The Community Options Program (COP):

A Public Choice for Personal Choice in Long Term Support

Research and Written by
Jerry Spann
Spring 1987

The Robert M. La Follette Institute of Public Affairs
University of Wisconsin–Madison
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The Community Options Program (COP) was conceived in Wisconsin's State Department of Health and Social Services and given legislative life in 1981. By January of 1982, the first phase of COP's long, statewide implementation process was well underway. With only 8 of Wisconsin's 72 counties participating and a biennial budget allocation of only $3.6 million, COP's initial geographic and fiscal scope were quite limited. Its central goals, values, and program design were, however, anything but modest. Program authors and advocates sought to do nothing less than successfully challenge the privacy of nursing homes and other institution-based medical models of long-term support for vulnerable elderly and frail citizens of the state.

Beyond this direct challenge, COP held out the promise of client choice in the selection of alternative modes of long-term support. Aimed at honoring the Department's long-standing policy of respecting consumer choice, dignity and self-determination, COP gave many nursing-home-eligible persons the option of electing supportive services provided in the client's home or in a home-like setting in the community. In doing so, COP reflected and reinforced a new policy direction for the State Department of Health and Social Services and created a new set of prospects for those persons with serious, chronic conditions, who face the greatest risk of losing out their lives in nursing homes and large state centers: the frail elderly, persons with developmental disabilities (autism, cerebral palsy, epilepsy, and mental retardation), persons with mental and physical handicaps, as well as chronic abusers of alcohol and other drugs. Beginning in 1986, a budget amendment granted program eligibility to persons with irreversible dementias.

COP's funding strategy was as ambitious as its policy direction. Capitalizing on an impending crisis, program planners spotlighted rising Medicaid costs which were driving the Department of Health and Social Services budget and apparently spiraling out of control. By 1986, these costs neared the billion dollar mark in Wisconsin alone, frightening agency officials and state legislators. Departmental analysis showed that over 60% of these costs were going to licensed nursing homes. Demographic studies offered even more cause for fiscal concern, projecting a substantial increase in longevity among the aging population in general, and the frail elderly in particular. Wisconsin's current Medicaid problems were therefore destined to escalate without an effective counter-weight to institutional long-term support.

As a corollary to the COP program, Health and Social Services thus proposed and won legislative support for a moratorium on all new nursing home construction. With the moratorium in place, COP could, at least theoretically, be funded out of the state's share (42%) of Medicaid expenditures saved by the moratorium. At the client level, this strategy meant that the average cost for each COP-eligible person would amount to far more than the state's contribution to the daily per person rate for nursing home care.

COP promised, in short, to better align the State's long-term support values and dollars by funding a program concept that honored client choice and fostered the development of viable community-based services. By linking the nursing home diversion strategy with the moratorium, COP originsators set attractive client-centered values into a context of fiscal prudence at a time when the decision-making environment was clouded by growing antagonism to
new social programs and irresistible pressures to cut costs.

COP's large cast of characters will be familiar to participants and observers of high-level state decision-making: cabinet secretaries, agency professionals, governors, interest groups, advocates, county political leaders and social service workers, program recipients, lobbyists, state legislators and members of the press. All those involved in COP's creation had to confront, from very different perspectives, compelling need, competing interests and contracting dollars. The decisions they made, the compromises they struck, the legislative strategies they devised and their public statements offer valuable lessons to public sector managers from a variety of government service areas.

II. Decision Making: The External Forces

While COP was innovative in design, it was also a response to the political, social and fiscal forces of its time, as well as a reaction against Wisconsin's historical reliance on large, medically-oriented institutions of long term care. Chapter II sketches in broad-brush fashion several major trends that directly affected the development of COP. Chief among these were (A) the state's rapid expansion of nursing home capacity between 1950 and 1980; (B) national and local critiques of institutional care in the 1970s and (C) the status of Wisconsin's community services by 1980.

A. The Institutional Romance

Economic prosperity and the best of intentions cooperated to provide for a massive expansion of nursing homes, hospitals and colonies for the developmentally disabled, beginning shortly after World War II. This boom began in 1947 after the release of a shocking report prepared by a legislative-appointed committee charged with investigating overcrowding and abuse at State Colonies (now "Centers") for persons with developmental disabilities, during the war years. In response to the ensuing scandal, the State Legislature spent some $31 million over a 10-year period toward the rehabilitation and enlargement of the colony system. Old colonies were refurbished, given new staff and physical facilities, and Central Wisconsin Colony and Training School was built in Marathon. The Department of Public Welfare's noble goal was to offer the best care to the widest possible client population "in modern, well-staffed institutions," modeled after conventional medical facilities.

A decade later, state and federal legislatures were similarly generous in the area of nursing home construction, which received a huge impetus with the 1965 enactment of Title XIX of the Social Security Act (Medicaid). Created to establish a "minimal level of health care for the poor," Medicaid offered a valuable, sizem suffice match (50%) to states for the purpose of upgrading patient care in large institutions and nursing homes. This new source of funding had a massive impact on the direction of long term care policy in Wisconsin and elsewhere, both because the federal resources were so enormous and because they were tied to institutional care.

Medicaid dollars offered a bonanza to states inclined to seize an immediate opportunity to shift the huge fiscal burdens of long term care away from their own budgets and onto the federal budget. Counties began to "transform" their hospitals into licensed nursing homes. Medicaid funds also became a major source of new revenue to support the maintenance of the Centers and the buildup of private nursing homes. Without malice aforethought, Wisconsin's enthusiastic embrace of Medicaid funds served to anchor and reinforce "for years to come the bias in favor of segregated," institutional care for people with chronic disabling conditions.

During the 1960s and 1970s, the State was approving the construction of new nursing homes throughout Wisconsin. It also imposed new regulations in an effort to end abuses and ensure quality care. Community after community asked for and received a spanking-new nursing home facility for its aged and disabled residents. "Ma and Pa" operations, widely thought to be antiquated and inefficient, were typically replaced by much larger facilities designed to achieve medical sophistication and economies of scale. These new facilities were typically located on the outskirts of towns or in rural areas, away from population centers and easy access. By 1980, uncontrolled growth was contributing to an extraordinary use of nursing-home beds. In fact, studies showed Wisconsin to be the number two state in the country in nursing home use, with a utilization rate almost twice that of the national average.

B. The Call For Change

There were, however, forces at work that would shift the climate of opinion dramatically during the 1970s. The successful civil rights advocacy of the previous decade had sensitized the whole country to the rights of oppressed minorities and the social evils of segregation. The resulting cultural changes paved the way for an assault on institutions that stereotyped, isolated and abused the elderly and persons with mental, physical and development disabilities. Anti-institutional feelings were reflected in and fueled by national and local media exposés that focused public opinion on gross forms of abuse and neglect. Many
such scandals appeared first as sensational front-page news stories and later as class-action suits filed in federal district courts across the country.

At Alabama’s Bartow State School and Hospital (for persons with mental illness), several deaths due to “understaffing, inadequate supervision and brutality were widely reported.”1 General physical abuse, sexual, and psychotropic drug abuse were prevalent conditions and lack of minimal care and treatment were charged in a national media exposé of the Penhurst School and Hospital (for persons with mental retardation) in Spring City, Pennsylvania; a similar story emerged around conditions at the Willowbrook State School in Staten Island, New York.2

While in some of these cases federal judges merely ordered corrective action in the form of new staff and institutional appropriations, others determined that the offending institutions were beyond repair. Conclusions of this kind led to deinstitutionalization orders and new public policies ensuring the patient’s right to adequate and effective treatment in the least restrictive environment possible. At the same time, rapid advances in rehabilitation medicine and the growing sophistication and use of psychotropic drugs made noninstitutional care a practical possibility for large numbers of persons who were previously thought unable to live beyond institutional walls. The actual results of federally mandated deinstitutionalization were beyond those projected. Only a few years after federal orders had been put in force, 5,350 of Willowbrook’s 5,400 retarded residents had been relocated to community settings.

Since the 1930s, Wisconsin’s Centers had suffered sporadic investigations and embarrassing media attention related to charges of overcrowding, inadequate staff and insufficient programming.3 Beginning in the early 1970s, the Centers also experienced periodic difficulties meeting the technical and substantive requirements of Medicaid standards. The lessons of these problems, as well as more dramatic examples like Penhurst and Willowbrook, were not lost on the Wisconsin State Department of Health and Social Services.

A small but significant number of the Centers’ more capable residents had in fact been moved into small group homes by the early 1970s. By the same time, hundreds of less capable residents had been transferred to licensed, medicaid-eligible nursing homes. Clearly the motives for these actions were mixed. Deinstitutionalization saved millions of state dollars by capturing federal medicaid funds. The agency could, however, also argue that nursing homes represented the lesser of two evils, because they were smaller and less subject to overcrowding.

Many advocates and rehabilitation professionals questioned the nursing-home placement initiatives, citing lack of specific standards for the care and treatment of non-elderly disability groups. More radical critiques asked why young persons with mental retardation and adolescents with non-acute, medically-controlled mental illness were being placed in nursing homes designed and staffed for the frail, and often gravely ill, elderly.

The 1970s were also a time of new and aggressive advocacy on behalf of persons with physical disabilities. In 1973 Governor Patek Lucey established the Governor’s Task Force on Problems of People with Physical Handicaps to study the special social and educational problems faced by this group and to make recommendations designed to address barriers and ensure the achievement of full civil rights. A year and a half after its founding, the Task Force submitted its Final Report to the Governor.

Early sections of the report noted that the number of persons with physical disabilities was steadily increasing, due to Viet Nam War casualties, highway accidents and industrial mishaps, coupled with medical advances that were achieving unprecedented survival rates. The report also argued that “the delivery of health care services, however, continues to be geared to the infectious diseases with far too few resources allocated for the rehabilitation of the ever-increasing number of persons with chronic physical disabilities.” Commission members also deplored civil rights failures and social practices that... labelled, segregated, isolated and sometimes institutionalized... persons with disabilities... The report’s wide-ranging recommendations urged initiatives designed to further “opportunities for self-determination and independent living...” One of the strongest and most consistent calls for change came from Lieutenant Governor Martin Schreiber’s Nursing Home Ombudsman Program. Between 1972 and 1979, the program generated a steady stream of news releases and articles exposing nursing-home treatment scandals, decrying the state’s inadequate regulation record and illuminating the need for and the difficulties associated with reform. Exhibit 1 is a representative example of the Ombudsman Program’s concerns, reflecting its commitment, energy and growing skepticism about regulation as a solution to client abuse and neglect. Schreiber’s continuing interest and support, in addition to the activities of the Ombudsman Program, led to increased public discussion among aging groups about alternatives to nursing-home care. These discussions eventually inspired the development of the Community Care Organization (CCO), to be discussed later in this chapter.

The need for alternatives to nursing-home care was also dramatically set forth in a 1980 report entitled Life in Limbo, published by the Wisconsin Coalition
Nursing home abuses revealed

Schreiber report describes
casualties of behavior control

BY ROY BECKEL

In her report, a Madison nurse became a
dedicated advocate of patient rights, of
which she wrote, "Nursing home abuses
are so pervasive that the issue is
neglected or ignored."

Schreiber's report details the
casualties of behavior control, an
tactic used in nursing homes to
restrict patient freedom and autonomy.

Tied to chair in isolation,
he wanted to die—and did

BY ROY BECKEL

The case of seven Madison nursing home patients who
were tied to chairs in isolation and a Madison nurse
who wrote about it has been highlighted by a
report from the Madison City Council's Hospital
Committee. The report, which was presented to
the committee at a meeting on Monday, March 6,
indicates that the practice of tying patients to chairs
in isolation is not just a problem in Madison,
but also in other cities across the state.

Carter moving quickly
to reduce nuclear arms

BY KEVIN THOMAS

In a move that has surprised many, President
Carter is taking quick action to reduce nuclear
arms, a move that has been hailed as a
historic step towards nuclear disarmament.

Exhibit 1. "Nursing home abuses revealed." Capital Times, Madison, Wis., January 24, 1977
Old man wanted to die—and did

(Continued from Page 1)

be terminated, periods that the man allowed himself to be fed. According to the report, several efforts at weaning were made. Another factor in the decision to "terminate" was the old man's condition. He was said to have been "feeble" and "demented" and it was believed that further efforts to care for him would be "fruitless."

It was stated that "feeble" and "demented" were terms used to describe the man's condition. He was said to have been "feeble" and "demented" and it was believed that further efforts to care for him would be "fruitless."

The decision of the doctors to "terminate" the man's life was met with widespread criticism. "Feeble" and "demented" were terms used to describe the man's condition. It was believed that further efforts to care for him would be "fruitless."

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Nursing home abuses revealed

(Continued from Page 1)

The report on the nursing home abuses revealed that the facilities were operating in violation of the laws governing them. The report stated that the abuses were widespread and that they were occurring in homes throughout the state. The report was based on extensive investigations conducted by the state's health department.

The report revealed that many nursing homes were neglecting the health needs of their residents. Some homes were reported to be overcrowded and poorly maintained. The report also found that some homes were using degrading and abusive methods to control their residents.

Unfortunately, "behavior modification techniques" were frequently used to control the residents. These techniques included "time out," "reinforcement," and "verbal abuse."

The state of Oregon has taken steps to improve the quality of care in nursing homes. The state has implemented new regulations and is working to ensure that all nursing homes meet the standards set by the federal government.

In conclusion, the report on nursing home abuses revealed that significant problems existed in many homes throughout the state. The report called for improvements in the quality of care provided to nursing home residents. The state of Oregon has taken steps to address these issues, but much work remains to be done.
for Advocacy, the State's official protection and advocacy agency for persons with developmental disabil-
ties. Although the report focused attention on a sin-
gle disability group, it painted a picture of life in
nursing homes that was so vivid and disturbing that
its message got widespread attention and substantial
play in the press.

The report's authors, Judy Zitske and Betty Hall-
gren, chose a sample of 23 state nursing homes (with
developmentally disabled residents), representing a
broad range of sizes, locations, and types, as well as
licensure and ownership categories. Each establish-
ment was visited and observed for approximately 12
hours to develop a portrait of typical physical envi-
ronments, relative restrictiveness, patient groupings,
activities, relationships and the like. What
the observers saw and reported characterized the
nursing homes sampled as isolated, impersonal
businesses, organized for staff convenience around
bureaucratic and medical routines at the expense of
residents' needs and rights. The report asserted that
different disability groups were not only segregated
from the community, but often totally segregated from
each other; or, alternatively, mixed in completely ira-
tional groups that served no useful educational or
social purpose. The staffs, typically inadequate in
size and training, often distanced themselves from
the residents or treated them as dependent children.
A majority of the residents sampled had no meaning-
ful relationship in or outside their institutional
"homes." The recommendations and conclusions of
Life in Limbo were stark and unequivocal.

The use of nursing homes as residences for people
with developmental disabilities should be immedi-
ately discontinued. No new admissions should be
permitted. For people who are so ill as to literally
require 24 hour/day hospital-like care, generic hospi-
tals or one of the three state centers for people with
developmental disabilities should be used.

Furthermore, the individual, residential and com-
nunity support needs of all people with disabilities
already in nursing homes should be assessed by
multi-disciplinary teams of competent developmen-
tal specialists. Planning should begin immediately
for the true reintegration of these people into the
community.

Re-integration, in this sense, means movement
into small, dispersed and culturally typical resi-
dences which are in close physical proximity to
population clusters, family and community
resources.12

The report went on to argue that Wisconsin's decision
to "deinstitutionalize" thousands of developmentally
disabled citizens through the use of nursing homes
amounted to "massive involuntary confinement of people
without due process."13

It is important to note that Life in Limbo and the
many companion social critiques of the period dif-
fered in one very important respect from the Partlow
and Pennhurst media exposés. Rather than spotlight
isolated, lurid abuses, they sought to show—as
Samuel Gridley Howe had 120 years before—that
institutions were inherently flawed because they iso-
lated people from normal formative relationships and
experiences, because they were dominated by routine
and standardization at the expense of individual dig-
nity and choice, and because they stood as ugly, reinf-
oring symbols of society's decision to segregate
those labeled as disturbing and different.14

A new theoretical and ideological basis for these
critiques was to be found in the teachings and writing
of Dr. Wolf Wolfsenberger, an expert in the field of
the treatment of persons with developmental disabilities.
His work in Scandinavia, Canada, and the U.S. had
spawned a professional movement with a large fol-
lowing, which, by the late 1970s, included many
local advocates and Department of Health and Social
Services professionals representing a number of dif-
ferent disability groups. Wolfsenberger's work argued
that persons perceived as different are systematically
devalued by rejection, segregation, reduced auton-
omy, poverty of experience and stereotyping.15 The
guiding principle of his theories, "normalization," held
that growth and achievement of full potential
could only occur when such persons were systemati-
cally interpreted by society as "human, healthy, con-
tributing, belonging and growing individuals."16

The principal means of normalizing lay in "increasing
the physical presences and valued participation of handi-
capped people within the community" through
placement in homes, consistent social contact with
valued members of society, individualized learning
programs and the like.17 In this view, nursing homes—however well-intentioned and well-
managed—could never foster the goals of
normalization.

C. The Status of Wisconsin's
Community Services in 1980

By the fall of 1980, the principles of normalization
and the state's past and recent history with regard to
institutional and noninstitutional forms of long term
support were being scrutinized within the Depart-
ment of Health and Social Services, with an eye
among major new policy and program development.

Certainly the fiscal facts of the matter were indisput-
able and could easily be illustrated in graphic terms.

In any comparison of state and federal expenditures
for long term support, it was clear that community-
based support was a stepchild to its institutional
counterpart, as Exhibits 2 and 3 demonstrate. Further,
Exhibit 2 compares the funding available in community and institutional settings for 1976 and 1981. The amount for community services in this graph includes all funds (for all services) allocated to 51 county and departmental social services, except funds for a few categorical children's programs (Day Care Expansion funds, uniform foster care supplemental funds, Child Welfare Services funds, state direct services phase-down monies, and Youth Aids funds) and the Work Incentive Program (WIN). Thus, the amounts for community services include much more than long term support services. The figures for nursing homes, on the other hand, reflect services devoted exclusively to long term support services. They do not include expenditures for services to nursing home residents by other providers (e.g., physicians, visits, drugs, etc.), which are estimated at about $35 million per year. The nursing home figures also do not include the cost of day services or sheltered employment provided by counties for certain nursing home residents, estimated at $5-6 million annually, nor do they include the expenditures of local property tax revenues for county nursing homes, estimated at $2-3 million annually.

Data provided by the State Department of Health and Social Services, Office of Program Initiatives. February 1983.

Exhibit 3 distills the 1981 information from Exhibit 2 (State and Federal Funding for Community and Institutional Services) into three categories. Some of the $313.3 million in community aids pays for services to children and to non-critically disabled adults. We estimate that $69.7 million of the $212.5 million in community aids and $35.8 million in MA dollars pays for non-institutional long term support. MA inpatient costs for the AFSC population have been removed from the third column of Exhibit 3 above. Finally, the $603.8 million is our estimate of the amount that Medicaid pays for long term support in institutions. Keep in mind that this is only Medicaid, and therefore does not include other things, such as Medicare. The picture that emerges in Exhibit 3 puts into even better relief the structural imbalance between community and institutional long term support.

Data provided by the State Department of Health and Social Services, Office of Program Initiatives, February 1983.
the imbalance was growing worse. Exhibit 4 illustrates this trend by comparing relative increases in community versus institutional funding between 1976 and 1981. There was no denying that the state and federal governments had joined hands in supporting a far better, better support system that was massively biased toward institutional care, in direct opposition to explicit written aims.

In addition to these worrisome fiscal and policy realizations, there were some decidedly hopeful examples of what progress was possible in Wisconsin communities given government support. The most directly relevant of these encouraging experiences was the Community Care Organization (CCO), a research and demonstration project largely conceived and administered by the Office of Lieutenant Governor Martin Schreiber. Funded by a grant from the W.K. Kellogg Foundation and a medical assistance waiver obtained from the U.S. Department of Health, Education, and Welfare, the CCO operated in La Crescent, Baraboo, and Milwaukee Counties between 1975 and 1980. The program grew out of mounting concerns about inappropriate nursing home placements: it aimed, therefore, to demonstrate that “a substantial proportion of indigent [elderly and functionally disabled] persons could be maintained in the community through the services arranged for or provided by the CCO at a cost no greater than the cost of institutional care which might otherwise be required.”

The program created a new care organization or agency (the “CCO”) in each pilot locale that served as the single point of contact for clients seeking alternatives to institutional care. The CCO helped assess community support needs as well as create and monitor care plans to enable elderly and functionally disabled persons to remain in their homes or in home-like settings in the community. CCOs also stimulated the development of a host of services that assisted clients with the tasks of daily living (housekeeping, shopping, meal preparation, transportation, etc.).

Experim ental research results generally validated the original, community-based hypotheses. CCO clients expressed high levels of satisfaction with the program and evidenced cost-saving decreases in hospital and nursing home stays. Total public costs for experimental groups (CCO clients) were significantly less than those for control groups (non-CCO indigent elderly and disabled). State costs were about the same for both groups. Project results further suggested that inter-agency and interdisciplinary service management for different functional disabilities could be accomplished within a single program.

By the time the CCO had become a reality, the state of Wisconsin had fully implemented legislation (State Statute 51.42 and 51.437) that made counties responsible for providing treatment and rehabilitation services to persons suffering from serious mental illness, developmental disabilities and acute alcohol and drug addiction. While the State acted as a general supervisor, providing some centralized planning and evaluation functions and serving as a conduit for dollars, this newly established, local control model mandated local response to the needs of these target groups. (No such mandate existed for the elderly or the physically disabled.) This system offered a newly made and quite unique framework for community-based programming.

Some of the first and most impressive innovations to grow out of this new arrangement were county operated Community Support Programs (CSPs) for persons with mental illness. CSPs avoided traditional, facility-based treatment to the greatest extent possible, preferring instead to take assistance directly into the homes and work places of program clients and to make outpatient therapy and supportive services readily available. CSPs maintained 24-hour crisis intervention services and hotlines, sent mobile units to respond to calls for help, and emphasized the development of social and daily living skills for life in the community. In addition to gaining national recognition for their efficacy and cost-effectiveness, Wisconsin CSPs helped convince Department of Health and Social Services program managers that community-based treatment was appropriate for persons with severe, chronic mental illness.

Not all the useful early experiments in nursing home diversion and deinstitutionalization were products of public sector planning: some were born of crisis. When, for example, a spokesperson for the UUnicare Corporation announced a precipitous closing of one section of the Riverview Nursing Home (Waupaca County, 1980), a State Department of Health and Social Services relocation team was forced to intervene on behalf of the affected residents. Within a very short time, the team was able to find successful residential placements for a third of these residents in spite of limited community resources. The Riverview closing was the most dramatic of several such nursing-home crises of the period, occurring in the midst of departmental discussions that led to the CEC concept. Insiders drew confidence from the intervention's positive outcome, judging that both the State and individual counties had the ability to create much broader alternatives to the existing long term support system.

Growing dissatisfaction with institutional care, the awesome fiscal bias in favor of such care, as well as heartening success stories like the CCO, the CSPs and Riverview made a strong case for major policy and program change. Chapter VI was forth the response of the Department of Health and Social Ser-
Exhibit 4 indicates the total increase from 1976 to 1981 for institutional long term care—$331.0 million—was almost 8 times the $43.3 million in community long term support.

*Data provided by the State Department of Health and Social Services, Office of Program Initiatives, February 1983.*
III. The Birth of COP at the Department of Health and Social Services

A. COP's Authors

In the summer of 1977, Governor Martin Schreiber replaced Department of Health and Social Services Secretary Manuel Carballo with Donald E. Percy. The change was to prove much more than just another bureaucratic shuffle. The agency had recently undergone a second major reorganization in a decade, and the new governor and the outgoing secretary had clashed frequently and openly over departmental issues, not the least of which were nursing home regulation and other initiatives directly affecting the elderly. These changes in leadership and organizational structure were seen by many as both a real opportunity and a mandate for charting a new course for the Department.

A planner by background, and a gifted writer and speaker with a thoughtful and confident writing style, the new secretary, who had served as an assistant to a former governor, quickly distinguished himself as a man with a mission who intended to leave a definable legacy of specific policies and programs that would reach far into the agency's future. He neither underestimated the difficulties of his new role nor doubted his capacities to manage Health and Social Services. His assessment of the agency's condition at the time of his arrival was reflected in a memorandum addressed to newly inaugurated Governor Lee Sherman Dreyfus, dated June 16, 1980.

Under this agency, with no sense of mission or direction, an unseemly sense and record of professional performance and a myriad of defects including: the Legislative (where initial complaint was the Department of Health and Social Services never answered correspondence nor made responses to its committees); the Medicaid provider groups (few, count em) whose claims payments were months and years behind; and whose reimbursement was never adequate; the categorical grant associates who would rather risk interesting workers than settle for an integrated service effort; the counties who felt no one cared and no one listened statewide regulating and the regulated both sure they were right no matter what; a relatively efficient welfare system with benefits and programs wanting to believe the worst about recipients—yet a system in need of further reform constrained by a federal government unwilling to allow it to occur; a department which had been recognized twice in ten years, but never criticized; and, yes, the day-to-day set of crises well beyond anything we had seen in our university experience.

In the same communication, he offered a fascinating glimpse of his view of both followers and leaders. He regarded respectable bureaucrats as those who were "willing to overcome or ignore stereotypes and take risks creatively." He believed his proper role to be that of "an environmental engineer" seeking to allow creative bureaucrats to become what their potential promised in the first place. The COP's story clearly suggests a successful effort to create an internal administrative framework and an organizational climate that freed and focused the talents and professional passion of "creative bureaucrats," and which widened the agency's channels of communication, providing a more effective link with advocates and consumers of departmental services. Subsection II sketches the broad outlines of Percy's efforts to construct a productive managerial environment and provides thumbnail portraits of several: "creative bureaucrats" who exemplify one or more of three critical roles with respect to COP's development process: (1) the managerial enablers (2) the program translators and (3) the "misionarios."

The reorganization provided Percy with tools never before available to a Health and Social Services agency secretary: centralized policy analysis, and planning and budget capabilities, which had the potential to help him draw together for the first time the far-flung "principals" that make up Health and Social Services. He moved immediately to strengthen these central services and to establish department-wide planning and evaluation functions that would become the structuring administrative processes of his tenure.

Barely a year later he had outlined these new resources in a search for five or six "strategic goals that would serve as agency priorities for the foreseeable future. He insisted on the widest possible range of inputs into this search. Hundreds of letters requesting ideas for agency goals were sent to Health and Social Services employees at all levels, external advocacy groups, advisory committees, county officials and workers, agency clients and virtually anyone else who was likely to have an opinion on the matter. His planning staff conducted informational interviews with "key informants," including advocates, county staff, and state employees at all levels. Open-ended responses were encouraged and welcomed. After planners had pored over the results of their data-gathering efforts, they presented the Secretary with a list of common themes. From this list Percy identified five goals that would shape the agency's future initiatives: Long-Term Support, Welfare Reform, Children's Services, Health Promotion and Protection and Improving Local Human Service Delivery Systems. Each initiative was to be elaborately conceptualized.
in a planning guideline "developed with broad citizen and local official input" and designed to embody the values and directions associated with each initiative. 27

Percy selected Long Term Support as the agency's first central planning effort. This choice was both pragmatic and value-oriented. It was believed that the Long Term Support Initiative would be easier to conceptualize than welfare reform because it did not necessarily contain mutually exclusive goals, and because the notion of community-based long term support had a kind of conceptual coherency that was not necessarily true of the other goal areas. Furthermore, Percy's principal advisers were "on fire" and pressing for a strengthened community-based policy and there was spirited external advocacy feeding this internal zeal. The Department of Health and Social Services was determined to make the most of a great opportunity to effect a major redirection in agency policy.

To begin the development of the planning guideline that would serve as the conceptual map for the Long Term Support Initiative, Percy once again reached out in all directions for ideas. In doing so he typically nodded respectfully at agency hierarchy by stressing both vertical and horizontal communication. He also emphasized what he called "diagonal communication," which allowed employees with a special talent and passion for a given issue to have major developmental roles, irrespective of their relative ranks in the organization. Employees were thus regarded as "citizens of the Department," rather than as functionaries in isolated work units.

He took pains to cultivate the expression of conflicting opinions but insulated creative thinkers from obstructionist elements in the bureaucracy, so that "radical" ideas could surface and evolve without being obscured by artificial issues or squabbles over turf. Fortunately, this inclination was mirrored by many key managers at the division level and below, partly because of Percy's personnel decisions, partly because his subordinates chose to "copy" his management style, and partly because of the obvious peer placement. This widespread practice permitted an internal value consensus to develop before a policy was officially formulated and announced. Once issues had been substantially fleshed out through discussion and debate, Percy himself would review areas of agreement and contention and make the final decisions about agency direction.

Policy formulation at the Department of Health and Social Services was not, however, merely an internal affair. Percy had great respect for the function of advocacy, and he demonstrated it routinely by hiring vocal advocates and giving them space to work inside, and by making certain that all relevant advocacy interests were represented in policy choices and program decisions. He also gave outside advocates direct access to his office. Institutional representatives of major advocacy groups sought audiences with him two or three times per year with structured agendas and official roles to play; both these representatives and more grassroots types understood that this informal input would also be listened to, subjected to tough examination and respected as part of the policy formulation process. The efforts of advocates representing all of COP's client groups strongly influenced the shape of the program and its subsequent political destiny.

In May of 1986, Percy published Planning Guideline #1 Long Term Support, announcing that it prescribed "a process for interdivisional efforts to resolve longstanding issues within a departmental context" and "would become a model for future initiatives." 28 Long Term Support Services have developed rapidly in recent years and undergone major changes in guiding philosophy, program emphasis, and in the delivery system itself. These continue to be dislocations and inappropriate services within this system, however. The concerns identified include lack of responsiveness to the needs of vulnerable or multiply handicapped persons; the continuation of incentives for institutionalization; and a need for improved evaluation, program integration and control mechanisms. A process of policy review, planning and re-identification of resources is needed to make available a comprehensive and balanced system of appropriate supportive services for persons with chronic needs.

Long Term Support Services should be developed and delivered in a manner consistent with the Department's mission of "... enable people to sustain wellness and independence in the physical, mental and social dimensions of their lives. ..." Goals are established to achieve improvements in the delivery system which are consistent with the mission. Goals for individuals include normalization and least restrictive setting, self-sufficiency and independence, and participation. These require programs focused on individuality and rights, seeking the utilization of maximum potential and including clients and their families in program planning and development; such programs should emphasize skills, behaviors, and service settings which foster maximum feasible participation in community life. Goals for the service delivery system include comprehensiveness; availability/accessibility; cost-effectiveness; integration; balance; coordination; and state/local partnerships. These goals emphasize the importance of flexibility, responsiveness and sequencing of service which respond to the changing needs of individuals and communities. They assume that systemic problems must be resolved through effective focusing of policy, staff and fiscal resources with mollification where necessary. There is no respect...
nation of substantial additional resources to meet the identified problem areas.

An Action Plan to resolve Long Term Support issues will involve a DBP (Division of Policy and Budget) analytical team and staff from program divisions on specific task assignments. Divisions expected to have substantial interest and continuing involvement in policy development are DBP (Division of Health), DCS (Division of Community Services), and DVE (Division of Vocational Rehabilitation). All divisions are asked to identify issues which must be resolved to meet these goals and staff responsible for any effort currently underway. Program division staff will be heavily involved in task assignments when specific issues. Opportunities for program division staff to participate in broader conceptual design will be offered to divisions wishing to participate at that level. Commitment to state/local partnership will be honored throughout the policy development process. Questions of involvement of county, state, program, and other local or advocate representatives will be resolved on a case-by-case basis.20

Elsewhere, the Guidelines asserted that the resulting long term support system "must contain a bias toward community services while continuing to provide out-of-home care of adequate quality for those persons who genuinely require it." The Division of an alternative system was to become the client's prerogative. Only a month or so later, Percy sent out a series of memoranda outlining ten separate task assignments and establishing task forces charged with resolving policy questions and strategy issues in ten different long term support areas. Although the Secretary's input processes leading to the development of the Guidelines and its resulting task forces were wide-open and unstructured, the assignments themselves were highly structured, as well as demanding and ambitious. Task Assignment #1: Navigating Home Preadmission Screening and Community Service Integration is a representative example of the ten assignments because it contributed most directly to COP's ultimate program design, and because it is an excellent demonstration of Percy's managerial concerns for depth of research, coordination of effort, and comprehensiveness, as well as planning structure and closure (see Exhibit 5-1).

The memorandum and the initiatives it fostered are also noteworthy in a number of other respects. As usual, Percy's staffing requirements ensured interdivisional cooperation and communication between the Division of Community Services, Department of Health, Division of Planning and Budget and the Division of Vocational Rehabilitation. They also respected divisional hierarchy at the same time that they mandated and opened further possibilities for active participation from persons outside the normal chain of command. Broad-based participation by the very county agencies most likely to be involved in program implementation was emphasized as well (local social service agencies, boards for the developmentally disabled and mentally impaired and area agencies on aging).

Less obvious are the assignment's strategic treat of leadership roles vis-a-vis different advocacy group interests. Major client groups were represented by at least one insider well-known and highly respected by each group. Leadership on the task groups, as well as subsequent nuts-and-bolts committees was shared by these representative insiders so that no one group would appear to have a special mandate. This strategy helped to create a "coalition of categories" that would prove to be essential to COP's success in winning both broad advocacy support and legislative approval. It was not unusual for county representatives and advocates on nuts-and-bolts committees to outnumber state staffers by a fair margin.

Finally, the assignments built in deadlines, as well as both short and long term reporting requirements that were adhered to rigorously, and framed to enable the inclusion of meaningful policy and program recommendations in the upcoming biennial budget process. Divisions also had six-month work plans covering the major initiatives, as well as other operational priorities. Percy and his planning shop reviewed these plans regularly. Top administrators met with the Secretary bi-weekly and always discovered that their boss had been fully updated in advance by his planners on the progress of each task in the six-month plan. Managers who moved forward on the major initiatives could expect to be rewarded in the agency's budget, through necessary new personnel allocations and the like.

While Percy's own style and administrative mecha provide a managerial framework that enabled creativity, the hard work of COP's conception and delivery was left to others. It would be a mistake to assume that their work on the task assignments and on COP's other arduous intellectual and political chores proceeded in a strictly formal, cerebral or mechanical fashion. What is most distinctive about the atmosphere in which COP was born was the remarkable degree of enthusiasm emanating from the program's principal authors and the high degree of cooperation between program-level "realists" and their respectful but more management- and process-oriented colleagues in the centralized Division of Policy and Budget. While many new program ideas surfaced in the head air generated by warring advocacy-oriented professionals and budget-shop skeptics. COP flourished in the fertile chemistry that developed between these two essential groups.

This constructive relationship was less a matter of
TO: ROBERT DURKIN, DIVISION OF HEALTH
PETER TROPHAL, DIVISION OF POLICY AND BUDGET
BURTON VAGNER, DIVISION OF COMMUNITY SERVICES

FROM: Donald E. Percy, Secretary

SUBJECT: Nursing Home Preadmission Screening and Community Service Integration

A. Issue Summary

In Wisconsin, Title XIX residential care has grown to become the dominant element in what should be a continuum of services and care for disabled adults. Recent state laws remind us of individuals' right to treatment and care which is provided under the least restrictive possible conditions. Placement reviews indicate that our present continuum of support is incongruent with this goal.

The Long Term Support Initiative is an effort to remedy this situation by developing a coherent and progressive state policy for meeting the treatment/support needs of individuals with chronic problems in the least restrictive most normalizing settings possible. One critical component of this Initiative is the review of access to nursing home care. This is necessary in order to develop mechanisms to ensure that clients receive the most appropriate form of care, mechanisms which now exist in only a few Wisconsin counties. Preadmission screening offers a significant point of client contact as well as an opportunity for greater usage of community care. While the state cannot and will not deny nursing home services to those who definitely want them, experience with nursing home preadmission screening processes in other states indicates that most individuals requiring long-term support prefer alternatives to nursing home care.

About 65% of nursing home admissions are from general hospitals and 16.5% are from private residences. Of discharges from nursing homes, about 40% return to general hospitals, 26% go to private homes and only 17.5% are discharged to alternate care. Yet there are current estimates that at least 17% of geriatric residents, 11% of the chronically mentally ill, and 7% of the mentally retarded in nursing homes could readily function in an environment providing less medical care. This is in addition to people who, with appropriate medical and non-medical support services, could function in a less restrictive, normalized environment more like that of the general population.

We know as well that private pay patients, who often later become publicly supported, find their way into health care facilities without any governmental review, and that reviews of Medicaid patients in nursing homes are after the fact. Once a person is in a nursing home, discharge to alternate care is often impossible because a dependency has developed and transfer trauma could occur.
Over the years, Wisconsin and other states have developed preadmission screening proposals and programs. The New York preadmission screening long term care program reports promising results. For example, in 1978 there was a 28% decline in nursing home admissions of Medicaid patients, and the cost of home care for Medicaid clients was less than half the comparable institutional cost. Virginia, Washington, and Georgia have also developed successful nursing home preadmission screening programs.

More generally, there is a need for coordinated review of residential placements not only where community-based systems interface with the state-administered Title XIX system, but also within local systems where Chapter 51 and social service domains meet. Improved linkages should encompass preadmission screening, periodic review of placements in effect, discharge planning, and service coordination related to both Title XIX and non-Title XIX residential programs.

Improving the above linkage areas will constitute a formidable endeavor. It may therefore be appropriate to begin the effort by focusing initially on nursing home preadmission screening, placement review, and discharge planning within the overall context of strengthening service coordination in the community-based system. This means, among other things, that community agencies must be accorded sufficient responsibility and authority in Title XIX residential placements to allow for true service coordination and integration.

Finally, it is inadequate to improve screening or local service integration without also ensuring that the resources for services are both available and sufficiently flexible to allow use in those services determined appropriate by any review process. For this reason, efforts under this assignment must be coordinated with Task Assignments 1.7 and 1.8.

B. Task Committee

To address the above issues, I am creating a work group to which the following individuals from your Divisions should be appointed:

From DCS: Gerald Born (as committee chair)
        Donna McDowell (as committee vice-chair)
        Cathy Swenson
        Beverly Scholtes
        Jeanette Nelson
        Aniga Dombrowicki

From DOH: Peg Smelser (or designate)
        Jan Rabidou
        Ed Naizhan

From DPB: John Goergen
        Marilyn Slaughterback
        Robert Griss
        Sharwood Seigel

From DVR: Richard Kosmo

If there are additional or alternate personnel you feel should be members of this group, please submit their names to me and I anticipate your request will generally be approved, contingent on committee size and required expertise.
In addition, one representative from Social Service Departments, one from the 51 boards, one from the Area Agencies on Aging and one from the DHS regional offices should be added to the committee.

C. Committee Responsibilities

The Committee should:

1. Become familiar with the Nursing Homes without Walls Program in New York, Virginia's preauthorization of nursing home admissions system, Monroe County's (New York) Access Project, the CCD Project, the Triage Project in Connecticut, the nursing home preadmission screening programs in Washington and Georgia, and other relevant models.

2. Determine those key agencies at the local level from the health, social service, and 51 board systems which should be involved in and responsible for the screening and review process, and how coordination between involved agencies might be affected.

3. Determine other administrative arrangements necessary at the local level to ensure effective screening and coordination. The screening and review administrative arrangement should actively involve local agencies such as the 51 board and social service department while at the same time allowing sufficient independence to ensure as much objectivity as possible. The arrangement should also lend authority to the review process results, and should be compatible with the Functional Assessment Process for personal care and supportive home care developed under Long Term Support Task Assignment #1.1.

4. Determine how a nursing home preadmission screening process can be integrated with the work of task committees under 1.7 and 1.8.

5. Determine how a close working relationship might be established with hospital and DMH/IPR discharge planning, and how the local service coordinator role identified in the DMH/IPR discharge planning policy might be integrated with the processes developed under this Task Assignment.

6. Review available products of the case management project to determine ways in which case management can be coordinated or integrated with the processer developed under this Task Assignment.

7. Determine methods of funding the screening, review and coordination processes.

8. Determine administrative arrangements necessary at the state level.

9. Develop methods of ensuring coordination and service integration related to services for individuals residing in Title XXI facilities, including consideration of the following possibilities:
   (a) Requiring local agency (51 board/social service department) approval of service plans for some or all MA residents.
   (b) Requiring nursing homes and community agencies to sign agreements on roles and responsibilities for MA residents.
(c) Requiring or allowing community agency participation or attendance in HCA/IFR reviews.

(d) Requiring or allowing community agency staff to replace state developmental disability teams for nursing home reviews.

(e) Developing effective means of communication to inform community agencies of the status of NH residents and progress in service plans.

10. Determine how effective case management and service coordination might be ensured.

11. Determine how alternate resources will be identified and arranged.

12. Determine what assessment tools will be used, any mechanics of the process not identified previously, and the manner in which appropriateness of placement will be ascertained.

13. Determine how the process might be implemented, including the possibility of phasing, and/or voluntary piloting, and any incentives or sanctions which might be desirable.

14. Determine how to ensure participation of private pay patients in any nursing home preadmission screening process or local service integration effort being considered or recommended.

15. Determine how data on the number of persons diverted from nursing homes should be collected and reported.

D. Timeline

The committee should proceed in two phases. The first phase should cover those items necessary for consideration by other long term support committees and/or related to the biennial budget. The primary such item is identification of the composition, funding and administrative arrangements for a screening, progress review and service coordination process. The second phase should involve development of the full specifications for this process.

In particular:

1. Within six weeks from the date of this memorandum the committee is to complete Task #1 and draft tentative responses or options to #2.

2. Within 8 weeks, draft responses or options for Tasks 3 through 8, 13 and 14.

3. Within 10 weeks, draft a response to Task #9.

4. Within 12 weeks, complete responses to Tasks 2 through 4 and 13.

5. By October 15, 1980, complete all other Tasks (9, 10, 11, 12, 14, 15) and add any details I find are necessary after I complete my review of the work done on Tasks 2 through 8 and 13.

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chance than one of conscious intention and will. Next to Percy Viney, the chief management enabler of this cooperation was Peter Troegam, head of Policy and Budget during COP's development and statewide implementation processes. Charged with coordinat-
ing the overall policy development process, Troegam cultivated spirited debate and constructive participa-
tion by all relevant parties. He also exhibited consist-
tent support for the community-based long term sup-
port idea that had so engaged program-level profes-
sionals. His particular blend of factual realism and philosophical backing lent internal and external credibility to the evolving COP concept. Later, his experience as a former state legislator would prove invaluable when the program moved into the political arena.

COP's principal hands-on authors numbered only a dozen or so. They personified the value system inherent in the COP idea, and they exuded a kind of "religious" faith in the program's values and pros-
psects. Through their commitment, conviction and productivity, they collectively created a kind of in-
house social movement. While zeal characterized all of their contributions, the major members of this in-
house social movement were two different hats: some operated as program translators integrating and com-
municating management and advocacy concerns; oth-
er served as "go-betweens," aggressively defining and asserting the needs and interests of individual client groups.

The special inspiration that characterized both of these groups is perhaps best exemplified in a speech by one of COP's most articulate translators, Douglas Nelson, then Assistant Administrator of the Division of Community Services. In a speech delivered before the Community Living Ways and Means Conference in Wausau, Wisconsin in 1980, shortly after the publi-
cation of Planning Guideline #1—Long Term Support, Nelson elaborated his vision of the movement's philosophy.

I've chosen to dwell on what I consider the horror and strength of the systems that we're up against [medically intensive institutional care] to establish what is almost the inexpressible importance of mak-
ing community care succeed. I mean meaningful sense of the word, peoples' lives are at stake in this business, ... First, those of us who are committed to the concept of community care must not be casual or resigned about that commitment. This is not, let me emphasize, a job or a profession, this is a movement. We cannot afford to dwell on the difficulties, the limit-
tations or the risks of offering community care under existing circumstances. ... We are involved in nothing less than changing a major economic and political system in this state and in this country. We are at a very early stage of that effort. The task, in my judgment, is enormously diffi-
cult, the odds are not particularly good, but the stakes in this effort are so incalculably high of all of us who really care are obliged to make a passionate and even desperate effort to change that system. For reasons that I don't fully understand and I don't think that I can articulate, I somehow remain confident that we will prevail.11

An aging advocate and a disciple of the "normaliza-
tion" principles that grew out of Wolfensberger's work on developmental disabilities, Nelson was widely regarded to be "the conscience of Health Social Ser-
vices" on the COP issue. His gifts as a conceptualizer, writer and teacher allowed him to communicate the philosophy and values of COP to a broad range of insiders and outsiders and to help translate con-
science into program design.

He was often joined in these efforts by Donna McDowell, Director of the Bureau on Aging. Her cre-
dentials in aging-program advocacy and manage-
ment, as well as early training in journalism served her well in her important role as one of COP's fore-
most translators. As the program structure evolved, key committee decisions would be routinely pre-
vented to her to be transformed into official descrip-
tive language reflecting the agency's vision. Her comp-
pelling speeches and communications humanized bureaucratic language. Therefore influencing the atti-
dudes and perceptions of the state. Her professional advocacy gave COP preeminence on the political agenda of the powerful network of advok-
ates for the elderly. The efforts of "creative bureau-
crats" like Nelson and McDowell helped ensure that COP not only retained its identity as a program for real people, but that it also became marketable to cat-
tegorical interests in spite of its multi-disability ("generic") approach.

Clearly other groups needed to hear this message, as well. Advocates for persons with developmental disabilities saw a trustworthy agency leader in the person of Gerry Born, Director of the Bureau on Devel-
opmental Disabilities. Born was an ardent believer in the principles of "normalization" and a long-time sup-
porter of state deinstitutionalization initiatives. He saw COP as a systematic way of achieving what the Bureau had tried to bring about through a series of different and somewhat fragmented experiments. His leadership on the COP issue helped turn good intentions into program structure that appealed to developmental disability advocates, inside and out-
side of the agency.

Less visible perhaps was Tom Hamilton, Assistant Director of the Bureau of Alternative Care. Regarded by many as the unsung father of COP, Hamilton came to the development process with a planner's back-
ground, and a strong social conscience but no spe-
cific background with any of COP's major constitu-

22
ency groups. It fell to him to convert broad policy and agreed-upon general program characteristics into an operational plan that could be implemented in 72 different counties. Required to have worked 60-hour weeks in 1979 and 1980, Hamilton welded together values, program elements and hard data to form an evolving series of operational plan options. Further, COP's fiscal leaners had to be designed and placed into a context that made sense in terms of the mone	
ty l


tary language of medicaid-supported institutional care. He also supervised a small staff of "missionaries" in the Division of Community Services. They mapped out budget strategy, coordinated the activities of the bureaus and divisions affected, and forged coalitions among outside advocacy groups. Later, they prepared data for the legislators and trained county staff engaged in the implementation of the program.

Translators and managers depend to a large extent on the perceptions and hard labor of the "missionaries," the often single-minded and uncompromising program-level advocates for the basic needs and rights of individual disadvantaged groups. "Missionaries" are the closest to the street and to the pain of individuals and are therefore best able to define the specific dimensions of a special need and the specific barriers to its fulfillment. Without them, programs lack heart and concreteness and are vulnerable to failure in either the political arena or the operational context. Dennis Hanks, at that time a planner in the Developmental Disabilities Office, is a representative example of the many internal "missionaries" who gave COP much of its vitality. He was, for example, the chief architect of the Riverview relocation initiative that vividly demonstrated how large numbers of very disabled persons could effectively be relocated from nursing homes to the community. Hanks reflected an intense and unshakable commitment to the principles of normalization and to the form those principles took in the broader program design of COP.

Surely part of the special zeal and competence of COP's cadre of authors was due to specific individual temperaments and to the fact that more than a few of these principals had come to maturity in the 1960s when ideas of social change were cultural staples. But there were also strong institutional supports that unleashed their talents. To a large extent this appeared to be the work of Percy himself. He provided them with a mission and a suitable administrative structure. He also persuaded them that excellent performance would receive his support and that their initiatives would ultimately result in real change. Once he had set the planning and development process in motion, he stood to the side, synthesizing and monitoring the evolving program research and debate. When these endeavors were concluded and committed to paper, he was together core areas of consensus and he resolved conflict through managerial decision-making. Within two years, COP was transformed from a concern about existing long term support policy into a full-blown program proposal in Governor Diefenbaker's Executive Budget.

8. COP's Program Structure

COP's program structure grew quite logically out of its major goals: to preserve client choice in the determination of long term support needs and in the election of relevant services to fulfill those needs. Thus, client-centered needs assessment and case-planning processes were at the heart of COP's program design, as were incentives for the development of coordinated health and social services in the local community. While COP represented a striking departure from earlier long term support policy, it was at a conceptual level, quite simple, taking its basic program elements largely from what already existed but had not been brought together: client preferences for the maintenance of self-directed life at home, the expertise and processes of various county social service agencies, and existing state and federal funds as well as funding support services and programs at the community level. At the center of COP's basic structure was the functional relationship that existed between the State Department of Health and Social Services and Wisconsin's 72 counties (see Exhibit 6).

By the time COP had become a budget proposal in 1980, State legislation establishing county responsibility for treatment and rehabilitation services for the mentally and developmentally disabled, as well as for chronic alcoholics and drug abusers, had been in force for six years. Substantial experience with local response offered a foundation for a community-based long term support structure. County social service departments and statutory 51.42 and 51.437 tombs were the functional agencies in this unique local response system. They were joined in 1979 by county-based area agencies on aging that provided programs and services for the elderly and would play 51.480 roles in the setting of COP. This unique-state-county relationship became the structuring principle of COP. It must be acknowledged that the relationship also gave rise to tension caused by a partnership in which one party (the state) had the money and authority, while the other (the counties) had the responsibility of dealing with complex mandates and administrative challenges.

Although COP was to be funded by the State, the statute authorizing COP left virtually all significant program administrative decisions to the counties through the county board, which remained the uti-
Exhibit 6. The COP Administrative Structure.

mate authority at the local level. Even the choice of where to begin COP program participation remained largely a county decision. While all 72 counties would ultimately participate, only those who volunteered to participate would be part of the initial and intermediate phase of the implementation [see Appendix A for county phase-in schedule]. The State reserved the right to mandate participation if an appropriate blend of counties did not materialize on a volunteer basis, but this right did not need to be exercised. Participating counties were also allowed to phase in their own program implementation, using a high degree of discretion in determining the best methods for gradually achieving full implementation. State planners reasoned that the highest possible degree of flexibility in all program dimensions was desirable to achieve the best results and to limit conflict in what had always been a delicate and difficult relationship. The gradual implementation concept also acknowledged limited start-up funds, the need for time to debug as county capabilities evolved, and the limited nature of existing community-based services. At an operational level, the program was to be run by a county-based planning committee to be determined by the local county board. The committee’s overriding tasks were to take care of COP’s basic planning activities, coordinate the often fragmented and sometimes contentious sub-agencies within individual county systems and produce a COP plan that detailed the local program. Designed specifically to foster a coordinated and comprehensive program outlook, the Planning Committee was to contain, according to statute, an elected county official, as well as representatives from county health and social service functions, commissions on aging and 51 board structures. COP’s concern for client empowerment was reflected statutorily in its mandate to have at least two clients on the central planning committee. Day-to-day operational decisions were made by a lead agency, often the social service department, sometimes both the social service department and the 51 board structure. At the center of the program’s value base was the notion that money, program decisions and services should “follow” the client and be sufficiently flexible to allow for maximum client choice. This concept necessitated a strong assessment process and empowered case planning. The statute honored these aims by allocating funds for precisely these purposes. Counties were to be reimbursed an average of $60.00 per client assessment for medicare-eligible persons. Separate allocations were earmarked for detailed case plans to be developed for COP-eligible persons whose assessment indicated that staying home or state center diversion was both desirable and feasible. Each case plan was to be reimbursed at an average rate of $200.00. Any monies not used for assessments and case plans could be transferred for use in actual diversion services, such as personal care attendants, chair assistance, home modifications, occupational therapy, and the like. It is worth noting here that while non-medicaid-eligible persons must pay for their own COP services, they are not barred from the program, and, in theory, receive state-funded assessment and case-planning services. The decision to broaden the program’s client base in this way proved extremely wise, since it went a long way toward distancing COP from the stigma of “a welfare program,” at the same time adding greatly to its advocacy and political appeal. Funds for community-based diversion services were designed to be highly flexible and gap-filling in nature, augmenting existing state and federal monies through such sources as community aids, meals-on-wheels, home health care, supplementary security income (federal SSI), HUD and Section 8 Housing Subsidies. To enable persons to remain at home or in another non-institutional setting, the COP statute allowed counties to spend an average of $400.00 per month per client, an amount estimated to be the average state share of nursing-home reimbursement per person in 1980. So long as counties did not attempt to use COP funds to cover pre-existing obligations, they were free to purchase virtually anything or any service that would help the client stay out of an institutional setting. In addition to flexibility, the state statute attempted to ensure funding stability, stating unequivocally that counties would not become liable for services beyond those funded out of state and federal funds. Counties, of course, had legitimate historical reasons to fear that such legislative promises could be confounded by rising local demand for services and changing legislative-funding priorities. These fears would later lead to spirited justifying as COP was debated in the political arena. The program design mandated outreach of a new kind. Unlike many earlier programs, COP provided a categorical approach, asking counties to merge their separate treatment modalities for different disabili- ties, to form a common program based on individual need. Money was therefore allotted to service processes (assessment and case planning), rather than to individual disability groups. There was a method to this new madness. In addition to mobilizing the several client groups in support of COP, the State wanted to encourage counties to learn how to serve a broader range of disabilities and to offer an incentive for sometimes distanced staff functions to work together. It should be noted here that the enabling statute built a high degree of discretion and flexibility into the timeframe for achieving this new generic outlook.
Countries could prioritize disability groups in the step-up phase based on existing service capabilities, although all groups had to be served by a time certain in the future. Flexibility was also allowed to counties in determining the goal number of assessments per year, although it was understood that local programs would ultimately make an assessment available to everyone about to enter a nursing home or to those currently placed in nursing homes. Since COP planners believed that roughly 10–20% of current institutional placements were inappropriate, they reasoned that COP might serve a like percentage of persons once it was fully implemented. Early descriptive estimates were often somewhat more conservative, in the range of 10–12%.

Planners were equally cautious in predicting the program’s ultimate fiscal impact. Many of the original cadres of COP authors in fact shied away from selling COP on any fiscal grounds. To them, its primary goal was to assist elderly and disabled persons to lead lives in the community with as much dignity, value and independence as possible. Early descriptive literature downplayed, however, include rather guarded optimism in terms of cost containment. Predictions of this kind suggested that COP would not average be a more expensive than institutional care and might be less expensive. Such expressions were typically linked to a belief that the Medicaid program, too, would help at least slow Wisconsin’s escalating medical expenditures.

No such restraint was evident in planners’ faith in COP capacity to effect major changes in local systems of long-term support. In their view, COP was bound to increase counties’ capacities to coordinate their often fragmented service capabilities, to create new linkages between systems of social services and health care, and to help counties better mobilize and package diverse community services. Some goal statements even predicted that COP would begin to create a new interface between community-based services and institutions, to better meet client needs.

C. COP’s Clients

Perhaps the most illuminating examples of COP’s purpose and program design are to be found in the real life stories of its clients. The eight vignettes that follow illustrate the range of problems and disabilities that bring people to COP, the many services it provides, as well as the costs involved in addressing vastly different life circumstances. All of the COP stories were researched and written by the State Department of Health and Social Services, Office of Program Initiatives.22 The vignettes document client arrangements made during the first year or so of the program’s operation. Names have been changed to guard client confidentiality. In all other respects they are factual. (See appendix B and C for news articles featuring still other COP clients.)

1. An older woman disabled by a stroke spent an unusually long time in the hospital while many professionals and family members tried to convince her that she needed to go to a nursing home. She refused to enter a nursing home but there were not enough funds or services available for the support she needed at home. Supportive home-care funds and meal providers were available during the day, but she would not have been able to stay alone at night. COP paid for someone to stay with her at night and thus allowed her to return home. Since this woman was grateful to be home and determined to stay there, she is working extremely hard and improving rapidly. She will probably not need a person with her all night for very much longer. Her family and the professionals involved are in agreement that had she gone to a nursing home against her will she would have been permanently disabled and her condition would immediately have deteriorated rather than improved.

2. Jean Meyer, a 30-year-old developmentally disabled woman with profound mental retardation is being served in her community through the assistance of the COP. Jean was removed from her family at age 6 and lived in a state institution for 18 years. At the age of 24, she was moved to a nursing home, despite the fact that she is in good physical health, has many skills in communicating and can take care of herself with much help.

The local the board was paying for a work program outside the nursing home, but they did not have sufficient resources to help her move to her own home in the community until COP. About $640 of COP money is now being spent to help Jean and two other women to set up their own apartment with one live-in staff and part-time staff. The COP money covers a gap between the $381 paid monthly by Supplementary Security Income (SSI) for personal expenses, public transportation, recreation, etc., and the $792 per month paid by the board for the cost of Jean’s work program.

3. Bob Nelson, 74, went into a nursing home eight years ago following an accident. He was very unhappy and claimed that he could never even get a good night’s sleep because of people who moaned all night. Although his veterans’ benefits were enough to pay his nursing home bill and he would have paid for whatever he needed in the community, there was no person or agency to help Bob make the arrangements to move back out.

Bob used a wheelchair and needed a live-in atten-
dent and an accessible place to live. He also needed everything with which to furnish an apartment. In its capacity as a coordinating mechanism, the COP made all the contacts to obtain the apartment, furniture, support, and services, referred a live-in attendant (recruited and trained by the nearby independent living center) and helped Bob move. Although he pays all his own bills, COP will continue to coordinate and manage the supports and services that Bob needs.

4. Before age 1, Karen Wright was in an auto accident that caused severe brain damage as well as other lasting injuries. After her hospital recovery, the local human services staff tried to secure a foster home for her until her mother was able to handle her at home. This became impossible and as a result she was institutionalized until the age of 3, when she returned to her community in a foster arrangement provided with the assistance of the COP.

Karen requires total assistance in all self-care areas including feeding, dressing, bathing, toiletting, and positioning. She has little control over her body movements and spends most of her time in a wheelchair. Because she has seizures, she needs to have four different medications administered. She has few verbal responses, except whining or coos when she becomes uncomfortable in her chair.

COP money pays for her to live in a foster family who love her and consider her part of their family. The family is also provided with in-home services for a home training specialist and some respite. Without COP, she would be living in a large institution, isolated from the rest of the world at a cost of more than $30,000 per year. Instead, about $6,500 per year of COP money maintains her at part of a family and a community. It is hoped that this arrangement will allow Karen’s birth mother to once again become involved in her life.

5. Sometimes, more than one family member is able to benefit from the Community Options Program. One example is an 86-year-old woman who has cared for her 60-year-old retarded son throughout his life. Recently, this became increasingly difficult, to the point that a nursing home for the mother, a group home for the son, and separation after a lifetime together, seemed inevitable. Funding and services come from two different agencies because of her age and his disability. Neither agency would assume responsibility for both individuals. A referral to COP and a complete assessment for both mother and son got the agencies working together and clarified what was needed.

Since these two people need assistance both in the morning and the afternoon of every day, the existing funding sources did not have adequate money and the help was difficult to find. Finally, an arrangement was made with a granddaughter to help at times when agency supportive home care providers do not work. She is paid with COP funds, and the mother and son appreciate having a familiar family member coming in regularly.

6. Florence Jones, a 59-year-old woman in an isolated rural area of a new COP county has been dependent on her 74-year-old daughter Emma for some time. Florence has lost her speech and requires total care including turning, lifting, feeding, suctioning, and changing. Although the daughter was extremely reluctant to put her mother into a nursing home, she was becoming exhausted by the strain. The county has no respite program, and it was becoming almost impossible for Emma to get out of the house at all or have any time for herself.

Florence’s situation was recently assessed by the county Community Options Program. One new service has been arranged so far and that is one-half day a week of care in the home by a respite worker. The COP coordinator has regular contact with Florence and Emma and monitors the need for additional services or supports to both women. The daughter says that she has peace of mind and is reassured by COP. She can get out of the house to shop and relax, and she is being recognized and supported in what she is doing. Meanwhile her mother can remain secure in her familiar home environment.

7. Jason Thomas, 22, was paralyzed in a diving accident when he was 18. He had been forced to move to a neighboring state to get the $1,000 a month worth of attendant services he needed to avoid going into an institution. Although his sister and his family were willing to have Jason live with them and his preference was to return to his home town, no funding was available to pay the sister the little he needed to offset her expenses. Almost a year ago, Jason’s home county was one of the first to volunteer for the COP. Jason was one of the first people referred. He now lives with his sister, who is paid only $200 a month, and he is glad to be back in his home town.

8. The last COP vignette involves a family of five. The mother who is 24 became disabled by what is known as Lou Gehrig’s disease during the summer; she worked full-time until July and by August she was in a wheelchair. Her children are 3, 5 and 12. The father has a full-time job. This family’s crisis includes different kinds of needs from all of the family members, including the long-term support needs of the disabled mother. It was an appropriate referral to the Community
Options Program, which serves as a coordinating mechanism across age groups, disability categories, and funding sources. In this case, the decision had to be made whether the father would quit his job to take care of his wife, small children, and home. In that case they would have to be supported by AFOC, food stamps, and other welfare payments. The family decided that it would be less disruptive for the father to continue to work outside of the home and to obtain the supports and services necessary to enable the mother to continue to make decisions and manage her household and family as much as possible.

The Community Options Program has coordinated and/or paid for a number of different services that the woman and her family need. These include: home modifications, such as grab bars and ramps; the lifetime services, which come from another county, the therapy ordered by the woman’s physicians and occupational therapists, who are located in a third county; and the nurses, supportive home-care workers and backup support providers who go into the home.

Someone is in the home from 8 A.M. until 5 P.M. every day, at a cost of $700 a month in COP dollars, to do the home management, cooking, cleaning and to provide emotional support to the disabled mother as well as the rest of the family. The Community Options Program maintains involvement to ensure that services are adequate but see not more than the woman needs to remain as much in control as possible for as long as possible, and that they are flexible enough to change as the needs of this woman and her family change.

IV. Selling COP: The Agency, the Legislature, Interest Groups and Counties

While developing COP’s innovative goals and program design were significant achievements, they represented only the first leg of long and arduous journey. Ahead lay the 1981-83 biennial budget process, shadowed by the constraints of a “new federalism”; beyond that a complex and increasingly expensive statewide expansion effort that would eventually (in 1986) involve all 72 counties and require a budget appropriation sure to dwarf the initial request of $3.6 million. COP’s first challenge in the legislative arena was to gain the status of a mandate. In subsequent years, it would have to achieve its growth milestones, successfully undergo modification and stand up to the scrutiny of program evaluators and watchful legislators. Part A of Chapter IV tells the story of COP’s struggle to gain a legislative beachhead in 1981. Part B highlights subsequent program developments that occurred between 1983 and 1987.

A. The 1981-83 Biennium

In many ways, COP’s authors and principal advocates were in an enviable position as they prepared to take their program to the legislature in the winter of 1981. Among opinion leaders and in the general public there was a growing consensus that community-based long-term support was an idea whose time had come. Governor Dreyfus was supporting COP in his Executive Budget, and gubernatorial hopefuls Earl and Kohler were giving the program nods from the hustings. Since the sitting governor was Republican and the legislature was controlled by Democrats, it even appeared that bipartisan support might emerge. Owing largely to Fercy’s leadership and the political savvy of top aides, the Department of Health and Social Services was then enjoying excellent relations with key legislative committees.

No one interested in COP’s success was resting on predictions of easy victory, however. There were some serious early rumblings of disfavor from lobbyists both for the nursing home industry and for the County Boards’ Associations. Beyond that, the Joint Finance Committee, sure to be the biggest legislative hurdle, would have tough questions about fiscal impact. Even if COP passed the legislature with flying colors, there were larger challenges ahead: agency representatives and advocates had to get the counties, the legislature and the interest groups on board for what was going to be a very long fiscal and program development process; this process would necessitate at least two additional return visits to the legislature requesting increasingly larger amounts of money. Immediately after initial adoption, further, more, 8 counties would have to be recruited as early volunteers for the phase-in. After them, 64 counties would have to be coaxed to join the COP expansion effort over a 5-year period. None of this was going to be easy. The COP team had to get the go-ahead, start out very well indeed and then keep the momentum going over what could be regarded politically as an eternity. All this, of course, would have to proceed in the face of opposition.

One might have expected COP’s strongest opposition to come from the nursing-home industry’s powerful, well-funded and superbly organized lobbyists. After all, COP was, in effect, a critique of the industry and its services. COP was also beginning to steal the limelight and might, in future budgets at least, begin to cut into the institutional care purse. Nursing-home lobbyists did in fact mount an early onslaught, asking questions about the potential quality of care in the community and the possibility of wasteful duplication of services. At least publicly, they opposed the cap on new nursing home construction, as well (see Appendix B).
Circumstances, however, conspired to weaken their positions before they could have an appreciable effect. First, the elderly had a strong and very effective lobby of its own that made clear that any group that stood against community-based services would do so at great political peril. As the primary client population of the nursing homes, they could hardly be ignored by industry lobbyists. Secondly, the atmosphere of anxiety that surrounded an out-of-control Medicaid budget compromised their influence over a legislature, which had repeatedly been called into special sessions to enact budget cuts over the previous three years. Finally, lobbyists understood that the moratorium, though troublesome in some respects, would serve to decrease future competition to existing homes. In the face of all this, the nursing-home lobbyists contended themselves with licking some severe public relations wounds, keeping a polite silence on COP and turning their political attention toward securing a favorable state reimbursement rate.

The several interest groups representing potential COP clients were naturally disposed to campaign for the program but had a number of private questions and anxieties. The chief source of such questions was COP's program design feature of generic funding and service delivery. If individual disability groups were not to be singled out for categorical treatment as they always had been in the past, wouldn't the strongest lobbies walk off with the prize benefits, leaving newer, less glamorous causes to the lurch? And if county-level staff had expertise in serving only a few of the targeted groups, who could guarantee that the others would receive competent attention? It was clear that the agency needed a way of ensuring a confluence of the categories and the political level.

As it turned out, however, the major opposition to COP was to come from the Wisconsin County Boards' Association (See Appendices D and E for news coverage.). The cry of the association was rather familiar to state administrators and legislators: "Here's another fancy state program that will create an irresistible local constituency; the state will say a lot of nice words and then renage on the funding commitment, leaving us holding the fiscal bag." Here, in short, was a mandate without certain money. To some county legislative and managerial types, COP also held out the unhappy prospect of onerous, "mickey-mouse" paperwork and implementation headaches initially obscured by the emotional rhetoric of advocates and glossed over in the State's descriptive literature. More general opposition coalesced around a fear that the State would strange the counties with administrative controls, depriving them of needed flexibility in when and how to do program implementation. Some counties with substantial vacancies in their expensive hospitals-turned-nursing homes feared direct competition from COP.

For its part, the legislature began deliberations in a disposition quite favorable to COP. In spite of information to the contrary, however, many lawmakers' vision of the program was rather parochial and time-limited. A significant number of the legislators saw COP as "the old folks' program" or a kind of political litmus test vis-a-vis the elderly, although the State's literature stressed the generic focus of the program over and over again. Many legislators failed to understand the extent of COP's fiscal expansion goals. Some, like Paul Offner and John Maurer, however, worried seriously about money early on: "Was the initial request of $3.6 million simply a camel's nose in the tent?" Still others worried that COP was really just another welfare hand-out. Others voiced fears that COP would merely add to the long-term support caseload and, by increasing absolute demand, fail to make any real difference in containing costs.

The Department of Health and Social Services had an extremely thoughtful and aggressive strategy to win both initial adoption and the critical continuing support of advocates and the county boards. Soon after adoption, the agency undertook additional measures aimed at ensuring the cooperation of county line workers and advocates who would be most responsible for COP's success or failure at the local level, once implementation had begun. In a very real sense, the selling of COP began with program and statutory design. To forestall overwhelming county opposition at the legislative level, a number of strategic choices had been made in the shaping of COP.

Percy had asked his staff to develop several possible models. From these he picked the version that was least punitive and controlling from a county perspective. To create an attractive fiscal package to appeal to legislators in general and conservatives in particular, Percy and his staff had elected to go with a slow fiscal build-up model and decided against adding extra capacity-building funds. These decisions allowed him to stay within his budget constraints. At a more basic level, the idea of the moratorium on new nursing-home construction and the possibility of further cost-containment through less expensive or budget-neutral community services were practically irresistible. When these ideas were linked to the popular "new" values of client-choice, self-determination and dignity, broad-based appeal became a virtual certainty.

In a more subtle way the generic focus of the program added to its legislative appeal. Although advocates continued to have their anxieties about equal treatment, they nonetheless presented a united front that added to their political strength and relieved the legislature of the need to deal with many different advocacy groups each clamoring for its share of the pie. Those few "fiscal minimizers" who could hold out against all these blandishments were quickly vis-
ted by well-prepared managers from the agency's Division of Policy and Budget, and/or treated to heart-rending testimony from people who were des- tined to be COP's first clients.

When lobbyists for the County Boards' Association persisted in pounding the local-control drum at legis- lative hearings, Representative Mary Lou Munts—the major Assembly "broker" for COP—facilitated a series of meetings attended by advocates, agency profession- als, lobbyists and skeptical legislators. Some 17 issues were put on the table for debate and resolu- tion. In the end, the State yielded on a majority of them, regarding many as matters of language and administrative detail. Some, in fact, had been included initially as possible bargaining chips.

The issue of who would determine when and if a given county participated in COP was, however, clearly a matter of great importance. Initially, coun- ties wanted participation to be completely voluntary. The State wanted to be assured of having a statewide program and an appropriate blend of counties for each step of the expansion process. Movement on the issue was finally achieved when the legislature allowed counties to "volunteer" with the proviso that the State could exercise a pre-selection option if an insufficient number and/or mix of counties resulted at any phase of the implementation scenario. As it turned out, the State's reserve option was never exer- cised and the apparent compromise cleared the air by removing the ossus of a future turf war.

The Department's strategy for selling COP and maintaining its growth momentum reached far beyond features of program design and the formal set- tings of legislative debate. While large new programs often use a mass media blitz to drum up public sup- port, agency professionals judged that the receptive political and social climate obviated the need for such an approach. Although early informational dis- cussions were held with Milwaukee Journal editorial writers and social service reporters, strategists' ener- gies were for the most part directed elsewhere: to grassroots advocates and county decision-makers and future program implementors.

The agency used a wide array of client-oriented advocacy groups as a major source of political mus- cle. These groups were cultivated in a conscious and thoughtful way before, during and after the 1981-83 biennial budget deliberations. The first step in win- ning advocacy support occurred inside the depart- ment, as planners tried assiduously to shape a non- bureaucratic language that would both match and convey COP's nontraditional value base. Its home and hearth orientation and its people-centered program elements.

The descriptive literature, manuals, and external correspondence that emerged were pitched toward the consumer, remarkably free of bureaucratic jargon, and often quite personal in tone. An open letter to advocates and county health and social service pro- fessionals that appears as an introduction to COP's first (1981) guidelines and procedures manual (see Exhibit 7) is a good example of this approach.

Addressing its audience as respected colleagues and partners in a noble and difficult venture which was going to change society, the letter defines the goals of COP in surprisingly ordinary and emotional terms. Its four closing paragraphs create appeal by capturing the special power of COP to preserve independent life for its clients. This life is described in terms of the sights, sounds and familiar premises of an ordinary day at home.

Language like this was directly lifted by advocates for immediate use in newsletters, articles, flyers, alerts and other informational pieces. Once the COP story began filtering into this large advocacy network, organizations began mobilizing politically and approaching the local press in their communities. Human interest stories began popping up in newspa- pers around the state.

Advocates also went to see their senators and assembly representatives. Groups like the highly visible Wisconsin Coalition on Aging swarmed the legis- lature. They were joined by other advocacy organiza- tions like the Wisconsin Coalition for Advocacy, the Survival Group, and the Wisconsin Difference. All of them buttonholed key legislators, identified riveting client testimonies and kept the legislative hot-line ring- ing off the hook. The campaign was so successful in 1981 that some legislators demanded that agency staff- ers cool down the super-heated grass-roots troops.

Once COP had been reoundingly voted in, the agency continued to disseminate information and work up support. After a year of operations, for exam- ple, the Division of Community Services hired a highly specialized media consultant who put together a slide tape of six successful and very touch- ing COP client stories. Soon after, the Division of Community Services and the Council on Develop- mental Disabilities jointly purchased an extensive media library that it made available free of charge to county political leaders and program implementors, as well as advocacy groups. These consumers could find and use any number of audio-visual aids on community-based service provision for a variety of different disability groups.

Between 1979 and 1984, the State sponsored or participated in at least 200 major conferences and presentations related to COP. Managers prepared speeches for many of these events, which were charis- matic evocations of basic COP values and compelling solicitations for advocacy support. (See Chapter 3, p. 22 for an excerpt from one such speech). During the same period, State and county administrators and direct service workers were urged to attend COP-
December 8, 1981

Dear Colleagues,

For a number of years, we have all pursued agency and program goals which have been framed in the rhetoric of "independence ... dignity ... self-determination ... least restrictive." But we have pursued our goals, as indeed we still do, in a policy environment which encourages institutional care, and which places the needs of buildings and bureaucracies above the needs of persons.

The development of the Community Options Program has fostered a new optimism that we have the means and the will to provide for disabled persons in caring communities. Our optimism comes from the new coalitions forged among representatives of the disabled, from the public affirmation of a common sense approach to long-term care, and from the wit and skill of professionals who have volunteered to develop and implement this initiative.

The Community Options Program will ultimately demand that we pool our collective knowledge and resources and apply our imaginations to support in our communities larger numbers of more severely disabled people than our history of pilots and demonstrations has prepared us for.

We are bridging a formidable gap between medical and social care. We are venturing into non-categorical, multi-disciplinary territory with its risks of turf battles and over-professionalization. We are testing the reliability of our assessment, case planning and case management technology. We are, even more, testing the social fabric of our communities: our collective capacity to value differences as well as similarities; to acknowledge and empathize with the struggles of individuals to overcome personal adversity; to accept responsibility for the protection and at the same time encourage the independence of vulnerable individuals.

The success of this venture depends on our ability to articulate and achieve goals which are meaningful to the citizens we will serve. When we speak of options and alternatives to institutions, we are generalizing from some much more personal particulars about quality of life:

We are offering more than access to services. Hopefully, we are seeking for disabled citizens access to public transportation, libraries, theaters, grocery stores, churches and softball fields.
2-12/81

We are offering a home with a kitchen table and a dresser cluttered with souvenirs and a fridge stocked with snacks to a retarded adult who chooses and maintains his own personal possessions and associations.

We are seeking with disabled citizens the secure neighborhood sounds of roller skates on pavement, basketballs thudding on garage doors, mothers shouting to their children, screen doors slamming and the greetings of neighbors carrying out the trash.

Even for the old person who will not leave her room again, we are offering the faces and voices of family and friends in order to preserve the familiar, to evoke the past and offer the reassuring continuity of the presence of future generations.

These may be sentimental, but they are not trivial sentiments. We believe them to be the goals of the Community Options Program - that we can assist disabled people to create or preserve environments and experiences which make lives whole and meaningful.

Larry Born, Director
Bureau of Developmental Disabilities

Donna McDowell, Director
Bureau of Aging

Bill Busongony, Director
Bureau of Mental Health

Larry Honson, Director
Bureau of Alcohol and Other Drug Abuse

Dan Johnson
Physical Disabilities Coordinator

Bill Griffin, Director
Office of Coordinated Community Services

Douglas J. Nelson
Assistant Administrator of Program
focused training and "Pee" workshops that taught employees service evaluation techniques based on the Wolfensberger principles of normalization. To all this, the State was selling an instrument designed to help implement a social movement.

B. COP Developments 1983–87

In general, the program has been successful in accomplishing its goals of supporting individuals in the community at somewhat less cost than would be incurred if they entered nursing homes. Though these savings may be offset by growth in the number of persons served,20

Dale Cattanach, State Auditor
February 29, 1987

If the 1981-83 biennium saw COP achieve the status of a legislative mandate, the next four years saw its expansion into all of Wisconsin’s 72 counties. During this period COP underwent no less than three full-scale evaluations at the State level, as well as a host of smaller studies undertaken by individual counties. Legislative scrutiny has increased markedly as appropriations have grown. This scrutiny, the lessons of implementation experience and evaluation findings, have led to several significant program modifications. The balance of Chapter IV offers a brief summary of COP’s current scope and effectiveness points to the major findings of the Legislative Audit Bureau (LAB) 1987 evaluation of COP and highlights program changes and unresolved issues.

COP has managed to expand more or less on schedule, surviving a change of administrations and maintaining its integrity as it spread throughout the state. The program has consistently enjoyed very high client satisfaction ratings. Surveys in a broad range of counties suggest that recipients of COP services believe that COP is giving them what they need and is doing it in a satisfactory manner. The new LAB evaluation also found "...that most Community Options clients are well served."21 Departmental sources estimate that over 10,000 persons have undergone COP assessments, and the LAB study reports that 6,400 actually received services in 1986.22

Despite an increasingly hostile funding environment, the program has grown steadily by large increments. As Exhibit 9 indicates. To a great extent, this growth was anticipated in COP’s original program design: fiscal evolution has not, however, proceeded without setbacks. Program requests were cut by $3.5 million in the 1985-87 biennial budget process and by another $3.5 million in the 1986 Fiscal Management Plan.

Although some growth seems assured for the near term, the rate of this growth is likely to decrease. Department support for very substantial expansion remains strong, but the new governor (and perhaps the legislature) seems likely to take a more conservative approach, as this statement in the LAB evaluation indicates:

The Department’s 1987-89 biennial budget request includes a 45 percent increase in GPR over the previous biennium in Community Options funding to serve up to 10,200 individuals per year by 1988-89. The Governor’s budget recommendation includes a 15 percent increase in funding over the previous year.23

The fiscal picture is not without its bright spots. The monorail has remained in place, and the LAB evaluation (as well as earlier studies) has indicated that COP services on a per-client basis are cheaper than those provided in institutional settings.

"...the total public cost of the Community Options [Program] clients is approximately one-half the cost of nursing home care [$7,522.00 as opposed to $3,725.00] and, the state portion of the cost is somewhat less than the state portion of nursing home costs. [$558.00 as opposed to $625.00].24 Precise cost comparisons are difficult to achieve, however, and advocates as well as skeptics worry that in the long run, savings may be offset by growing demand and by rising prices in the community-based service sector. COP’s values, appealing as they are, have always acted as a measure of protection from the program’s cost containment potential. Advocates in particular fear that these values may lose ground or be seriously compromised should current fiscal anxieties find objective validation in the future.

The next major target setting issues have received continuing scrutiny over the last four years. The legislature has repeatedly pressured the Department and the LAB to investigate whether COP is serving only those persons who would, in fact, otherwise be in nursing homes or in one of the State centers, a question that obviously reaches to the concern about limiting consumer demand. Early evaluation findings (1983) indicated that approximately 80% of those served were COP-eligible, strictly speaking. The recent LAB evaluation suggests that such targeting has improved markedly and is now in the range of 90%.25

A second targeting issue relates to the relative proportions of different disability groups served by the program. Evaluation data from the first year of operation indicated that elderly clients were being referred to the program in disproportionately high numbers. Non-elderly disability groups—persons with mental illness and the chemically-dependent—were treated far less. This situation, of course, did not appear to be faring any worse in terms of either numbers of persons served or appropriateness of service. To correct such problems, the legislature insti-

19
Exhibit 8. COP's Fiscal Development in Terms of General Purpose Revenue, by Calendar Year.

$ in Millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>$878,600</td>
</tr>
<tr>
<td>1983</td>
<td>$5,174,700</td>
</tr>
<tr>
<td>1984</td>
<td>$10,205,500</td>
</tr>
<tr>
<td>1985</td>
<td>$17,082,000</td>
</tr>
<tr>
<td>1986</td>
<td>$22,796,100</td>
</tr>
</tbody>
</table>

Data provided by the Division of Policy and Budget, State Department of Health and Social Services.
the program, counties are required to meet these goals in terms of allocating services per disability group. The LAB evaluation suggests that "the program was reasonably successful statewide in 1985 in serving the proportion of clients from each group."  

In spite of the significant proportions and the generally good program performance, several problems remain to some extent, and some disability groups are convinced that COP does not serve all groups equally well in terms of sheer number and in terms of program effectiveness. Recent legislative testimony, for example, shows that 33 of 39 counties studied have offered no services to the chemically dependent. A State point-in-time survey conducted to monitor county achievement of significant proportions for persons with severe mental illness showed that 36 of 72 counties had failed to meet the 7-11% significant proportion established for this group as of June 1986. Beyond numbers, advocates for this disability group worry that COP treatment modalities may be more effective in serving the elderly than in serving persons with mental illness. While the political and fiscal advantages of the generic approach currently prevail, the "coalition of categories" is tenous in some respects. 

Counties, too, have their concerns. The State's original diversion rate estimate of 30-12% has proven to be too conservative for some counties that may experience diversion demand as high as 30-40%. This disparity has resulted in funding short-falls and in long waiting lists in a few counties, a circumstance that creates difficult problems for local implementers to address. County officials and workers also complain about planning requirements of dubious value, onerous paperwork requirements and burdensome complexity in fiscal tracking imposed by COP's program design. There seems to be no doubt that COP's fiscal concept of letting the money follow the client presents a new and cumbersome monitoring challenge to counties accustomed to block-grant funding and auditing mechanisms. Legislative concern for program evaluation led to additional documentation demands, as well. County personnel and some legislators are also uneasy about COP's legislative status as "the" community long term support program, suggesting that it has the effect of starving out other necessary and extremely valuable programs (e.g., CSP, youth aids, child welfare, to name only three). These contentions are disputed by agency professionals who maintain that other programs have continued to grow and that their primary vulnerability from a legislative point of view lies in their block-grant fiscal format. The thrust of all these complaints seems to point toward improving COP rather than to any radical change. Direct service workers, in particular, want to see more COP money and legislative recognition that there are needs that must be addressed through other programs and funding mechanisms. 

All this is easier said than done. Most COP watchers acknowledge that, from a political perspective, money is the biggest problem facing COP and other social programs. Legislative scrutiny of COP has increased steadily as the program has evolved. COP-like all rising stars, has a lot its fans as other priorities have moved onto center stage and as the fiscal pie has shrank. Since the economy may remain shaky for the foreseeable future, and since there is a growing resistance to raising taxes, no program, however popular, can be sure of its future, particularly if that future involves expansion. A second overriding concern expressed from all quarters is the issue of quality assurance. To date there have been no scandals in the COP program, no lurid stories of patient abuse or fraudulent billings. Nonetheless, a reform system that grew out of a critique of the heavily monitored nursing-home industry can hardly afford to operate with its fingers crossed. Professionals at the Department of Health and Social Services, social workers and advocacy-oriented friends of COP all identify effective quality assurance as a challenge only slightly less compelling than the need to assure COP's continued fiscal health. Developing a monitoring system that truly measures such intangibles as personal autonomy, community participation, social interaction and other normalization values will not be easy. Equally difficult is the challenge of ensuring compliance with basic fair employment laws and principles. Should quality client services be had at the expense of COP's "employees," some of whom have no union representation, earn little more than minimum wage and may not have basic benefits? Planners are now directing their attention to these qualitative priorities. 

A final concern raised repeatedly in the LAB evaluation is the need for improved fiscal management practices. Investigators found uneven performance in their sample of counties and recommend better, more uniform controls at the local level. The report also found that "the Department does little monitoring of the effectiveness of county operations" and urges more oversight by the Departments of Health and Social Services. Clearly the State's reluctance to impose additional requirements on counties already complaining about "onerous" demands, will have to be balanced off against legislative interest in achieving improved program management. 

V. Conclusions and Considerations for the Future

Many fortuitous circumstances converged to facilitate the birth of COP. A call for national and local
social change and compelling fiscal pressures offered decisionmakers unique problems and opportunities. Aggressive, talented leadership capitalized on these difficulties by crafting a program that made its case on both deeply felt values and fiscal prudence. While COP's client numbers and funding levels remain limited by comparison with institutional standards, there is already a consensus regarding its major contributions to date. Near-term challenges and unresolved issues are also relatively clear.

COP has without question created the possibility of real choice for elderly and disabled persons who less than a decade ago would have had no alternatives. Attitudes about what constitutes effective long term support have been altered among policy-makers and practitioners as well as among clients. It can also be argued that the consumer is in the driver's seat to a much greater extent than at any time in recent memory, in terms of defining the focus of long term supportive care.

COP seems to have been a catalyst for major system change, as well. It has helped foster the development of a newly strengthened array of community services; it has empowered case management that focuses on client needs, strengths and prospects, rather than on limitations and institutional convenience. While the relationship between the State and the counties remains complex, COP seems to have introduced a degree of funding and program flexibility that is unique, if not totally to counties' liking. Some counties have reported that COP guidelines have played a positive role in unifying and coordinating county long term support agencies and services. While performance and support levels vary widely among counties, COP seems to have brought to many a coherent long term care philosophy, linked to flexible money and useful system improvement requirements.

Certainly difficulties and uncertainties lie ahead. If COP is to grow as an alternative to its still mighty institutional counterpart, it will need to secure substantial new funds on a continuing basis. Some of these monies can be realized through economies achieved by improved program and fiscal management, but additional State and federal funds are obviously needed. While the current atmosphere of fiscal restraint persists, new appropriations at the State level will be harder to win, and the trade-off between values and dollars is likely to become both more painful and more painfully evident.

COP's "coalition of categories" remains somewhat uncertain and may yet come unseamed. Planners and advocates may succeed in modifying the existing program to address disparities felt by individual disability groups: if this is not possible, a well managed "divorce" may be the next best option. Hopefully, should the latter materialize, the circumstance can be handled so that program values and existing services are not compromised.

Planners and implementers busy with installing and expanding COP between 1982 and 1986 must turn their attention to issues of quality assurance. Standards, monitoring mechanisms and resources relevant to the program's goals must be created to ensure that appropriate services are being provided and to guard against damaging scandals. The State and the counties must cooperate to improve fiscal controls and operations management without further complicating state-county relations.

Less demographic pressures will make long term support a major national policy issue for years to come, as a Mathematica Policy Research study has recently shown: Changing demographic patterns have been a major factor contributing to the growth in the need for long term care. Nationally, the proportion of the U.S. population over age 65 has risen from 3.3 percent in 1900 to 12.9 percent in 1980. Wisconsin's share is even higher, at 11.9 percent. The older group—the over age 75—is growing at an even faster rate (Glick 1979). This over-75 group, which has a much greater likelihood of institutionalization, represents 41.5 percent of Wisconsin's elderly; only six states have a higher proportion (CAO 1983). In addition to the elderly, national data estimate the number of handicapped adults at 9.6 million individuals, with an additional 11 million individuals experiencing developmental disabilities (NASW Committee on Long Term Care 1984). In Wisconsin alone, there are 5,000 developmentally disabled individuals in nursing homes, and an additional 2.78% individuals in state centers for the developmentally disabled (DHHS 1983). (See Appendix F for more detailed, local demographic analysis.)

At aging conferences around the country, planners and practitioners are beginning to debate such concerns as trust fund for care, based on 1% payroll taxes, special HMO coverage, as well as innovative private/public asset mixes. It seems clear that no one is sure yet how to manage the long term care question in a comprehensive way.

Many observers, advocates and others are daring to imagine several different futures for COP; several of these possible futures are considered in the following outline.

1. The most pessimistic prospect sees COP as destined to be starved for additional funds. Should the cost-containment-through-diversion idea lose its legislative appeal, COP could be maintained as a separate program for 3-4 years and then lose its separate identity and gradually be folded into general categorical community aids programs for elderly and disabled persons.

2. More hopeful is the notion that COP will retain its separate identity and be funded in a reduced
growth mode for the indefinite future. This would allow it to function and gain strength in the lower counties, but still fail to solve the prob-
lem of waiting lists.
3. A variant of this conservative but somewhat hope-
ful notion sets COP being broken out by disabili-
gy group, with each group forming its own “COPlet” and fighting on its own terms for fund-
ing.
4. Optimists hypothesize that COP will continue to
grow, but that its chief source of new monies will be federal in nature. These theories believe that the federal waiver will become the key to COP’s future growth and health. The state is now pursu-
ing these different federal waivers, each of which would have the effect of channeling new federal monies into the community-based side of the long term care equation, thereby reducing reli-
ance on State general purpose revenue (GPA) to fund COP’s continuing growth.
5. Still more ambitious is the COP that becomes “immed” to some objective measure of client demand growth, such as the demographics dis-
cussed above. This is a COP still largely depen-
dent on State GPA, a foundation which, of course, leaves it open to frequent political tinker-
ing.

Whatever view is advanced, there is a general con-
sensus that community-based support is destined to be a permanent fixture in our society, as the Cabinet Secretary of Department of Health and Social Ser-
vice‘, Linda Reivitz, noted in her recent remarks to a Wisconsin gathering, celebrating the county’s fifth anniversary as a COP “pioneer” county.

There is nothing so powerful as an idea whose time has come, and I would suggest to you that the ideas of community integration, and normalization, and least restrivitive care, are ideas whose time has come. We may lose a little ground here and there. There may be a budget which is disappointing, or a court case that we wish had gone the other way, or changes in per-
spective that make us concerned about the future.

There is surely hard work that needs to be done. But the gent is out of the battle and he will not go back. Long term care, in communities, is here to stay and I think we can all be proud that we played a role in this quiet revolution.

Notes:
1. Samuel Gridley Howe is quoted by David Brad-
2. Ann V. Rugg, Children of Misfortune/One Hun-
dred Years of Public Care for People with Mental Retardation in Wisconsin, 1871–1971 (Madison, Wis.: Wisconsin Council on Developmental Dis-
abilities, 1984), p. 35.
3. Ibid., p. 3.
in Council on Developmental Disabilities.)
5. Rugg, p. 41.
7. Ibid., p. 3.
8. Final Report/Study of the Early Implementa-
10. Ibid., p. 19.
12. Ibid., p. 41.
15. Ibid., p. 8.
17. Ibid., p. 71.
18. Douglas Nelson, Transcript of speech delivered at the Community Living Ways and Means Conferen-
tce, Wausau, Wis., 1980, p. 18.
20. Ibid., p. 91.
22. Wisconsin Community Care Organisation, origi-
nal grant proposal submitted to the U.S. Depart-
ment of Health, Education and Welfare, Sep-
tember 19, 1974, p. 6.
25. Ibid., p. 3.
26. Ibid.
27. Ibid.
28. Wisconsin Long Term Support Planning and the Community Options Program, prepared by the
Case Study Resources

Resource Persons for COP Case Study
(In Alphabetical Order)

The Robert M. La Follette Institute of Public Affairs wishes to thank the following persons for offering their perspectives on COP during the case study preparation and revision process.

1. Jonathan Barry
   Dane County Executive
   Madison, Wisconsin

2. Betsy Benson
   Manager
   Gas Market Planning and Analysis
   Wisconsin Power and Light Company

3. Harold Bergan
   Former Policy Advisor to Governor Anthony Earl
   State of Wisconsin

4. Warren Braun
   Director, Department of Social Ministry
   Archdiocese of Milwaukee

5. Lynn Breedlove
   Executive Director
   Wisconsin Coalition for Advocacy

6. Jim Canales
   Coordinator, Long Term Care Services
   Portage County Community Human Services Department

7. Marianne A. Cooke
   Chief of Planning and Implementation
   Bureau of Economic Assistance
   State Department of Health and Social Services

8. John Easterday
   Administrator,
   Outpatient and Community Programs
   Milwaukee County Mental Health Complex

9. Wendy Fearnside
   Assistant Director, Bureau of Planning
   State Department of Health and Social Services

10. Billy Feitlinger
    Legislative Aide to
    Senator Russ Feingold
    State of Wisconsin

11. Betty Ferris
    Formerly Executive Director
    Wisconsin Coalition for Advocacy

12. Diane Greenly
    Attorney
    Wisconsin Coalition for Advocacy

13. Tom Hamilton
    Acting Director
    Bureau of Long Term Support
    State Department of Health and Social Services.

14. Sue Herbst
    Dane County Board Supervisor and
    Chair of the Community Options Committee

15. Robert Jauch
    Wisconsin State Senator

16. Dan Jehl
    Executive Director
    Wisconsin Association of Homes and Services for the Aging

17. Dan C. Johnson
    Director
    Office of Persons with Physical Disabilities
    State Department of Health and Social Services

18. Blake Kellogg
    Professor of Journalism
    Department of Communication
    Division of University Outreach
    University of Wisconsin

19. Nancy Livingston
    Client of COP Services
26. Tom A. Laftus
Speaker of the Wisconsin Assembly

27. Jean Logan
Associate Director, Milwaukee County Department of Health and Human Services

28. John Lecroy
Supervisor, Long Term Support Systems State Department of Health and Social Services

29. Gerti Lydias
Director, Community Options Program Milwaukee County Department of Human Services

30. Sinikka McCabe
Associate Director Community Support Program Section Office of Mental Health State Department of Health and Social Services

31. Donna McDowell
Director, Bureau on Aging Division of Community Services State Department of Health and Social Services

32. Chuck McLaughlin
Long Term Support Supervisor Jackson County Human Services Department

33. Paul Meyer
Director, Dane County Community Support and Health Services Department

34. Mary Lou Munt
Chairperson, Public Serv Commission, State of Wisconsin

35. Doug W. Nelson
Deputy Director, Center for the Study of Social Policy Washington, D.C.

36. Donald Percy
President, The Management Group Madison, Wisconsin

37. Linda Reivitz
Former Cabinet Secretary State Department of Health and Social Services

38. Tim Sieterfield
Legislative Program Analyst Legislative Audit Bureau State of Wisconsin

39. Kayn Segin
Former Service Program Manager Dane County Social Services Department

40. Marilla Slaughterback
Associate Director Bureau on Aging State Department of Health and Social Services

41. Catherine Swanson
Community Program Specialist I Office of Mental Health Division of Community Services State Department of Health and Social Services

42. John Torphy
Administrator for the Division of Health State Department of Health and Social Services

43. Peter Troupman
Former Administrator Division of Policy and Budget State Department of Health and Social Services

44. Judy Wilcox
Former Housing and Long Term Support Specialist State Department of Health and Social Services

45. Jayn Wittenmyer
Executive Director Wisconsin Council on Developmental Disabilities

46. Judy Zitske
Social Service Specialist I Bureau of Long Term Support State Department of Health and Social Services

Bibliography of Resource Materials

The following resource materials have been divided into two broad categories: Section I includes all those materials directly cited in the text of the case study; Section II includes those materials that provided useful background information, but are not cited.

I. Cited Resource Materials

A. Program Memoranda, Evaluation and Information Materials


2. Discussion of the Community Options Program, prepared by the Wisconsin Department of Health and Social Services, March 1981.


4. Final Report/A Study of the Early Implementation Experience of the Wisconsin Community Options Program, prepared by


6. Memorandum by Health and Social Services Secretary Donald Percy to Governor Lee Sherman Dreyfus, June 16, 1980.

7. Memorandum by Stilkka McCabe (Office of Mental Health) to Community Service Program/Social Service Department Directors and Others regarding "New COP Screening Tool As It Applies to Persons with Long Term Mental Illness," January 31, 1980 (plus enclosures).

8. Personal Experiences: The Community Options Program, prepared by the Office of Program Initiatives, State Department of Health and Social Services, 1983 (Includes 14 written vignettes of early COP client experiences plus several related news articles.)


B. Monographs, Articles, Reports and Speeches


II. General Background Materials

A. Program Memorandums, Evaluation and Information Materials

1. Evaluation data on COP program operations for 1982 and 1983, published by the Department of Health and Social Services, Division of Policy and Budget.


5. Memorandum on the Long-Term Support
Initiatives by Jean Logan, Milwaukee County
Health and Social Services, October 1980.

6. Memoranda on COP prepared by the Legis-
lative Fiscal Bureau for members of the Joint
Finance Committee, March 1981 to April
1985.

7. Memoranda from the Wisconsin Office on
Aging to the Long Term Support Manage-
ment Reference Group and others, July and
August 1986.

3. Articles, Speeches and Audio-Visual Materials
1. Contents of the COP newspaper clipping
files maintained by the Capitol Times, the
Wisconsin State Journal, and the Milwaukee

2. COP speeches by Department of Health and
Social Services Secretary Linda Reivitz:
October 11, 1985; September 23, 1986 and
September 24, 1986.

3. COP speeches by Douglas Nelson: August 6,
1982; February 11, 1983; October, 1983; June

4. "COP" a slide tape of six vignettes featuring
the experience of early COP clients, pro-
duced under the direction of the Depart-
ment of Health and Social Services, Divi-
sion of Community Services, 1983.

5. Feature articles on institutional care pub-
lished in The Blueprint, a newsletter of the
Wisconsin Council on Developmental Dis-
abilities: Winter 1985; Spring 1985; Summer
1985 and Fall 1985.
### Counties Participating in the Community Options Program by Year of Entry

<table>
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<tr>
<th>Year</th>
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<td>Clark, Door, Dunn, Lincoln, Oneida, Oconto, Ozaukee, St. Croix, Shawano, Waukesha</td>
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<td>1986</td>
<td>Buffalo, Crawford, Dodge, Florence, Forest, Green Lake, Juneau, Kewaunee, Lafayette, Langlade, Marquette, Sawyer, Vilas</td>
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</table>
A quiet revolution
Program offers home services for elderly, disabled

By Rose Benedict

When Mother was diagnosed with what was then called armchair arthritis, she needed a crutch. Her legs were aching and she was unable to walk as far as she used to. She decided to get out into the sunshine, so she didn't have to go out.

These small acts of kindness can bring happiness to those who are shut out of thought and who need help. The Community Options Program, designed to aid persons who are home-bound, has appreciably reduced the number of elderly, disabled and the mentally handicapped.

It is a revolution that is in its early stages, expected to double in the next year. The program, designed to gather community, church and school aid, is run by Norma Benedict in a white, modern house.

The Community Options Program, which officially opened in Milwaukee County April 1, is assisted by the other residents of the county. In addition to the work of three women who are baby-sitting, there are also the services of a home health aide and a personal aide.

The Community Options Program offers a wide range of existing social and health services.

The Community Options Program is designed to meet the needs of those who are too old to care for themselves or are a burden to their families. A primary goal is to provide a comprehensive approach to the needs of the elderly and disabled.

For Mother Benedict, a volunteer who has lived with her mother since she was a child, the Community Options house is a place of solitude.

This is the first of two stories on placing the elderly and handicapped back into the community.

Through the session in which Milwaukee County intends to cut costs of $1.1 million this year, the Community Options Program is able to offer a wide range of services.

Turn to Care, Page 49
New program offers care alternatives

Care From Page 1
"It's really a win-win in the long run, whether you're a home health provider or the client," said one of the program's developers. "It's also a win-win for the client, because they get the care they need, and the provider gets the care they need, too."

The program, called Community Options, is designed to provide care for people who are unable to care for themselves due to age, illness, or disability. It is funded by the state of New York and is administered by a local nonprofit organization.

The program includes a range of services, including home health care, personal care, and transportation. Participants can receive services for as little as $5 per hour, and the program is designed to be flexible and responsive to individual needs.

"This is a great opportunity," said one participant. "I feel like I have more control over my life now, and I feel like I'm getting the care I need."

The program is still in its early stages, but early results are promising. Many participants have reported increased mobility and improved quality of life since beginning the program.

"I'm really happy with the program," said one participant. "I feel like I'm getting the care I need, and I feel like I'm living a better life."

The program is expected to continue to grow and expand over the coming years, and it is hoped that it will eventually serve thousands of people in the area.

"We're really excited about the program," said one of the program's developers. "We think it's going to make a big difference for the people who participate."
For Carolee Ann Parsons, the choice was clear. Either leave her family and move to a state where she could get more money to hire an attendant, or spend the rest of her life in a hospital at extreme risk.

Parsons, a resident of Madison's far east side, had polio during the 1960s and now wears a wheelchair with the help of a respiratory nurse 24 hours a day.

Early last summer, Parsons realized her parents "were at the point where I felt they were physically having difficulty caring for me," and she needed to make a decision soon.

"In my case, a nursing home wasn't an option," Parsons said, "because they wouldn't be able to handle my respiratory status or give me the number of hours of care I need."

"I had already explored several states, but I kept pre-qualifying about making any definite moves. Yet if I would have to live at a hospital, my life would have absolutely no meaning. I would cease to want to exist," she said.

After six months of feeling "tremendously discouraged at the prospect of having only those two options available to me," Parsons happened to read a newspaper article about the Dane County Community Options Program (COP).

The state-sponsored program, in effect in the county the past two years, has been able to help Parsons and others like her stay out of institutions and nursing homes and live in the community instead.

"The feeling of the COP long-term planning committee is that a person's self-worth and self-dignity should be recognized as having a value," Tom Fisher, chairman of the committee said. "Even if it cost just as much to keep a person in the community, the person should have the opportunity to make that decision.

"I think we're talking about quality of life versus dollars, " he added, "and quality of life has to be a serious consideration."

This year, Dane County received $587,000 in COP funding from the State Department of Health and Social Services, and priorities getting approximately $1.8 million in 1982.

The program, approved by the State Legislature as response to the growing cost of institutional care, provides funds for assessments, for individual care plans for clients, and for the support services a person needs to live in the community.

From January through June of this year, the Dane County COP program diverted 66 persons from institutions.

By Barbara Molhem
Capital Times Staff Writer

"COP helps disabled to live more full lives," Capital Times, Madison, Wis., October 2, 1981.
Details may bog down community care plan

When the debate on the "Long- Term Care Options Program" began in the legislature, more questions were asked about the details of the plan than about the concept.

The Wisconsin Board on Aging, the Wisconsin Council on Developmental Disabilities, the Wisconsin County Board Association, the Wisconsin Association of Nursing Homes, and an ad hoc legislative committee on nursing home use have declared their support of community care.

However, those declarations of support have sometimes been accompanied by reservations.

Rep. Michael Kirby, D-Milwaukee, a member of the Joint Finance Committee, predicted most questions will come from the counties and the nursing home industry.

Terry Buttenuth, human services director of the county boards organization, said her group's questions concern the pre-screening process and the freedom the counties will have to develop their program.

The association wants to "substantially modify" the program's proposal in those respects before it supports the program.

In addition, counties say the pre-admission screening will create another level of regulation. It duplicates the hospital discharge planning, nursing home admission criteria, and level of care determination requirements that already exist, Ms. Buttenuth said.

She also called it "a dangerous assumption" to say that community-based care is always cheaper than institutional care.

"A number of our counties have found that is not always the case," she said.

Both Doug Nelson and Donna McCallow said the Department of Health and Social Services knows it will have to work closely with the counties. "We're going to have to provide assistance to the counties with less highly developed networks of services to help them get off the ground," Ms. McCallow said.

She said the tension in developing the program will be those found in any new human services program - how to give the system independence and flexibility while having it be accountable and responsible.

Nelson added the department's confidence in the program "does not mean we don't anticipate any problems or confusion or tinkering with the mechanism."

Assembly Majority Leader Thomas Lofthus, D-Nousha, along with Sen. Paul Offer, D-La Crosse, headed an ad hoc committee on nursing home use that recommended a program similar to the department's. Lofthus predicted the nursing home industry will fight the two-year moratorium on nursing home construction that is part of the Community Options Program and the proposal to limit increases in Medicaid reimbursements to 8.75 percent during the next biennium.

"If we lose on that, there won't be enough money around to pay for some of the innovative things like this," he said.

James Bullion, from the Wisconsin Association of Nursing Homes, said that attitude amounts to "stealing money from another program."

His association said there should be additional money appropriated to pay for the program.

Bullion said the state's proposal would create "a new proliferation of agencies," and suggested nursing homes could be used as a base for community services.

Bullion said meals, nurse service, medication supervision and other services could be coordinated by a nursing home on an outpatient basis.

The association opposes the moratorium because Bullion predicted it will not accomplish its purpose. He said it will mean more restrictions in the choices available to older people.

Nelson said the department anticipated industry opposition. "It's in their interest in the long run but it may take them a while to realize that," he said.

-By Mary Frances Schonberg

"Details may bog down community care plan." Wisconsin State Journal, Madison, WI., February 18, 1983.
Nursing-home changes backed

A committee of the Dane County Commission on Aging Wednesday recommended that the commission support a County Board resolution calling for significant modifications to the state's proposed Com- munity Options Program.*

The program, proposed by the Department of Health and Social Services as a way to prevent inappropriate use of nursing homes, would use a pre-admission screening and coordination of community-based services for those who can and prefer to live outside of a nursing home.

The committee will vote on the recommendation at its March 10 meeting.

Wisconsin counties have objected to the fact that 22 counties, including Dane, would be required to participate in the second year of the program. They also said that parts of the program duplicated existing services.

The County Board resolution supports the intent of the program, citing the $1.2 million it budgets for similar services, but says that it will support the program only after changes have been made.

Dropping the requirement of mandatory participation and, instead, allowing counties to apply for money on a grant basis is the major change outlined in the resolution. The county also wants the program to end after 1983, requiring specific legislative action to continue.

"If it worked and the bugs were out of it, I am sure that the counties would come running to the Legislature, demanding that the program be continued," James Collier, county human services director, told the committee.

Dan Vegter of the state Bureau of Alternate Care, who testified during the meeting, said afterward that it would be a mistake to make the program voluntary with a 1983 sunset provision. He said that not enough evidence of the program's results would be available by the time the Legislature had to review it. "I'm very much afraid that the program would be cut in mid-1983 and that there would be a hiatus, at which point we'd have to start over from the ground floor," he said.

Collier said that it could cost Dane County nearly $200,000 to run the Community Options Program because the state will not provide enough money.

"We want to provide quality service and the state is not coming up with the money," Clayton Dunn of the county executive's office said.

The resolution asks that the state provide 100 percent of the funding or allow the county to stop the program.

After the state money is gone.

It also calls for more freedom in setting up and running the program, including the right to restrict the program to a certain number of nursing homes to make it applicable to Medi- cal Assistance recipients only and to use existing screening systems rather than start new ones and asks that counties not be restricted to the state's $100 estimate of each screening visit.

Hershey said that the modifications have been agreed to by the Department of Health and Social Services and sent to the Joint Finance Committee.

*By Mary Frances Schjoenberg
The State Journal

"Nursing home changes backed." Wisconsin State Journal, Madison, Wis., March 5, 1981.

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<th>Age/Chronic Disability or Illness</th>
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* It is assumed that all older persons with long term support need have aging process associated functional impairment.