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State of Delaware
Division of Developmental Disabilities Services

MERCER
Human Resource Consulting

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Introduction

This document describes the technical aspects of the State of Delaware Rate System and associated Inventory for Client and Agency Planning (ICAP) formulas used to assign rates to individuals. As such, it is intended to serve as a user's manual for future reference and updates. The document is divided into two parts. The first part describes the Direct Service Staff Rate System (DIRECT SERVICE STAFF), and the second part describes the Individual Service Authorization Protocols. Additionally, an Executive Summary and Recommendations are offered as background for the User's Manual.

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Executive Summary and Recommendations

The State of Delaware is committed to shifting the focus of support for people with developmental disabilities from a system based on program capacity to a person-centered approach. This approach emphasizes the development of a rate methodology that connects reimbursement rates to individual need. The rate methodology will be consumer-driven, family-oriented, choice-based, and market-focused. To further this initiative, in 2001, the State of Delaware Division of Developmental Disabilities Services (DDDS) selected Mercer Human Resource Consulting (Mercer) to conduct a study to assess DDDS's current Medicaid Home- and Community-based Services (HCBS) rate structure, and to conduct the following tasks:

- assess the current rate methodology and individual needs assessment approach for residential habilitation, day habilitation, respite, and transportation services offered under HCBS;
- assess alternative rate methodologies and individual needs assessment tools;
- determine, and recommend from these assessments, options for applying a rate methodology based upon self-determination principles and individual needs;
- develop a detailed rate model which is cost effective to DDDS and the Division of Social Services (DSS), which recognizes the varying needs of individuals with developmental disabilities, and allows for adequate cost recovery to DDDS contract providers; and
- implement the rate model and individual needs assessment approach.

To accomplish these tasks, Mercer conducted the following activities:

1. Conducted analyses of cost, vacancy factors, and service utilization data for all provider and agency services to include facility and non-facility costs, and established financial baselines for each provider.

2. Designed reimbursement rates for residential and day habilitation programs offered under the Medicaid HCBS Waiver.

3. Designed transportation rate methodology and associated rate matrix.

4. Conducted analyses of housing costs and determined standardized market-based pricing approach to room and board reimbursement practices as well as assisting in negotiating future housing contracts with ARC.

5. Coordinated the design and implementation of rate reporting requirements with EDS, provider leadership, and DDDS.

6. Conducted analyses of ICAP scores and current provider staffing and support patterns and developed usual and customary service standards and associated service algorithms for determining individual authorization levels.

7. Designed an Individual Cost Guideline (ICG) instrument using the ICAP as the defining criteria for cost allocation.

8. Conducted analyses of special populations and outlier situations and developed exception protocols.

9. Facilitated Pilot Committee meetings and conducted fact finding and consensus-building activities on behalf of DDDS.

In completion of the project, Mercer respectfully offers the following recommendations for further refinement of the reimbursement rate and individual needs assessment processes:

1. Develop clear standards to determine eligibility for group home residential services. There appear to be persons within those settings whose needs are minimal and could be supported in a manner that is equally appropriate but less costly.

2. Review and alter, as appropriate, current prerequisites for supported/supervised living. Current practices may result in people directed to group living who could be supported in an apartment.

3. Amend the HCBS Waiver to expand options and alternatives to the current limit of services, specifically services that expand options to more non-traditional services (i.e., community guides).

4. Introduce outcome measures within provider contracts to gauge whether appropriate services are being provided.

5. Eliminate the "special population" designation and use *individual need for support* as the determination for higher rates.

6. Phase out of the ARC group home purchase arrangement; allow all providers to secure their housing supports and encourage leasing rather than purchasing.

7. Therapy services should be individually authorized and not bundled in a therapy contract.

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Direct Services Staff Rate System

Description

The DIRECT SERVICE STAFF approach is a model where a single rate is developed for a unit of time provided by a staff person who provides care for a person receiving the service. The service is expressed as a unit of time spent in the service by an individual, but the costs are based on the time spent by people providing the service. The billable unit remains a day or an hour (depending on the service), but each rate will vary in exact relationship to the level of Direct Service staffing. In this way, a published rate environment is created, but variability according to the needs of each individual is maintained.

The rates are built using the hourly wage of the staff person, then adding percentages for *Employment-related Expenditures* (FICA, FUTA, Workers Compensation), *Program-related Expenditures* (program supplies other than food, direct staff supervision, and other categories), and *General and Administrative (G&A)* (all other indirect costs of operating a business).

History

The DIRECT SERVICE STAFF was originally developed as a published or standardized rate schedule that seeks to be responsive to the needs of the individuals receiving services and fair to the agencies providing them. It accomplished this by the approach to rate construction itself. This system is completely predicated on the people who will be providing the service in a "hands on" manner with the people receiving them, and varies according to the quality and quantity of that staff time. Behind the entire system is the belief that the most prominent and important variable in the determination of quality and the successful adherence to standards is the DIRECT SERVICE STAFF profile. By no means does it imply that this is the only cost component necessary to create rates, only that it is the most prominent in the furtherance of standards of quality care.

The rate system also depends on the belief that all other cost components, which are equally necessary although less directly variable in response to the needs of the individuals who will receive the services, can be expressed in relationship to DIRECT SERVICE STAFF costs.

The rate system finally depends on the belief that if all the compensation components are studied and their relationships to DIRECT SERVICE STAFF cost profiles can be determined, a standardized rate system can be produced by establishing DIRECT SERVICE STAFF profiles and then building the total compensation (rate) according to the relationships of the other components to the service staff costs.

Methodology

There are four standard cost components that are assumed to be common to all (if not most) residential and congregate social and medical services. These include:

- direct service (or care) staff wage,
- Employment-related Expenditures,
- program-related but not direct expenditures, and
- G&A Expenditures.

An understanding of these components is critical to an understanding of the rate system as a whole and hence, the components are defined in some detail in the section below:

Direct Service Staff

The definition of DIRECT SERVICE STAFF consists of two elements:

1. The staff must be people who are performing their tasks in the furtherance of the objectives of the service. In other words, they must be doing what they are doing in order to meet some objectives defined in the service. They are not considered DIRECT SERVICE STAFF by nature of their qualifications alone, it is also important to regard the nature of the tasks they are doing.

2. The person who is receiving the service and who is expected to benefit from it must be present, most of the time. "Most" is defined as 90 percent or more. This is also referred to the "face-to-face" requirement; the direct staff person must be face-to-face with the person receiving the service.

There may be staff that have the same qualifications as customary DIRECT SERVICE STAFF present but who are not performing tasks related to the service and so would not satisfy the minimum requirements of the service standard.

Employment-related Expenditures

Simply stated, these are all the benefits received by employees of the service agency. Benefits generally fall into two categories:

1. Discretionary Benefits: Those benefits that employers may elect to provide but are not mandated to do so by any governmental authority (*Health Insurance, Dental Insurance, Profit Sharing, Retirement Programs, Tuition Reimbursement, Clothing Allowance).*

2. Non-discretionary Benefits: Those benefits that are mandated by a governmental authority (*FICA, FUTA, SUTA, Worker's Compensation).*

Program-related Expenditures

These are all the expenditures that support the objectives and the provision of the service, but cannot be tied to any single or particular person receiving the service. For this reason they are considered "indirect" but they are not G&A. They differ from G&A Expenditures, the other indirect expenditures category, because they *are* related to the program or service being provided, but cannot be tracked or considered to vary with each individual receiving the service. Supervision of DIRECT SERVICE STAFF, supplies related to the service, consultative services to general staff, in some cases transportation, and in some cases facility costs, are all examples of Program-related Expenditures. It is important to note that many factors influence the inclusion or exclusion of cost types in this category but the two most prominent are the service standards and the funding source regulations. This will be explained further in subsequent sections of this report.

G&A

These costs are the costs of being in business; whether you are doing any business or not. They have nothing to do with the program, the service, or the product offered. Examples include: Executive Director salaries, Accounting and Finance, Claims Processing, Legal Costs, General Liability Insurance, and any and all costs related to the administrative offices where no program activities occur.

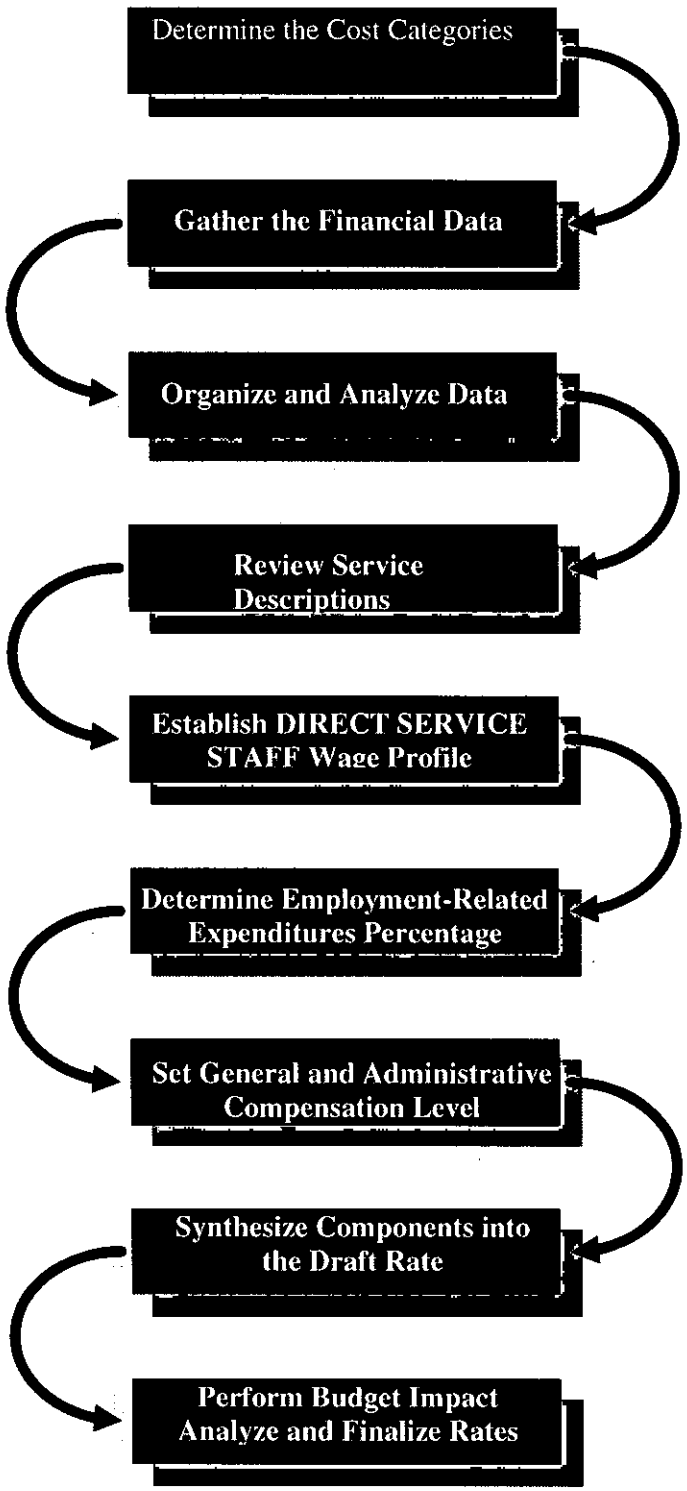
Cost Classification Discussion

Accounting classifications are somewhat standardized as to their role in relationship to cost categories (Balance Sheets generally include Assets, Liabilities and Equities, and Income Statements generally include Income, Expenses, and Provisions). However, the classification of different expenditure account line items is often the discretion of management, and is determined in order for expenditures to be organized in ways that are meaningful to management. For this reason, classifications will vary from one financial entity to another. While all G&A Expenditures are 'indirect' by nature (they do not vary 'directly' with the change in the volume of business activity) not all 'indirect' expenditures are G&A (some may be considered 'Program related'). Since the cost components in this rate architecture are used to build the rates based on the DIRECT SERVICE STAFF costs, some effort is needed to make sure that the line items of the various businesses are grouped in similar manner before any percentage calculations are established. This may mean that some expenditure line items have to be reclassified, for some provider agencies.

Description of the Rate Development Methodology

The methodology to develop rates based on DIRECT SERVICE STAFF profiles, and associated cost categories, proceeds in a sequential fashion. The pictorial on the following page provides an overview of the process and each phase is discussed in detail in subsequent sections of this report.

Rate Development Methodology — A Process Chart



The following narrative identifies each phase of the rate development in general terms.

Phase 1 — Determine the Cost Categories

The first phase in developing standardized rates in this architecture is to study the service standards, prevailing best practices, licensure regulations (if applicable), contract provisions (if applicable), service descriptions wherever they may occur (contracts, funding regulations, agency charters), and any adopted course of change for the services which the rates will be expected to fund. The rationale for this analysis is to determine if the four categories described above will be sufficient or if additional categories will be needed.

For example, Medicaid Waiver programs prohibit the inclusion of room and board expenditures in the set daily rates for community-based residential facility services, but their inclusion is mandated in institutional settings. Consequently, if rates were needed for institutional settings under Medicaid, room and board charges would generally be folded into the "Program-related" cost category (there are exceptions). In community-based facilities, they would be broken out entirely.

Some components will vary because of differences in the way services are described. For example, in some institutional settings, nursing care is considered an integral part of the services that each resident will need and levels of nursing are expressed as requirements of the service description. In this case, nursing would be considered a DIRECT SERVICE STAFF event because the two principles of the definition of DIRECT SERVICE STAFF have been met while in other institutional settings, nursing care may or may not occur or it may be of a consultative nature to the facility itself and not normally specific to any particular resident. In this case, it would be considered a component of Program-related Expenditures.

Phase 2 — Gather the Financial Data

The second phase of the rate development process is the determination of the nature, quantity, and quality of existing expenditure data in the community of providers of the service(s) in question. This can sometimes be an arduous process. The underlying questions are always (in this order):

1. Are there any line item cost reports related to the services?
2. Are they in enough detail so as to be identifiable in the categorizations identified in phase one of the rate development?
3. If not, in what manner will the information be gathered?
4. Assuming existing cost reports, are they current?
5. Are they reliable (do they correlate to any audited financial documents)?
6. Assuming existing cost reports, are the line items contained within them consistent between provider agencies?

These questions (and others that result from review of documentation) are intended to establish the requirement that cost information reports must meet the following conditions to be useable in rate development:

- they must be available (reports must exist),
- they should be current,
- they should be accurate and objectively supportable,
- they should be in enough detail so as to allow for categorization according to the determined categories necessary, and
- line items within them should be consistent between providers of the same service.

Because the audited financials are usually used in this phase of development, it is customary to perform ratio analysis while in this phase. Ratio analysis, performed on the Balance Sheet and Income Statements, serve the purpose of assessing the general financial health of the community of providers studied. These ratios, referred to as "liquidity" ratios, are generally analyzed for the purpose of determining the ability of provider agencies to service debt and maintain operations at a standard of one-month availability of cash reserves. These ratios are used to determine "going concern" status and are described as follows:

Ratios to Determine "Going Concern"

CURRENT RATIO — Current Assets to Current Liabilities: Short-term solvency: the ability to satisfy current liabilities with cash and disposable assets.

QUICK (ACID) RATIO — Cash and Accounts Receivable to Current Liabilities: Short-term solvency; similar to above but expressed at a more rigorous level.

CURRENT DEBT — Current Liabilities to Net Worth: A security ratio used to measure the extent that current short-term liabilities exceed net worth.

LONG-TERM DEBT — Total Liabilities to Net Worth: A security ratio used to measure the extent that total liability levels exceed net worth.

OPERATING — Cash and Accounts Receivable to One-Month of Operating Expenditures: Length of time organization could withstand a total interruption of cash flow. This is the "going concern" status ratio, which ties to the 30-day standard of continuity of care. Note: this ratio is sometimes split into to separate ratios, with one being the ratio of cash only – to one-month of operating expenses.

The results of the liquidity analysis and the application of the calculations related to these ratios indicate the general financial health of the community of providers.

Phase 3 — Organization and Analysis of the Data

In this phase, the cost report information is organized so that all reports are structured in comparable ways and the component analysis is performed. The final result of the component analysis is the understanding of the each of the cost components' relationship to DIRECT SERVICE STAFF costs. Additionally, these components are expressed in terms of that relationship (usually as a percentage).

Phase 4 — Review Service Descriptions

In the fourth phase of development, the analysts return to the service descriptions to establish the proper quality and quantity of DIRECT SERVICE STAFF and the general profiles of the DIRECT SERVICE STAFF specific to the service standard. This information will form the basis of the completed rates.

Phase 5 – Establish DIRECT SERVICE STAFF Wage File

In Phase 5, the wages associated with the staff described in the standards as DIRECT SERVICE STAFF are established. This can be performed in a number of ways. Wage and Benefit studies can be performed, research into objective sources of wage and benefit information (such as the Bureau of Labor Statistics) can be done, prevailing market wages currently paid by providers in the area can be reviewed, and finally, they can be set by administrative discretion as a matter of policy.

Phase 6 — Determine Employment-related Expenditures Percentage

In this phase, the Employee-related Expenditure percentage is determined. This is done by comparing the percentage revealed by the analysis of the cost reports to known information about benefit percentages. As with the wage levels, a decision must be made as to whether to use the existing market percentage revealed in the current providers' cost reports, or to use an objectively determined "fully loaded" benefits package such as might be available from an objective source, or to set this percentage by administrative discretion as a matter of policy.

Phase 7 — Set G&A Compensation Level

The G&A percentage must be set. It is important to include a brief discussion about G&A Expenditures in the description of this phase of rate development.

G&A Expenditures are almost always and almost completely "fixed" in nature, which means that they do not vary in periods of less than one year (sometimes many more). Because G&A Expenditures are not related to the type of business (service or product) that the company provides, they will never vary in a direct relationship with the amount of business that the agency does. This kind of cost component, if expressed as a percentage of costs (or anything else), is extremely sensitive to scale.

What that means is that if you do a lot of business (measured as either a high level of revenue dollars, or high level of expenditure dollars), the percentage will be very low and if you do very little business the percentage will be high. But if you express the cost as a percentage, that percentage will be very different at every level of business activity.

This means that two companies with exactly the same dollar amount of G&A Expenditures but with very different general levels of business will have very different G&A percentages.

This creates a dilemma for rate setting because it must be standardized and if it is not expressed as a single percentage it results in a very complicated rate system. Fortunately, most government-funding agencies set G&A reimbursement levels by policy and express the compensation limit as a single percentage.

Phase 8 — Synthesize Components into Draft Rate

In this phase, the math is performed. All the numbers are combined and reassembled using the base wage for the DIRECT SERVICE STAFF and all the percentages. Note: The Program-related percentages are almost always going to differ by service, just as the DIRECT SERVICE STAFF most probably will differ.

Phase 9 — Perform Budget Impact Analysis and Finalize Rates

After all the rates have been developed in draft, a process is performed to study the impact of the rates on the existing service budget for the funding agency. This is performed in a variety of ways determined by many different factors (billable unit, vacancy factors, bundling, etc.).

The process used to perform the Budget Impact Analysis consisted of the following steps:

1. Establish the existing budget (by provider) by determining contracted and capacity bed day levels and current contracted or equivalent rates.
2. Establish proposed rates. Two rate systems were created for review. The first assumes a blended General Medical basket of direct care staff skill sets as available in residential provider environments. The second replaces this group with a single assumption of the use of Certified Nurse Assistants and Medical Attendants.
3. Calculate the difference between current rates and total budgets to the proposed rates and the resulting budgets if contracted bed days were to be paid at proposed rates.
4. Calculate the percentage adjustment to the proposed rate that would be necessary to maintain budget neutrality throughout implementation of the proposed rates. This was performed in two ways. The first analysis compared the proposed budget to the existing budget across all services (Residential and Substance Abuse). The second, and recommended approach, isolated separate budget impacts for Residential Services and Substance Abuse and applied discreet adjustment factors for each.
5. Measure the impact on each individual provider agency expressed in total dollar amounts as well as by percentage.
6. Add a comparison of current budget to the budget implied by the full funding of the capacity for each provider. Add a comparison of the current budget to the budget for the full capacity of all provider agencies, if funded at the proposed rates.

Phase 10 —Study Rate Impact by Provider (Optional)

The final phase of rate development is an optional phase but one that most funding agencies usually choose to perform. Any time that an existing environment of many different rates developed over long periods of time, with different negotiation characteristics, is replaced with a standardized published rate system for the very same services for the very same providers and recipients, some providers will see increases and some may see decreases. It is prudent to study the impact of the rate system on each provider to determine the amount of increase or decrease they will experience. Beyond a certain level, a decrease could be devastating to a provider and would jeopardize their financial health; it could even put them out of business. The loss profile of the individual providers (if any) is studied to determine if any are at intolerable risk of loss. If there are providers whose potential loss exceeds what would be considered tolerable, the assumptions are reviewed to determine the applicability for the specific provider.

Rate Development for Residential Habilitation

The rate development for residential habilitation followed exactly as described above. The component calculations were as follows:

Cost Center	Factor
Direct Care Average Wage	$10.50 per hour
Program-related Percentage	30.5%
Employment-related Percentage	34.0%
G&A Percentage	Varied (Small, Medium, Large Agency)

The calculations were performed as follows:

- Direct Care Wage (A) multiplied times Program-related Percentage (B) = Program-related Dollar Equivalent (C).
- Direct Care Wage (A) multiplied times Employment-related Percentage (D) = Employment-related Dollar Equivalent (E).

The sum of the first three components (A, D, and E) divided by One Minus the G&A Percentage (the inverse of the G&A Percentage) = total rate for day of Residential Habilitation for one person receiving the service, if only one hour of direct care staff time is assumed to occur in any given 24-hour period.

Rate Development for Day Habilitation

Development for Day Habilitation programs differed from Residential Habilitation programs in three significant ways.

First, there are four versions of Day Program rates that respond to four different configurations of cost categories (and consequently four different tables):

One: Facility costs are included in addition to the four categories that make up Direct

Staff Costs (Wage, Program-related, Employee-related, and G&A). These programs are facility-based, in that they employ the use of a building where people who are enrolled in the program go to spend the day in different activities there at the site. This is as distinct from Employment Programs sometimes referred to as "sheltered work shops".

Two: No Facility Costs are assumed to be part of the program profile, but Transportation Costs are added to the categories that make up the Direct Staff Costs. A separate transportation profile is compiled and the total costs are then calculated on a per person day. In this program description, there is no facility involved in the provision of the day program services, but the program involves the transportation of people into the community for activities in the community of a variety of different types.

Three: Both Facility Costs and Transportation Costs are added to the four categories that make up Direct Staff Costs. In this program description, there is a facility operated by the program, but the service also includes daily integration into community activities and so necessitates the transportation of individuals receiving the service as part of the program.

Four: Neither Facility nor Transportation Costs have been added to DIRECT SERVICE STAFF costs. In this program, the people involved are out in the community during the day, but are using public transportation or are providing their own transportation. For this reason the transportation costs are not included as a component.

Second, rather than express the individual rates as single hours in a six-hour or eight-hour period, the staff-to-client ratio is retained as an expression of the staff intensity of the program for any given person.

The reason to use a single hour of staff time within a larger period of time, as opposed to staff-to-client ratios, is in order to capture small client ratios with a larger number of hour increments possible for the group (smaller total groups, but larger possible staff hours within a 24-hour period). In day programs, the number of possible people in the program is larger (on some occasions more than 100) but the total number of hours possible in the day is much reduced (programs are usually six hours). The ratios therefore, occur in much more subtle increments than single hour.

Third, the treatment of G&A Expenditures is different. In Residential Habilitation there are three G&A percentages expressed and each one corresponds to a different size organization, size determined by number of dollars of revenue. Consequently, each hour increment of the possible DIRECT SERVICE STAFF carries three distinct rates.

For Day Programs, G&A costs were split out between the fixed component and the variable component with the variable component bracketed between a minimum and maximum level. In this way, the G&A responds somewhat to size differentials between

large and small programs, but in far greater detail of increment. This allows small programs to capture G&A in a truly proportionate way to larger programs, even though G&A is paid as a percentage of total dollars (not as a total dollar amount). This also allows for greater flexibility of funding for any given program what changes in size of population frequently.

Adjustment Factors

Adjustment factors are those items that might change in the rate system after it has been introduced; essentially any one of the rate components could be considered a change factor. It is important to note that in any published rate system; changes that occur in the financial environment that directly relate to the components of the rate system do not automatically initiate a change in the published rates.

Wage levels change every year and may become out-of-date and what are often referred to as "unfunded mandates" and are usually not at the discretion of either the providers or the funding agency (unemployment insurance rates, Worker's Compensation, etc.).

Changes in Service Descriptions or standards that occur through whatever processes govern their establishment can have a profound influence on the continued accuracy of the published rates.

Future Rate Change Process

Pressure to revise the rate amounts can and will occur without the necessity to change the architecture of the rate system itself. The system is adaptable to change by an adjustment to the calculations within the system.

If political will exists to increase the assumption of DIRECT SERVICE STAFF wage levels and the decision to increase them is made and funded, the wage levels can be immediately changed and the rates will automatically recalculate.

If unfunded mandates become funded, those changes can be made to the appropriate component (usually Employment-related Expenditures or G&A) and again, the rates will automatically recalculate.

Service Descriptions or standards revisions will usually either affect the DIRECT SERVICE STAFF profile or the Program-related Expenditure percentage. If so, these may involve a more complicated recalculation of the rate system components but the architecture remains the same.

4

Individual Service Authorization Protocols

Description

This section describes the process and approach used to integrate the DIRECT SERVICE STAFF with the ICAP assessment instrument. The Individual Service Authorization Protocols were developed using four primary steps.

1. Apply ICAP to Pilot Group: A group of agencies was selected for participation in a pilot demonstration project, and the ICAP was administered to people receiving services from those agencies. People receiving the ICAP were known as the Pilot Group. In addition, DIRECT SERVICE STAFF service utilization levels for each individual were computed by analyzing provider staff ratios and expenditures.

2. Compare Individual Service Levels to ICAP Scores: Individual service utilization levels were determined for a sample of Pilot Group members, and these Service Level were then correlated to two key ICAP scores: Broad Independence Index, and General Maladaptive Behavior. Individuals in the Pilot Group were placed into service level categories using multiple regression analyses based upon the amount of paid supports received. ICAP Broad Independence Index score ranges were determined using the distribution of scores for each of the Service Levels. Because the Delaware individual service level data for people needing behavioral supports was insufficient to conduct extensive analysis, the ICAP Maladaptive Behavior Scale as defined in the ICAP scoring guide was used to define the thresholds for behavioral support needs.

3. Compare DIRECT SERVICE STAFF ratios to "Best Practice": The current Service Levels were converted to DIRECT SERVICE STAFF ratios, and a "best practice" review was conducted by Futures Health Corporation to determine the adequacy of using current Service Levels to benchmark the Individual Service Authorization assumptions. This best practice review examined the Delaware service and cost thresholds employed by four states which currently use or are planning to use the ICAP for service authorization: Nebraska, Wyoming, Texas, and Pennsylvania. In

addition, two other states (Florida and Arizona) were reviewed. While these states do not use the ICAP for authorization, sections of their individual authorization tools contain items and Service Levels similar to the Delaware ICAP model.

4. Apply DIRECT SERVICE STAFF Rates: The DIRECT SERVICE STAFF was applied to the DIRECT SERVICE STAFF ratios in order to determine Individual Service Authorization resource levels for people receiving Residential Habilitation and Day Habilitation Services. This last step calculates the financial amounts assigned to each service level. There are two key aspects which were considered in applying the DIRECT SERVICE STAFF. First, the rate system was applied to all people who had received ICAP scores at the time of the project. This analysis revealed the initial budget impact of the Individual Service Authorization Protocols using the DIRECT SERVICE STAFF Rates. Second, various budget impact models were examined to determine strategies for containing costs within the current legislative appropriation, as well as projecting future budget impact for changes in caseload enrollment and service utilization.

The following sections of this report list the data tables for the Individual Service Authorization levels, and the findings from the review of other states.

ICAP Scores and Service Level Adjustments

As described in the previous section, people from the Pilot Group were assigned to Service Levels based upon the correlation of their current level of staff support and ICAP scores for two domains: Broad Independence Index and General Maladaptive Behavior. These Service Levels were developed independently for Residential Habilitation and Day Habilitation Services. In addition to the statistical correlations, a group of clinical staff from Futures Health Corporation representing medical, nursing, behavioral, therapies, and employment reviewed specific cases to determine the adequacy of levels of care. These clinical reviews were conducted using the ICAP data supplied by Arbitre, Incorporated, and individual cost and service utilization data collected by Mercer. The following tables describe the ICAP Service Levels and associated DIRECT SERVICE STAFF adjustments, as recommended from those reviews.

Residential Habilitation

Broad Independence Add-On Worksheet

Apartment / Community Living Hours Per Person

	Weekday Hours				Weekend				Weekly Total	Average Daily	Level	Night coverage	Supported Living Hourly Add-on Adjustment
People	AM	PM	Night	Total Weekday	AM	PM	Night	Total Weekend					
1	8	16	8	160	16	16	8	80	240	34.3	Exception	Awake	32.6
2	8	16	8	160	16	16	8	80	240	17.1	#3	Awake	15.4
3	8	16	8	160	16	16	8	80	240	11.4	#2	Not Awake	9.7
3	2	2	2	30	4	4	2	20	50	2.4	#1	Awake	0.7
3	2	2	0	20	4	4	0	16	36	1.7	Base	Not Awake	0.0

Regular Neighborhood Group Home Hours Per Person - Adults 18+

	Weekday				Weekend				Weekly Total	Average Daily	Level	Night coverage	Group Home Hourly Add-on Adjustment
People	AM	PM	Night	Total Weekday	AM	PM	Night	Total Weekend					
1	8	16	8	160	16	16	8	80	240	34.3	Exception	Awake	30.5
3	8	16	8	160	16	16	8	80	240	11.4	#3	Awake	7.6
4	8	16	8	160	16	16	8	80	240	8.6	#2	Awake	4.8
4	4	8	8	100	12	12	8	64	164	5.9	#1	Awake	2.1
4	4	8	2	70	8	8	2	36	106	3.8	Base	Awake	0.0

Mal Adaptive Add-On Worksheet

Apartment / Community Living Hours Per Person

	Weekday				Weekend				Total week	Average Daily	Level	Night coverage	Supported Living Hourly Add-on Adjustment
People	AM	PM	Night	Total Weekday	AM	PM	Night	Total Weekend					
1	2	8	8	90	8	8	8	48	138	19.7	Exception	Awake	19.7
2	2	8	0	50	8	8	8	48	98	7.0	#3	Awake	7.0
2	1	4	0	25	8	8	0	32	57	4.1	#2	Not Awake	4.1
3	1	4	0	25	4	4	4	24	49	2.3	#1	Awake	2.3
3	0	0	0	0	0	0	0	0	0	0.0	Base	Not Awake	0.0

Regular Neighborhood Group Home Hours Per Person - Adults 18+

	Weekday				Weekend				Total week	Average Daily	Level	Night coverage	Group Home Hourly Add-on Adjustment
People	AM	PM	Night	Total Weekday	AM	PM	Night	Total Weekend					
1	4	8	8	100	8	8	8	48	148	21.1	Exception	Awake	21.1
3	4	8	8	100	8	8	8	48	148	7.0	#3	Awake	7.0
4	4	8	4	80	8	8	8	48	128	4.6	#2	Awake	4.6
4	4	4	4	60	8	8	8	48	108	3.9	#1	Awake	3.9
4	0	0	0	0	0	0	0	0	0	0.0	Base	Awake	0.0

Specialized Neighborhood Group Home Hours Per Person - Adults 18+

Broad Independence Add-On Worksheet

	Weekday				Weekend				Total week	Average Daily	Level	Night coverage	Specialized Group Home Hourly Add-on Adjustment
People	AM	PM	Night	Total Weekday	AM	PM	Night	Total Weekend					
1	12	16	8	180	16	16	8	80	260	37.1	Exception	Awake	30.1
2	12	14	8	170	16	16	8	80	250	17.9	#3	Awake	10.8
2	8	12	8	140	16	12	8	72	212	15.1	#2	Awake	8.1
3	8	12	8	140	12	12	8	64	204	9.7	#1	Awake	2.7
3	4	8	8	100	8	8	8	48	148	7.0	Base	Awake	0.0

Specialized Neighborhood Group Home Hours Per Person - Adults 18+

Mal Adaptive Add-On Worksheet

	Weekday				Weekend				Total week	Average Daily	Level	Night coverage	Specialized Group Home Hourly Add-on Adjustment
People	AM	PM	Night	Total Weekday	AM	PM	Night	Total Weekend					
1	4	8	8	100	8	8	8	48	148	21.1	Exception	Awake	21.1
2	4	8	8	100	8	8	8	48	148	10.6	#3	Awake	10.6
2	4	8	4	80	8	8	8	48	128	9.1	#2	Not Awake	9.1
3	4	4	4	60	8	8	8	48	108	5.1	#1	Awake	5.1
3	0	0	0	0	0	0	0	0	0	0.0	Base	Not Awake	0.0

Day Habilitation

Broad Independence

Day Hab Blended Hours						Day Hab Hourly Add-on by Adjustment						Daily Hours		
Ratio	Day Program	Work Program	Supported Employment	TOTAL	Level	Ratio	Day Prg Fac & Non-Fac	Work Prg Fac & Non-Fac	Supported Employment	TOTAL	Level	Hours	People	Average
1 to 1	2.3	2.3	3.0	7.5	Exception	1 to 1	1.8	1.8	2.4	6.0	Exception	7.5	1	7.5
1 to 2	1.1	1.1	1.5	3.8	#3	1 to 2	0.7	0.7	0.9	2.3	#3	7.5	2	3.8
1 to 3	0.8	0.8	1.0	2.5	#2	1 to 3	0.3	0.3	0.4	1.0	#2	7.5	3	2.5
1 to 4	0.6	0.6	0.8	1.9	#1	1 to 4	0.1	0.1	0.2	0.4	#1	7.5	4	1.9
1 to 5	0.5	0.5	0.6	1.5	Base	1 to 5					Base	7.5	5	1.5
6 to 10	0.5	0.5	0.6	1.5	Base	6 to 10					Base	7.5	5	1.5

Maladaptive Behavior

Day Hab Blended Hours						Day Hab Hourly Add-on by Adjustment						Daily Hours		
Ratio	Day Program	Work Program	Supported Employment	TOTAL	Level	Ratio	Day Prg Fac & Non-Fac	Work Prg Fac & Non-Fac	Supported Employment	TOTAL	Level	Hours	People	Average
1 to 1	1.2	1.2	1.6	4.0	Exception	1 to 1	1.2	1.2	1.6	4.0	Exception	4.0	1	4.0
1 to 2	0.6	0.6	0.8	2.0	#3	1 to 2	0.6	0.6	0.8	2.0	#3	4.0	2	2.0
1 to 3	0.4	0.4	0.5	1.3	#2	1 to 3	0.4	0.4	0.5	1.3	#2	4.0	3	1.3
1 to 4	0.3	0.3	0.4	1.0	#1	1 to 4	0.3	0.3	0.4	1.0	#1	4.0	4	1.0
1 to 5	0.0	0.0	0.0	0.0	Base	1 to 5					Base	0.0	5	0.0
6 to 10	0.0	0.0	0.0	0.0	Base	6 to 10					Base	0.0	5	0.0

ICAP Domain Scoring Keys & Individual Hours of Direct Care Staff Time

Domain	Cost Center	Score	Adult Foster Training Home	Apartment / Community Living	Neighborhood Group Home	Neighborhood Group Home (Specialized Population)	Day Program (Non Facility & No Transportation)	Day Program (Non Facility & with Transportation)	Day Program (Facility Base & No Transportation)	Day Program (Facility Base & with Transportation)	Supported Employment
			Adaptive Behavior				**Adaptive Behavior**				
Broad Independence	Base	525 to 600	0	1.7	3.8	7.0	1.5	1.5	1.5	1.5	3.0
	Adjustment #1	470 to 524	1.0	0.7	2.1	2.7	0.4	0.4	0.4	0.4	0.5
	Adjustment #2	400 to 469	2.8	9.7	4.8	8.1	1.0	1.0	1.0	1.0	1.0
	Adjustment #3	350 to 399	5.5	15.4	7.6	10.8	2.3	2.3	2.3	2.3	2.0
	Exception	1 to 349	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan
			Maladaptive Behavior				**Maladaptive Behavior**				
General Maladaptive Index	Base	minus 10 to plus 10	0	0	0	0	0.0	0.0	0.0	0.0	0.0
	Adjustment #1	minus 20 to minus 11	1.0	2.3	3.9	5.1	1.0	1.0	1.0	1.0	0.5
	Adjustment #2	minus 30 to minus 21	2.8	4.1	4.6	9.1	1.3	1.3	1.3	1.3	1.0
	Adjustment #3	minus 40 to minus 31	5.5	7.0	7.0	10.6	2.0	2.0	2.0	2.0	2.0
	Exception	minus 41 +	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan	Individual Service Plan

ICAP Service Levels and DIRECT SERVICE STAFF Rate Cost Adjustments

The ICAP Service Levels for Residential Habilitation and Day Habilitation Services were converted to individual reimbursement rates by applying the DIRECT SERVICE STAFF rate schedule. The following table details the specific DIRECT SERVICE STAFF ratio and corresponding costs for each of the ICAP Service Levels.

ICAP Service Levels and Direct Service Staff Cost Adjustments

ICAP Key Domain	Service Level Benchmark	ICAP Score	Residential Habilitation						Day Habilitation				
			Neighborhood Group Home (Large)	Neighborhood Group Home (Medium)	Neighborhood Group Home (Small)	Neighborhood Group Home (Specialized)	Apartment / Community Living	Adult Foster Training Home	Day Program (Non Facility & No Transportation)	Day Program (Non Facility & with Transportation)	Day Program (Facility Base & No Transportation)	Day Program (Facility Base & with Transportation)	Supported Employment
Broad Independence / General Maladaptive Index	**Base**	**499-600 (BI) minus10 to plus 10 (GMI)**	**$28,534**	**$28,852**	**$29,529**	**$54,972**	**$12,813**	**$0**	**$8,089**	**$9,848**	**$8,766**	**$10,515**	**$9,626**
Broad Independence	BI Adjustment #1	450 to 498	$15,613	$15,787	$16,157	$20,800	$5,276	$2,738	$2,022	$2,462	$2,189	$2,629	$2,475
Broad Independence	BI Adjustment #2	400 to 449	$36,071	$36,473	$37,329	$63,143	$73,111	$7,528	$5,393	$8,565	$5,838	$7,010	$5,445
Broad Independence	BI Adjustment #3	350 to 399	$57,606	$58,248	$59,615	$84,315	$116,074	$15,056	$12,133	$14,771	$13,134	$15,773	$11,055
Broad Independence	BI Exception	349 and below	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
General Maladaptive Index	GM Adjustment #1	minus 20 to minus 11	$29,072	$29,396	$30,086	$40,115	$17,587	$2,738	$5,393	$6,565	$5,838	$7,010	$2,475
General Maladaptive Index	GM Adjustment #2	minus 30 to minus 21	$34,456	$34,840	$35,657	$71,315	$30,687	$7,528	$7,190	$8,753	$7,783	$9,347	$5,445
General Maladaptive Index	GM Adjustment #3	minus 40 to minus 31	$53,120	$53,711	$54,972	$82,458	$52,761	$15,056	$10,785	$13,130	$11,675	$14,020	$11,055
General Maladaptive Index	GM Exception	minus 41 +	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Experience from Other States

To determine the adequacy of the Delaware ICAP Service Levels, experience from other states was reviewed. Three states were examined which current use the ICAP to determine Individual Service Authorization Levels base their cost allocation process on historical expenditures rather than staff ratios. Nebraska, Texas, and South Dakota established ICAP service thresholds by grouping ICAP scores with expenditures similar to the approach in Delaware. Texas and Nebraska have standardized provider reimbursement rates. These states were selected because each uses the ICAP Broad Independence Index and General Maladaptive Behavior domains as their defining criteria for assigning provider reimbursement rates. A review of these state ICAP Service Levels is presented.

Nebraska ICAP Service Levels

Mercer recently conducted a review of the Nebraska ICAP scoring criteria. A complete description of the Nebraska Objective Assessment Process (OAP) is contained in "Objective Assessment Process: Description of the Development of the Formulas used in determining Level of Support", 2004, which was prepared by Don Severance in his capacity with the Nebraska Developmental Disabilities System (DDS). In summary, the Nebraska OAP process is designed to meet six goals. The intent of the assessments is to assign financial resources to people in an equitable fashion based upon individual ability. The assessments are intended to allow for individual change and promote portability of service. Finally, the assessments are intended to assist DDS in improving resource management and maintaining revenue neutrality.

The Nebraska OAP process considers only one criterion, functional abilities, for assigning individual financial resources. DDS selected the ICAP as their functional assessment instrument. The ICAP was selected because it is relatively simple to administer and has documented psychometric characteristics. The ICAP also does not require administration by licensed staff.

To determine the amount of public funds to assign to ICAP scores, DDS selected a sample of people (2,256 in residential services, and 2,461 in day programs) and examined the amount of services (in dollars) that this sample group received over the course of one year (State Fiscal Year 2003). Using multiple regression analyses, DDS developed correlations between the ICAP scores and service utilization patterns. These correlations were converted to "ICAP formulas" which DDS will use to assign future public funds to individuals. Funding levels from 2002/2003 were established as the financial baseline to calibrate the ICAP scores. State service coordinators have been trained and reliability measurement systems have been implemented. Multiple regression analysis was used to analyze the relationship between the number and cost of service units and the ICAP functional assessment scores, and funding formulas for residential and day programs were developed. Those formulas are presented in the following table, and are further described in the Severance 2004 study referenced previously. Each formula is a constant followed by the addition or subtraction of an ICAP score multiplied by the empirically

derived weight. The total is multiplied by 1.015 to reflect the 1.5 percent increase in the provider rates for Fiscal Year 2004.

Nebraska OAP/ICAP Scoring Formulas

Day Services Level of Support in Dollars = (8236.684 -32.299*Broad Independence Index + 0.0242*Broad Independence Index Squared + .00268*Motor Skills Index Squared + 10.373*Community Living Skills Index - 0.0107*Community Living Skills Index Squared + 4.271*General Maladaptive Index + 0.285* General Maladaptive Index Squared + 83.652*Hurt to Self Severity + 50.917*Hurtful to Others Frequency + 51.349*Hurtful to Others Severity + 35.592*Unusual or Repetitive Habits Severity + 44.496*Health Medication + 93.176*Behavior Medication + 77.209*Seizure Medication + 32.247*Arm/Hand -22.778*Age in Years + 0.00167*Age in Years Cubed) * 1.015.

Day Services Level of Support in Dollars

Sign	Variable	Function	Weight
	(Constant)	Equals	8236.684
-	Broad Independence Index	Multiply	32.299
+	Broad Independence Index Squared	Multiply	0.0242
+	Motor Skills Index Squared	Multiply	0.00268
+	Community Living Skills Index	Multiply	10.373
-	Community Living Skills Index Squared	Multiply	0.0107
+	General Maladaptive Index	Multiply	4.271
+	General Maladaptive Index Squared	Multiply	0.285
+	Hurtful to Self Severity	Multiply	83.652
+	Hurtful to Others Frequency	Multiply	50.917
+	Hurtful to Others Severity	Multiply	51.349
+	Unusual or Repetitive Habits Severity	Multiply	35.592
+	Health Medication	Multiply	44.496
+	Behavior Medication	Multiply	93.176
+	Seizure Medication	Multiply	77.209
+	Arm/Hand	Multiply	32.247
-	Age in Years	Multiply	22.778
+	Age in Years Cubed	Multiply	0.00167
	Total	Multiply	1.015

Residential Services Level of Support in Dollars = (10350.253 - 18.021* Broad Independence Index + 0.00497* Motor Skills Index Squared - 0.303* General Maladaptive Index + 0.867* General Maladaptive Index Squared - 0.798*Internalized Maladaptive Index Squared + 160.011* Hurt to Self Severity + 198.728*Hurtful to Others Severity + 91.263* Unusual or Repetitive Habits Severity + 580.710* Behavior Medication + 228.971* Seizure Medication + 723.825*Mobility - 57.1435*Age in Years + 0.00511* Age in Years Cubed) * 1.015.

Residential Services Level of Support in Dollars

Sign	Variable	Function	Weight
	(Constant)	Equals	10350.253
-	Broad Independence Index	Multiply	18.0210
+	Motor Skills Index Squared	Multiply	0.00497
-	General Maladaptive Index	Multiply	0.303
+	General Maladaptive Index Squared	Multiply	0.867
-	Internalized Maladaptive Index Squared	Multiply	0.798
+	Hurt to Self Severity	Multiply	160.011
+	Hurtful to Others Severity	Multiply	198.728
+	Unusual or Repetitive Habits Severity	Multiply	91.263
+	Behavior Medication	Multiply	580.710
+	Seizure Medication	Multiply	228.971
+	Mobility	Multiply	723.825
-	Age in Years	Multiply	57.143
+	Age in Years Cubed	Multiply	0.00511
	Total	Multiply	1.015

DDS has also tested for consistency of ICAP scoring by service coordinators. Test-retest reliability for persons currently in services (correlation between previous and current administration of scale with a score of 1.0 representing the highest possible score) is as follows:

- ICAP Service Score — .839
- General Maladaptive Index — .637
- Broad Independence Scale — .918

Also DDS tested the ICAP scales to ensure that they were accurately measuring functional abilities. Chronbach's Alpha scores (1.0 representing the highest possible score) are as follow:

- Broad Independence Scale — .9832
- Motor Skills — .9456
- Social and Communication Skills — .9442
- Personal Living Skills — .9518
- Community Living Skills — .9388
- General Maladaptive — .9070

DDS did not test for cost variables related to provider contract differences, geographic cost of living factors, or individual consumer diagnoses. Currently, DDS is completing ICAP assessments on all people and calculating individual budget allocations. As further steps, DDS is collecting responses from individual Interdisciplinary Teams to determine those instances where the ICAP assigned funds may be inadequate. From this review,

DDS intends to identify additional measures and recalculate cost allocation formulas as needed. As a future consideration, DDS intends to apply personal outcomes to the cost allocation formulas.

Texas ICAP Service Levels

Texas translates the overall ICAP score to Service Levels and establishes dollar values to those levels. The following table is an example of how Texas utilizes the ICAP for rate setting. The ICAP scoring of maladaptive behavior can range from +10, which is indicative of overall good adjustment, to –74 representing severe and serious misconduct. The scales are set with an average score of 0 and a standard deviation of 10. The Service Score can range from 0 to 100, with a score of 100 representing independence, no behavior problems and very minimal needs for support.

ICAP Service Score	Texas Level of Need	Foster Home Scale	Group Home Scale	Day Support Scale
70-100	Intermittent to Limited	42.23 to 45.51	100.73 to 110.30	14.52 to 18.15
40-69	Limited to Extensive	45.51 to 61.95	110.30 to 124.64	18.15 to 24.20
20-39	Extensive to Pervasive	61.95 to 84.97	124.64 to 148.54	24.20 to 36.30
1-19	Pervasive	84.97	148.54	36.30
Note "a"	Pervasive Plus	111.27	196.35	145.22
"a" Certification that self-injurious, disruptive, or aggressive behavior constitutes a clear and present danger to the individual or others with constant one on one supervision needed to ensure health and safety.				

South Dakota ICAP Levels

South Dakota uses components of the ICAP as part of a formula that drives the total number of staff hours authorized for an individual for a year's period. In South Dakota, services are divided into categories. One category represents a flat rate reimbursement and the second reflects rates that vary with the intensity required as determined by consumer characteristics. Direct support hours thus can vary significantly, and as a result rates for key service areas (Case Management, Residential, Day/Vocational, and Nursing) can vary dramatically. Other services such as physical therapy are reimbursed at a flat rate. To determine the amount of service to provide, the following formula is applied:

Service Unit:_____			
ICAP Broad Independence score	x	-0.30	=
ICAP General Maladaptive Index	x	-0.91	=
ICAP Seizure	x	-0.524	=
Multiple calculations for age and other factors			

The result generates an authorization for direct support coverage required addressing the support needs of the individual.

Non-ICAP States

Montana and Florida apply staff ratios to their individual resource assessments. Montana employs the Montana Needs Assessment (MONA), and Florida employs a similar instrument called the Florida ICG. Summary tables of Montana and Florida individual assessment scores and associated DIRECT SERVICE STAFF ratios are attached for reference (See Attachment #2 and Attachment #3). Staffing levels for these states are directly similar to those employed in the Delaware ICAP Service Levels.

References

Biographical summaries for the Futures Health Corporation clinical staff are attached for the following people as Attachment #1:

- Sarah B. Bannon, MSW, ACSW
- Domenico J. Cavaiuolo
- Trudy J. Fletcher
- Jeffrey Alan Keilson
- Leo V. Sarkissian

Data presented from other states has been taken from the following studies:

1. Campbell, Edward M., "Target Budget Projection Three Demonstration Models", Pennsylvania Office of Mental Retardation. December 2001.
2. Severance, Donald, "Objective Assessment Process: Description of the Development of the Formulas used in determining Level of Support", Nebraska Developmental Disabilities Program. April 2004.
3. Stokes, Billy, "Texas ICAP Service Levels", Texas Department of Mental Retardation. 1999.
4. Shalock, Robert, "Review of Supports Intensity Scale Service Levels", unpublished report prepared for Mercer. May 2004.
5. Brezausek, Carl, and Craig Ramey, "An External Review of Mercer Validation Data for the Florida Individual Cost Guidelines: A Final Report", Center for Educational Accountability, School of Education, University of Alabama at Birmingham, and Georgetown Center on Health and Education.
6. Davis, Norm, and Roger Deshaies, "Montana Service Utilization Standards", Montana Developmental Disabilities Program. June 2004.
7. Wideman, Keith, and Jan Blacher, " Purchase of Services Study II: Modeling the Variation in Per Capita Purchase of Service Across Regional Centers", California Department of Developmental Services. August 2003.

Standards used by the Futures Health Corporation review of the State of Delaware service algorithms include the following:

1. Council on Quality and Leadership in Supports for People with Disabilities.
2. Commission on Accreditation of Rehabilitative Facilities: Assisted Living Standards.
3. Commission on Accreditation of Rehabilitative Facilities: Employment and Community Services Standards.
4. Medicaid HCBS Quality Review Protocol.
5. Developmental Disabilities Nurse's Association: Standards of Practice.
6. Association for Behavioral Analysis: Concepts and Principals.
7. American Medical Association Disability Evaluation, Second Edition
8. Connecticut Quest for Excellence Standards.
9. Developmental Disabilities Quality Coalition: Building a Comprehensive Quality Management Program.
10. Pennsylvania Independent Monitoring Project Standards.

Attachment #1

Futures Health Corporation Biographical Summaries

Sarah B. Bannon, MSW, ACSW

Ms. Bannon has over 20 years health care and human service experience including nine years in managed care, primarily as Director of Government Programs for two large health plans, and 10 years as a clinician in the mental health and juvenile justice fields. She in one of three consultants that work nationally for HRSA providing technical assistance and training on integrated health care delivery.

Ms. Bannon has extensive experience working with state and community agencies, budget planning and analysis, and interpretation and compliance of complex governmental and health plan contracts. She has served as the primary liaison for all health issues including network expansion, primary contact with community-based, state and federal agencies, oversight for case management and tracking processes, and lead consultant on six different multi-collaborative mental health grant projects. Currently Ms. Bannon is working with several counties that are implementing integrated health care delivery systems via public sector organizations in partnership. Ms. Bannon is working with the Institute for Health Care Studies and Wayne State University on implementation and evaluation of evidenced-based behavioral health programs. Ms. Bannon also serves as co-chair of the national workgroup on the (WEDI-SNIP) HIPAA Notice and Consent guidelines.

Core Competencies

1. Over 15 years experience writing and maintaining grants from various fund sources (federal, private, local government, etc.)
2. Over 10 years experience writing and negotiating contracts in the health care field, including capitation, MOA/MOU, fee-for-service, etc.
3. Almost 15 years experience in strategic planning and program development. Emphasis on evidenced-based best practices and associated evaluation and measurement.
4. Proven capacity to maintain long-term viable relationships with numerous health carriers throughout the state of Michigan.
5. Clinical experience and contacts are in many areas of the health care industry including mental health, substance abuse, managed care, juvenile justice, and developmental disabilities.
6. Over 15 years training experience before diverse audiences including physicians, government leaders, management teams, university faculty, and general public on a wide variety of topics.
7. Other technical competencies include: Knowledge of coding, coordination of benefits, state of Michigan regulations and benefits pertaining to Medicaid, mental health/substance abuse, juvenile justice, etc. Also well versed on HIPAA regulations, BBA, and other over-arching mandates that impact the health care system nationally.

Domenico J. Cavaiuolo
706 Mickley Road
Whitehall, PA 18052
(610) 435-8938
dcavaiuolo@po-box.esu.edu

EDUCATION:

Temple University
Ph.D., Special Education – December, 1994

State University College at Buffalo
M.S., Multidisciplinary Studies in Vocational Education, Program Planning and Evaluation, and Developmental Disabilities - 1987

State University College at Buffalo
B.S., General Studies/Social Science/Psychology - 1981

CURRENT EMPLOYMENT:

East Stroudsburg University
200 Prospect Street, East Stroudsburg, PA 18301
9/98, Assistant Professor, Special Education/Rehabilitation

UNIVERSITY SERVICES:

- Advisement of graduate students
- Member of Rehabilitative Services Program Advisory Council
- Member of School of Professional Studies NCATE work group
- Member of University Speakers Bureau
- Aided the Department of Special Education and Rehabilitation by covering for extended sick leave of colleague
- Undeclared advising in Academic Advising Center
- Advisor of the University Chapter of College Best Buddies
- Member of the Honorary Degree Committee
- Official for the ESU Wrestling Team during the team's "wrestle offs"

COMMUNITY SERVICES:

- Member of the Board of Via of the Lehigh Valley
- Co-authored and obtained Grant form the ESU Foundation Board in three consecutive years to present "Through Their Eyes: Successful People with Disabilities" conference
- Past Co-Chair of the Lehigh Valley Supports Coalition, made up of school and service providers of individuals with disabilities
- Conducted values and philosophy training about people with disabilities to schools and community service provider
- Founder and current president of the Board of Person-to-Person: Valley Citizen Advocacy

- Participated in panel discussion on issues of self-determination for individuals with disabilities
- Rehabilitation and educational consulting to families and schools and providers of service
- Consultant and member of the Program Evaluation and Quality Assurance Team to Washington, D.C. Department of Human Services

SPECIAL RECOGNITION AND SERVICE AWARDS:

- Gamma Xi Chapter of Kappa Delta Pi Outstanding Professor of the Year (2000 – 2001 academic year)
- State University of New York – Niagara County Community College Distinguished Alumni 1998

PREVIOUS TEACHING EXPERIENCES:

- 1994-1998, Adjunct Instructor, Holy Family College Department of Education/Special Education
- 1988 – 1990, Adjunct Instructor, Temple University Department of Special Education

PREVIOUS EMPLOYMENT EXPERIENCES:

Via (Formerly: Lehigh Association of Rehabilitation Centers)
336 West Spruce Street, Bethlehem, PA 18018
10/93 – 9/98, Senior Vice President of Support Services

Pioneer Agency Inc.
2516 Lodi Street, Syracuse, NY 13208
7/90 – 9/93, Executive Director

PROFESSIONAL MEMBERSHIPS AND COMMUNITY ASSOCIATIONS:

American Association on Mental Retardation (AAMR)
American Red Cross - Volunteer
Association for Persons in Supported Employment (APSE), Member of the State Board
Association for Supervision and Curriculum Development
Bethlehem Musikfest Association - Program Committee
Council for Exceptional Children (CEC)
Division on Mental Retardation (CEC - MR)
Lehigh Valley Center for Independent Living – Past Board Member
The Association for Persons with Severe Handicaps (TASH)
Via of the Lehigh Valley – Member of the Board

PROFESSIONAL TRAINING AND APPOINTMENTS:

*Appointed and selection by the Special Master and Federal Judge to conduct a review of the level of compliance in the court case "Southbury Training School vs. U.S.", Southbury, Connecticut. (10/01)

*Internship Virginia Commonwealth University, RRTC, Training of Supported Employment (9/85)

*Marc Gold and Associates (two week training seminar on the Try Another Way Teaching Method) (3/80)

SEMINAR AND CONFERENCE PRESENTATIONS:

2004 Fourth Annual Conference on Down Syndrome: Home, Health, and Future 2004. Community Integrated Employment for all: Supporting People with Disabilities in Community Job Settings.

2003 National Down Syndrome Congress: Annual Convention. Choose work: Navigating the Waters of integrated employment.

2003 National Down Syndrome Congress: Annual Convention. Community employment: Supporting people with disabilities in community job settings.

2003 Self-Determination and Employment: Ideas and Possibilities: Networks for Training and Development. Self-determination and Assessment

2002 Competence and Confidence: Partners in Policymaking: Temple University Supported employment: Past, present and future

2002 Mental Retardation and Developmental Disabilities Administration: Washington, D.C. Person centered planning to develop individual support plans.

2002 Pennsylvania Department of Public Welfare/Office of Mental Retardation: Everyday Lives Conference: Making it Happen – Best practices in career planning.

2001 Pennsylvania Association of Rehabilitation Facilities Annual Conference – Career planning with people with disabilities

2001 The 2nd Annual Literacy Conference: Co-teaching and collaboration.

2001 Pennsylvania Council for Exceptional Children State Wide Convention – Transition: From regulations to best practices

2001 Competence and Confidence: Partners in Policymaking: Temple University Supported employment: Past, present and future

2001 University of Tennessee – Technology, Inclusion and Employment Conference: Positive behavioral supports in the workplace

2001 University of Tennessee – Technology, Inclusion and Employment Conference:"The times are a changin" or "I gotta get out of this place": Conversion of traditional rehabilitation services to community-based supports

2001 Transition to Life: North Hunterdon School District – Keynote Speaker

2001 The Employment Support Symposium: Promoting Self-Determination and Improving Employment Outcomes: Assessment and self-determination

2001 Transition to Success: Seminar Series: Transition: From IDEA to reality; Self-determination; Employment: Positive supports in the community

2000 American Association on Mental Retardation 124th Annual Conference; Ethics, Genetics, Leadership and Self-Determination: Self-determination and vouchers in vocational rehabilitation, or is it cost containment to a failed system

2000 Networks for Training and Development, The Ultimate Job Coaching Conference: Situational assessment for employing people with severe disabilities

2000 Everyday Lives: in our communities, OMR Statewide Convention: Training staff to support employment as a primary outcome

2000 Washington Township School District, NJ: Transition from School to Adult Life: How are we doing and are we meeting compliance?

1999 Washington Township School District, NJ: Transition from School to Adult Life: How are we doing and are we meeting compliance?

1999 Competence and Confidence: Partners in Policymaking: Temple University Supported employment: Past, present and future

1999 New Jersey Protection and Advocacy Association Conference on Transition: Transition Services in New Jersey and the Country

1999 Teaching and Learning Banquet: "Celebrating Teachers Learners". Evalution strategies for student centered instruction.

1999 Opportunity Knocks: Help Open the Door. Creative, supportive and caring environments or positive behavior supports: What's the difference?

1999 Fitzmaurice Community Services, Inc. Training Seminar: Understanding and Using Person Centered Planning

1998 Pennsylvania Association of Rehabilitation Facilities Annual Conference: Voucher System for Individuals with Mental Retardation

1998 Self-Determination: Whose Life Is It?:Self-Determination and Vouchers: A Provider Perspective

1997 International TASH Conference: We the People, All the People: Systems Change: Conversion of a Rehab Center into Community-Based Support Services

1997 OMR Statewide Convention: Everyday Lives: Shaping the Future: Best Practice Employment Strategies in PA

1996 International TASH Conference: Renewing the Promise: Understanding Current Practices Supporting Inclusion: Insights for Personnel Preparation

1996 The ARC - PA Convention: Rhetoric to Reality: Self Advocacy Panel Discussion

1995 International TASH Conference: Many Voices, One Future: Philosophy of Choice and Empowerment Through Individualized Purchasing Power

1995 Statewide OMR Convention: Every Day Lives: Facilitating Natural Supports in the Workplace: Strategies for Support Consultants

1994 Fifth Annual Institute for Summer Studies, New Jersey Department of Education: Methodologies in Community Based Instruction and Supported Employment

1994 Paving the Way: A Conference on Transition from School to Work: Keynote Presenter: Interagency Collaboration for Effective Transition Services: State and Local Systems Change

1994 New Jersey APSE Conference: The Changing Focus of Supported Employment: From Job Coach to Employment Consultant

1993 Fourth Annual Institute for Summer Studies, New Jersey Department of Education: Secondary Education: Planning for the Future

1993 Networks for Training and Development of Philadelphia: Contemporary Vocational Services Series Management of Community Integrated Employment: Issues and Strategies

1992 Third Annual Institute for Summer Studies, New Jersey Department of Education: Natural Support Concepts and Inclusion: What's the Relationship?

1992 The Association for Persons in Supported Employment, NJ Chapter: Transition Seminar: Development of a State Wide Mission Statement for Transition

1991 Temple University: Fifty Annual Conference on Supported Employment: Facilitating Natural Supports in the Workplace: Strategies for Support Consultants

1991 Third Annual Community Mental Retardation Services Convention: Every Day Lives: Pioneer's Conversion from Facility Based to Community Integrated Employment

1991 CPS Spring Seminar: Consultation Learning and Changing as an Interactive Experience: Transition from School to Adult Life for Persons with Disabilities and the Role of the Consultive Teacher

1988 Delaware Valley Partial Hospitalization Association: 13th Annual Conference: Employment Opportunities for Persons with Mental Illness

1987 Pennsylvania Association of Rehabilitation Facilities Conference: Supported Employment in the Rehabilitation Agency

1987 Project RETAP of Buffalo Conference: Employment Opportunities for Persons with Mental Retardation: Regional Differences

1986 Virginia Commonwealth University: RRTC Third Annual Symposium: Supported Employment for Citizens who are Mentally Retarded Symposium: Panel: Inservice training Methods for Supported Competitive Employment.

SCHOLARLY PAPERS:

Steere, D. E. & Cavaiuolo, D. (2002). Connecting outcomes, goals, and objectives in transition planning. Teaching Exceptional Children, 34 (6), 54 - 59.

Browder, D., Cooper, K., DaCosta, J., Lim, L., Rucker, R., & Cavaiuolo, D. (1999). An evaluation of variables that influence the selection of participants for innovative services. Journal of Developmental and Physical Disabilities, 11(1), 47-59.

Cavaiuolo, D. (1995). Dissertation: A comparative study of job satisfaction of persons with disabilities in sheltered employment and competitive employment.

Cavaiuolo, D. (1994). Cooperative learning as an effective full school model: Review and implication for students with severe handicaps. Quality Outcomes Driven Education, 4 (2), 21-29.

Cavaiuolo, D. (1993). Systems change and its relation to transition from school to adult life: A collaborative process. Transition from school to adult life for people with disabilities: Best practices and planning a process of transition into adult life. New Jersey Department of Education Office of Special Education Programs Monograms.

Developing natural supports in the workplace: A manual for practitioners (1993). Cavaiuolo, D., et al., Contributing Author. Center on Human Policy, Syracuse University.

Becoming a part of our community: Interagency guidelines for transition planning from school to work (1992). Cavaiuolo, D., et al., Contributing Author. Onondaga County Department of Mental Health

Syracuse City School District (1992). Cavaiuolo, D., et al., Contributing Author. Syracuse city school district transition planning guidelines.

Temple University Training Manual on Supported Employment (1991). Chapters: (1) Haugh, R. & Cavaiuolo, D., Job development methods and techniques; (2) Cavaiuolo, D., Job site issues.

Cavaiuolo, D. & Nasca, M. (1991). The relevance of social survival skills in the job retention of workers with mental retardation. Vocational Evaluation and Work Adjustment Bulletin, 24 (1), 27-31.

Cavaiuolo, D. & Gradel, K. (1990). The effects of distributed feedback and videotape self-monitoring on the productivity of a janitorial trainee with mental retardation. Research in Developmental Disabilities, 11, 327-340.

TRUDY J. FLETCHER
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PROFESSIONAL EXPERIENCE

Consultant to governmental and non-governmental agencies and organizations that serve people with disabilities to develop and implement public policy initiatives that support individualized supports and services promoting the principles of self-determination. Development of strategic plans to create capacity within systems to promote person directed supports. Assistance with financial restructuring to support individualized services. Facilitator of person directed planning. Certified Person Centered Planning Trainer and Training specialist in person directed planning and self-determination. Current and previous contracts are listed below.

9/01-present **Commonwealth of Kentucky, Developmental Disabilities Council**
Consultant to the Council to facilitate the development of a statewide, not for profit self-advocacy organization for people with developmental disabilities.

11/02-Present **Developmental Disabilities Specialist Consultant to Navigant/Tucker Alan, Inc.**
Developmental Disabilities Specialist for company in review of contextual Medicaid claims for payment accuracy study and Medicaid eligibility study in Colorado and Florida. Completed operational review ICF and HCBS waiver program for Texas DMHMR.

11/02-5/04 **State of Arkansas, Division of Developmental Disabilities**
Member of Team providing consultation for Personal Assistance Services and Supports pilot project for consumer direction. Provide training in person centered planning, consultation for centralized Intake and Eligibility process.

10/02 **Facilitator to North Carolina Association of Self-Advocates**
Facilitated development of strategic plan for continuation funding from the State Office on Developmental Disabilities.

2/02-8/02 **CNMI Council on Developmental Disabilities, Saipan**
Training instructor and facilitator for teens and family members on self-advocacy, self-determination and person centered planning.

2/02-Present **Council on Developmental Disabilities, Hawaii; Division of Developmental Disabilities, State of Hawaii**

Consultant to the Council to evaluate the state case management program and make recommendations for future organizational structure. Continued consultation to implement organizational change to support consumer self-directed supports.

11/11-14/01 **Self-Advocacy Southern Collaborative, Facilitator**
Group facilitator to develop strategic action plan for 17 Southern Collaborative promoting self-advocacy and self-determination within twelve southern states.

2/15/01 **University of Knoxville, UT-TIE Program, Tennessee**
Developed and facilitated videoconference for seven sites on Effective Circles of Support.

10/01/00-4/30/01 **State of Texas, DMHMR**
Program Operation Specialist to Tucker Alan Inc., Consultant to State of Texas, DMHMR.

7/99-6/04 **State of Tennessee, DMR**
Consultant to the State of Tennessee to develop and implement a self-determination demonstration project as part of a remedial order for individuals of the Arlington class who either live at the Arlington Developmental Center or lived at Arlington in the past.

STATE OF NEW YORK, Office of Mental Retardation and Developmental Disabilities (NYS-OMRDD), Central Office (temporary position)

11/00-8/01 **Clinical and Operational Specialist for NYS OMRDD Self-determination Project**
Assist OMRDD Director of Policy, Planning and Individualized Initiatives with development of policies and procedures for statewide implementation of self-determination. Operations Specialist to implement funding option in newly approved Home and Community Based Services Waiver to support self-determination. Liaison between thirteen (13) district offices and the OMRDD Central Office.

STATE OF NEW YORK, OMRDD: District Office at the Finger Lakes Developmental Disabilities Services Office (FLDDSO)

8/98-12/03 **Director, Office of Advocacy and Consumer Directed Supports**
Direct and manage activities of creative initiative within the OMRDD to support advocacy, self-advocacy and self-determination for people with developmental disabilities. Created small, highly specialized Office of Advocacy and Consumer Directed Supports to work in partnership with people with disabilities to implement the principles of self-determination, to develop leadership capacity of self-advocates. The Office promotes partnerships between people with disabilities and the OMRDD in decision making and policy setting within the FLDDSO District.

Developed, implemented and currently coordinating the self-determination project for the Finger Lakes DDSO.

Master Trainer for the NYS-OMRDD statewide training team for self-determination. Chairperson for the statewide OMRDD self-determination Committee on Service Coordination and Support Brokerage.

10/95-8/98 **Director, Service Coordination Services**
Developed and implemented independent service coordination department for three newly consolidated state district offices of OMRDD supporting people with developmental disabilities who live in the ten county district area. Supervised 121 service coordinators, direct service coordination supervisors and service coordination district managers. Staff of the department served greater than 2400 consumers, most of who were enrolled in the Home and Community Based Services Waiver program. District coordinator for service coordination services for state and provider based service coordination services. Developed unique models of service coordination services focusing on individual choice and specialized needs. Developed community- wide plan for all service coordinators related to training, networking, learning opportunities and support.

District office coordinator for the Care at Home program, a specialized Medicaid Waiver program for children with developmental disabilities and complex health care needs. District office coordinator for the Comprehensive Medicaid Case Management, Home and Community Based Waiver Service Coordination service. District office liaison with 30+ contract agencies for all service coordination services.

9/91-10/95 **Treatment Team Leader**
Administrator for Family Support Services Unit, the Case Management Unit and the Family Care Program. Supervised 46 mid-level managers, case managers and other clinical professionals who provided professional support and clinical services to 500+ individuals and families of children with developmental disabilities who live in certified and non certified residential settings. Developed and implemented case management services for individuals enrolled in the Home and Community Based Services Medicaid Waiver Program.

Administrator for the Family Care Program of 125 Family Care Providers serving 100 individuals with developmental disabilities. Responsible for recruitment and retention of Family Care Providers, regulatory and programmatic compliance, services development for persons with developmental disabilities. Managed implementation of Medicaid Waiver program for all individuals living in OMRDD certified Family Care program. Responsible for program compliance and quality services oversight.

District office coordinator for Nursing Home project, designated liaison with OMRDD Central Office for Case Management, Care At Home Program, Aging Services and the Children Resource Network.

9/90-9/91 **Community Services Administrator**
District office coordinator to work with local Health Systems Agency to plan,

develop and implement nursing home expansion beds designated for people with developmental disabilities.

Acting Treatment Team Leader for Family Support Services Unit. Supervised staff of 25 professionals and 50 Family Care Providers. Managed implementation of Comprehensive Medicaid Case management Program in state sector.

Family Support Services Team Manager for Specialized Case Management Team. Developed unique team of specialized case managers to implement concept of specialized case management within Family Support Services.

Designated DDSO liaison with Central Office for the Care At Home Waiver program, Case Management, Agent Orange Programs, Children's Resource Network and for Aging Services.

9/89-8/90 **NYS-OMRDD Career Development Program, Albany, New York**

State-wide Project Coordinator, Supported Employment

Developed and coordinated statewide regional training sessions. Developed and implemented statewide study of Prevocational Programs. Developed and implemented comprehensive study of "Minimum Wage" for Supported Workers. Developed evaluation tool for audits. Assisted in development of statewide transition plan of Supported Work.

State-wide Coordinator of Aging Services

Assisted with implementation of new federal regulations for people with developmental disabilities in nursing homes (PASARR) including development of screening tool for identification of persons with developmental disabilities. Assisted and managed the issuing and review process of a Request for Proposal for Senior Day Programs. Collaborated with Developmental Disabilities Planning Council, State Office for Aging, local Counties and Areas on Aging for day and residential program development for seniors with developmental disabilities. Assisted Bureau Director with numerous presentations and publications.

9/86-8/89 **Monroe Developmental Disabilities Services Office, Pittsford, N.Y.**

Program Director, Crisis Intervention

Program Director of innovative Crisis Intervention Services Program operated jointly with the University of Rochester, UAPDD. Administered and managed all program activities, developed and implemented policies and procedures. Supervised interdisciplinary professional clinical team. Chairperson of regional steering committee.

Developed entry point into the developmental disabilities system for individuals with behavior management problems. Collaborated with Integrated Mental Health, local hospital Emergency Departments and local Community Mental Health Centers.

4/86-8/87 **Acting Treatment Team Leader**
Responsible for administration and management of six community residences. Supervised interdisciplinary clinical treatment team plus residential directors. Managed daily activities including programmatic, regulatory and quality of life issues, physical plant maintenance, program evaluations and audits and budget compliance.

10/80-3/86 **Member of Interdisciplinary Treatment Team**
Clinical social worker for people with developmental disabilities living in community based residential programs including Community Residences, Community Based Intermediate Care Facilities, Supervised and Supportive Apartments.

Performed case management activities to support individuals with varying disabilities. Conducted individual and group therapy, family assessments. Completed initial and annual comprehensive assessments and developed individual treatment plans. Provided clinical supervision to social work assistants and college student interns. Participated in community education training programs including Mainstreet and the Monroe Players.

EDUCATION

BARRY COLLEGE, Miami, Florida
Masters of Social Work Degree, 1980
Bachelors of Social Work Degree, 1979

DUTCHESS COMMUNITY COLLEGE, Poughkeepsie, New York
Associate of Applied Science Degree, 1977

CERTIFICATION: Certified Social Worker (CSW),
New York State Education Department, 1981

HONORS

EMPLOYEE OF THE YEAR, 1985-86
Monroe Developmental Disabilities Services Office, Rochester, New York

CAREER DEVELOPMENT PROGRAM, 1989-90
NYS Office of Mental Retardation and Developmental Disabilities, Albany, New York

PROFESSIONAL MEMBERSHIPS

- American Association on Mental Retardation, Member
- The Association for Persons with Severe Handicaps (TASH), Member
- American Association for People with Disabilities, Member
- The Center for Self-Determination, Individual Member
- National Association of Case Management, Member
- New York State Self Advocacy Association, Member
- National Association of Social Workers, Member
- Kentucky Self-Advocates Form Freedom, Inc., Member

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PROFESSIONAL EXPERIENCE

Consultant ***2001 to present***

Working as an independent consultant with private and government agencies on implementing more effective ways to meet the challenges in supporting the elderly and children and adults with disabilities and their families. Concentrating on supporting self-determination and facilitating the development of self-advocacy, implementing recruitment and retention strategies to address workforce issues, professional development, leadership training, systems change, improving quality of supports, strategic planning, and grant writing. Working (worked) with:

- Council on Developmental Disabilities, Commonwealth of Kentucky
- Department of Mental Health, Commonwealth of Massachusetts
- National MS Society, Central New England Chapter
- Office of Disability Services, State of New Jersey
- Institute on Disability, University of New Hampshire
- Heller School, Brandeis University, Waltham, Massachusetts
- Center for Health Policy & Research, UMass Medical School
- Department of Mental Retardation, Commonwealth of Massachusetts
- Council on Developmental Disabilities, State of Hawaii
- Council on Developmental Disabilities, State of Wisconsin
- Division of Developmental Disabilities, State of Wyoming
- Futures HealthCore, Inc.

Advocates, Inc., Framingham, Massachusetts ***2004 to present***
Vice-President for Strategic Operations

Responsible for directing the implementation of a more person directed system of services for people with disabilities receiving supports from Advocates.

Massachusetts Department of Mental Retardation
Regional Director, Metro Region ***1992 to 2001***

Managed services in a Region covering 40% of the State's population. Budget of $270M, with $100M in federal reimbursement. Supports provided to 8750 individuals and their families in the community, 300 people in an ICF/MR, and 29 people in a state-operated nursing facility. Services directly provided by state employees or through contracts with 130 private agencies. Successes included the development of community governance in communities of color providing supports to 700 children, adults and their families, recipient of a Robert Wood Johnson Foundation grant supporting self-determination, and directing the transition of 350 individuals from nursing homes and developmental centers to new homes in the community. Implemented an innovative workforce development initiative to help address the challenge of recruiting and retaining direct support professionals.

Assistant Commissioner, Community Programs ***1987 - 1992***
Directed a responsive statewide community system for 15,000 individuals and their families with an annual budget of $310M. Achievements included implementing an agreement with the State Department of Education to promote the integration of children with disabilities in communities across the State and directing the development of a comprehensive network of supports and the transition of more than 250 persons with mental retardation, with an average length of stay of eight years, from mental health facilities to new homes in the community. Developed the management structure for community services for the new Department of Mental Retardation and directed 6 Regions, 18 local offices, and a central office staff.

Massachusetts Department of Mental Health
Director, Eric Lindemann Mental Health Center ***1982 - 1987***
Directed a comprehensive community mental heath center, including a 50-bed inpatient unit, affiliated with Massachusetts General Hospital. Implemented a range of new services for persons with mental illness and/or alcohol dependence providing needed supports for them to be integrated in community life.

Director of Programs
Mental Retardation Services Director, Region VI ***1976 - 1982***
Managed community supports for persons with mental illness, mental retardation, and alcohol or drug dependence. Directed the implementation of comprehensive licensing and evaluation systems.

Senior Program Analyst, Worcester Area ***1976***
Responsible for community services for persons with mental retardation. Developed community
employment and residential supports for persons with mental illness.

Program Planner, Region II ***1974 - 1976***
Monitored quality of existing community programs and directed the development of new services. Developed a summer program that integrated persons with special needs with non-disabled persons.

OTHER CONSULTING EXPERIENCE

Advocates, Inc., Framingham, Massachusetts
Wrote successful proposal to the Virginia Wellington Cabot Foundation for "Implementation of Person-Centered Planning as a Tool for Empowering People with Disabilities and Direct Support Professionals."
Futures Health Care Group, Greeland, New Hampshire
Participated in reliability study for Individual Cost Guideline tool for State of Florida.
Department of Aging, State of Ohio
Consulted on developing state-wide initiative on recruiting direct support professionals.
Centers for Medicare and Medicaid Services (CMS), Baltimore, Maryland

Member of review panel for FY 2003 "Demonstration to Improve the Direct Service Community Workforce" initiative.

South West Rehabilitation Center, Rock Springs, Wyoming

Assisted in writing proposal in response to "Demonstration to Improve the Direct Service Community Workforce" RFP issued by the Centers for Medicare and Medicaid Services.

Council on Developmental Disabilities, State of Mississippi

Consultation with the Council and other key stakeholders on developing a comprehensive workforce initiative to address the recruitment, retention and training of direct support professionals.

Department of Mental Health, Commonwealth of Massachusetts

Assisted in writing "Pathways to Culturally Competent Health Care" proposal funded by the Blue Cross/Blue Shield Foundation of Massachusetts.

Area Agency for Developmental Services of Greater Nashua, Nashua, New Hampshire

Consultation with Diversity Council on implementing self-determination initiatives for people with disabilities and their families in the diverse communities in the greater Nashua area.

Council on Developmental Disabilities, Commonwealth of the Northern Mariana Islands

Conducted workshops on advocacy for parents of children with developmental disabilities, self-advocacy for young adults with disabilities, on self-determination, and on legislative advocacy.

MEDSTAT, Cambridge, Massachusetts

Conducted site visits assessing how successful states were in transitioning people from nursing homes to new homes in the community and in diverting people from nursing home admissions.

Work, Inc., Quincy, Massachusetts

Facilitated strategic planning effort to position agency to be more responsive to employment needs of people with disabilities.

Colorado Association of Community Centered Boards, Denver, Colorado

Expert witness consultation to Community Boards regarding the "wait list" litigation in Colorado.

American Network of Community Options and Resources (ANCOR)

Consultation on development of a national campaign to increase public awareness of critical role played by direct support professionals in supporting people with developmental disabilities.

Office of Developmental Disabilities, State of Oklahoma

Consultation on the implementation of strategies to address the workforce crisis created by the lack of quality direct support professionals, and in the State's role in supporting self-determination.

Division of Developmental Disabilities Services, State of Arkansas

Played key role in writing "Community-integrated Personal Assistance Services and Supports" grant awarded by the Centers for Medicare and Medicaid to the State of Arkansas in the amount of $900,000.

Maryland Association of Community Services
Consultation with provider and staff officials on the implementation of a comprehensive plan to help address the crisis created by the lack of direct support professionals in the State of Maryland.
Centers for Medicare and Medicaid Services (CMS), Baltimore, Maryland
Member of review panel for "Systems Change Grants for Community Living" initiative.
University Affiliated Program, State of Arkansas
Consultation to develop a comprehensive workforce development initiative for direct support professionals.
Department of Social and Health Services (DSHS), State of Washington
Consultation on the implementation of initiatives to provide more effective supports to families that have need for services from more than one state agency. Presented best practices in case coordination.
Community Support Network, Concord, New Hampshire
Consultation on implementation of a comprehensive plan to address the workforce crisis in New Hampshire.
Office of Mental Retardation and Developmental Disabilities, State of New York
Consultation on the use of multiple strategies to insure success in the implementation of self-determination.
South Shore Mental Health Association, Quincy, Massachusetts
Assisted in the development of community supports for persons with mental illness.
General Learning Corporation, New York, New York
Planned secondary and higher education components for an educational system in New York City, focusing on the role of business in providing educational and employment opportunities.
DC Housing Authority/Police Boys Club, Washington, D.C
Worked with pre-school program and obtained funding and implemented environmental education program for teenagers in danger of dropping out of school.

EDUCATION

Program for Senior Executives
John F. Kennedy School of Government, Harvard University
MA, Urban Affairs and Policy Analysis,
New School for Social Research, New York, New York
BA, American Studies,
George Washington University, Washington, D.C.

PROFESSIONAL ACTIVITIES/PRESENTATIONS

Reports/Publications
- Keilson, Jeffrey, "The Role of Public Policy in Creating the Foundation for Supporting Self-Directed Supports," The NADD Bulletin, 2003
- Keilson and Fletcher, "Coordinating Individual Services and Supports: Moving from System-Centered Case Management to a Person Centered Approach," Hawaii Council on Developmental Disabilities, 2002
- Keilson, Jeffrey, "Recruiting Human Services Employees," Promising Practices Home Page, Centers for Medicare and Medicaid Services Co-author, "An

Educational Services Network for South Jamaica, New York," General Learning Corporation

- ***Special Presentations, Human Services***
- Presenter, Pre-Conference Workshop, "The Workforce Crisis: Strategies That Work," ANCOR Governmental Activities Seminar, 2001
- Presenter, Pre-Conference Institute, "Addressing the Workforce Crisis," sponsored by
- University Affiliated Programs, State of Arkansas, 2001
- Presenter, General and Closing Sessions, "Self-Determination...A New Way of Thinking/Impact on Future Services," Arkansas State Conference, "Self-Determination: Dreams to Reality," 2001
- Presenter, Pre-Conference Institute, "Staff Recruitment and Retention Strategies," Texas Council of Community MH/MR Centers, Staff &Trustee Annual Conference, 2001
- Presenter, Plenary Session, "Self-Determination from a Multicultural Perspective," Southeast Regional Conference on Self-Determination, 2000
- Keynote Speaker, "The Art of the Possible," Conference Centre, Cambridge, England, 1999
- Presenter, Symposium, "Managed Care--Impact of the Delivery of Psychological Services," American Psychological Association Annual Convention, 1999

Self-Determination/Self-Advocacy

- Trainer, "Developing an ISP Using the Principles of Person Centered Planning," ResCare, 2004
- Presenter, "People with Disabilities and Family Members as Employers," National Association of State Directors of Developmental Disabilities Services (NASDDDS) Annual Meeting, 2003
- Presenter, "Implementation of an Individualized Budget System: Making it a Reality," Ohio Association of County Boards of Developmental Disabilities Spring Conference, 2003
- Presenter, "Person-Centered Planning," CMS Living and Working in the Community Conference, 2003
- Trainer, "Person-Centered Planning," Rainbow of Challenges, Hope, Arkansas, 2003
- Trainer, "Implementing the Principles of Self-Determination into Everyday Lives and the Person Centered Approach to Planning," Advocates, Inc., 2002
- Presenter, "Self-determination: A Brighter Future," "Turning Shared Vision to Reality" Conference, Oregon Rehabilitation Association, 2002
- Facilitator, "Protecting Individualized Community Supports When Budgets are Cut," NASDDDS, 2002
- Presenter, "Managing Supports in Your Community," Connecticut Family Support Conference, 2002
- Presenter, "Self-Determination: Decision Making, Risk and Safety, and Quality of Life," AAMR, 2002
- Presenter, "Balancing Personal Freedom Against Public Accountability" and "Ready or Not—The Changing Marketplace," Conference on Self-Determination, State of Connecticut, 2002

- Presenter, "Developing Self-Advocacy: Kick Starting a Grassroots Campaign," YAI Conference, 2002
- Presenter, "The Road to Implementation of a Self-Directed System," Conference on Self-Determination, State of Hawaii, 2002
- Keynote Speaker, PALS for the Future, Networks for People with Special Needs, Conference 2001
- Presenter, "Transitioning from School to Adult Life," Ark Council on Developmental Disabilities, 2001
- Presenter, "Providing Culturally Appropriate Services," New Opportunities for Community Living: A Systems Change Conference, Health Care Financing Administration, 2001
- Presenter, Grassroots Consortium on Disabilities Leadership Retreat, 2001
- Presenter, "Linking Literacy for Adults with Disabilities to Person Centered Planning," AAMR, 2001
- Presenter, "The Balancing Act: Addressing the Elements of Risk When People Direct Their Own Supports," NY Association of Community Residential Agency's Annual Conference, 2001
- Presenter, "Self-Determination--The Massachusetts Experience, and "Changing Role of State Service Coordinators," Conference on Self-Determination, State of Hawaii, 2000
- Presenter, "Self-Determination from a Multi-cultural Perspective: Role of Family Governance in Communities of Color," Florida Family Care Councils State Conference, 2000
- Presenter, "Promoting Quality thru Person-Centered Planning," NASDDDS midyear meeting, 2000
- Presenter, "Self-Determination and Adults with Developmental Disabilities," YAI Conference, 2000
- Presenter, "Innovations in Support Brokerage," Southeast Regional Conference, 2000
- Presenter, "Power Sharing and Governance," NASDDDS Annual Meeting, 1999
- Presenter, State of Washington Conference, Introduction to Self-Determination, 1999
- Presenter, Robert Wood Johnson Foundation Conferences, 1999 and 1997
- Presenter, "Promoting Self-Determination in Communities of Color," AAMR & YAI Conferences, 1997

Workforce Development

- Presenter, "The Workforce Crisis: Meeting the Challenge Now and in the Future," ADD Commissioner's Forum, 2003
- Presenter, "The Workforce Crisis: Strategies that Work," Ohio County Boards of Mental Retardation and Developmental Disabilities 19th Annual Convention, 2002
- Presenter, "The Workforce Crisis: Strategies that Work," "Turning Shared Vision into Reality" Conference, Oregon Rehabilitation Association, 2002
- Facilitator, Roundtable Discussion on Workforce Development, "Fulfilling the Promise of Community," Conference sponsored by Centers for Medicare and Medicaid Services, 2002

- Presenter, "Workforce Development: Finding New Strategies for Recruitment, Training and Retention," Conference sponsored by the Council on Quality & Leadership, 2001
- Presenter, "Implementing Strategies to Help Address the Shortage of Direct Support Professionals," Conference sponsored by the MH/MR Coalition, Commonwealth of Pennsylvania, 2001
- Presenter, "Innovative Strategies to Address the Workforce Challenges," Staff Recruitment & Retention: We Can Solve This Together Conference, Ocean State Association of Residential Providers, 2001
- Presenter, "Workforce Recruitment and Retention," New Opportunities for Community Living: A Systems Change Conference, Health Care Financing Administration, 2001
- Presenter, "Cooperating to Recruit Human Service Employees," AAMR & YAI Conferences, 2001
- Presenter, "Strategies to Help Address the Workforce Crisis," NASDDDS Annual Meeting, 2000
- Presenter, "A Unique Opportunity for Reinvesting State Employees," AAMR Annual Conference, 1997

Other Related Activities

- Adjunct Lecturer, MBA Program, Heller School, Brandeis University; course entitled "Management Issues in Systems and Organizations Serving Elders and Persons with Disabilities," 2003
- Member, Public Policy Committee, NADD, 2002 to present
- Board Member, Advocates, Inc., 2002 to 2004
- Board Member, Autism Alliance of Metrowest, Inc., 2002 to present
- Member, Advisory Board, Pediatric Alliance for Coordinated Care, 1995 to 2000
- Chair, Mental Retardation and Alzheimer's disease Committee, Governor's Conference, 1994
- Presenter, National Association for the Dually Diagnosed Conference, 1990
- Presenter, Mental Retardation and the Criminal Justice System Symposium, 1990
- Consultant in Public Agency Administration, Department of Psychiatry, MGH, 1985 - 1987
- Presenter, Mental Health: The Challenge Conference, 1985
- Presenter, American Association of Workers for the Blind, Northeast Alliance Conference, 1982

Community Service

- Co-chair, School Space and Enrollment Study Committee, Ashland Public Schools, 2000
- President, PTO, Ashland High School, 1999 - 2001
- Co-chair/Member, School Site Council, Ashland High School/Mindess Middle School, 1993 to 2001
- Member, Consumer Advisory Committee, OPTIONS Mental Health, 1993 - 1996
- Board Member/Coach, Ashland Youth Basketball and Youth Baseball and Softball, 1991 – 1996

Awards

- Recognition for Leadership and Commitment to the Latino Community, 2001
- Recognition for Dedication to Families with Children with Autism, Boston Families for Autism, 2001
- Outstanding DMR Employee, GBARC, 2001
- Outstanding DMR Employee, Walnut Street Center, 2000
- Professional Partnership Award, Toward Independent Living and Learning, 2000
- Recognition for Dedication to the Solidaridad Program, Latino Health Institute, 1998
- Recognition for Commitment to Children with Disabilities, Boston Public Schools, 1997
- Recognition for Pointing us in the Right Direction, BWAC, 1997
- Citation for Outstanding Performance, Commonwealth of Massachusetts, 1990
- Recognition for Commitment to Child Care for Children of all Abilities, City of Boston, 1989
- Recognition for Outstanding Contribution to the Quality of Mental Health and Mental Retardation Services, North Suffolk Mental Health Association, 1987

Leo V. Sarkissian
The Arc of Massachusetts
217 South Street
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Key Accomplishments

- Developed new funding sources and support to renew statewide advocacy organization
- Led organization's efforts to insure more than $200 Million in new services for individuals with developmental disabilities
- Directed 3 federal grant projects and numerous state or foundation programs
- Developed and managed a multi-service agency with $4 Million plus annual budget
- Played key role in 3 public relations campaigns on state and local level
- Experienced leader and manager with more than 20 years of experience

Professional Experience

The Arc of Massachusetts, Waltham, MA **1991 to present**
Executive Director

- Lead ongoing advocacy for 120,000 person/family constituency
- As CSO, nurture network of 21 affiliates, 40 plus agencies and thousands of members
- Direct role in judicial activities including four high profile class action lawsuits
- Obtain media coverage, TV, Radio and Press; managed 2 media campaigns
- Oversee Federal and other projects addressing disability services or education
- Write or organize publications materials, testimony and grant proposals
- The Arc is recognized as premier disability advocacy agency

South Shore Arc, Weymouth, MA **1984 to 1991**
Executive Director/President

- Led agency from .5 Million to more than $4 Million annual budget
- Developed a full range of community services including new Early Intervention and Personal Care Attendant Programs
- Led more than 30 successful grant proposal submissions
- Developed new board members from business community and expanded donor base

South Norfolk County Arc, Norwood, MA **1981 to 1984**
Director, Residential Services

- Managed five residential programs and contracts totaling $2 Million
- Developed new privately funded housing program for elders and oversaw final phase of HUD funded project
- Developed a strong team of managers including training and human resources support

Coastal Area Department of Mental Health, Quincy, MA 1979 to 1981
Social Worker, Planner

- Consulted to 10 community agencies in the South Shore
- Worked as a member of planning-policy team for 10–town region
- Provided direct counseling services to families, children and adolescents and consultation to school systems
- Provided emergency services to all ages as part of a team
- Chaired personnel benefits committee for mental health center

Education

University of Chicago, School of Social Service Administration Chicago, IL
MA in Social Work, 1979 Concentration in systems and generalist practice.

Eastern Nazarene College Quincy, MA
BA in Psychology/ Philosophy, 1976 Magna Cum Laude
Who's Who in American Colleges and Universities, 1976
Senior Editor of Campus Paper

Other Education & Activities

- Auditor's Institute at the University of Massachusetts Boston, 1984
- Licensed as L. I. C. S. W., Licensed Independent Clinical Social Worker, 1981
- Resource Development Committee of The Arc of the US, 2001-
- Board Member, National Conference of Executives of The Arc, 2004-
- Member of the Advisory Board, Fellows Program (LEND) of the Shriver Center,
- New England Medical Center and Suffolk University, 2000-
- Past activities have included:
  - Sunday School Teacher,
  - Weymouth Family and Youth Council, board member
  - The Council on Accreditation and Leadership, board member
- Edited "Building A Future", handbook for families developing housing
- Received various awards: New England Region of the American Association on Mental Retardation (September, 1995), Massachusetts Association of Rehabilitation Facilities (June, 1995), North Shore Arc Leadership Award-1999, United Arc-2001 Marguerite Canedy Award, SNCARC Advocacy Award-2001 and Charles River Arc, "2003 Man of the Year".

Attachment #2

Florida Service Algorithms

Florida DCF/DDP - HCBS DS Waiver Program
WebICG "Personal Budget" Algorithms and Assumptions:

BASE Profile Monthly Costs:

Loaded at the midpoint of 37.50 to 50 percentile using FMIS SFY 2003 data, utilization has been adjusted based on expert panel (Roger, Futures, and DDP), and normalized using the published rates. The BASE excludes Support Coordination (W9588), Wheelchair/Adaptations (W9536), Accessibility Adaptations/Assessments (W9549), and Personal Care (W9538 and W9552).

Age Group	Living with my family, relatives, or others in a family home or in my own home (In-Home)	Living in a licensed facility(Group Home or Foster Home) (Out-of-Home)
03-06	$518.68	$3,231.46
07-12	$501.34	$3,229.81
13-17	$529.72	$3,397.69
18-21	$655.68	$2,139.25
22-44	$1,171.09	$2,781.76
45-64	$1,237.10	$2,774.02
65+	$1,193.03	$2,954.17

The above BASE rates were reviewed by DDP on September 9, 2003. Recommendations were made to adjust the BASE utilization of the following services:

W9537 = Consumable Medical Supplies
W9558 = Supported Living Coaching
W9540 = Physical Therapy Assessment
W9513 = In Home Support
W9548 = Companion
W9553 = PERS Service Charge
W9550 = Homemaker

ResHab for licensed facility (Out-of-Home) is based on the following assumptions:

Age Group	Annual/Monthly	Assumptions
03-06	$37,405/$3,117	Residential Live-In Model Ratio 1:3; $102.48 daily rate and assuming **365** days annual utilization.
07-12	$35,352/$2,946	Residential Live-In Model Ratio 1:3; $102.48, daily rate and assuming **345** days annual utilization.
13-17	$39,559/$3,297	**7** staffing hours per day @ $18.23 hourly rate per hour, using **310** days annual utilization.
18-64	$22,605/$1,884	**4** staffing hours per day @ $18.23 hourly rate per hour, using **310** days annual utilization.
65 +	$26,616/$2,218	**4** staffing hours per day @ $18.23 hourly rate per hour, using **365** days annual utilization.

- **Supported employment service has been removed from BASE and will be calculated based on request from focus person (adults only) from the ICG "Employment" module.**
- **In-Home Support: Using 22 days as a monthly conversion; Average daily cost is $122.45.**
- **ADT: Daily unit rate is $41.40**
- **Residential Nursing Services quarterly hour rate is $8.12 (blended with RN and LPN rates).**

Please refer to Norm Davis's worksheet <BASE Service Profile by Rate Cell.xls> for the detailed assumptions of the utilization by services in each BASE rate cell.

Geographic Adjustments:

Geographic adjustments are applied to focus persons who reside in districts 9, 10, and 11 as follows:

- **12%** add-on to the BASE for **Palm Beach, Broward,** and **Miami-Dade** counties
- **18%** add-on to the BASE for **Monroe** county.

This geographic adjustment will be prorated based on the number of months the focus person intends to move during a 12-month period.

Domain Adjustments:

Value will be added onto the BASE and geographic adjustment, if applicable based on the percentages below:

Community Inclusion (11 Items)	Any one item or more scored 5	+5%
	Any two items or more scored 4	+5%
	Any one item scored 4	+2%
	Any three items or more scored 3	+1%

Challenging Behavior **(5 Items)**	Any one item or more scored 5	Appendix B
	Any two items or more scored 4	Appendix B
	Any one item scored 4	+30%
	Any three items or more scored 3	+30%
	Any two items scored 3	+10%
	Any four items or more score 2	+10%
Current Abilities (10 Items) – Age 18+ who live in supported living only.	Total scores 0 – 26 (Standard PCA); Units capped at 1,113 hours	**$15.44** Unit Cost
	Total scores 27 – 39 (Moderate PCA); Units capped at 1,114 to 2,028	**$17.20** Unit Cost
	Total scores 40+ (Intensive PCA); Units capped at 2,029 to 3,640	**$20.16** Unit Cost
	Note: Current Abilities did <u>not</u> apply to recipients who live in licensed group home. For kids (ages 3-17) who live with their family, a flat add-on $4,296 will be adjusted (score > 1) to a 12-month period.	
Health and Heath Care **(9 Items)**	Any one item or more scored 5	Appendix B
	Any two items or more scored 4	Appendix B
	Any one item scored 4	+30%
	Any three items or more scored 3	+30%
	Any two items scored 3	+10%
	Any four items or more scored 2	+10%

Employment Services (Adult Ages 18+ Only)
Per DDP Meeting on September 23, 2003:

For adults who want a job: Total number of hours needed within a 12-month period multiple by the unit rate of **$39.00**. The hours are capped at **46** annually. This value ($1,800 annually = $200 monthly x 9 months) is considered to be an add-on in addition to the ADT service loaded in the base and will be adjusted for geographic factor. This assumption (i.e., three months of employment services will be reimbursed by VR) needs to be tracked and reviewed whether the support employment adjustment should be warranted in year 2.

For adults who have a job and would like training to hold the job: Zero adjustment will be made, given the ADT has been loaded in the BASE.

Home Modifications:

Per request and cost estimate by focus person – the value will be validated and approved by DDP and/or local district office.

Specialized Equipment:

Per request and cost estimate by focus person – the value will be validated and approved by DDP and/or local district office.

Individual Additions (Appendix B):

Triggered by the WebICG system based on "Health and Health Care" and "Challenging Behaviors" domains. Appendix B includes the choices of paid staff support for behavioral and health care services and hourly rates as illustrated below:

Behavior Analysis Services (Board Certified)	**$83.19**
Behavior Analysis Services (Fla. CBA)	$40.72
Behavior Analysis Services (Associate)	$38.36
Private Duty Nursing (RN)	$38.36
Private Duty Nursing (LPN)	$26.58
Skilled Nursing (RN)	$40.70
Skilled Nursing (LPN)	$26.58
Residential Nursing Services (RN)	$38.37
Residential Nursing Services (LPN)	$26.58
Behavior Services Assistant Services	$18.82
Specialized MH Therapy	$60.57

Per request and annual hours estimate (capped at **2,080** annual per service) by focus person – the request will be validated and approved by DDP/or local district office. This value will be replaced the original percentage adjustments from "Health and Health Care" and "Challenging Behaviors" domains. The value will be adjusted for geographic factor.

Support Coordination:

Based on monthly cost of **$148.58**. Each focus person will receive 12 months of support coordination annually per DCF/DDP policy.

ICG "Personal Budget/Resource Allocation" Ranges:

1. Base Profile Costs
2. Geographic Adjustments
3. Four Domains Add-On
4. Employment Services (Adults Only)
5. Home Modifications, if any

6. Specialized Equipment, if any
7. Individual Additions (Appendix B), if applicable
8. Support Coordination

Total the values from 1 through 8. Budget ranges are set **at plus or minus 5% for "Out-of-Home" groups (regarding of ages) and 7% for "In-Home" groups (regarding of ages).** No factor will be applied to those who move from in-home to out-of-home and vice versa in the personal budget range calculations.

Attachment #3

Montana Service Utilization Standards

Attachment #3

Montana Service Utilization Standards

Montana Direct Care Staff (DCS) Hour Utilization Benchmarks

Day Habilitation

DCS Hourly Benchmark						DCS Add-On Adjustment						Client Ratio		
Ratio	Day Hab	Voc Trng	Enclave	TOTAL	Level	Ratio	Day Hab	Voc Trng	Enclave	TOTAL	Level	Hours	People	Average
1 to 1	1.80	1.80	2.40	6.00	Exception	1 to 1	1.4	1.4	1.9	4.8	Exception	6	1	6.00
1 to 2	0.90	0.90	1.20	3.00	#3	1 to 2	0.5	0.5	0.7	1.8	#3	6	2	3.00
1 to 3	0.60	0.60	0.80	2.00	#2	1 to 3	0.2	0.2	0.3	0.8	#2	6	3	2.00
1 to 4	0.45	0.45	0.60	1.50	#1	1 to 4	0.1	0.1	0.1	0.3	#1	6	4	1.50
1 to 5	0.36	0.36	0.48	1.20	Base	1 to 5	0.0	0.0	0.0	0.0	Base	6	5	1.20
6 to 10	0.36	0.36	0.48	1.20	Base	6 to 10	0.0	0.0	0.0	0.0	Base	6	5	1.20

Residential Habilitation - Supported Living

	WEEKDAY				WEEKEND				Total Week	Average Daily	Level	Night Coverage	Hourly Add-On Adjustment
People	AM	PM	Night	Total Day	AM	PM	Night	Total Day					
1	2	8	8	90	8	8	8	48	138	19.7	Exception	Awake	16.0
2	2	8	4	70	8	8	4	40	110	7.9	#3	Awake	6.1
2	2	4	4	50	4	4	4	24	74	5.3	#2	Not Awake	3.6
3	2	2	4	40	4	4	4	24	64	3.0	#1	Awake	1.3
3	2	2	0	20	4	4	0	16	36	1.7	Base	Not Awake	0.0

Residential Habilitation - Group Home (Adults 18+)

	WEEKDAY				WEEKEND				Total Week	Average Daily	Level	Night Coverage	Hourly Add-On Adjustment
People	AM	PM	Night	Total Day	AM	PM	Night	Total Day					
1	2	8	8	90	8	8	8	48	138	19.7	Exception	Awake	16.0
2	2	8	8	90	8	8	8	48	138	9.9	#3	Awake	6.9
3	2	8	8	90	8	8	8	48	138	6.6	#2	Awake	3.6
4	2	8	8	90	8	8	8	48	138	4.9	#1	Awake	2.0
4	2	8	0	50	8	8	0	32	82	2.9	Base	Not Awake	0.0

Level	Behavior Add-on hours	Health Add-on hours	Total available Staff hrs	Factor
Exception	4.8	4.8	24	0.200
#3	1.6	1.6	16	0.100
#2	1.2	1.2	16	0.075
#1	0.8	0.8	16	0.050
Base	0.0	0.0	16	0.000

Residential Habilitation - Group Home (Children Ages 7 to 18)

	WEEKDAY				WEEKEND				Total Week	Average Daily	Level	Night Coverage	Hourly Add-On Adjustment
People	AM	PM	Night	Total Day	AM	PM	Night	Total Day					
1	8	8	8	120	8	8	8	48	168	24.0	Exception	Awake	18.0
2	8	8	8	120	8	8	8	48	168	12.0	#3	Awake	6.0
3	8	8	8	120	8	8	8	48	168	8.0	#2	Awake	2.0
4	8	10	8	130	8	10	8	52	182	6.5	#1	Awake	0.5
4	8	8	8	120	8	8	8	48	168	6.0	Base	Awake	0.0