



# Oregon

Theodore R. Kulongoski, Governor

## Department of Human Services

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September 15, 2010

To Whom It May Concern:

I am writing about the medical foster home operated by Allan and Eunice Phillipi. A child on my caseload, who I will refer to by the pseudonym "Lynn", has been placed in the Phillipi home for almost 3 years. Lynn is an extremely complicated ten year old girl with severe cognitive and motor disabilities. DHS has been the guardian for this child since 2002; I've been the responsible caseworker since 2004, so I've had an opportunity to observe her care over time. Lynn is a ward of the state because her legs were broken by an unknown person when she was two years old, and because her parents were involved with methamphetamine and extensive criminal activity.



Lynn was injured during birth due to a true knot in the umbilical cord which cut off oxygen needed for normal development. She cannot move herself and lives entirely in her wheel chair and her bed. She is severely retarded and does not communicate. She is fed through a G-tube. A summary of her medical status by problem can be found at the end of this letter.

Because of her severe medical needs she resided in a nursing home for several years; her care there was minimally adequate. The state determined children like Lynn should be cared for in a more family-like setting and she was moved to the Phillipi home.

The reader may wonder whether Lynn's case is unique - how many children with similar severe needs are in the care and custody of the state? I can't give you numbers, but I can say she is not unique. Most child welfare permanency caseworkers have at least one such child with severe needs on their caseload. Oregon's decisions about care of children with severe needs have evolved and improved over the years. Such children were cared for at Fairview Training Center in Salem from 1908-2000. I remember seeing many such children, deformed and unable to function, lying hour after hour in cribs in drab wards at Fairview. The approach to caring for these children changed in the 80's and 90's. Housing them in the "community" was considered a more humane approach. This is where options like the Phillipi's became essential.

In Lynn's case, she was first placed in a pediatric nursing home. (Her care there was never as good as it is in the Phillipi home.) In 2007 the State

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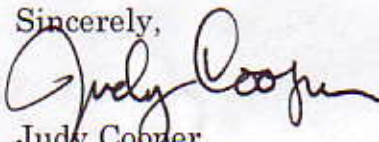
determined children like Lynn should not be kept in nursing homes. Lynn was assessed to need 24/7 nursing care and was moved to the Phillipi home. To the extent possible for a child with her severe disabilities, she has thrived in the care she receives there.

The Phillipi's are unique in several ways.

- Theirs is a family operation, with consistent care of residents by members of their extended families who have worked and lived together for years.
- Unlike a typical DD home, when they make a commitment to a special needs child, they make a lifetime commitment. Most homes that take DD clients stop serving them at age 18 and they have to move. Not so the Phillipis.
- Creating a sense of "family" for the residents is an important value. I've come to the home unannounced and seen Lynn in her wheelchair sitting at the table while adults are meeting for business. One day as I was leaving the house, I spoke with a TriMet Lift driver who was delivering a child to the home. She commented, "There is a lot of love in this home; I can tell because of the way my passengers feel when they arrive at the house." She added, "This is the best place that I deliver people to."

The need to provide care for children with mental and physical disabilities is one that does not go away. The Phillipi's provide the best kind of care: a home-like setting that provides both safety and excellent care. I wholeheartedly support their plans to expand their Center. They have demonstrated a lifetime commitment to quality of care for seriously disabled children and adults.

Sincerely,



Judy Cooper

Social Services Specialist

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\* Summary of Lynn's status by problem: hypoxic ischemic encephalopathy – from birth; cerebral palsy – profoundly impaired; feeding problems – child has severe dysphasia and takes nothing by mouth (has a g-tube); gastro esophageal reflux – she gags and coughs quite a bit due to pulmonary secretions (has only 1 functioning lung); chronic respiratory disease – she has had aspiration pneumonias repeatedly since infancy; mental retardation – profoundly impaired; uncertain how much she can see. She smiles, coos, and does some laughing. Does not have a yes/no response but does anticipate some events, like going to her bedroom at night. Gingival hyperplasia – many of her teeth are completely covered; agitation – episodes of agitation where she becomes diffusely tremulous and tachycardic.