be gained at the WLRC. In answering these two questions, all of the study requirements of HEA81 were completed.

Structure of the Report and Report Roadmap

The following report addresses and fulfills all of the requirements of HEA81. After Section One, Overview of the Study and Report, Section Two describes the process by which the WDH completed the study. In Section Three, the subject of the study, the Wyoming Life Resource Center, is described in detail. Finally, Section Four sets out the WDH study findings and conclusions. In this section, the WDH answers the questions required by HEA81: (1) whether some or all the WLRC clients should be transitioned out of the WLRC to be served through community based services; and (2) whether there are efficiencies that can be gained at the WLRC.

REPORT ROADMAP

Section One:	Overview of the Study and Report
Section Two:	WLRC Study Process
Section Three:	The Wyoming Life Resource Center | Overview
Section Four:	WLRC Study Findings
Section Five:	Conclusion and Next Steps

SECTION TWO: WLRC STUDY PROCESS

WDH Study Team

The WDH began this study with the creation of the WLRC work group, which included a variety of internal research and policy staff, administrators, and additional topic matter experts as needed. This work group met regularly throughout the study process. The WLRC Administrator, along with a variety of WRLC staff members were consulted at every juncture of the project to ensure a quality process. Work group members performed general research on client services and operational efficiencies, examining both scientific literature and practice-based evidence across the nation. For clarity, the WLRC work group will simply be referred to as the WDH for the remainder of the report.

Meetings

The WDH conducted a variety of meetings to gather information for this study. Internal meetings were held on a regular basis, and included key stakeholders in the WDH Director's Office, the Behavioral Health Division (BHD; the Senior Administrator of the BHD is responsible for overseeing the operations of the WLRC), the Office of HealthCare Financing, and the Wyoming Life Resource Center. External meetings were held with the guardians/family members of the clients of the WLRC in March 2013 and October 2013. Attendees participated both via conference call and in person. Members of the WDH Administration also met with members of the Lander community (in March 2013) to discuss the study.

Expert Consultant

An expert consultant in both Intermediate Care Facility (ICF) and Acquired Brain Injury (ABI) services was contracted to provide additional detail and guidance related to both client service needs and operational efficiencies at the WLRC. The consultant interviewed key stakeholders, toured the WLRC, and gathered and analyzed information about client services and facility operations.

Research and Data Sources

Every attempt was made to ensure that quality and reliable data were used in this study. WDH internal staff and WLRC staff were consulted to determine data availability for WLRC client data and comparison Medicaid adult developmentally disabled (DD) and ABI waiver client data. Where data were out of date, steps were taken to update the information so that the best possible data could be analyzed. For instance, it was discovered early in the study that some clients did not have updated service assessments on file at the WLRC. The BHD contracted with experts at the Wyoming Institute for Disabilities (WIND) to complete an updated service and ability/disability needs assessment for all clients at the WLRC.

Financial data were obtained from WDH fiscal staff, as well as from the WLRC directly as needed. Data were analyzed using the most descriptive and efficient statistical models available. Details about individual analyses and their results are presented throughout this report.

PROCESS: CLIENT SERVICES AND POTENTIAL TRANSITION

The approach used for the client services and client transition components of this study included a full review of client demographics, history of service at the WLRC, current service needs, client ability/disability information, and general needs/cost comparisons between the WLRC clients and current Medicaid adult DD and ABI waiver clients. WLRC client-specific data were obtained from WLRC staff directly, and Medicaid DD/ABI waiver client data were obtained from Medicaid program staff.

PROCESS: EFFICIENCIES

A thorough analysis of the WLRC's 2012 expenditures and position rosters allowed the WDH to separate out direct care costs from the various support functions and focus on savings with the greatest potential. Once potential efficiencies were identified, the WDH combined WLRC data, national standards and, in some cases, Medicaid claims data to determine ranges of potential savings. The WDH was able to compare the WLRC against other facilities nationally using ICF cost and staffing data from the University of Minnesota's National Residential Information Systems Project (RISP). This dataset not only provided the useful facility benchmarks required by the legislation, but it also allowed the WDH to focus on the significant and controllable driver of per-client cost: staff ratios.

SURVEYS

In addition to existing data sources, three web surveys were designed, distributed, and analyzed. The first was designed to gather information from WLRC staff members related to specific operational efficiencies at the facility. The second asked parents, guardians, or family members of the 90 WLRC clients (as of March 1, 2013) to provide input related to their client's experience at the WLRC, in prior community settings, and their general beliefs related to the potential for client transition from the WLRC to a community setting in the future. The third survey, sent to current waiver services providers across the State of Wyoming, was designed to gather information about community readiness should some or all of the WLRC clients' transition to Wyoming communities. Results of the WLRC staff survey are presented in Section 4 of this report, as are the results of the Guardian and Provider Surveys.

Process Note

Due to the fluid nature of an ICF's operations and clients, the legislation specified that all data and information about the facility should be current as of March 1, 2013. Therefore, all client data and staffing information used in this study was current as of that date. Where limitation to that date was not sufficient, such as review and analysis of budget and expenditures, the most recent year's data (SFY2012) was used.

SECTION THREE: THE WYOMING LIFE RESOURCE CENTER | OVERVIEW

WLRC: History

The Wyoming Life Resource Center (WLRC) has seen many changes in function and name in the past 101 years. It was originally established in 1907 as "an institution for the custody, care, education, proper treatment and discipline of the feeble-minded and epileptic persons, under the name of the 'Wyoming Home of the Feeble-Minded and Epileptic'."[1] Before the facility opened its doors in1912, legislation passed changing its name to the "Wyoming State School for Defectives." In 1921 the name was changed to the Wyoming State Training School, by which it was known until 2008 when the Legislature changed the name to the Wyoming Life Resource Center (WLRC).

Throughout its existence, the WLRC has continued to change and evolve. The WLRC first opened in June of 1912 with three children enrolled.[2] By the end of the year, enrollment had grown to 23. At its peak, the WLRC served more than 700 clients (1960's), and today it serves approximately 90 clients.

The first efforts to certify the WLRC as an Intermediate Care Facility for the (at that time) Mentally Retarded or (ICF-MR) began in the late 1980s, with the first ICF-MR certifications received in December 1989. All units at the WLRC were certified by 1993. The ICF-MR, or as it is now known, the ICF-ID (intellectually disabled) designation allows federal financial participation (Medicaid match), but also requires compliance with federal regulations.

Significant changes were made in the early 1990s, due to a lawsuit, *Weston et al. v. Wyoming State Training School, et al.*, Civil Action no. C90-0004, filed with an intent to "…improve services to people with intellectual disabilities"[3] both at the facility and across the State. Specifically, the lawsuit commenced in January 1990 "seeking improvement of conditions at [the Wyoming Life Resource Center], expansion of community resources and support services and transfer of class members to community programs."[4] As a result of the lawsuit, approximately 200 clients transitioned out of the WLRC into community settings, and attention greatly increased to the services provided to persons with intellectual disabilities in Wyoming.

The lawsuit was settled by the parties. The Settlement Agreement formally recognized ongoing obligations of the State with respect to services and supports for people with developmental

[1] Session Laws of Wyoming, 1907, Chapter 104.
[2] A Century of Empowerment, Past, Present and Future, a handbook
[3] A Century of Empowerment, Past, Present and Future, a handbook
[4] Weston et al. v. Wyoming State Training School, et al., Civil Action No. C90-0004, Consent Decree, Stipulated Agreement, March 13, 1991.

disabilities.[5] The Settlement Agreement is no longer in effect; it terminated December 31, 1996.[6] However, the State remains committed to upholding the spirit of the obligations set out by Weston.

Since the Weston Settlement, additional protections have come about with regard to the institutionalization of individuals with intellectual disabilities. The State, as well as the WLRC, must comply with many federal and state codes, statutes and regulations, as well as the interpretations of these laws by U.S. courts.

The Visions program was developed in the late 1990s for people with ABI. This program first accepted clients in 1998. The Visions program is not certified as an ICF, and thus receives no federal financial participation (Medicaid match).

Finally, in 2008 the Wyoming legislature passed a number of amendments to the WLRC statutes that still govern the facility today. The WLRC statutory authority is set out by Chapter 5 of Title 25 of the Wyoming Statutes.

WLRC Today

Today, W.S. § 25-5-103 sets out the purpose of the WLRC, stating:

> [T]he Wyoming life resource center is established to provide the following residential, active treatment and medical and therapy services to individuals with a disability: (i) Intermediate care facilities for people with intellectual disability…; (ii) Services to persons with acquired brain injuries; (iii) Disability, therapeutic and assistive technology services for persons with a disability; (iv) Training for state employees, other service providers and caregivers on disability, medical, developmental and therapy services; and, (v) Care provided under authority of the director…

Facility

The WLRC is a residential facility that provides both medical support services and habilitation services, to include vocational/day programming, therapeutic horse riding, therapeutic aquatics, and behavioral supports.[7]

Clients are distributed among three major programs: Canyons, Visions, and Horizons.

> The **Canyons** program is licensed as an intermediate care facility for people with intellectual disabilities (ICF-ID) and receives funding from federal and state Medicaid funds on an

[5] Weston et al. v. Wyoming State Training School, et al. Civil Action No. C90-0004, Annotated Settlement Agreement including the Order Approving Settlement Agreement and Dismissing Action, signed December 5, 1994.
[6] Weston et al. v. Wyoming State Training School et al., Civil Action No. C90-0004, Annotated Settlement Agreement at pg. 16.
[7] In addition to serving its clients, the WLRC provides services to the broader Wyoming DD community. These services include a therapeutic equipment lending library, therapeutic equipment shop, and staff training curriculum.

approximate 50% federal - 50% State General Fund basis.[8] The census as of March 1st, 2013 was 77.

The **Visions** program serves people with acquired brain injuries and is funded with 100% State General Funds. The census as of March 1st, 2013 was 11.

Both Canyons and Visions clients live in homes with three to nine other individuals; each client has an Individual Program Plan (IPP) developed for vocational training, healthcare, and recreation. Job exploration and paid work are important components of these plans, necessary for developing important social and life skills as well as fostering the highest level of independence possible.

The **Horizons Healthcare Center** provides acute and long-term medical care to individuals with extreme support needs (e.g. ventilator-assisted breathing). The census as of March 1st, 2013 was two.[9] Care is funded with 100% State General Funds.

Additionally, the Healthcare Center provides inpatient and outpatient care to all WLRC clients. In addition to physicians, physician assistants and nurses, capabilities include dental, x-ray, respiratory therapy, a certified laboratory and a full pharmacy.

The facility is licensed to serve up to 142 clients. The WLRC is located in Lander, Wyoming. A map of both the campus and the grounds is provided in Appendix A.

WLRC Clients

Of the 90 clients living at the WLRC in March 2013,[10] fifty clients (56%) were male and forty clients (44%) were female. Clients ranged in age from 22 years to 89 years, with an average age of 53 years. The 90 clients originated from a variety of Wyoming counties (approximately 19 different counties) and other states. The greatest number of clients indicated that their home counties were Fremont (16, or 18%), Sweetwater (14, or 16%), or Natrona (12, or 13%). More details about the WLRC clients are presented in Section Four, Part One.

Staffing

In March 2013, the WLRC had 429 budgeted positions; however, only 381 of these positions were filled. For the purposes of this report and for ease of discussion, the positions at the WLRC can be grouped into four categories.

1. **Direct care**: includes aides, teachers' aides, technicians and direct support workers not covered on any of the licensed professional categories. At the WLRC, the following

[8] Up to current Medicaid per diem of $718 per day. All costs above Medicaid per diem are 100% GF.
[9] Current census at HHC is 1 as of the writing of this report (this client spends portions of the day in a habilitation program and nights at the HHC).
[10] All client numbers presented in this report are as of March 1, 2013, unless otherwise noted, as required by HEA81.

positions are considered "direct care": Human Service Aides, Human Services Specialists, Shift Supervisors, and Vocational Trainers. Direct care staff accounted for 248 of the budgeted positions in March 2013.

2. **Medical/Therapies**: includes all nurses, other health care workers and therapists. The WLRC had 60 medical/therapies positions in 2013.

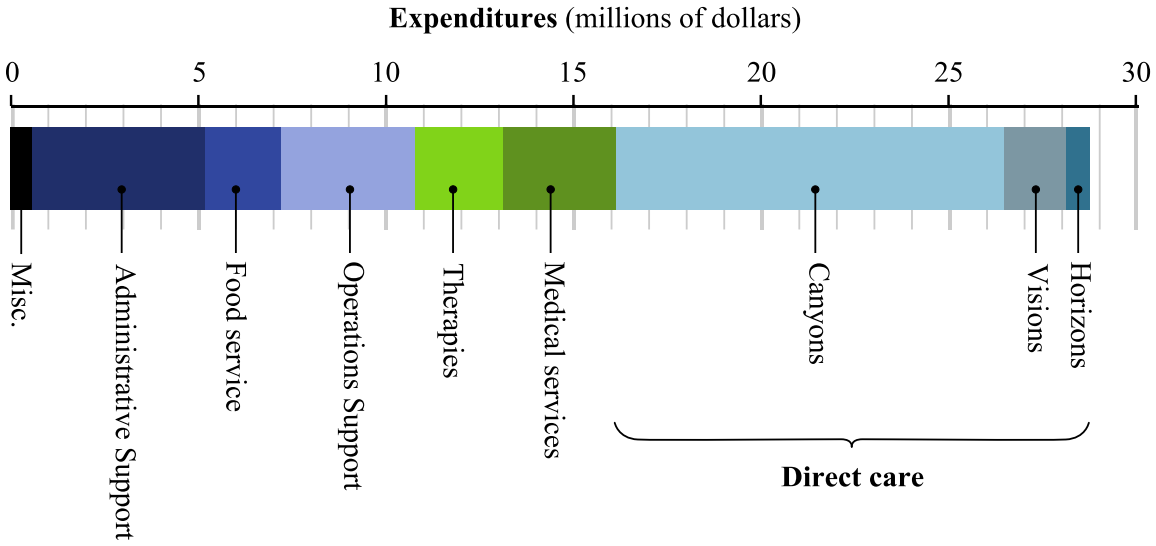
3. **Administrative Support:** includes all levels of management above front-line and working supervisors, as well as human resources, quality assurance and other miscellaneous administrative positions. The WLRC had 53 administrative support positions in 2013.

4. **Operations Support:** includes all positions that maintain and support the facility itself – plumbers, painters, housekeepers, food service workers, security guards, mechanics, as well as accounting positions. The WLRC had 68 operations support positions in 2013.

Budget and Expenditures

The WLRC biennial appropriation for 2011/2012 was $56.8 million. WLRC expenditures for SFY 2012 were $28.7 million.[11] Of the expenditures in SFY2012, $12.6 million went to direct care, $5.4 million to medical services and therapies, $4.6 million was spent for administrative support, and $6.1 million went to operational support services, which included food service. A summary can be seen in the figure below:

Figure 1. Total WLRC Expenditures (SFY2012)



[11] While the HEA81 requires a study of the WLRC as of March 1, 2013, at the time of this study, the most recent complete year of expenditures available was SFY2012.

Taking the total SFY2012 expenditures, the average per-client cost was $305,932. Breaking down SFY2012 expenditures by program, the following table shows how per-client costs vary slightly between Canyons and Visions, but are markedly higher in the Horizons Healthcare Center.

Table 1: Average per-client cost by program, SFY 2012

Program	Average Cost	Census (Jan 2012)	Total Cost (millions)
Canyons	$302,325	80	$24.2
Visions	$304,648	12	$3.6
Horizons	$457,925	2	$0.9
WLRC	$305,932	94	$28.7

Further break down of these per-client costs by program and service type offers a clearer picture of varying expenditures (see Table 2).

Table 2: Average per-client cost by program and by service type, SFY 2012

	Canyons		Visions		Horizons	
Total	$302,325	100.0%	$304,648	100.0%	$457,925	100.0%
Direct care	$129,294	42.8%	$138,871	45.6%	$311,384	68.0%
Medical	$31,756	10.5%	$31,756	10.4%	$31,756	6.9%
Therapies	$25,607	8.5%	$25,607	8.4%	$25,607	5.6%
Admin Support	$49,700	16.4%	$47,854	15.7%	$28,618	6.2%
Operations Support	$37,743	12.5%	$37,743	12.4%	$37,743	8.2%
Food service	$21,434	7.1%	$21,434	7.0%	$21,434	4.7%
Misc.	$6,788	2.2%	$1,380	0.5%	$1,380	0.3%

Historical Trends

HEA81, Section 1(a)(ii) required report of a ten-year historic trend of the number of clients served at the WLRC and the associated costs of those services. This section presents these trends in several figures and tables. Overall, with the exception of a jump in the number of clients in 2007, both staff and client numbers have steadily decreased over the last ten years. The total staff to client ratio, however, has remained between 4:1 and 5:1. The direct care staff to client ratio has remained between 3:1 and 2:1.

Figure 2. 10-year Trend in Number of Clients at the WLRC

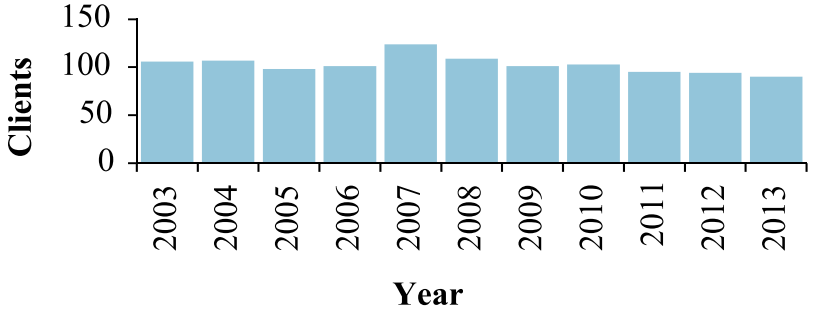


Figure 3. 10-year Trend in Staff Positions at the WLRC

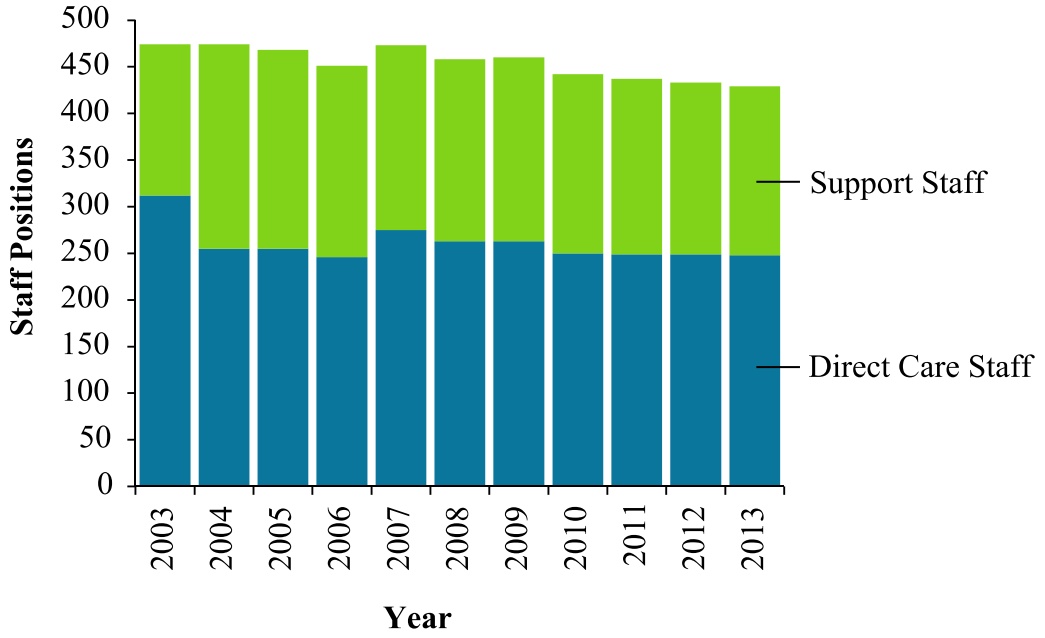


Figure 4. 10-year Trend in Staff-to-Client Ratios at the WLRC

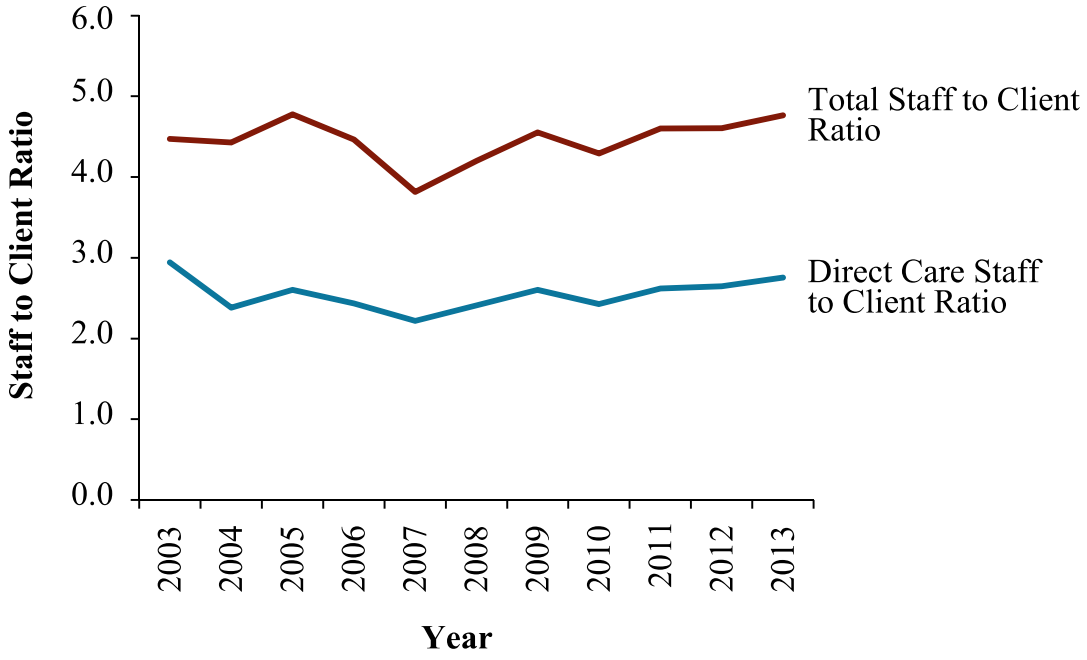


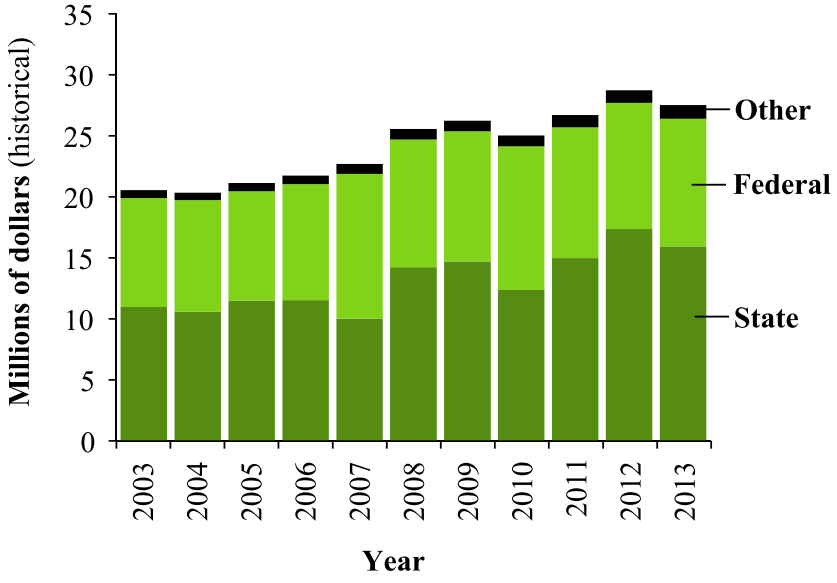
Table 3 shows that expenditures have risen steadily since 2003. It describes trends in staffing, clients, and costs. For better reference across the ten-year period both historical and inflation adjusted costs are shown. Note that the decreasing number of clients has led to generally increasing annual per-client cost, even when adjusted for inflation.

Table 3: Trends in WLRC Clients, Staff and Expenditures

Year	Budgeted Staff	Client Count	Total Expenditures (historical)	Cost/Client (historical)	Total Expenditures (inflation-adjusted to 2013 dollars)[12]	Cost/Client (inflation-adjusted to 2013 dollars)
2003	474	106	$20,558,372	$193,946	$28,492,120	$268,792
2004	474	107	$20,343,767	$190,128	$26,829,107	$250,738
2005	468	98	$21,136,896	$215,682	$26,385,314	$269,237
2006	451	101	$21,739,873	$215,246	$25,837,931	$255,821
2007	473	124	$22,711,431	$183,156	$25,649,309	$206,848
2008	458	109	$25,566,162	$234,551	$27,475,995	$252,072
2009	460	101	$26,264,407	$260,043	$28,305,151	$280,248
2010	442	103	$25,039,562	$243,102	$26,272,111	$255,068
2011	437	95	$26,722,068	$281,284	$27,242,808	$286,765
2012	433	94	$28,757,687	$305,932	$28,864,553	$307,069
2013	429	90	$27,547,048	$306,078	$27,547,048	$306,078

The expenditures showed in the above table vary by fund/source (Federal Funds/Medicaid, State General Funds and Other, which includes Trust and Agency Funds, the Permanent Land Fund and patient contributions). Because only the Canyons program, a designated ICF, is eligible for matching federal funds through Medicaid, the majority of the expenditures at WLRC are paid for with state money. Figure 5 shows the ten-year trend in expenditures broken out by source.

Figure 5. 10-year Trend in WLRC Expenditures



[12] Because state spending goes to a different basket of goods than what is measured by the Consumer Price Index, the GDP Implicit Price Deflator is used for State and Local Government purchases (US Bureau of Economic Analysis, Table 1.1.9.)

Private funds collected from clients in both Canyons and Visions are included in the "Other" category. These funds are collected as "established charges" pursuant to W.S. §25-11-101 through 107. Charges are set on a sliding fee schedule established by the WLRC. Clients pay small amounts from Social Security payments or wages they earned from working at the WLRC. In a few cases, agreements were reached with guardians for greater contributions when a client had previously received an accident settlement or trust fund. The following table shows the total amount of reimbursement to the State General Fund from clients since 2003 as required by HEA Section 1(a)(ii). The WLRC does not currently receive any reimbursement or payments from third party payers/insurance companies.

Table 4: **State General Fund Reimbursements from WLRC Clients**

	Visions	**Canyons**	**Total**
2003	$76,478	$520,318	$596,796
2004	$43,013	$519,369	$562,382
2005	$58,506	$520,452	$578,958
2006	$70,898	$519,422	$590,320
2007	$115,574	$589,040	$704,614
2008	$135,760	$606,051	$741,811
2009	$166,480	$577,485	$743,965
2010	$174,883	$589,470	$764,353
2011	$202,232	$608,863	$811,095
2012	$195,60	$613,641	$809,242
2013	$238,066	$605,025	$843,091

SECTION FOUR: WLRC STUDY FINDINGS

Sections One through Three provide discussion of the information gathered for this study. Additional information that supports the WDH findings is provided in Section Four, along with the corresponding study finding. Section Four has two Parts that answer the two main questions posed in HEA81: (Part 1) Should some or all the WLRC clients be transitioned out of the WLRC to be served through community based services?; and (Part 2) Are there are efficiencies that can be implemented at the WLRC?

Part One: Should WLRC Clients Transition to the Community?

To answer the question posed by HEA81, the WDH conducted significant research, data gathering and data analyses. This research and analysis generated eight (8) considerations. This Part begins with a discussion of WLRC client longevity, service needs, and behavioral issues. Next, a comparison is made between the clients at the WLRC and Medicaid waiver clients (those being served in community settings), followed by a review of input from guardians/family members, and a discussion of community provider willingness to provide services to additional high-need clients. Then, a review of specific legal issues related to client placement at the WLRC is presented, followed by a cost comparison between WLRC clients and waiver clients, and estimation of future costs for WLRC clients to be served in Wyoming communities. Finally, the WDH recommendation related to client transition concludes this Part.

CONSIDERATION #1: WLRC CLIENT LONGEVITY

The amount of time that a client has lived in a residential/institutional setting is an important consideration when discussing potential transition to the community. To get a better understanding of client longevity, the number of years of residency by decade was examined. This examination revealed that most of the clients (68%) have lived at the WLRC for 11 or more years (see Table 5). A significant number (44%) of the clients have lived at the WLRC for over 40 years.

Table 5. Client Years Living at WLRC by Decade

Decade #	*# Years*	*# of Clients*	*Percent*
1	1-10	29	32.2
2	11-20	7	7.8
3	21-30	3	3.3
4	31-40	11	12.2
5	41-50	20	22.2
6	51-60	12	13.3
7	61-70	6	6.7
8	71+ years	2	2.2
Total		**90**	**100.0**

The number of years of residence divided by the clients' ages shows the percentage of living years spent at the WLRC (see Table 6, below). These figures were separated into quartiles (or, 25% increments). The pattern shows that the majority of clients (50%) have resided at the WLRC for 76% or more of their lives. This is followed by a smaller group (34%) that has lived at the facility for 25% or less of their lives. The remaining 16% or so fall in the middle.

Table 6. Proportion of Living Years spent at WLRC (by quartiles)		
% of life spent at WLRC	*# of Clients*	*Percent*
0-25%	31	34.4
26-50%	7	7.8
51-75%	7	7.8
76-100%	45	50.0
Total	**90**	**100.0**

CONSIDERATION #2: MOST WLRC CLIENTS HAVE HIGH SERVICE NEEDS

The second consideration in the discussion of client transition from the WLRC to the community regards client service needs. Clients residing at the WLRC have a wide range of behavioral, personal, and medical needs. Each client's service plan is unique, and is determined by the use of standardized clinical instruments that measure both need and ability.

In order to examine client service needs in a consistent manner, client scores on an assessment called the Inventory for Client and Agency Planning, or ICAP, were used to categorize clients into similar groups. The ICAP is a widely-used instrument for children and adults with developmental disabilities or disabilities resulting from life events.[13] The ICAP Service Score (a combination of adaptive and problem behaviors) is most useful for service planning and knowledge if it has been recently assessed for each individual.[14]

The scale for the Service Score ranges from 1-100, with lower scores indicating that a person has more intense service needs, and higher scores indicating that a person has less intense service needs related to a disability.[15] Scores are commonly grouped into what are called "Levels" for more

[13] The ICAP gathers information from at least two people that are close to the individual being assessed on a variety of areas to determine the type (what a person can and cannot do) and amount of assistance that the person needs in his/her daily life. The questions are asked in such a way that the instrument records what is called 'adaptive' behaviors, as well as 'problem' behaviors, and results in an overall Service Score that combines the two to provide guidance on level of care, supervision, or training that is needed.

[14] For this reason, the Wyoming Institute for Disabilities (WIND) with the University of Wyoming completed updated ICAP assessments for all WLRC clients in the Spring of 2013. The detailed scores were then shared with the WDH.

[15] It should be noted here that often a person has a variety of presenting problems, including developmental, physical, mental health/behavioral, and other needs. The ICAP does not assess the entirety of these complex issues, but instead focuses on measuring the adaptive and problem behaviors associated most with a person's developmental or trauma-related disability. Because the focus of the WLRC is to provide care for people with developmental/intellectual

concise description.[16] In general, the majority (91%) of WLRC clients fall in the higher-intensity service levels (1-4), which are described as total or extensive personal care needed, along with intense or constant supervision. The remaining 9% (or 8 clients) fall into levels 5-7. There were no clients with ICAP scores in Levels 8 or 9. Overall, the clients at the WLRC have extremely high needs for care and supervision.

Table 7. WLRC Client ICAP Scores by Level

*Service Score Level**	*# of Clients*	*Percent*
1	41	45.6
2	18	20.0
3	11	12.2
4	12	13.3
5	4	4.4
6	3	3.3
7	1	1.1
Total	**90**	**100.0**

**ICAP Levels Definition: Level 1 = most intense services/supervision required | Level 9 = least intense services/supervision required*

CONSIDERATION #3: MANY WLRC CLIENTS HAVE SEVERE PROBLEM BEHAVIORS

The third consideration related to client transition is an examination of problem behaviors exhibited by clients. The ICAP instrument (described above) contains a section devoted to the measurement of problem behaviors. There are eight (8) specific subcategories, including: hurtful to self, hurtful to others, destructive to property, disruptive behavior, unusual or repetitive habits, socially offensive behavior, withdrawal or inattentive behavior, and uncooperative behavior. Generally, the patterns of problem behavior in the current WLRC client population (N=90) look like this:

1. 49 (54%) have moderate, severe, or critical problems being hurtful to themselves
2. 41 (46%) have mild, moderate, or severe problems being hurtful to others
3. 7 (8%) have mild, moderate, or severe problems being destructive to property
4. 58 (65%) have moderate, severe, or critical displays of disruptive behavior
5. 18 (20%) have severe or critical problems with unusual or repetitive habits
6. 19 (21%) have moderate, severe, or critical problems with socially offensive behavior

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disabilities (and/or disabilities related to a life trauma, such as Acquired Brain Injuries) it is believed that the ICAP is the best available instrument to discuss the requirements of the legislation.

[16] Each level represents approximately 10 points on the 1-100 Service Score scale (except Level 1, which captures scores between 1-19). For example, if a person's Service Score is 73, he/she would be categorized a Level 7 (e.g., needing limited personal care and/or regular supervision). If a person's Service Score is a 9, he/she would be categorized a Level 1 (e.g., needing total personal care and intense supervision).

7. 2 (2%) have critical problems with withdrawal or inattentive behavior
8. 62 (69%) have mild or moderate displays of uncooperative behavior

These results show that for three of the eight (i.e., being hurtful to themselves, disruptive behavior, and uncooperative behavior) problem behaviors, over half of the WLRC clients exhibit displays of difficult behavior. Very few of the clients have difficulty with being destructive to property (8%).

CONSIDERATION #4: SOME WAIVER CLIENTS ARE SIMILAR TO WLRC CLIENTS

The fourth consideration involves a comparison of WLRC clients to another group based on similar characteristics. It was decided that WLRC clients be compared to Medicaid waiver clients (Adult DD or ABI waivers only) based on their ICAP scores (this is one of the few consistent metrics that is available between the two groups). Before this comparison is presented; however, it is beneficial to compare general services available at the WLRC and in the community.

WLRC and Waiver Service Type Comparison

A general listing of the types of services offered by the Medicaid Waver programs is presented in Table 8. Using information from the WDH and the WLRC, the following table shows the similarities and differences in the types of services provided to clients in each care setting. Some of the services provided by the Medicaid Waiver programs would not be applicable to a campus residential setting such as the WLRC, and so are listed as "N/A" in the WLRC Services list. Many of these services are the ones that would allow for a client to live successfully in a community setting (e.g., Homemaker, Companion Services, etc.).

(continued on next page)

Table 8. Comparison of Medicaid Waiver and WLRC Offered Services	
Medicaid Waiver Traditional Services	**WLRC Residential Services****
Case Management	**Yes, Team Management**
Cognitive Retraining Services (ABI Waiver Only)	**Yes**
Community Integrated Employment (18+)	**No**
Companion Services (18+)	**N/A**
Day Habilitation	**Yes**
Dietician Services	**Yes**
Environmental Modifications	**Yes**
Homemaker	**N/A**
Personal Care	**Yes**
Physical, Speech, & Occupational Therapy (Adult/ABI Waivers Only)	**Yes**
Residential Habilitation (18+)	**Yes**
Respite Care	**Yes**
Skilled Nursing	**Yes**
Specialized Equipment & Supplies	**Yes**
Supported Living Services (18+)	**N/A**
***Self-Direction Services**	
Agency with Choice	**N/A**
Community Integrated Employment (18+)	**N/A**
Companion Services (18+)	**N/A**
Fiscal Employer Agent	**N/A**
Independent Support Broker	**N/A**
Individual Directed Goods & Services	**N/A**
Personal Care	**Yes**
Respite Care	**Yes**
Supported Living Services (18+)	**N/A**
Unpaid Caregiver Training & Education	**Yes**

*N/A indicates that the service is not applicable to the residential setting in which the WLRC operates.

**The WLRC also offers the following services on its campus that did not fit into a wider category: On-campus Health Services, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy, Aquatic Therapy, Equine Therapy, and Horticulture Therapy. The Waivers do fund PT, OT, and Speech Therapy, which may be provided at residential or day habilitation location, or in a therapy setting.

Waiver Clients' Service Needs

As of March 1, 2013, there were 1,536 people with an active waiver case plan being served in Wyoming under the Adult DD Waiver (1,360 people) or the ABI Waiver (176 people). The figures below compare the distribution of both ages and ICAP scores for Adult DD and ABI Waiver clients and WLRC clients.

Figure 6. Age Distribution for Waiver and WLRC Clients

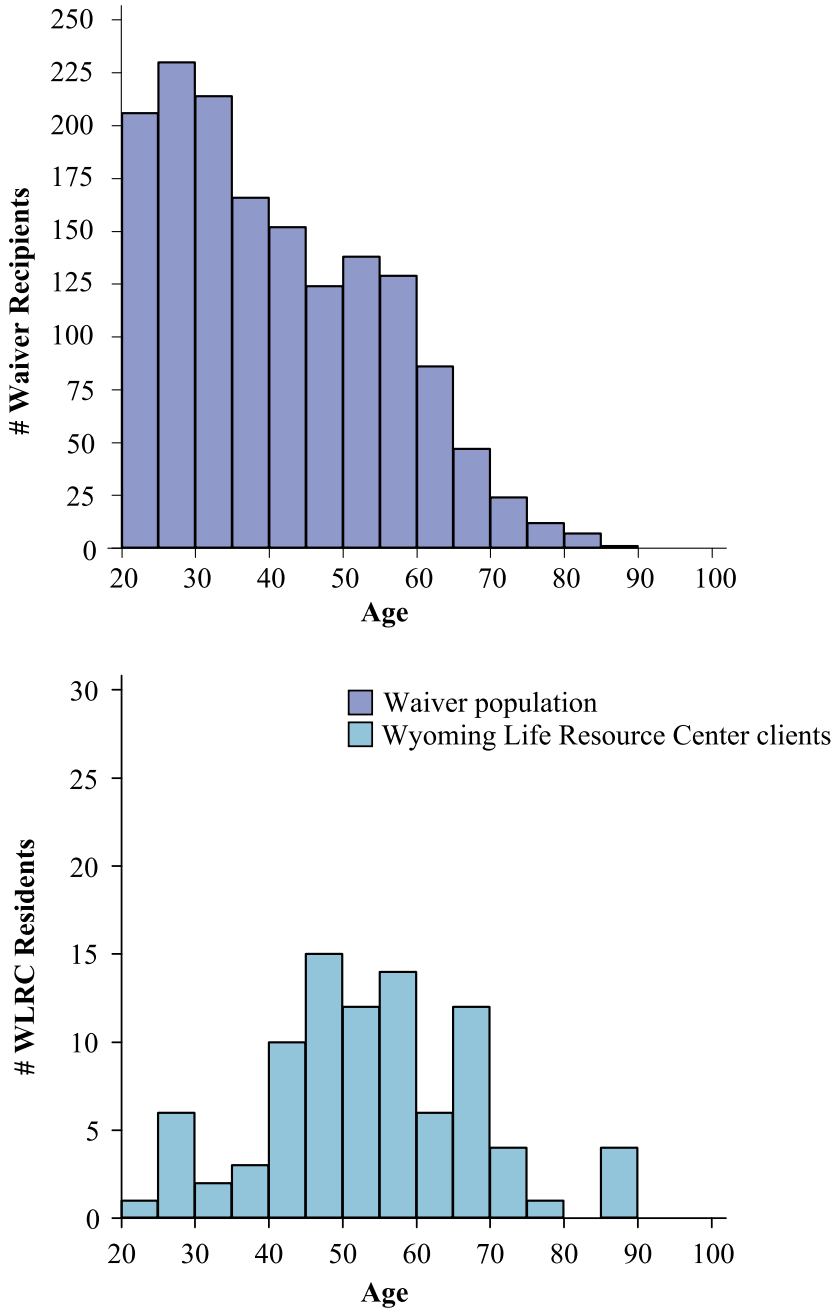

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Figure 7. Distribution of ICAP Service Scores for Waiver and WLRC Clients

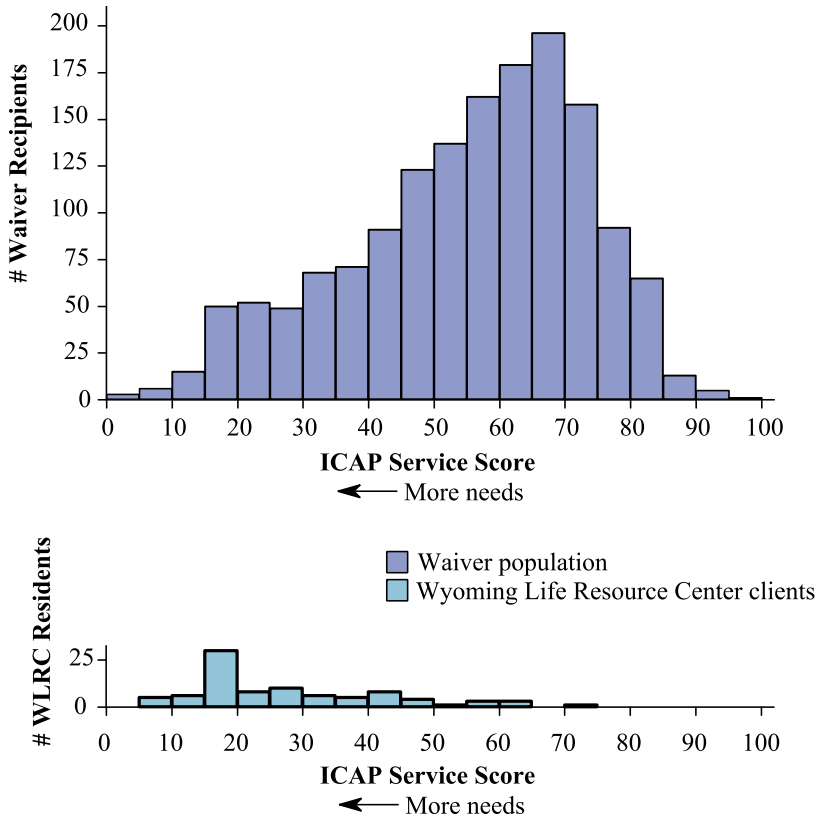

Table 9 provides a detailed view of the Waiver clients, divided between the ABI Waiver and the Adult DD Waiver, according to the ICAP service level. Remember, higher Service Levels mean that the person would require less intense services/supervision on a regular basis.

Table 9. ICAP Service Levels by Waiver Type

		ICAP Service Levels									Total
		More Services/Supervision								*Less Services/Supervision*	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
Waiver Type	ABI	4	7	12	16	32	37	43	22	3	176
	ADD	70	94	127	198	267	338	207	56	3	1360
Total		74	101	139	214	299	375	250	78	6	1536

One of the more interesting features of the table above is the finding that there are many people (N=175) in ICAP Service Levels 1 and 2 (the most intense care/supervision needed) being served on a waiver in community settings in Wyoming. This is a diverse group (aged 21 to 83 years) and is scattered around the State, located in 17 of Wyoming's 23 counties. Some of the other behavioral metrics found in the ICAP assessment indicate that there are clients in this group that show

particularly demanding issues. For instance, 161 (94%) have an intellectual disability, and 80 (46%) have a mobility condition (difficulty with mobility).

Specific to the eight (8) categories of problem behavior measured by the ICAP assessment, this high needs/supervision sub-group of waiver clients also shows a diverse array of issues. Of the 175 clients:

1. 42 (24%) have mild, moderate, or serious problems being hurtful to themselves
2. 42 (22%) have mild, moderate, or severe problems being hurtful to others
3. 16 (9%) have mild or moderate problems being destructive to property
4. 73 (42%) have mild or moderate displays of disruptive behavior
5. 30 (17%) have mild or moderate problems with unusual or repetitive habits
6. 34 (19%) have mild, moderate, or severe problems with socially offensive behavior
7. 21 (12%) have mild or moderate displays of withdrawal or inattentive behavior
8. 62 (35%) have mild or moderate displays of uncooperative behavior

This is a good indicator that very high need clients (even those with severe behavior problems) are being served in the community by existing providers and services in the State.

CONSIDERATION #5: MOST GUARDIANS ARE PLEASED WITH WLRC SERVICES

Another consideration related to WLRC client transitions is the input of the guardians\family members of WLRC clients. To allow all guardians/family members an opportunity to provide input, a survey with questions specific to the process of client transition from the WLRC to a community-based setting was conducted in April and May, 2013. Highlighted findings from this survey are presented below.

Guardian/Family Member Survey: Highlights

Thirty-one (31) responses were gathered on behalf of the 90 clients, a 34% response rate. Respondents were asked, "Do you believe that your WLRC client could have a different quality of life if he/she lived and received services in a community setting?" Responses were concentrated (23, or 79%) in one primary category: YES, Quality of life in the community would be worse than at WLRC (see Figure 8).

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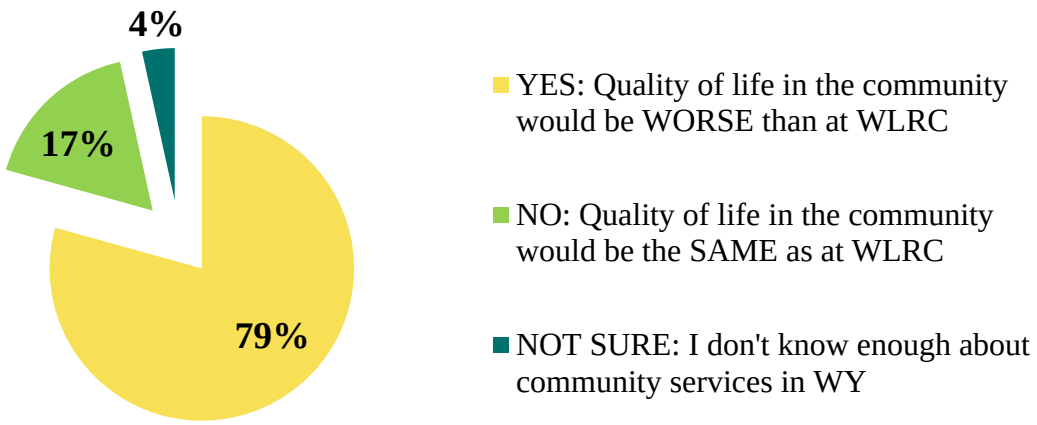
Figure 8. WLRC Guardian/Parent Perception of Client Quality of Life by Location of Services



Survey respondents were also asked an open-ended question about whether they had particular issues the WDH should consider as it studies options for client transition to community settings (24 people responded to this question). Responses were varied (i.e., many comments were very specific to a particular client), but some common themes emerged. These themes included:

- Consider how the services provided at WLRC would compare in type, number, and frequency to those available in Wyoming community settings
- Comparison of staff training and skills at WLRC versus those available in Wyoming community settings
- Consider ways to measure and compare quality of life for clients at WLRC versus community settings
- Examine how quality of care can be measured and compared between WLRC and community settings
- Comparison of costs on a client-level basis, as each client's needs are unique

In summary, guardians/family members of WLRC clients that chose to respond to this survey indicated that they (and their clients) are very satisfied with the services at the WLRC. Some also stated that in previous placements outside the WLRC, they and their wards were unsatisfied with the arrangement. Finally, the perception reported by the majority of the guardians/family members was that their clients would not experience as high of a quality of life as they do at the WLRC if they transitioned to a community setting.

Additionally, the WDH received input from the guardians/family members at the two meetings held with guardians/family members with regard to this study. Overwhelmingly, the guardians/family members that participated in those meetings were highly satisfied with the services and care provided by the WLRC.

CONSIDERATION #6: COMMUNITY PROVIDERS NEED TIME/RESOURCES

The work related to Consideration #6 also responds directly to HEA81 (Section 1(a)(vi)). The WDH distributed a survey to existing DD/ABI service providers in the State to determine capacity and willingness to provide care to additional clients, similar to those at the WLRC. Questions were asked as they applied to each of the two potential populations (adults with DD, adults with ABI). A brief synopsis and highlight of the findings are presented below.

82 providers responded, representing care providers in all 23 counties (though not all of them answered all of the questions asked on the survey). The counties most represented included Laramie (15.4%), Natrona (15.4%), Campbell (14.1%), and Fremont (12.8%).

New Clients and Time to Service. Survey respondents were asked to estimate both the number of new DD or ABI clients they could serve, and a time frame for adding DD or ABI clients to their existing caseloads. Their responses are detailed in the figures that follow. The pattern of response for both DD and ABI providers clearly indicates that as the number of new clients gets higher, the need for additional time to prepare becomes longer.

Figure 9. How quickly could your Agency provide services to additional DD Clients?

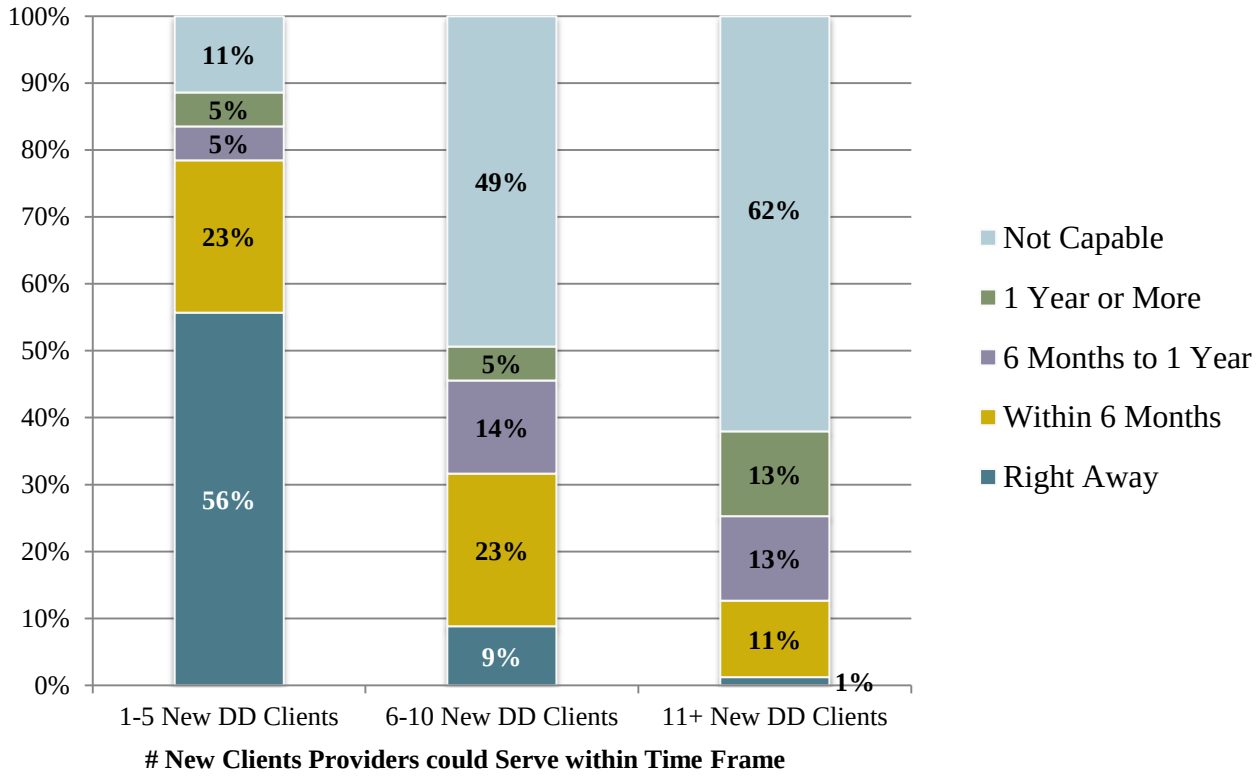
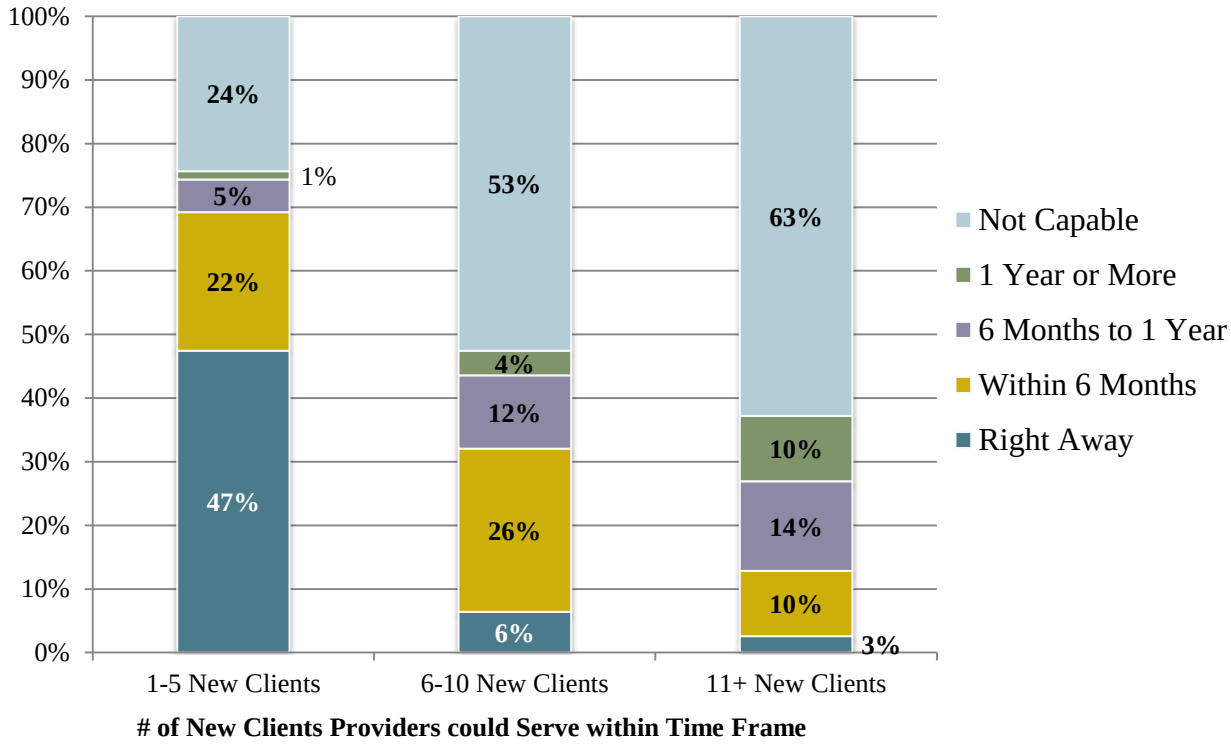
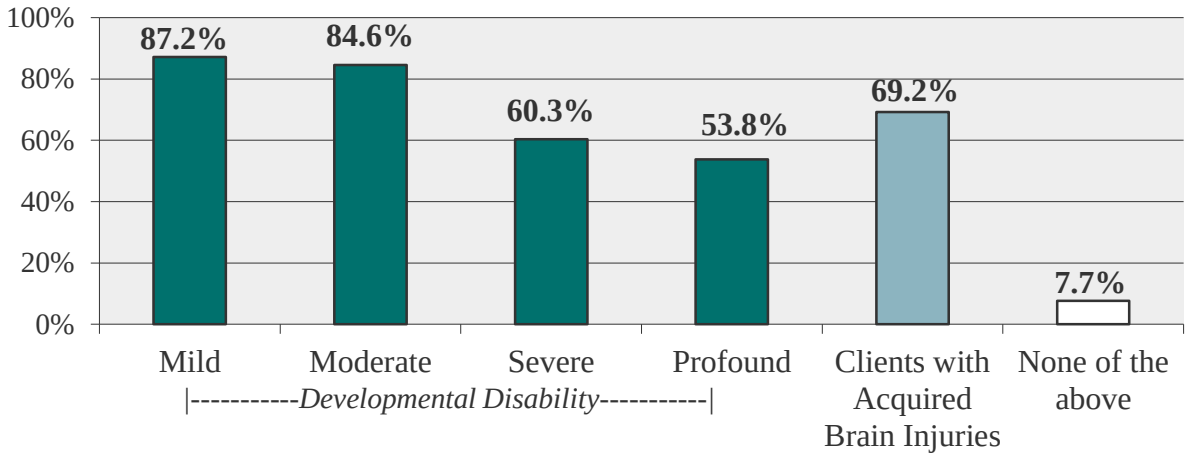


Figure 10. How quickly could your agency provide services to additional ABI Clients?



Provider willingness based on Client Type. Providers that responded to the survey were also asked about their willingness to provide services to clients of varying severity levels. As can be seen in Figure 11, fewer providers would be willing to provide services to the most severe/profound DD groups than those with mild/moderate DD. Nearly 70% of the respondents indicated they would be willing to provide services to clients with ABI.

Figure 11. Provider Willingness to Provide Services to New Clients by Severity/Type



Provider General Comments. The final question on the survey requested comments from providers related to their willingness/ability to provide services to additional DD or ABI clients that may transition from the WLRC into the community at some point in the future. Fifty-five (55; or 67% of all respondents) providers gave comment on this issue. After an examination of the comments, some themes emerged:

- Of the providers willing to serve additional clients, many indicated that they would need additional resources, time, and/or information in order to do so. This could include:
    - Need for additional physical space to serve clients (e.g., residential care space, housing for clients, etc.)
    - Need for added equipment to serve clients with high-level medical and/or behavioral needs
    - Need for additional staff to meet any staff ratios that are required
    - Need for additional training for existing staff if serving new client types
    - Need for more information on the new waiver structure (funding, services, etc.)
    - Need for more information on how services will be funded
    - Need for more information about how CARF certification affects provider ability to serve certain numbers/types of clients

Generally, it appears that the provider network in Wyoming is willing and capable of providing services to clients similar to those currently living at the WLRC, with a few caveats. The comments provided in the survey indicate that adding clients to existing provider caseloads would require careful consideration of client severity/need, timing for service provision, location of client care (e.g., residential vs. in-home community care, etc.), staffing and training of staff, as well as funding, for this process to happen successfully.

CONSIDERATION #7: LEGAL PARAMETERS RESTRICT CLIENT PLACEMENT

Currently, significant legal parameters exist to ensure a client's appropriate placement at the Wyoming Life Resource Center. Placement in an institution is not only restricted through federal regulations and case law, but also through Wyoming statutes, rules and policies. Specifically, W.S. § 25-5-114 precludes a person from being admitted to the WLRC if that person would be more appropriately served by a community program. Additionally, W.S. § 25-5-115 requires preadmission screening and assessment, and precludes a person from being admitted unless an "interdisciplinary team has determined that the center offers the recommended and most appropriate services in a least restrictive and most integrated environment consistent with informed choice[.]" Finally, W.S. § 25-5-116 requires all clients of the WLRC to have an individual program plan (IPP) prepared by an interdisciplinary team within 30 days of admission to the WLRC. The plan must be reviewed for appropriateness and feasibility of discharge or transition to another level of service 30 days after the plan is implemented, quarterly for the first year of residence at the WLRC, and annually thereafter.

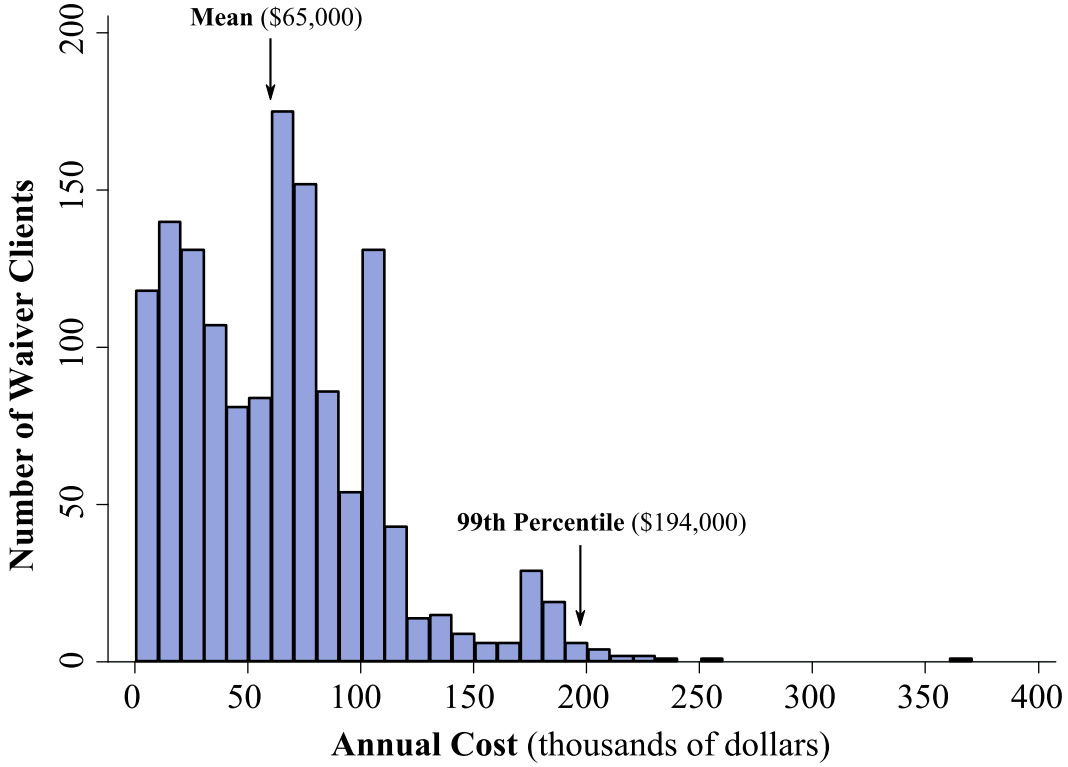
CONSIDERATION #8: COMMUNITY SERVICES COST LESS

As a final consideration, Section 1(a)(iii) of HEA81 required the WDH to provide cost estimates related to WLRC clients receiving care of the same quality and type were they to transition to community settings. Study of costs revealed that in no state in the U.S. is it less expensive to operate an ICF than to provide community services. In fact, it is a federal requirement that per-client waiver services, on average, must cost less than per-client institutional services. Total costs for transitioning WLRC clients into the community can be divided into (1) expected annual costs and (2) one-time transition costs.

Expected Annual Costs. Expected annual costs for WLRC clients, were they to transition to community-based settings (including nursing homes), include (a) expected cost on the DD or ABI waivers, to include residential and day habilitation services, supported work, and any add-ons (e.g. skilled nursing) and (b) any additional annual medical costs they may incur as Medicaid beneficiaries.

Expected Waiver Costs. The WDH estimated ranges of waiver costs needed to serve WLRC clients in two ways. The "rough" estimate takes, as its minimum, the straight average per-person waiver cost in the community ($65,000) times the 90 clients and, as its maximum, the 99th percentile of waiver costs ($194,000) times the 90 clients. The figure below shows the distribution of total waiver costs for Adult DD and ABI recipients.

Figure 12. Distribution of Waiver Population Annual Per-person Expenditures (2012)

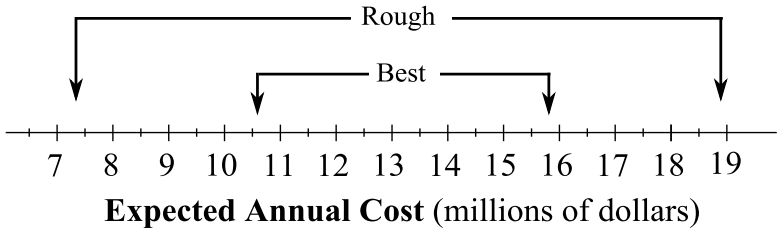


This method of estimation yields a relatively wide cost estimate (between $5.85 to $17.46 million). In order to determine a more specific potential cost for WLRC clients if they were to be served in the community, statistical modeling using client ICAP scores was used.[17] The model predicts a range of cost.[18] These ranges are presented by cost quartile (e.g., the least expensive 25% to the most expensive 25%) and can be seen in the table below. Please note that the Visions program is presented separately from Canyons/Horizons.

Table 10. Best Waiver Cost Estimate for WLRC Clients (millions)			
WLRC Program		**Low**	**High**
Canyons and Horizons		$8.12	$12.74
Cost Quartile	0-25%	$1.35	$2.59
	26-50%	$2.03	$3.21
	51-75%	$2.27	$3.35
	76-100%	$2.47	$3.59
Visions		$0.84	$1.55
WLRC Total		**$8.96**	**$14.29**

Expected Medical Costs. The WDH estimated medical costs by adding current WLRC costs for medical/therapy supplies and contracted services only ($916,631) to the average annual Medicaid billing of Adult DD and ABI Waiver recipients, multiplied by the 90 clients of the WLRC ($577,530). These total estimated medical costs come to just under $1.5 million. This estimate cannot take into account any unexpected medical conditions or spending that might arise from the stress of transition or being in a different care environment.

Total Estimate of Costs in Community. Adding together the waiver and medical costs, the "rough" estimate for expected annual cost for WLRC clients in the community falls between $7.3 and $18.8 million, and the best estimate for expected annual cost of WLRC clients falls between $10.5 and $15.7 million. These ranges can be seen in the figure below:



[17] The "best" estimate was computed using a statistical model that predicts costs in the waiver community using the ICAP Service Score and ICAP General Score (an index that reflects maladaptive behavior), and controls for the possible effects of available providers. With 1042 data points, the model explains approximately 53% of the variation (this is a very high figure in terms of model fit) in cost in the Adult DD and ABI Waiver community. The ranges of cost were separated by WLRC program (separating ABI and DD groups), since clients in these programs will need different types of services.

[18] Based on a 95% confidence interval

Transition Costs. As with service budgets in the community, one-time transition costs will vary between clients. In its closure plan for the Vineland facility[19], the State of New Jersey used an average transition cost of between $20,000 and $50,000 for service budgets that are comparable for Wyoming Life Resource Center clients. Using this range, WDH estimates one-time transition costs at between $1.8 and $4.5 million.

TRANSITION: WDH RECOMMENDATION

At the present time, the WLRC provides appropriate and needed care to a group of high-need people in the State of Wyoming. There are Medicaid waiver clients with similar ICAP service scores currently being served in the community. The majority of guardians/family members who responded to the survey indicated that prior community placements were unsatisfactory, and that they believe placement outside of the WLRC would result in a lower quality of life for their clients. In addition, while many community service providers could provide care to additional DD/ABI clients (with sufficient time and resources to prepare), they were less likely to indicate that they could provide complete and/or timely care to those with the most severe needs. There are federal and state laws and regulations that ensure appropriate placement of clients at the WLRC.

HEA81 Section(1)(a)(iii-v) also required the discussion of a cost comparison and estimate of community-based costs for WLRC clients, so it was included as a consideration. However, these cost comparisons and estimates were not a factor in the WDH's final recommendation.

Due to these considerations, legal constraints, and protections, the **WDH does not recommend forced transition of clients from the WLRC**. The WDH considers the WLRC to function as a necessary safety net in Wyoming. While there are many reasons for this recommendation, perhaps one of the most basic (yet critical) reasons is the fact that the majority of the current WLRC clients have resided at the facility for the majority of their lives. A transition could impact their physical and mental well-being, resulting in a decline in their current conditions.[20]

While the WDH does not recommend transition pursuant to this study, the WLRC remains committed to working with any guardian and client that is interested in pursuing a transition to the community. An assessment of the WRLC client's needs and client/guardian desires would be required in order to ensure a successful transition.

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[19] http://www.drnj.org/pdf/Vineland%20DC%20closure.pdf

[20] Large life changes are likely to present challenges and may make people more susceptible to disease and/or death in the time following those changes (e.g., Lund, Modvig, Due, & Holstein, 2000; http://www.ncbi.nlm.nih.gov/pubmed/11484796). However, there is some controversy in the research literature about people transitioning from institutional settings to community settings after varying durations of residency; see Lemay, 2009, http://www.socialrolevalorization.com/articles/lemay/deinstitutionalization-of-people-with-developmental-disabilities.pdf)

In addition to client-specific issues, at the writing of this report, the search for a new Administrator of the WLRC is ongoing. The WDH will work with the new Administrator to review the 'annual placement review' process to ensure that guardians and clients are well informed of any options for services in Wyoming. The guardian/family member survey showed that some guardians believe that their clients could thrive in community settings if sufficient guidance was provided. The WDH will work to provide additional information and guidance to those guardians and clients that are interested in exploring options for transition.

Part Two: Are there Efficiencies that can be implemented at the WLRC?

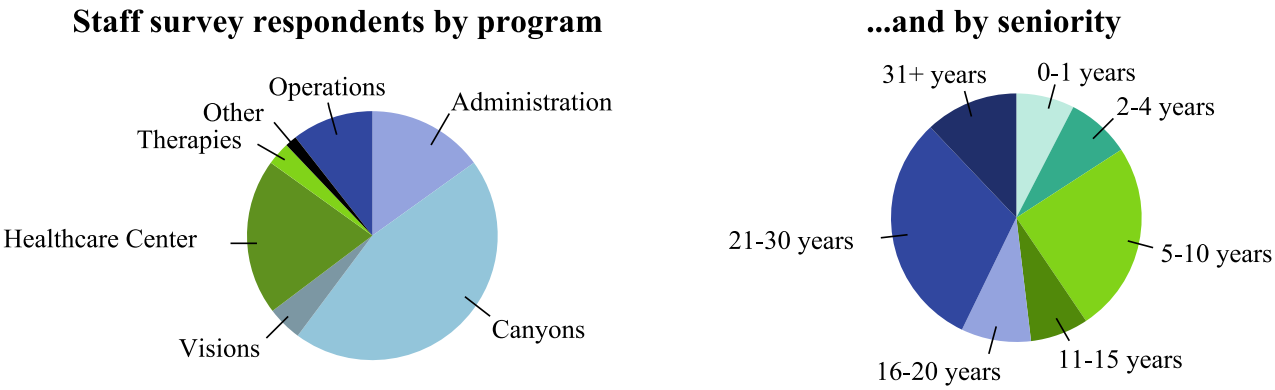
Next, the WDH presents its findings related to the identification of opportunities for efficiencies at the WLRC. Specifically, this Part of the report focuses on the study requirement to explore opportunities to reduce overhead and other operational costs at the WLRC (as required by HEA81, Section 1(a)(ix)) in order to develop a proposed plan for providing care most effectively and efficiently to clients at **t**he WLRC (HEA81, Section1 (a)(i)).

First, the results of the WLRC Staff survey are reviewed. Next, a comparison of WLRC with other similar facilities around the nation is presented. Finally, a variety of opportunities are presented with regard to providing care at the WLRC more efficiently, including the identified opportunities for reducing overhead and operations costs.

WLRC Staff Efficiency Survey Results

To obtain WLRC staff input on potential cost savings, the WDH administered an anonymous online survey in May of 2013. The survey asked WLRC Staff one open-ended question regarding their suggestions to increase efficiency at the WLRC. Known characteristics of the 133 respondents are shown in pie charts below. Note that the majority of respondents have over ten years of experience working at WLRC.

Figure 13. WLRC Staff Survey Respondents by Program and Seniority



After collecting survey responses, WDH categorized the results by themes. In order of prevalence, these ideas included:

1. **Decrease overhead**. Many respondents noted a top-heavy staff structure, with too many shift supervisors and day programming managers. Others noted opportunities for consolidation (e.g. collapsing the auto shop, grounds and maintenance). Administrative burden was another focus.

2. **Better use staff capacity; increase value**. Several noted that the Horizons Healthcare Center is severely underutilized. Others recommended that that therapy, day programming and vocational trainers should take a more direct role or be reduced. Scheduling inefficiencies and productivity issues (communication/training/professionalism) were also noted.

3. **Cut/consolidate facilities and services**. Some staff recommended demolishing or leasing out unused buildings and consolidating the campus. Others recommended energy efficiency improvements (e.g. solar panels). Several staff recommended eliminating the laundry contract; others recommended outsourcing janitorial/security/maintenance functions as well as reforming food service to eliminate staff meals and reduce the kitchen size.

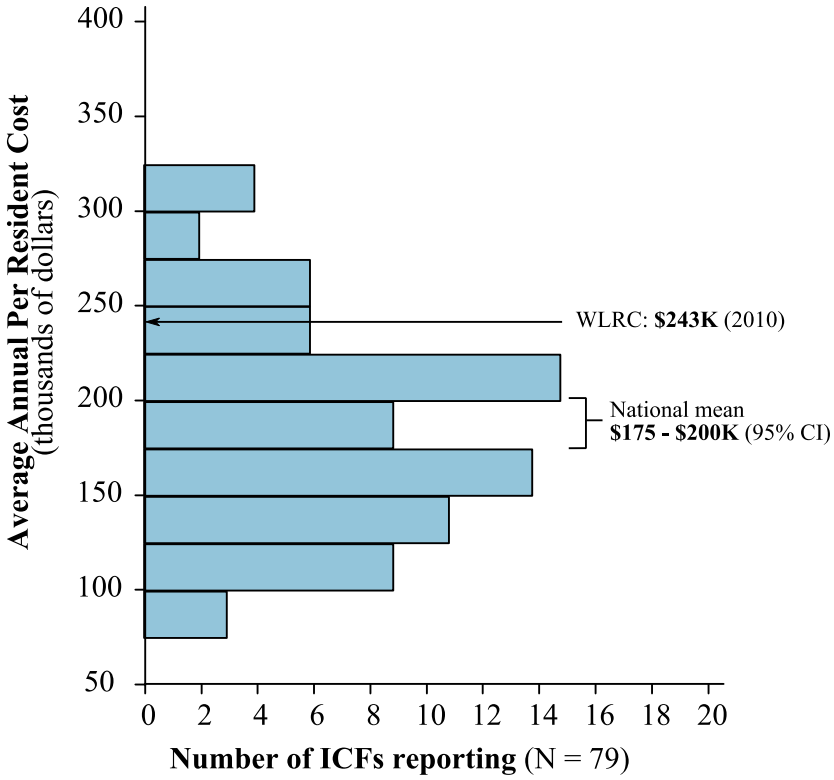
COMPARISON WITH OTHER ICFS

Comparison on Per-client Cost

HEA81 Section 1(a)(vii) required "comparisons of operational costs with similar facilities in other states on a per client basis[.]"[21] Additionally, a comparison with other ICFs is provided to give context and support for the options for efficiencies detailed later in the report.

To compare the WLRC to other facilities, the WDH analyzed data from over 100 large (16 or more clients) state-run ICFs compiled by the University of Minnesota Research and Training Center on Community Living's Residential Information Systems Project (RISP) survey (hereinafter RISP data). In comparison with other facilities, it is clear that the WLRC had above average annual per-client costs. Within the 79 facilities that reported cost data, the national mean for 2010 was estimated between $175,000 and $200,000 per client per year. The WLRC spent $243,102.54 per ICF client in 2010 (103 clients). This comparison against the national average and the distribution of per-client costs from ICFs nationally can be seen in Figure 14. While WLRC is significantly above average, it was not the highest cost facility in 2010.

Figure 14. Total per-client Costs: WLRC vs. Other ICFs



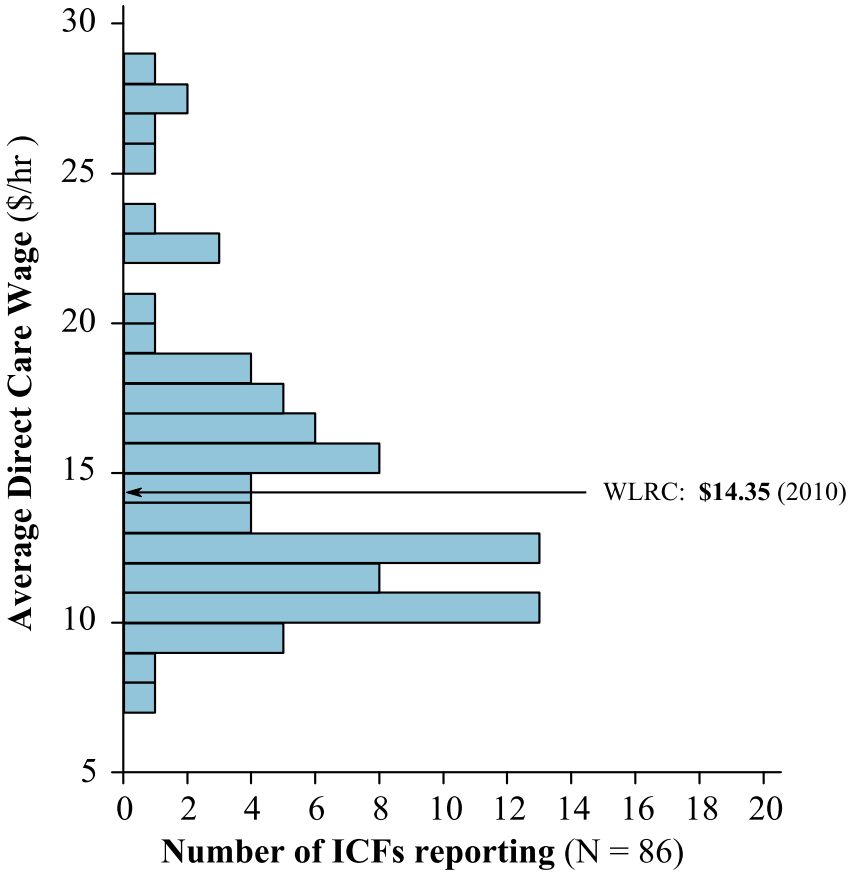
[21] It should be noted that comparison to "similar" facilities is limited due to the fact that no other state-run ICF-ID facility, to the knowledge of the WDH, operates state-funded programs for individuals with ABI in an ICF-ID setting or on the grounds of an ICF-ID. That said, to complete this section, the WDH analyzed data from over 100 large (16 or more clients) state-run Intermediate Care Facilities (ICFs) compiled by the University of Minnesota Research and Training Center on Community Living's Residential Information Systems Project (RISP) survey (hereinafter RISP data). Comparison data from the WLRC consisted of data reported by the WLRC to the RISP and/or data reported to the Wyoming Legislature through legislative reports. In either case, WLRC data does include its non-ICF population.

Comparison on Per-client Cost Associated Characteristics

In attempting to understand characteristics that were associated with per-client cost, the RISP data was further analyzed. The WDH identified three significant characteristics: (1) direct care wage; (2) total staff ratio; (3) age of the facility. In the following section, these characteristics are used to further compare the WLRC to ICFs nationally.

1. **Average direct care wage.** Possibly the most significant characteristic affecting per-client cost is the average wage paid to direct care employees. ICF expenditures are largely related to personnel, so it is intuitive that the average price of labor would account for a large amount of variation in per-client costs among facilities. As can be seen in Figure 15, the WLRC, with an average wage of just over $14 an hour, falls close to the middle of the distribution.

Figure 15. Average Direct Care Wage: WLRC vs. other ICFs



2. **Total staff ratio.** Staff ratio is another significant characteristic related to per-client cost. This, too, is intuitive as personnel costs account for a large portion of ICF expenditures. The figures that follow show how the WLRC compares with other ICFs on both total staff to client ratios and direct care staff to client ratios in 2010 and in 2013. As shown in Figures 16-17, the WLRC is an outlier, particularly when it comes to total staff ratio, meaning the WLRC employs more staff than most other state-run facilities.

Figure 16. Total Staff Ratio: WLRC vs. other ICFs

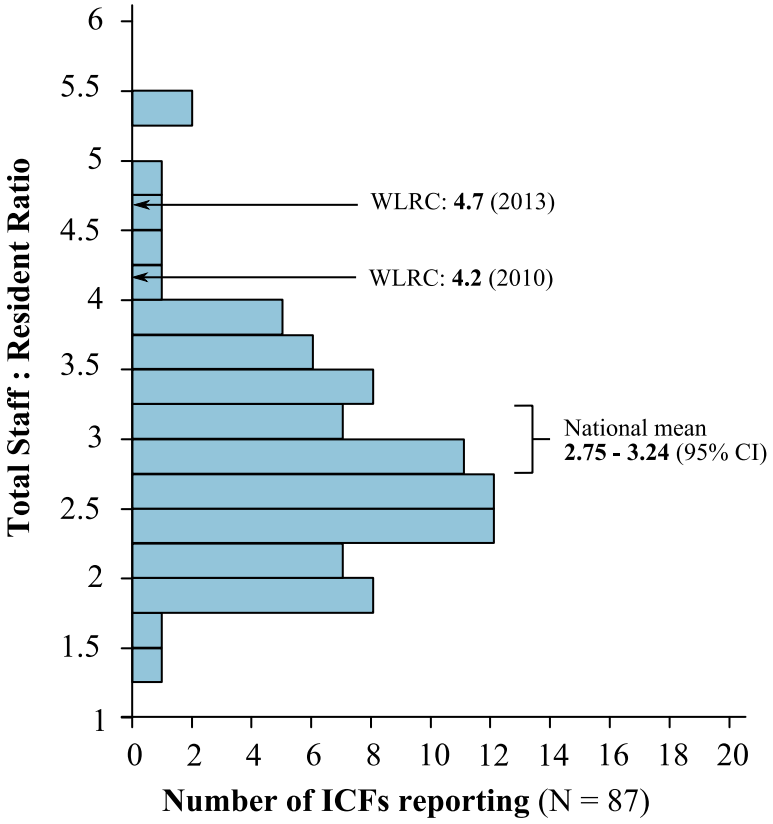
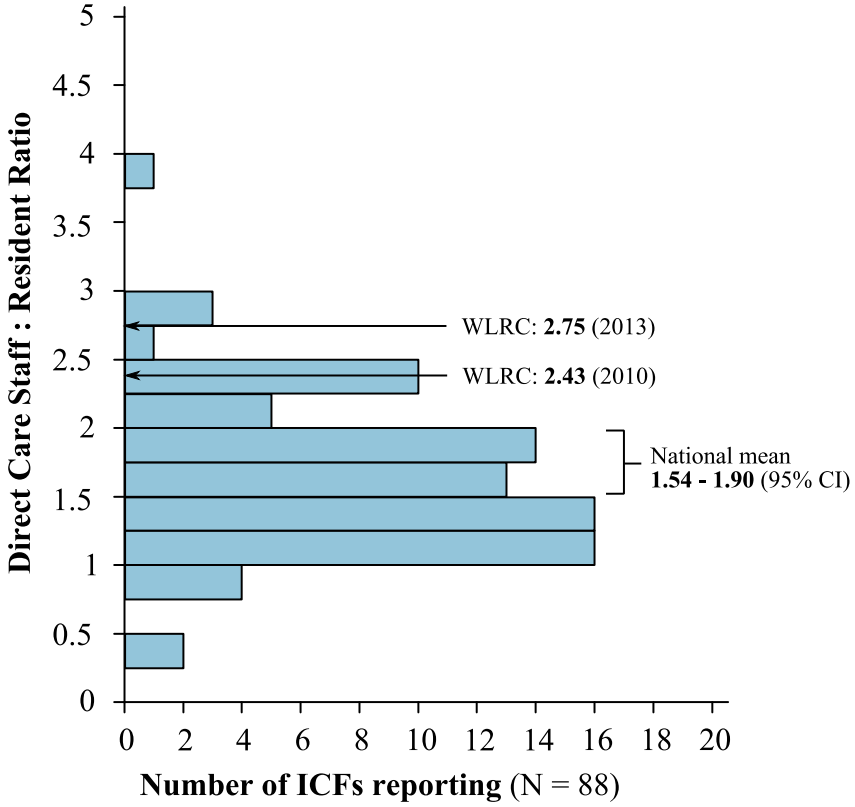
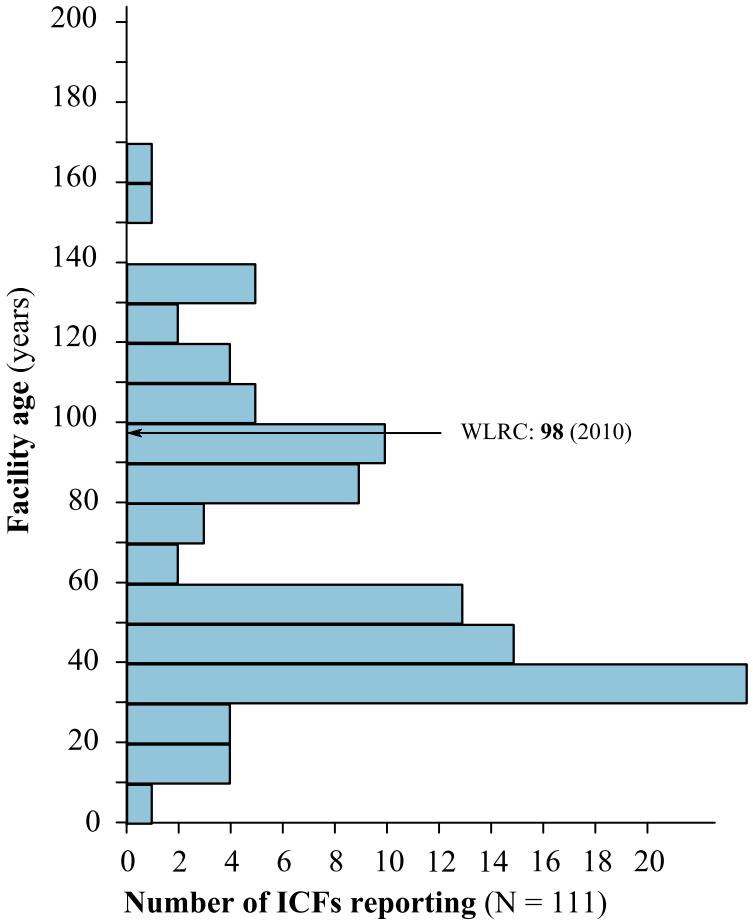


Figure 17. Direct Care Staff Ratio: WLRC vs. other ICFs



3. **Facility age.** While less significant than the other factors, a facility's age does seem to affect per-client cost. This is possibly because older facilities are oversized for their current client population following widespread deinstitutionalization and possibly because older buildings require more maintenance or lack modern design features that make providing care less costly. The data, as shown in the figure below, illustrates how the WLRC falls into an earlier generation of institutions built in the early twentieth century.

Figure 18. Age of WLRC Facility compared with other ICFs



The WDH attempted to identify "similar" facilities to the WLRC using all three of the previously discussed characteristics, but was unable to find any in the data. Thus, the WDH identified a group of ICFs similar to WLRC on two characteristics (wage and age of facility; excluding total staff ratio due to a lack of comparable facilities). The facilities that matched on similar characteristics to the WLRC are shown in Table 11, sorted by yearly cost per client in 2010. There were no matching facilities in the Rocky Mountain region.

Table 11: Facilities similar to WLRC on age and wage (2010)

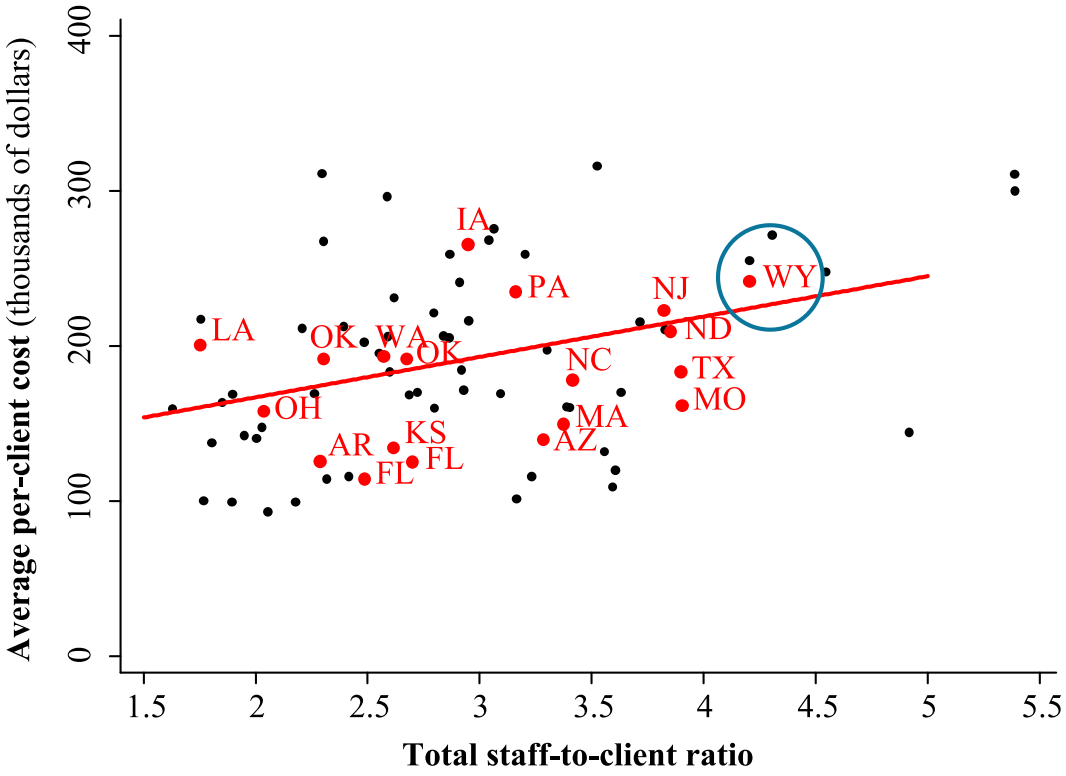
State	Facility	Clients	Yearly cost per client	Wage	Facility Age	Total Staff Ratio
FL	Sunland Center	337	$114,318.00	$10.70	49	2.49
FL	Tacachale	411	$125,319.10	$11.72	89	2.70
AR	Conway Human Development Center	496	$125,560.00	$10.97	51	2.29
KS	Parsons State Hospital and Training Center	190	$133,955.00	$14.37	58	2.62
AZ	Arizona Training Program	115	$139,430.00	$11.70	58	3.29
MA	Wrentham Developmental Center	309	$149,693.80	$17.57	103	3.38
OH	Mount Vernon Developmental Center	179	$157,804.10	$15.62	62	2.04
MO	Higginsville Habilitation Center	83	$161,435.90	$11.10	54	3.90
NC	Murdoch Development Center	506	$177,871.80	$14.95	53	3.42
TX	Mexia State Supported Living Center	430	$183,292.10	$12.21	64	3.90
OK	Southern Oklahoma Resource Center	135	$191,625.00	$11.61	58	2.30
OK	Northern Oklahoma Resource Center	117	$191,625.00	$12.34	101	2.68
WA	Rainier School	359	$193,001.10	$16.69	71	2.57
LA	Ruston Development Center	36	$200,538.30	$11.28	51	1.75
ND	Grafton Center	115	$209,196.10	$12.44	107	3.85
NJ	Vineland Development Center	417	$222,566.10	$15.88	122	3.82
PA	White Haven Center	164	$234,954.20	$15.76	109	3.16
WY	**Wyoming Life Resource Center**	**103**	**$243,102.50**	**$14.35**	**98**	**4.2**
IA	Glenwood Resource Center	292	$265,347.70	$17.01	134	2.95

Findings from Comparison Data

Changes in any of these three characteristics would affect per-client costs at the WLRC. Two of the three (age of the facility and average wages) are beyond the control of this study. Thus, the remaining characteristic, staff ratio, was chosen for further review.

The relationship between total staff ratio and per-client cost, controlling for facility age and average wage, can be seen in the scatterplot below. The "similar" facilities are highlighted in red in Figure 19. As can be seen by the red line, as total staff ratio increases, so does per-client cost.

Figure 19. Predicted Average Cost based on Staff Ratio, Facility Age, and Average Direct Care Wages (RISP 2010)



Opportunities to Reduce the Overhead and Other Operational Costs of the Center

The exploration into opportunities to reduce overhead and operational costs at the WLRC began with a review of the WLRC SFY2012 expenditures. Almost 90% of the WLRC expenditures were on personnel salaries and benefits. This factor, combined with the knowledge that the WLRC is an outlier for high staff ratios, led to a deeper analysis of personnel data as a starting point for identifying efficiencies.

This analysis identified potential for substantial savings from reduction in staff ratio. Along with staff ratio reduction, miscellaneous opportunities were also identified and are discussed in the section to follow.

Note on Study Limitation: This study, and its review of opportunities to reduce overhead and operational costs for the WLRC, has been somewhat limited by certain administrative and operational practices currently in place at the WLRC. For example, the WLRC does not track specific therapies received by clients at the WLRC, nor does it track specific therapy sessions provided by its therapists. Therefore, this report may not identify all of the opportunities for efficiencies at the WLRC.

Further, through this report the WDH does not want to require specific actions of the new WLRC Administrator before the position is filled. As such, opportunities for efficiencies at the WLRC, as identified through this study, are presented in general terms below. The WDH intends to work with the new WLRC Administrator, once hired, to further review these (and possibly other) opportunities for efficiency and to achieve savings at the WLRC.

OPPORTUNITY #1: REDUCTION IN STAFF RATIOS

As of March 2013, WLRC had 429 budgeted positions (381 were filled) with a staff to client ratio of 4.7 to 1. This ratio is significantly higher than an estimated national average for state-run ICFs (between 2.75 and 3.25 total staff per client).

This staff to client ratio is also higher than what was required by the Weston Settlement Agreement. The Agreement specified a minimum total staff ratio of 3.5 : 1. While the Weston Settlement Agreement is no longer in effect, a 3.5 : 1 ratio may be a good initial benchmark for the WLRC. Moving to a 3.5 :1 total staff ratio for 90 clients would allow for the elimination of approximately 114 budgeted positions. Again, not all of these budgeted positions were filled as of March, 2013. Position elimination could occur in all areas of the WLRC including: direct care, administration, medical/therapies, and operations.

Direct Care Staff

Savings could be achieved by reducing the direct care staff to client ratio, as well as increasing the span of control for front-line shift supervisors.

Direct care staff account for the majority of the positions at the WLRC. The WLRC has 248 budgeted direct care positions (220 were filled as of March, 2013), making a 2.75 direct care staff-to-client ratio. In other words, at the WLRC, for every client, there are 2.75 direct care staff positions. This can be compared with the national average (2010) of between 1.54 and 1.90 (for every client, there are 1.54 - 1.90 staff positions).

Reducing the number of direct care staff must be done carefully, as the direct care staff are the day-to-day providers of care to WLRC clients. In fact, federal regulations require ICFs to maintain a minimum number of direct care staff per client.[22] While the number of direct care staff required depends on the type of client (child, severity of disability etc.), the highest ratio required (for the most severely disabled clients and children) is 1.43 direct care staff to 1 client.[23] The WLRC direct care staff ratio is 2.75 : 1, which is significantly higher than what is required by federal regulations.

The current WLRC direct care staff-to-client ratio is also higher than what was required by the Weston Settlement Agreement. The Weston Settlement required that the minimum direct care staff

[22] 42 CFR 483.430 - Condition of participation: Facility staffing

[23] Assuming 3 shifts of 8 hours each, and 12 FTE for 11 positions (30 days of sick leave/vacation) as well as 7 FTE for 5 positions (to cover weekends).

ratio should not drop below 1 : 4 during normal waking hours or 1 : 10 during sleeping hours. Averaged over all shifts, the direct care staff ratio required by this Settlement Agreement would be 1 full-time direct staff per client (1 : 1).

Comparison of data from other ICFs nationally revealed that few, large state-run ICFs had a direct care staff ratio of less than 1 : 1. Further, comparison revealed that the ratios increase as the client mix becomes more challenging. This is intuitive; clients that are more difficult to care for require more care providers.

The WDH analyzed client data from the WLRC, as well as data from other ICFs to determine an appropriate benchmark for direct care staff-to-client ratio. This analysis suggested that the WLRC could move towards a filled direct care staff-to-client ratio of 2 : 1 without compromising care.

Additional savings could be realized from direct care by increasing the span of control – the number of employees under the supervision of each supervisor. The WLRC staff survey conducted as a part of this study revealed staff concerns over a "top-heavy" structure. This concern led to a review of the hierarchical structure at the WLRC. Upon the completion of this review, the WDH found that span of control could be increased.

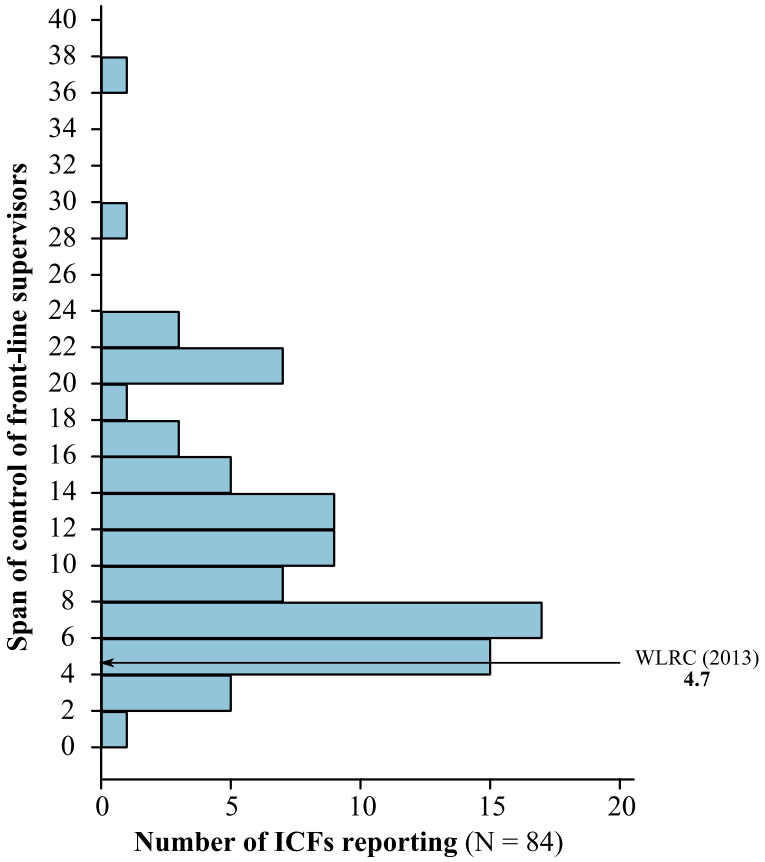
While span of control varies across programs, as shown in Table 12, on average the span of control at WLRC is around 4.7. On average, a shift supervisor oversees 4.7 human service aides.

Table 12: Span of Control at WLRC

Program	Human Service Aides	Shift Supervisors	Span of Control
WLRC Overall	171	36	**4.75**
Canyons North	95	19	**4.94**
Canyons South	55	11	**5**
Visions	21	6	**3.33**

(continued on next page)

Figure 20. Span of Control: WLRC vs. other ICFs



As seen in the figure to the left, the WLRC has a lower than average span of control; that is, there are fewer employees per front-line supervisor than the average for large state-run ICFs (median: 8, mean: 11).

The Weston Settlement specified a maximum span of control of 6. The WDH review of span of control at the WLRC suggests that the span of control could be increased to 6.

Administration Support Staff

As previously discussed, results from a staff survey revealed staff concerns over a "top-heavy" structure in place at the WLRC. This concern was validated by the WDH review of the administration at the WLRC. There appear to be several positions within the administration of the WLRC that could be eliminated without compromising client care. The WDH will continue to explore this issue once a new WLRC Administrator is hired and informed on the administrative structure at the WLRC.

Operations Support Staff

Similarly, there are positions within operations support of the WLRC that could be eliminated without compromising client care. Elimination is possible, in some instances, due to previously consolidated responsibilities.

Medical/Therapies Staff

There are additional opportunities for position reduction in medical/therapies. Two possibilities are the "re-sizing" of the Health Care Center and the outsourcing of Dental Services. Additional reduction may be possible in therapies, however, the WDH first must work with the WLRC to standardize and track therapy service and utilization in order to allow a detailed analysis of staffing needs.

OPPORTUNITY #2: FOOD SERVICE REFORM

Within the operations of the WLRC, opportunities to reduce overhead and operational costs were identified. An area identified for reform was food service. WLRC employs 19 food service employees in the kitchen at a total labor cost of approximately $1.3 million. In addition, the facility spends approximately $500,436 on raw food and food service supplies.

Thus, in SFY2012, $1.8 million dollars was spent to serve 177,456 meals resulting in an average per meal cost of $10.14. Of the $10.14, only $2.83 is actual food expense. This per meal cost is higher than other facilities in the Lander area and also higher than other state-run facilities.[24] Two reforms were identified: eliminate free staff meals and contract out food service.

Eliminate Staff Meals

The WDH identified the number of meals served (177,456) as out of line with the population at the WLRC. In March 2013, 35 of the 94 clients were on feeding tubes; with a few exceptions, these 35 clients are provided nutrition through liquid formula instead of prepared meals. Further review showed that the majority of meals served by the WLRC are consumed by staff at no charge to them.

Free staff meals cost the WLRC the cost of the food plus the labor of producing more meals. The policy of free staff meals is driving the need for more staff. Preparing meals for clients only would allow reduction in food service staff and save money on food costs.

Contract out Food Service

The WLRC could explore outsourcing its food service. Savings would be realized due to the elimination of positions.

OPPORTUNITY #3: RE-SIZING THE HORIZONS HEALTHCARE CENTER (HHC)

The average medical cost at the WLRC was $31,756.33 for each of the 90 clients. Of this, $23,343.39 (73.5%) went to salaries and benefits for Health Care Center medical personnel (not including therapies), $6,791.36 (21.4%) went to supplies and equipment and $1,621.58 (5.1%) went to contracted services, largely for dental exams.

The Horizons Healthcare Center provides inpatient and outpatient care to all WLRC clients. In addition to physicians, physician assistants and nurses, capabilities include dental, x-ray, respiratory therapy, a certified laboratory and a full pharmacy.

The HHC also provides acute and long-term medical care to individuals with extreme support needs (e.g. ventilator-assisted breathing). This inpatient unit is underutilized and paid with 100% state

[24] Westward Heights skilled nursing facility, for example, has a per-meal cost of $7.30. Meals at the Wyoming Veteran's Home average $8.53 and meals at the Wyoming Retirement Center average $7.40.

funds. Thus, there is opportunity for savings by re-sizing the HHC to close the inpatient unit of the HHC. Closing the inpatient unit would require shifting all hospitalizations to the community.

OPPORTUNITY #4: OUTSOURCE DENTAL CARE

A move from employing dental personnel to contracting for dental services could provide additional cost savings. However, the logistics of transportation, scheduling and community capacity must first be determined.

OPPORTUNITY #5: REEVALUATE OFF-CAMPUS DAY PROGRAMMING CONTRACT

Currently, 15 Canyons clients attend day programming outside the facility under a contract with a private provider. The contract costs the WLRC approximately $432,000 per year. The WLRC transports the clients to and from the day programming. The original intent of this contract was to explore the potential for community transition for certain high-functioning clients. None have yet transitioned. This arrangement could be reevaluated.

SUMMARY OF EFFICIENCIES

Staff reductions and the associated efficiencies are projected to save the WLRC between $4 and $5 million. A summary how this estimate was developed is shown in the table below.

Table 13: **Summary of Known Efficiencies**

Efficiency	**Net savings (millions)**		**Recommended Timeframe**
	Low	**High**	
Decrease the direct care staff ratio to 2:1	$1.6		Contingent
Reform food service	$1.1	$1.4	Medium-term
Resize the Health Care Center	$0.7	$0.8	Medium-term
Reduce administrative and operational overhead	$0.3	$0.9	Medium-term
Increase utilization of day programming	$0.4		Short-term
Total	**$4.1**	**$5.1**	

Based on the programs targeted, WDH estimates that 57% of net savings realized will be to the State General Fund, 43% will be to the federal match.

Staff Reduction Methods

To accomplish these staff reductions, the WLRC has three options, presented on the next page. The WDH would recommend options 1 or 2.

1. **Attrition.** The WLRC can wait until employees retire or leave their positions. This option would take time. However, this option would least impact morale and would not add extra cost to the State.

2. **Incentives.** If funding is appropriated, the WLRC could offer employees in targeted positions incentives to leave (e.g. early retirement). This option would reduce the time it takes to implement efficiencies with less risk of negatively impacting morale. However, it would add costs.

3. **Reduction In Force (RIF)**. The WLRC could eliminate positions, which would lead to lay-offs. This option would take the least time to implement, but would most likely affect morale at the WLRC and add costs for unemployment benefits.

SECTION FIVE: CONCLUSION AND NEXT STEPS

CONCLUSION

HEA81 directed the Wyoming Department of Health to conduct a study of the most effective and efficient means of providing care to clients of the Wyoming Life Resource Center (WLRC). The WDH welcomed this opportunity to closely examine the operations and clients at the WLRC.

The WDH focused its study on two questions: (1) whether some or all the WLRC clients should be transitioned out of the WLRC to be served through community based services; and (2) whether there are efficiencies that can be gained at the WLRC.

In answering the first question with regard to client services and transitions, research and analysis generated several considerations. Ultimately, the WDH, pursuant to this study, does not recommend any WLRC clients be forced to transition out of the WLRC. The WLRC provides appropriate and needed care to a group of high-need people in the State.

While the WDH believes the WLRC provides the State a valuable safety net, there are efficiencies that can be gained at the WLRC. The WDH is committed to working with staff at the WLRC and the new Administrator (once hired) to ensure appropriate opportunities for efficiencies are pursued. However, through the work to gain efficiency, client safety and services must not be compromised.

NEXT STEPS

The study conducted in response to HEA81 was limited in scope. The study reviewed current operations and clients at the WLRC, but did not attempt the examination of future possibilities for the WLRC or possibilities for a different or additional client base. This study did not explore such opportunities; however, some of the ideas for revenue generation shared with the WDH are described below.

Additionally, there were interested parties who expressed a need for the State to examine gaps in currently available services. Again, this study did not explore such gaps; however, certain concerns are relayed in the following section.

As a final note, there is a study being completed by the State of Wyoming, Department of Administration and Information, Construction Management on all five WDH facilities, resulting in a "Facility Master Plan." The Facility Master Plan is separate from this study. It is being conducted by an architectural firm at the direction of the Department of Administration and Information (A&I) pursuant to legislative request. The expected release date for this Plan is November 2013.

POTENTIAL REVENUE GENERATION OPPORTUNITIES

Throughout this study, multiple comments and ideas were brought forward with regard to revenue generation at the WLRC. The reasoning behind these comments was that rather than looking for ways to cut costs, the WLRC could look for ways to increase revenue.

Expanding Utilization

The unique value of the Wyoming Life Resource Center lies largely in its diverse therapy options: the pool, the greenhouse, the horse barn, the staff training program and the custom equipment shop. Instead of cutting any of these capabilities, the WLRC could attempt to increase utilization of these services to generate outside revenue.

Additionally, the idea of marketing the services provided by the WLRC to other states was suggested to the WDH. This would entail the WLRC offering to take clients in need of an institutional level of care most likely from states that are closing their ICFs or are no longer operating an ICF. This idea may be limited by the current costs of the WLRC. As discussed within the report, the WLRC per-client costs are well above most ICFs in the nation.

Another idea shared with the WDH during the study process was that of the WLRC better marketing its services to people in need within the State of Wyoming. This, too, would need more research if pursued. As discussed in the report, current law restricts admission to the WLRC because of its institutional level of care.

Making the Visions Program Eligible for Federal Match

The WDH heard from interested parties about the need to pursue federal financial participation, such as a Medicaid match, for the Visions program (ABI). In 2012, the Visions program cost approximately $3.6 million, all of which came from State General Funds. The WLRC could attempt to restructure the program in order to receive some federal financial participation. This option would require significant research if of interest. A cursory review identified three possibilities.

1. The WLRC could seek Skilled Nursing Facility (SNF) designation for Visions on the current campus. This would require some capital upgrades (e.g. generators, sprinklers) and a process for licensure with the Centers for Medicare and Medicaid Services (CMS). SNF Medicaid rates, however, are typically well below ICF rates ($187 is the highest SNF rate in the State, compared to the $834 per day per client required for Visions), so it is likely the federal match would only cover 10-15% of the cost of the program.

2. Visions program recipients could be put on the ABI Waiver and transitioned to the community. This would ensure a 50% federal match at a lower overall per-client cost. The WDH, however, does not recommend forced transition of any WLRC clients as a result of this study.

3. It may be possible for the Visions program to be set up as a new state-run "safety net" ABI Waiver home, completely separate from the WLRC campus that does not provide an institutional level of care. This option would require significant research to fully understand the extent to which the State may be successful in pursuing this option.

GAPS IN SERVICES

The WDH, in conducting this study, heard concerns regarding gaps in services that currently exist in the State. A common theme within these concerns was the inadequacy of the current "system" to appropriately care for individuals who have "dual diagnosis." That is, individuals who have intellectual disabilities or acquired brain injuries who also have mental illness.

While the majority of people with a dual diagnosis are able to live successfully in community settings, there are gaps in available services for those who have more challenging mental illness or aggressive behaviors. Both the WLRC and the Wyoming State Hospital are serving as safety nets for the most challenging clients with dual diagnosis; however, these facilities are finding that transitioning these clients to community settings is difficult due to a shortage of providers who have the ability to serve this population.

Similarly, the WDH heard concerns about an insufficient number of community providers who can serve geriatric clients with significant mental health challenges and/or difficult behaviors.

While this study did not review these gaps in services, the WDH Behavioral Health Division is currently researching options to complete the system of care and to fill in gaps in service for these populations. There certainly are opportunities for the State, as a whole, to develop a wider range of appropriate services for these populations, both in community settings and in facilities.

Appendix A: WLRC Campus Map