Oregon
Tina Kotek, Governor

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To: Dana Hittle, Interim Director, Office of Developmental Disability Services

From: Leslie Sutton, Residential Facilities Ombudsman

Re: Recommendations to support Oregonians with high support needs

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Dear Dana:

Everyone deserves support to succeed. For many Oregonians with IDD and significant support needs, SACU becomes a provider for them. SACU is called the “Stabilization and Crisis Unit” which leads people to believe they or their loved ones can get critical crisis supports to stabilize their lives. This is not the case for many people living at SACU. The RFO team has appreciated our conversations with ODDS about these difficult situations.

Under ORS 443.282, RFO can make recommendations for improvements in the residential facility system. Understanding the urgency of the cases RFO currently has in SACU, coupled with the urgency of legislative session, we offer the following observations and recommendations not just for people in SACU, but for people with high support needs who may have a crisis. For people in SACU and other crisis situations, these services must be delivered in two simultaneous streams, one to provide real services to stabilize the person at home or on a crisis placement and the other to plan for how to maintain that stability in the person’s life next living situation if they are in a crisis bed currently.

In carrying out our statutory duty to provide recommendations, RFO is not making comments on the current or future SACU staffing levels or the SACU budget. Our recommendations focus on ways to improve the lives of Oregonians with IDD. We would be happy to be part of a continued discussion about SACU and crisis system transformation.

Below you will find recommendations relating to:

1. Essential Values
2. Facilitated Person Centered Planning
3. Services that embrace the vision for the person’s life and get curious and creative with behavior supports
4. Environmental Modifications and technology access
5. Targeted, specialized case management
6. Supported Providers
7. Strategies to address stabilization as a hurdle for the system, not the person and ensure HCBS rights are given to all Oregonians with IDD in crisis
8. Crisis Services, learning from other states
9. Expectations of the crisis workforce must be centered on the values in HCBS and Oregon law
10. HCBS rules create whole lives for people. Limits on these rights should be reviewed by the Oregon Human Rights Commission

11. People with DD, their families, advocates, providers and case managers need to understand the purpose of DD services, what they can do, HCBS rules, who is eligible and who can provide the services.

Necessary components of supporting people with high needs include:

1. Values are essential

We can learn from the Employment First policy statement as we transform the crisis supports. The Employment First statement can be paraphrased as: Everyone can work and there is a job for everyone. As support, our job is to be tenacious to find the services and supports that make it possible for the person to work. The same is true for people with higher support needs.

A principles-based approach to guide the crisis transformation could be something like:

- Everyone can live meaningful lives in Oregon’s communities. As support, our job is to be determined and ensure there are supports and services in a person’s life so they can live in a home that meets their needs and be surrounded by their community and services that buy into their vision for their life full of self-determination.
- Everyone is ready. It is not the person who needs to be “ready” for community, but rather, supports and systems need to be ready to support that person to succeed. Our job is to make those supports and systems ready to help each Oregonian with IDD to thrive in our communities.
- The person and their team must be informed of the crisis process in advance. They need to know what points they control so they can process the information and participate in their services. The person must have this explained to them in a way that they understand. People are not at their best when in crisis. Knowing the steps of the crisis system before there is crisis ensures that the person has the beginning frameworks should a crisis occur.
- Crisis is the fault of the system, not the person. When someone needs crisis services, they need flexible supports to meet their needs while more long-term services are established at the same time. Both stabilization and long-term support conversations must happen concurrently.
- Whenever possible, crisis services should be delivered in a way that allows the person to stay in their current residence. When they need to leave their current residence for short-term crisis placement, the placement must not last more than 90 days. During those 90 days, the person and their team will work to stabilize them while concurrently building supports at their previous or next long-term home.
- Crises lasting more than 90 days are no longer crises, but rather, changes in support needs that must be accommodated in long-term supports, not crisis placements.
- People are healthier, safer and happier when they have long-term supports that allow for autonomy and match their vision for their life.
- An innovation workgroup must be developed to implement these principles and the DD system values in system change.

2. Facilitated Person Centered Planning

All people deserve to have a vision for what they want their life to look like. When they have a vision, the purpose behind supports in their life is clear. For people with disabilities, facilitated person centered planning is vital to setting that vision. It must bring together the person and the people who care about them to talk about what the person likes and wants to see in their life. It is this vision that guides the staff and people who support the person to live the life they want.

Over the last decade, the Residential Facilities Ombudsman staff in current and previous jobs, have met with many people with high support needs, their families, providers, and case managers. Some of these people have lived in residential settings, and some have lived in their family home. There is a stark difference between the experiences of people who have had true facilitated person-centered plans that develop a vision for their lives and establish a path for how people supporting them will help the person live their lives and those who have not. There is also a difference in the supports people receive when there is an expectation that the person's life will look a certain way. That builds an expectation that the person will be supported to engage in activities they love. We know that people are more successful when they have things in their lives that are meaningful to them.

Person Centered Plan facilitators are not case managers. A case manager is responsible for connecting the person with services. The Person-Centered Plan facilitator is there to help the person and those who care about them chart a vision for their life. Oregon tried to get facilitated person centered planning in the K Plan in 2013-2014, but it did not happen. Oregonians with IDD are paying the price now. They often have support with no purpose or effort to align supports with activities that are meaningful to them.

Washington State has a 1915(c) facilitated person-centered planning service for people with IDD.[1] The description is very detailed and worth a full read, however, the basic description is below:

> "Person-centered planning facilitation is an approach to forming life plans that is centered on the individual. It is used as a life planning model to enable individuals with disabilities or others requiring support to increase personal self-determination.
>
> Person-centered planning facilitation includes: 1) Identifying and developing a potential circle of support. 2) Exploring what matters to the waiver participant by listening to and learning from the person. 3) Developing a vision for a meaningful life, as defined by the waiver participant. 4) Discovering capacities and assets of the waiver participant and her/his/their family, neighborhood, and support network. 5) Generating an action plan. 6) Facilitating follow-up meetings to track progress toward goals.
>
> Person-Centered Planning Facilitation is a distinctly different service that does not duplicate nor replace the responsibilities of the DDA Case/Resource Manager who is responsible for developing the person-centered service plan, and this service does not replace an individual's person-centered service plan. The person-centered planning facilitators employ methods including total communications techniques, graphic facilitation of meetings and problem-solving skills in the development of a person centered plan, such as PATH (Planning Alternative

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[1] Washington State Individual and Family Services Waiver, Person Centered Plan Facilitation Service: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83526

Tomorrows with Hope), MAPS (Making Action Plans), personal futures planning and person centered thinking tools."

RFO Recommends:

1. ODDS develop a facilitated person centered planning service similar to Washington State's.
2. For efficiency, we recommend ODDS look to existing, approved Oregon Medicaid authorities to find the category for this service, then build out the service definition and provider qualifications. The service eligibility would presumably depend on which Medicaid authority applies in this circumstance.

3. Services that embrace the vision for the person's life and get curious and creative with behavior supports

Supporting people is personal. What works for one person will not for another. Successful behavior support requires creative, qualified behavior support specialists who observe the person, their supports and their environment and talk to the person and those they care about. The Behavior Support Specialists must buy into the vision for the person's life that the person has charted. Without this curiosity and creativity, the behavior support plan risks simply "containing" or "managing" behavior rather than supporting the person to live their lives full of self-determination. The behavior supports become the backbone to how staff are trained to support the person. If they are trained in the vision for the person's life and the purpose of their support, they will support the person with activities that are meaningful to them.

In contrast, a behavior containment or management focuses on depriving the person of something that is meaningful to them because the item broke or because the person had a "behavior". Behavior containment often refers to the person as "destroying" the item rather than the item breaking.

RFO Recommends:

1. Any behavior support in crisis settings must be able to transition easily into other settings. People must be supported and prepared for a full life. Currently, some people with high levels of support become regimented in restricted settings. The longer they stay in these settings without access to community and a vision for their life, the harder it is for them to live a full life. When people are in crisis either in their own home or a crisis placement, they must maintain access to their community professionals, including doctors, psychiatrists, behavior support professionals, job coaches, etc. Often, when people go to SACU, their providers may change to be connected to SACU. This means when they leave, they must transition to other providers.
2. As a crisis placement, SACU should use the professionals already in the person's life – and connect with other community professionals as needed. Community professionals supporting people in SACU will allow the transition to other placements easier.
3. Additionally, using the two concurrent tracks of crisis and long-term support outlined above, having continuity of professional providers will help the person successfully transition from crisis to long-term support because their professional team will know them.
4. Finally, people need things to do in crisis placements. Often, we see a lack of person-centered and meaningful activity options for people to use during the day. This leaves people unoccupied, bored, and frustrated. It also opens the home up to more conflict between residents and residents and staff because they are all squeezed into a small space with very little to do.

4. Environmental Modifications and technology access

People succeed when they have space that works for them. Oregon is lucky because we have Medicaid authorities to get environmental modifications and technology for people using services. Oregon, however, has over complicated the process to get home modifications or technology. There is a need for real home modification and technology consultation that can be curious and understand the environmental and technology needs of someone with IDD. They need to be asking “how does the person interact with their bathroom?”, “how does this structure support them to do the things they like to do at home?” and “that material broke, what was it about that material that didn’t work for the person? What would work better?” The same questions can be asked of technology.

What we see too often is when things break for people at SACU, they are simply removed or withheld. There are now people at SACU that have nothing to do, hardly any furniture, nothing on the walls and broken bathrooms. Additionally, they do not have access to technology that they are eligible to receive.

RFO recommends:

1. The idea that people are “destroying” things in their home must be reframed. Instead, there must be an understanding that the environment and technology is critical to how a person feels, communicates and acts. All behavior is communication. We must ask, “what are they telling us here?” rather than “they destroyed that”. There must be plans for short term and long-term modifications to the person’s home and technology to accommodate future needs related to aging, changes in medical needs or conditions.
2. For crisis placements, the idea should be about technology and modifications to stabilize, but at the same time work on their future home to ensure there is a strong transition and environmental modifications and technology access that will continue to build stability in the person’s life. That is where they will live longer term, and it must accommodate their needs.
3. Oregon needs to streamline the home modification process to allow these modifications to happen timely and effectively. We also believe that modifications to support someone with high support needs in a provider-owned setting often go beyond ADA accessibility and therefore should be paid for by DD services rather than the provider. Georgia allows for intensive home modifications in their Community Residential Alternative Program their 1915(c) Comprehensive Supports IDD waiver.[2]
4. In supporting providers with home modifications for people with high support needs, we strongly encourage ODDS to consider creating a provider type for an environmental modification specialist who understands the changing field of home technologies, construction, building codes and behavior support. This specialist can work with the person, the family, and the provider to develop a plan for each modification project. A similar path could be effective for technology identification and access.
5. In addition to funding these professionals, it would be worthwhile for ODDS to create a community of practice with a public website to share information about these modifications and technology. These fields change fast, and shared knowledge will lead to more ideas to help people. There have been efforts in other states to create this with varying levels of success, but we are not aware of these resources still online. Such a website would not only allow current professionals to get good information in this rather niche area, but it can also encourage more professionals to be engaged in supporting people with IDD.

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[2] Georgia Comprehensive Supports Waiver Program: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81431

5. Targeted, specialized case management for people with high support needs

Supporting people with high needs requires deep focus and capacity. Crises happen where the case manager needs to be locating and developing many services all at once while also working with the person to determine what supports would be most helpful. This requires a small caseload and access to other specialized case managers to share ideas with. To do this well, we recommend:

1. Caseloads of 10 plus a supported community of practice structure to connect these case managers. The community of practice should focus on giving these case managers tools and best practice ideas to support people with high needs in truly person-centered ways.
2. People doing this work must have the training to know best practices in supporting people with high needs and feel comfortable getting creative – and they need to have access to fast exception processes that can quickly deploy resources to meet someone's needs including getting specialized consultants on board quickly. They must be willing to call professionals outside of the region, supporting them to become Medicaid providers, etc. This capacity building is essential to creating the lives people deserve. It must be a core function of this level of case management.

6. Supported Providers:

At the end of the day, the person with high support needs will most likely have most of their interactions in a day with a provider.

RFO Recommends:

1. The provider must be well-supported through a robust yet flexible rate structure that allows for creativity, intentional planning but also fast response when needed.
2. The environmental modifications must be separate from the provider rate. The rate structure also must consider rates and wages that will allow for direct support professionals to stay in the job developing strong, lasting relationships with people they support. Without that, it is difficult to buy into the vision the person has for their life.
3. The rates must also consider transition time between different placements. If the person is in a crisis bed, there must be rates available for the crisis placement staff to come with the person on visits to their new home for a certain period. During these visits, the crisis staff can help the person get comfortable in their new home and work with the person and the new staff or family members to develop strong relationships and learn how to work together to be successful. In these transition moments, the rates must support both the crisis and long-term provider.
4. We must be focused on helping the people and providers who will support the person in both the short-term crisis and the long-term stabilization stages.

7. Stabilization is a hurdle for the system, not the person

The wording used when people move out of SACU is "they are moving to private" or "they are ready for community". This is incorrect. Everyone deserves to live and thrive in Oregon's Communities. SACU homes are already in our communities and local neighborhoods. By creating terms like "move to community," people and families are led to believe they must clear a hurdle to get out of SACU. The hurdle often is not clear or is ever-changing.

For SACU to be a short-term stabilization while more long-term supports are created outside SACU with home modifications, technology, transition and provider support, the hurdle is a system hurdle, not a personal hurdle for the resident. People utilizing these services will continue to have changing and high support needs.

RFO Recommends:

1. The system must be able to respond individually to each person's needs focused on what supports the person needs to succeed. When people are expected and supported to succeed, they do.
2. Just like other IDD 24-hour Residential Providers, SACU is a 24-hour residential Home and Community Based provider. It is important to ensure people living at SACU have access to the Federal and Oregon Home and Community Based Settings rights like access to food, visitors, community activities and services. Removing these rights and basic autonomy over their lives leaves people at SACU at a tremendous disadvantage to moving beyond crisis. Without access to these basic ideas, they lose skills, become isolated and real community life gets further away.
3. All supports must focus on skill building rather than behavior containment.

8. True crisis services

SACU is a 24-hour residential provider with the name "Stabilization and Crisis Unit". Yet, Oregon does not have a crisis service described in the DD services array. That is part of the problem. There are no crisis services descriptions, eligibility or provider qualifications in the Oregon DD System. Given the existing broad Medicaid authorities in Oregon, we strongly suggest ODDS consider how to incorporate these services under existing authorizations.

Other states have defined crisis services in waivers as follows:

Maine Home and Community Services for Adults with IDD or Autism Spectrum Disorder:[3]

Crisis Assessment: Comprehensive clinical assessment of a person who has required intervention by the State Crisis Team on at least three occasions within a two-week period. The assessment includes a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities and to develop a plan for early intervention and stabilization in the event of a crisis. The team may include, but is not limited to, licensed or certified practitioners with specific areas or expertise and experience with people with IDD. The list is specific with professional certifications and knowledge. RFO comment: we support a specific list of high credentials to ensure people have the knowledge and experience to do this work. We also suggest that any such providers assert that they believe in and support the values of the Oregon DD System as set in ORS 427.007 and HCBS.

Crisis Intervention: direct intensive supports provided to the participant experiencing psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the PCSP. Crisis intervention is commonly provided on a short-term intermittent basis. Crisis Intervention Services are only authorized in an emergency for a period of not to exceed two weeks.

Crisis Intervention provider qualifications: agency must have current Mental Health license issued by DHHS Division of Licensing and Certification. The agency must attest that individual partitioners (employees or contractors) are licensed in accordance with state regulation. Direct Support

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[3] Maine Home and Community Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder Waiver: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81896

Professionals who provide Crisis Intervention Services must have behavioral intervention training on approved behavioral intervention procedures (e.g. Mandt) in addition to completing a Direct Support Professional curriculum adopted by DHHS, or demonstrate proficiency, or complete the Maine College of Direct Support within six months of hire, DSP must have CPR and first aid certification, details when DSPs can assist with the administration of medication, supervisors have to meet all the requirements of the DSP position.

RFO Comment and Recommendation on Maine's crisis services as a model for Oregon: In addition to the Maine model, we would add that any DSP working in SACU should also have credentialling from National Association for the Dually Diagnosed which focuses specifically on supporting people with IDD who are dually diagnosed with mental health conditions. We do not believe the qualifications to do behavior support or participate in the COAT team at SACU are sufficient for the resident's needs or in-line with Oregon or HCBS values. Behavior support and crisis support are so important to a person's success that we need to invest in people with strong disability values, credentials, creativity and training. Furthermore, there must be continued support and expectations for staff of all levels to stay current with credentialling and implement the strategies learned into their daily work to support people. Training and learning cannot be done in isolation from the actual work of supporting people. If pay differentials are used to enhance the number of people trained, that differential must also include regular check ins to ensure the person is incorporating the training into their daily work in ways that fit the resident's needs and vision for their life.

Georgia's Comprehensive Waiver Supports Program:

Georgia has an intensive community residential alternative service which is a long-term residential support service for people with high needs. This service is a way for people who are currently out-of-state to go back to Georgia. This service is meant to be long-term and provided in 24-hour provider facilities with four or fewer residents. Staff working in these facilities are "highly trained staff at enhanced levels". The staff use highly-specialized behavior support plans focused on building up individuals' ability to define their own day, make choices, communicate their needs and wants and receive training on ADLs (including employment skills) ". Agencies doing this work must have 24 hour on call coverage to respond to any behavioral health crisis that occurs. The facilities are community settings with enhanced modifications like safety glass in the windows, industrial strength plumbing, reinforced walls, etc. Rates include the cost of paraprofessionals and clinical supports. Georgia must bundle the payment because people using this service are not eligible for behavior support, skilled nursing, environmental accessibility adaptions, etc.

Georgia also has a specialized community residential services alternative that is meant to be short-term (3-6 months). The service includes assessment and transition planning. There are two categories of supports: Behavior focused and Specialized. Behavior focused is for people who have challenging behaviors that need to be stabilized and transitioned to another setting. Specialized services are for people discharged from another setting, like a crisis home, who have demonstrated significant aggression, etc. The intent of these services is to develop stability while maintaining quality of life with the intent that the person return to settings with lower levels of support. These programs have comprehensive behavior support services with access to board certified behavior analysists 24 hours a day. The residents have access to 24-hour nursing as well.

RFO comment on Georgia's services. We like how Georgia layers their supports by long-term and short-term. This could be helpful when Oregon is looking at building a crisis model. We also like the focus on 24-hour support for behavioral health crises. We did not have time to examine their provider qualifications for these services and would want to be sure the qualifications build rigorous expectations of professionalism, knowledge and commitment to Oregon values of self-determination. For the short-term placement services, we would have liked to have seen an expectation of concurrent stabilization for the person plus planning for their next home.

North Carolina:

North Carolina's crisis services include crisis intervention and stabilization supports, out-of-home crisis supports and crisis consultation. Crisis intervention and stabilization includes staff trained to provide assessment if the situation can be stabilized in place or if a higher level placement is needed, determine and contact agencies needed to secure other placements as needed, provide direction to staff or provide direct intervention to de-escalate behavior, contact the tailored care manager/care coordinator after the intervention to arrange a team meeting and provide direction to providers. This can include additional staffing as needed. Out of home crisis supports are short term to allow for structured support and programming. This is in a licensed facility and is authorized in increments of up to 30 days. Crisis consultation allow consultation for people with significant, intensive, or challenging behaviors that have resulted or have the potential to result in crisis. These services include facilitating monthly meetings.

The provider qualifications for these services are high-level reflecting the importance and nature of this work. These include staff holding license as psychologist or psychological associate, staff providing the crisis services must meet all competency requirements including crisis prevention, intervention and resolution techniques and trauma informed care. Crisis services staff must have access to board-eligible or board-certified psychiatrist or psychiatric nurse practitioner with a minimum of one year experience serving people with IDD. All crisis services staff must have access to a licensed practicing psychologist with a minimum of one year experience working with people with IDD.

RFO comment on North Carolina: some of the work of these crisis providers is already done by Oregon's providers or case managers, however, it may be good to think about how to enhance or refocus the work already done and require credentials to enhance the professional workforce and extend expectations to implement the credentialling and training into their work.

9. Expectations of the crisis workforce must be centered on the values in HCBS and Oregon law

When looking at provider credential requirements of Oregon or other states, it is easy to get caught up in the basic credential requirements. However, change will not happen unless the workforce is also trained in the values expectations set out by ODDS leadership, federal rule and state law. The crisis providers must understand the DD system values, self-determination, the purpose of DD services and the innovations and changes of the DD system and other connected systems. Too often, we see SACU staff who are isolated from the broader DD system conversations. They are not told of initiatives, like Employment First, that SACU residents can access. They often do not know what services are available or how to access them. This disconnect ends when they are informed of the values, purpose and broader system initiative. Sometimes, when comparing training expectations, curricula and credentials, they look similar, but the outcomes appear to work better for people outside SACU. We hope to see a shift with clearly defined services, purposes and better communication across the systems.

10. HCBS rules create whole lives for people. Limits on these rights should be reviewed by the Human Rights Commission.

HCBS rules go to the core of what it means to be a human, including having access to food, visitors, control of your schedule, choice of who supports you, and autonomy in your life. If a person needs to have limits on these, there is a specific, prescribed process to limit these rights for a person called an "individually based limitation" (IBL). These rules are violated frequently without IBLs – and sometimes with IBLs that are overly prescriptive for the need. Four of the top five RFO complaints are about HCBS violations, but not all of these complaints relate to IBLs.

Oregon has a tool to ensure that people receive HCBS services. In 2018, the Oregon Legislature, established the Human Rights Commission in Oregon under ORS 427.401. The commission has been relatively defunct since its creation due to the pandemic.

RFO recommends:

1. Oregon reconstitute the Human Rights Commission and task it with reviewing and ultimately approving each proposed IBL for people using DD services. This will ensure the IBLs and PPIs are used appropriately, but also push teams to consider alternatives to IBLs and PPIs that allow people the dignity of risk and self-determination to the greatest extent.
2. Review of IBLs is critical to ensure that people's rights are modified only when necessary and alternatives have been tried and failed, etc. We have seen IBLs that are based on behavior that last happened over a decade ago when someone who is an adult now was still a minor. The idea that they would have an IBL renewed in perpetuity for this must change.

11. People, families, guardians, providers, direct support professionals, providers, case managers and advocates need to understand what DD Services are available, the purpose and values of the services, how they can be used, who is eligible and who can provide them

Everyone deserves support to succeed and be a member of Oregon's communities. Services are only as good as people understand how to use them. We have seen many times when people with IDD, their families, guardians, providers, direct support professionals, case managers or advocates do not understand the purpose and values of DD services and therefore cannot use the services in a flexible way to improve the life of someone with IDD. This also creates informal denials of services where service requests are not put in because "DD doesn't cover that." It also leads to missed opportunities where people are not supported to do things they would like because staff or providers do not know what is possible.

RFO Recommendation:

1. DD services are complicated, and it takes continued education for all members in the DD community to ensure people with IDD are supported completely. This includes educating people in what SACU, crisis, 24-hour residential, foster homes, in-home services, home modifications, technology, behavior supports, etc. can do for people and how to use each service. This information needs to include many examples of how people use each service to allow the person to truly understand how to implement the services in their life. If they do not know what is possible, they will not know to ask for it. Simply listing the services and explaining what an ADL/IADL is or that technology is available will not give people an idea of how to those services to have a dynamic life in community.
2. Part of understanding services is understanding rights. People must understand their rights and how to exercise them. Providers, direct support professionals, families and case managers must understand these rights too. When it comes to HCBS, the power is in the relationship between the provider and resident. The provider, staff and residents must understand how to implement these rules to give the person support to succeed. This education must be ongoing and not "one and done".

3. Implementing what is learned in these trainings about the purpose, values and implementation of DD services in people's lives must be part of job descriptions at each level from direct support professional to case manager.
4. RFO provides rights presentations as required by statute. We recommend partnering with us to create these trainings and materials.
5. SACU is a state-operated provider agency run by ODHS. As such, it should provide its policies on its website so people understand the services provided. Further, if SACU is the short-term crisis placement option, the website and materials must accurately reflect that information. Now, families believe they are getting the "highest" level of support when their loved one goes to SACU. That is not true. Currently, SACU is a 24-hour provider, just like many others. The website should reflect that.

Conclusion

Oregon is fortunate to have extensive Medicaid authorities already in place that can meet people's needs. We need to reframe support for this population to allow for intensive supports. We do this one person at a time, wrapping the person with meaningful person-centered planning, case management, well supported providers, curious behavior consultants, knowledgeable environmental modification consultants and technology. The teams will look different for each person because each person has different needs and different visions for their lives.

Thank you for the opportunity to provide these recommendations. We look forward to future conversations – but we really look forward to the day when Oregon's DD system includes robust crisis, environmental modifications, technology, case management, person centered planning and well-resourced provider systems.