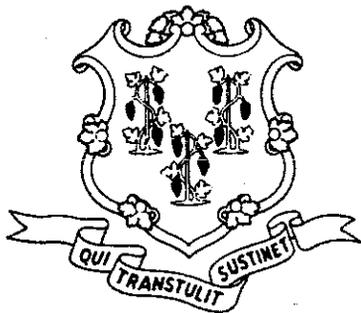


**MANAGEMENT AUDIT:
DEPARTMENT OF
MENTAL RETARDATION**

**Connecticut
General Assembly**



**LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE**

JANUARY 1990

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "Sunset" performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three of those members.

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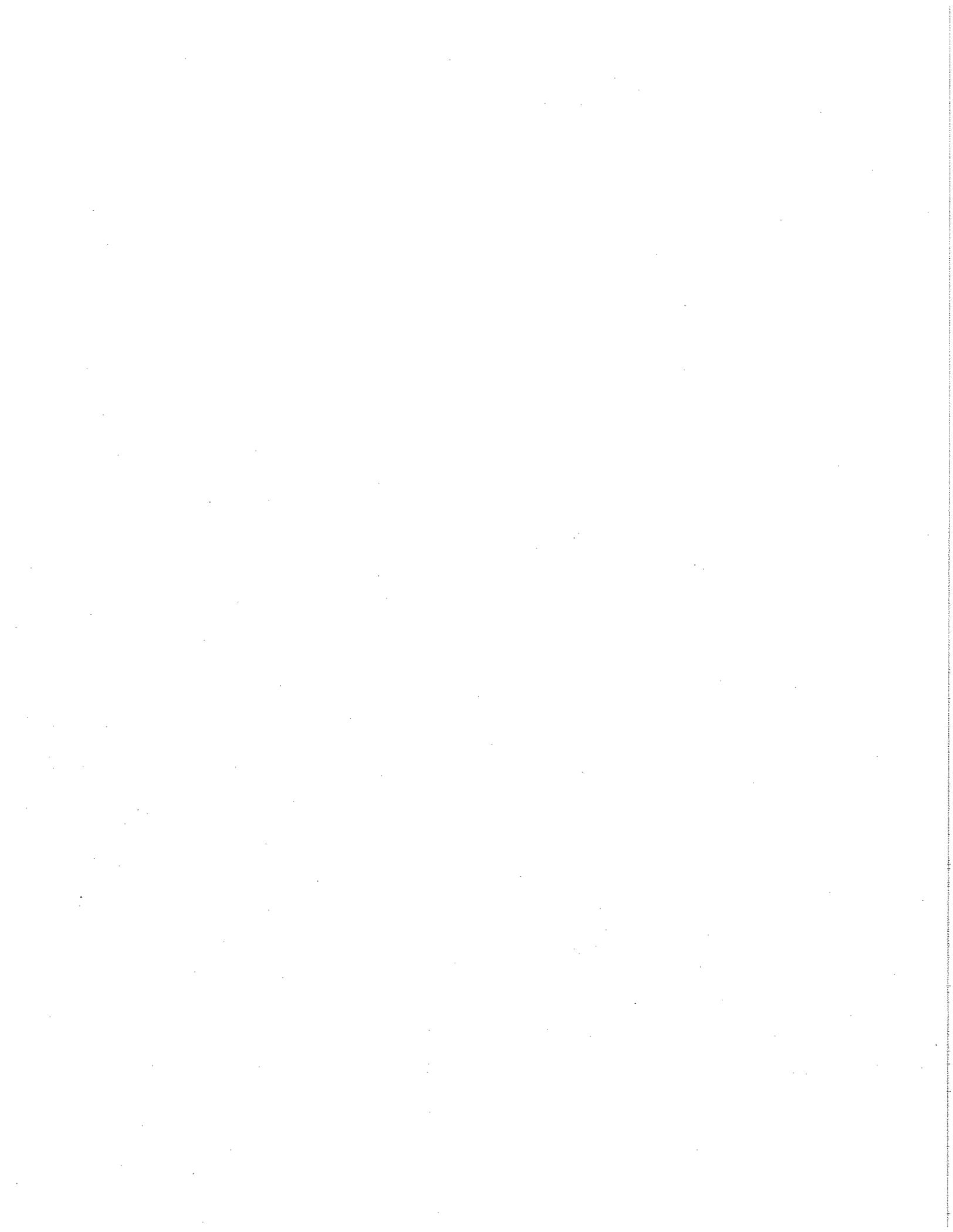


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SUMMARY

The program review committee voted to undertake a performance audit of the Department of Mental Retardation (DMR) in January 1989. The purpose of the study was to evaluate the overall management of the department, particularly as it is carried out by the central office. Specifically excluded from the scope of the study was any discussion or analysis of the merits of deinstitutionalization.

The department is statutorily responsible for planning, developing, and administering statewide services for individuals with mental retardation. Its activities are guided by a mission statement. The statement calls for the creation of living conditions for mentally retarded persons that enable them to participate in community life, develop competence, make choices about their future, have good relationships with family and friends, and experience respect and dignity.

In the opinion of the program review committee, the department's leadership has excelled in conveying and publicizing the mission to employees, providers, and advocates. Within the department, there is virtually no disagreement about the merits of the mission.

However, the committee found that the department has not been well managed. It lacks sufficient management controls to ensure it is operating in a uniform, efficient, and effective manner across all regions.

The decision-making process within DMR has all too frequently been based on individual cases rather than a systematic approach to problems. As a result, little recognition has been given to the impact of the program costs of one client on the availability of services for other clients.

The committee believes that top managers within DMR have also exhibited an unfortunate tendency to judge events in the context of winning and losing and to take actions aimed at rewarding supporters and punishing critics. This approach can subordinate the best interests of the clients to the inclinations of top managers.

The following recommendations adopted by the program review committee are intended to address inadequacies and inconsistencies found in DMR's current management system.

RECOMMENDATIONS

1. The current mission statement of the Department of Mental Retardation should be adopted into statute with a provision requiring it to be reconsidered by the General Assembly in 1992 and every four years thereafter.

The mission of the department to be included in statute is "to join with others to create the conditions under which all people with mental retardation experience:

- Presence and participation in Connecticut town life;
- Opportunities to develop and exercise competence;
- Opportunities to make choices in the pursuit of a personal future;
- Good relationships with family members and friends; and
- Respect and dignity."

2. The Department of Mental Retardation shall be required to annually develop a five-year plan. The department shall hold public hearings on a full draft of the plan and, beginning in January 1991 and annually thereafter, submit the final plan and a transcript of that public hearing to the committees of the legislature having cognizance over the department's operations and finances. The committees may hold a public hearing on the plan. The plan shall:

- set priorities;
- identify goals and objectives, and the strategies to be employed in achieving them;
- define the criteria to be used in evaluating progress;
- identify changes in priorities, goals, objectives, and strategies from the prior plan;
- describe and document progress made in meeting goals and objectives outlined in the prior plan; and
- estimate the type and quantity of staff and client services that will be needed over the life of the plan.

3. The Department of Mental Retardation should develop a system for tracking the cost of services purchased for individual clients.

4. Annually, each of the Department of Mental Retardation's regional offices should calculate and compare the total cost of services provided to each client residing within the region. The comparisons should also include pro-

jected cost with actual cost. The results should be circulated among assistant directors, case managers, and others responsible for making decisions concerning the provision of services to clients.

5. Whenever the proposed cost of providing a specific service to a client (e.g., day, residential, support, etc.) exceeds by more than 30 percent the average cost of providing that service to all other clients within the region, the regional director shall make a formal finding on the need and appropriateness of providing the service. For the service to be provided or continued, the finding must be either:
 - a. the service is necessary to maintain the client's health, safety, or existing skills; or
 - b. the anticipated improvement in the individual's skills or quality of life can reasonably be judged equal to or greater than the benefits other clients must forego in order to provide the service to the recipient.
6. The Department of Mental Retardation shall adopt regulations that define the criteria to be used in:
 - a. determining if a person is eligible for services provided by the department;
 - b. determining which clients will and will not receive a specific service; and
 - c. selecting private sector service providers.
7. The Department of Mental Retardation shall repeal all existing regulations conflicting with the Mansfield Consent decree or otherwise not legally binding.
8. The Department of Mental Retardation should develop guidelines that will ensure that the processes followed by the regional offices in selecting service providers and determining which clients will receive services are uniform. The guidelines shall specify the decision-making authority of the department's central and regional offices and set the parameters within which each shall operate.
9. Each regional office, following a format developed by the department's central office and taking into account regulations and guidelines adopted by the department, shall prepare written procedures outlining the processes

to be followed in selecting private sector service providers and determining which clients will receive services. The procedures shall be reviewed and approved by the department's central office.

10. The Department of Mental Retardation should develop a management oversight capability and submit reports at least annually to the legislature's committees of cognizance that:
 - a. evaluate each region's adherence to its approved procedures for selecting service providers and determining which clients will get services; and
 - b. identify and explain discrepancies between regions with respect to such things as staff-to-client ratios, cost-per-program models, cost per client for each type of service provided, gaps between clients served and those requesting services, etc.
11. The Department of Mental Retardation should identify management needs on an ongoing basis and develop appropriate training programs.
12. The Quality Assurance Division should only identify problems. Once uncovered, the division shall notify the applicable region. It shall be the responsibility of the regional office to oversee the resolution of any problem identified by the Quality Assurance Division. The regions shall report to the Quality Assurance Division when there is resolution.
13. The Quality Assurance Division shall issue a monthly report listing unresolved problems. The report shall identify the location, nature, and number of months since the problem was first identified. The Quality Assurance Division shall follow up by conducting a sample of those problems reported as resolved by the region. If the region has reported a problem resolved and the Quality Assurance Division judges otherwise, the regional director and the commissioner shall be notified.
14. Program quality enhancement reviews should be administered in the regions. To enhance community awareness/-involvement, recruitment efforts for volunteers should be centered in the community. Employees of DMR should not be allowed paid state time to participate as volunteers.

Information should be provided from the regions to the Quality Assurance Division regarding the results of the reviews. The Quality Assurance Division should then compile and analyze the information from the regions.

15. The Quality Assurance Division should develop a weighting system for categorizing deficiencies. This system should be used to determine the frequency of inspections.
 - a. Residential facilities that have undergone two consecutive inspections with no deficiencies shall be inspected biennially.
 - b. Residential facilities that have undergone two consecutive inspections and the deficiencies received have been categorized as noncritical shall be licensed on an annual basis.
 - c. Residential facilities that have undergone two consecutive inspections and the deficiencies received have been categorized as critical or the facilities that hold a provisional license shall be inspected at least semiannually.
16. The Quality Assurance Division should develop a capacity to analyze data and issue reports identifying system problems and reporting regional variations.
17. C.G.S. Sec. 19a-460 shall be amended to require that the commissioner of mental retardation be required to have "background, training, education or experience in administering the care, training, education, treatment, or custody of persons with mental retardation." In addition, the role of the Council on Mental Retardation with respect to the appointment of the commissioner shall be clarified. The council shall be allowed to advise the governor on the selection, but the governor shall not be required to appoint a person recommended by the council.

INTRODUCTION

The Legislative Program Review and Investigations Committee voted to undertake a performance audit of the Department of Mental Retardation in January 1989. The purpose of the study was to evaluate the overall management of the department, particularly as it is carried out by the central office. Specifically excluded from the scope of the study was any discussion or analysis of the merits of deinstitutionalization.

In conducting the review, a variety of sources and research methods were used. The committee held three public hearings and two workshops with department personnel. The meetings, which took place in Groton, Fairfield, and Hartford, generated over 400 pages of testimony.

State statutes, regulations, and written procedures governing the operation of the department were examined. Quantitative data related to the department's day and residential program activities, and its budget were collected and analyzed.

Committee staff conducted extensive interviews with department personnel, private providers, client advocates, and parents. Additional opinions of private providers and department staff were obtained through two surveys. Also, committee staff observed a representative sample of state and privately operated day and residential programs.

The report contains three sections. Section I outlines the history and organizational structure of the department. It also provides data on the department's client population and resources. Section II describes selected department activities including the budget and policy development processes, and the provision of day, residential, and respite services. The department's quality assurance efforts are also discussed in this section. Section III contains the program review committee's findings and recommendations.

Attached to the committee report are five appendices. Appendix A is a discussion of 16 sole source contracts awarded to 3 out-of-state consultants. Appendix B examines the change of the medical services provider for Seaside Regional Center. Detailed in Appendix C is an analysis of the Department of Mental Retardation's personal service agreements for FY 88 and FY 89. Appendix D is a copy of the opinion survey sent by the committee to the department's private providers.

It is the policy of the committee to provide audited agencies with an opportunity to review and comment on the final report prior to its publication. Formal agency responses, if submitted, are then included in the published document. A copy of the Department of Mental Retardation's response to this review is contained in Appendix E.

SECTION I: BACKGROUND

Overview

The Department of Mental Retardation (DMR) is statutorily responsible for planning, developing, and administering comprehensive and integrated statewide services for individuals with mental retardation. Originally set up in 1959 as a division within the Department of Health, DMR became an independent state agency in 1975.

The activities and operation of the department today are guided by the agency's mission statement, which was formally adopted in 1986. The mission calls for the creation of living conditions for persons with mental retardation that enable them to participate in community life, develop competence, make choices about their future, have good relationships with family and friends, and experience respect and dignity.

The major statutory responsibilities of the department concern: providing protective services for mentally retarded persons; ensuring the rights of such persons; court ordered commitments; admissions and discharges from mental retardation facilities; guardianship issues; residential programs, including development, licensing, and payment for services; day programs; Unified School District #3; and general planning, development, and administrative functions. The commissioner of mental retardation also serves on several commissions and is responsible for appointing various staff and the members of several commissions.

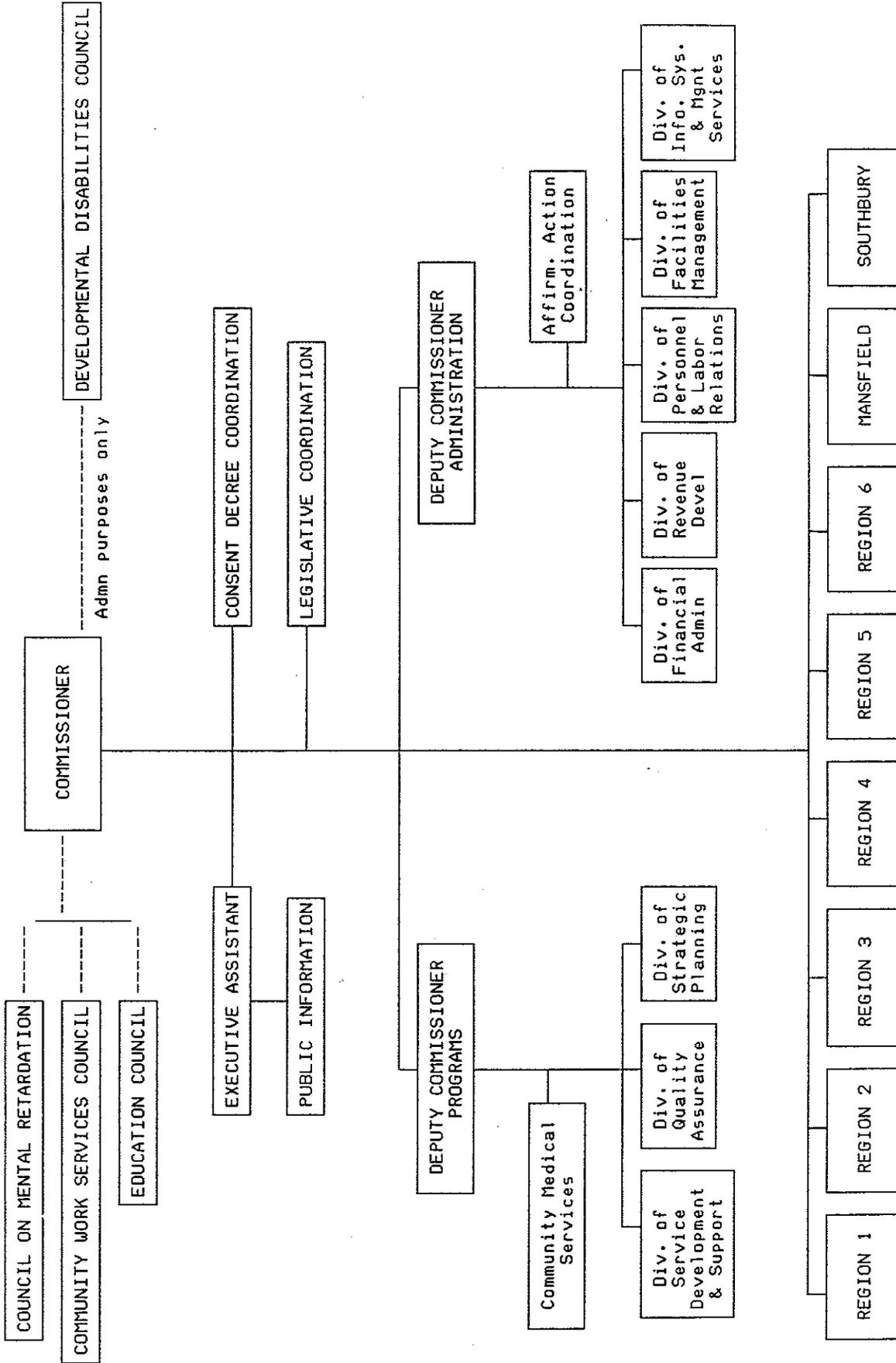
On a day-to-day basis the activities of the department that consume the greatest amount of resources are the provision of direct care services to persons with mental retardation residing in state-operated facilities of various types and the development and oversight of privately operated day and residential programs in the community.

Organizational Structure

The commissioner of mental retardation has overall responsibility for the Department of Mental Retardation. He is assisted by two deputies -- one for programs and one for administration. (See Figure I-1 for the current organizational structure of DMR.) The central office performs financial and oversight functions, while services for clients are handled through six regional offices, managed by directors. (See Figure I-2 for the boundaries of the regions.) The department also operates two large institutions -- the Mansfield and Southbury training schools.

DEPARTMENT OF MENTAL RETARDATION

FIGURE I-1



The activities of the department are divided into four functional service areas -- day, management, residential, and resource. Day and residential services each involve the planning, development, financing, and/or operation of programs in the respective areas. Management services encompasses a variety of administrative and internal support functions, such as data processing, personnel, and maintenance of state-owned facilities. Resource services includes case management, family and special support efforts, and staff training.

The Department of Mental Retardation is operated on a highly decentralized basis. Day-to-day decision making affecting individual clients and programs is the responsibility of the regional and training school directors. There are four assistant directors within each region, one for each of the functional service areas mentioned above. Appeal mechanisms are available within the department for clients, parents, or guardians who disagree with decisions about the programs being offered to a client.

A statutorily mandated Council on Mental Retardation advises the commissioner on the planning and development of services for persons with mental retardation. The 13-member council also makes recommendations to the governor and General Assembly on legislation it believes will improve the care and training of persons with mental retardation.

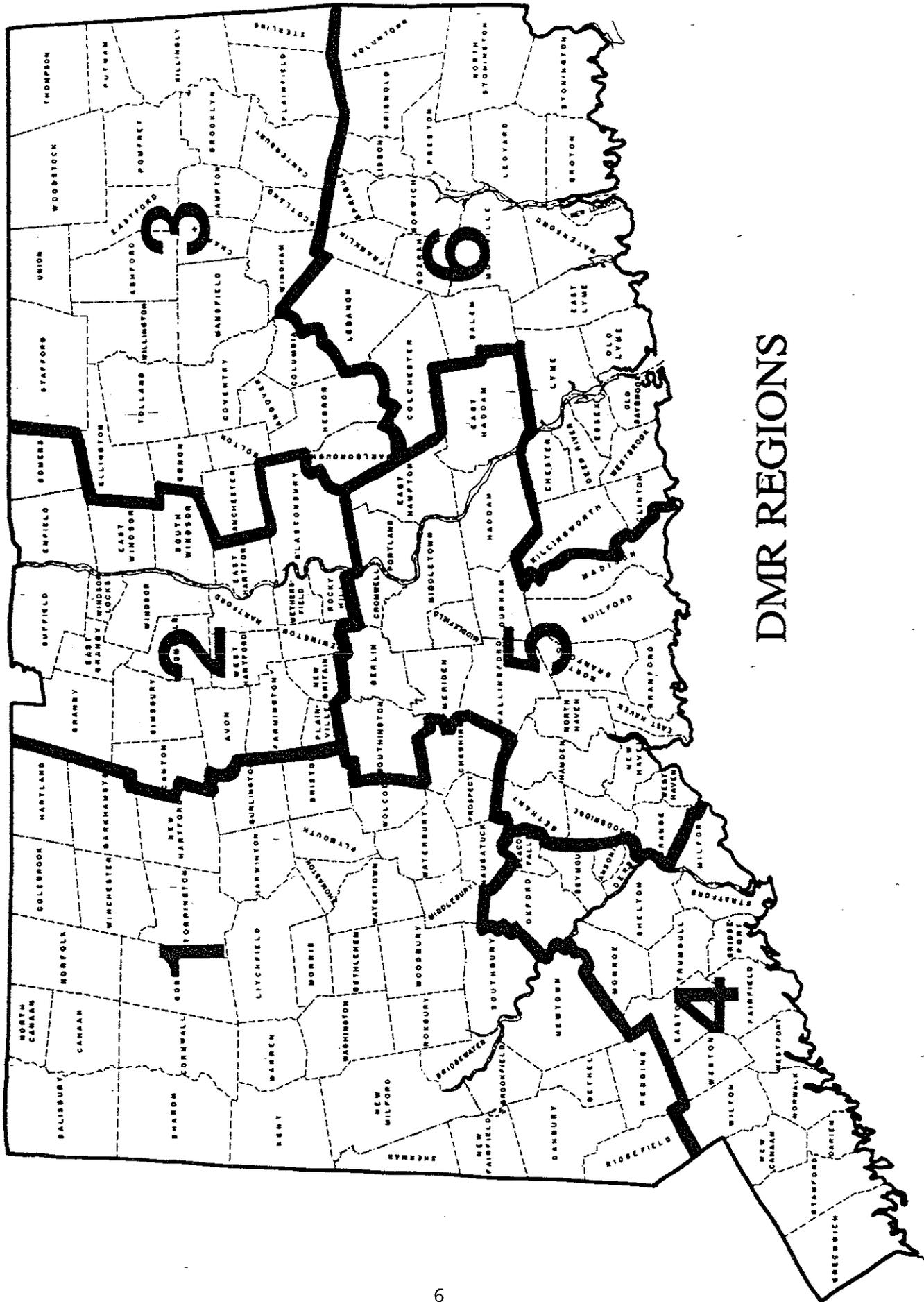
To supplement its regulations and statutory requirements, DMR has developed 13 detailed policies to govern its daily operations. These policies, which deal with clients' rights and the components of the case management system, reference the appropriate statutes and regulations affecting each topic and delineate specific steps to be taken when handling particular issues.

History

The philosophy, structure, and priorities of the Department of Mental Retardation have changed significantly since its establishment. Recognition of the rights of mentally retarded individuals has grown, and the department has increasingly emphasized community placements for such persons.

Many of the decisions made and actions undertaken by DMR during the past 10 years have been the result of two federal court cases -- CARC v. Thorne and U.S.A. v. State of Connecticut. Both cases were resolved when the state entered into consent agreements.

FIGURE I-2



DMR REGIONS

CARC, which was initiated in 1978 on behalf of individual plaintiffs residing at the Mansfield Training School, was settled in 1984 and has had the greatest impact. U.S.A., alleging civil rights violations based on conditions at Southbury Training School, was filed in 1984 and resolved in 1986.

The contention of the plaintiffs in CARC was that the care provided by DMR to clients living at Mansfield and certain individuals who had been transferred from there to long-term care facilities violated the U.S. Constitution and other federal protection laws. The results of the settlement applied to approximately 1,300 people meeting certain criteria, primarily residency at Mansfield on a particular date or risk of placement there at a particular time. These individuals are known as "class members" and retain their status as such even after placement into the community.

Among the requirements of the consent decree was the preparation and implementation of a plan to:

- assure the coordination of services to class members, representation in decision-making about their programs, and protection from abuse;
- increase the availability of community placements, including the necessary residential, day, and program supports;
- ensure maximum return on state funding for class members, including federal reimbursement and effective quality assurance systems; and
- enhance the quality of care and habilitation provided at Mansfield and reduce the population at the facility to less than 150 by June 1989.

Compliance with the plan has been overseen by a federal magistrate and four court-appointed monitors with expertise in the field of mental retardation. The monitors and their staff were originally to serve until December 1987. Delays in attaining all components of the consent decree have resulted in the continuation of the monitors by the court until at least the end of 1989.

Although no new admissions have been made at Mansfield, the area of compliance with the consent decree that has been delayed the most has been the reduction of the population to the targeted level. Residential placements in the community and the necessary supporting services had to be developed. The department's ability to facilitate such development has improved during the past few years, and it is now expected that Mansfield's population will be 150 by June 1990.

The U.S.A. case is more limited in its scope and only applies to individuals while they are in residence at Southbury Training School. As a result of the consent decree, DMR was required to develop an implementation plan addressing conditions that brought on the suit. Among the goals in the plan are to:

- assure sufficient staffing to protect and enhance the life of residents;
- provide periodic, professional evaluations of residents and facilitate communication about their care, training, and medical needs;
- create more community-based opportunities for residents; and
- improve the physical environment of the facility to eliminate fire and safety risks.

No new admissions are currently allowed at Southbury. In conjunction with the changes underway as a result of the U.S.A. case, DMR has been working to place more of the current school residents in the community. The department has set a target population of 825 residents for Southbury. When that number is reached, the adequacy of the facilities for that population will be reexamined.

Client Population

Any individual or their parent, guardian, or advocate may apply for a determination of eligibility for DMR services. The region where the applicant resides is responsible for providing intake and referral services.

To be eligible for Department of Mental Retardation services, a person must be a resident of the state and diagnosed as mentally retarded. By statute (C.G.S. Sec. 1-1g), mental retardation is defined as "a significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."

Thus, three elements must be present for an individual to be defined as mentally retarded and eligible to receive services from DMR. They are:

- 1) retardation must occur prior to an individual's 18th birthday (during the developmental period);
- 2) the individual's behavior must be significantly below what is expected for someone of the same age in the same cultural group (deficits in adaptive behavior); and

- 3) the individual must have an intelligence quotient (IQ) of approximately 70 or less as measured by a standardized intelligence test (significantly subaverage intellectual functioning).

Since IQ tests are inappropriate and measurement of behavior is difficult for infants (0-3 years old), the department determines eligibility for persons under three years old on the basis of medical documentation such as any child identified as having a genetic syndrome or medical condition commonly leading to mental retardation. An infant exhibiting developmental delays that commonly lead to mental retardation is also eligible for services on the basis of a comprehensive medical and social history, and in conjunction with a behavioral observation.

Over the past four fiscal years the DMR client population has grown by nearly 1,400 to a total of 10,140 clients as of June 1989. This represents a 16 percent increase and is shown graphically in Figure I-3.

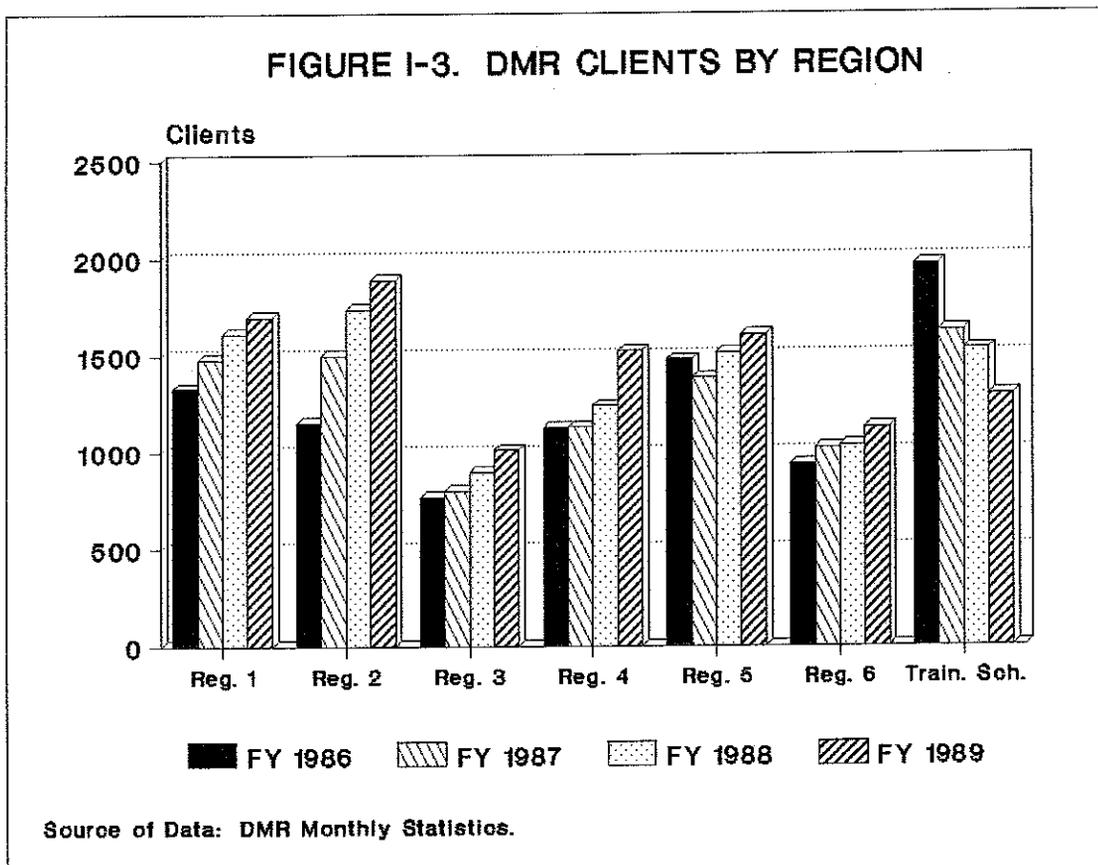
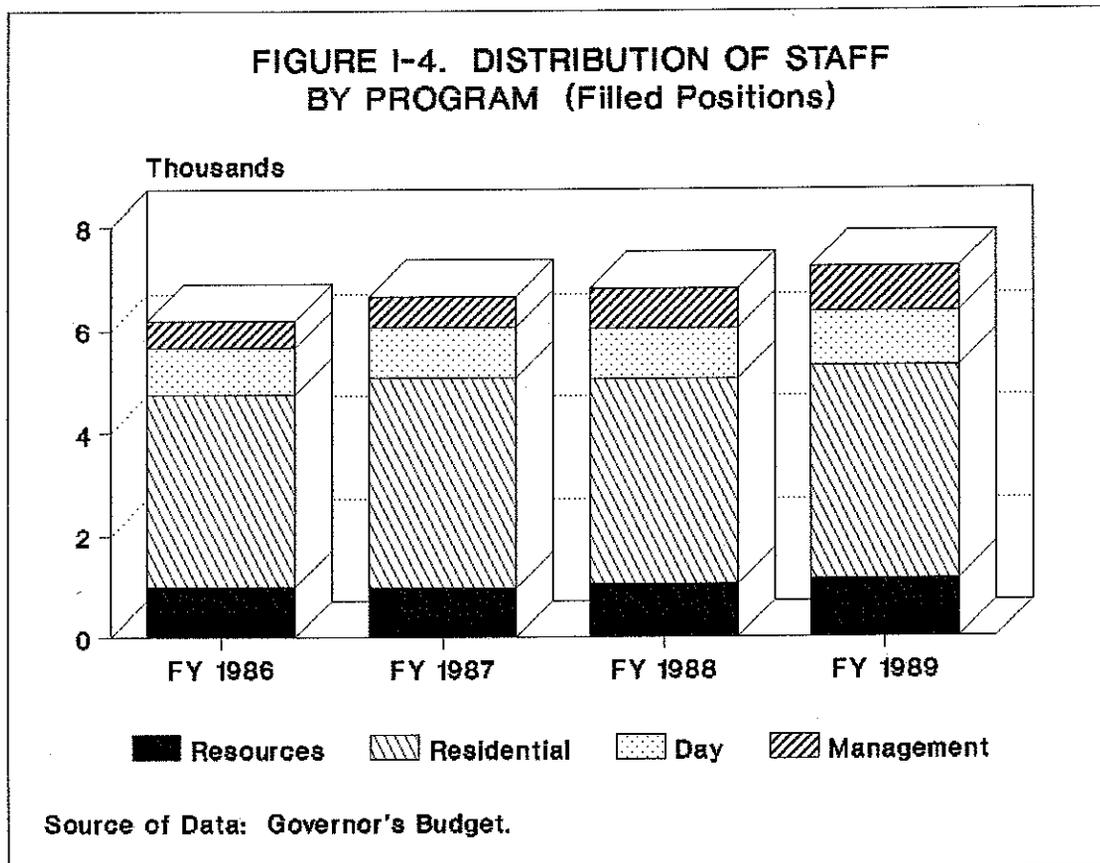


Figure I-3 illustrates the dramatic decline in the population of the state's training schools. During the period, population of these facilities was reduced by over 400 clients. Most of these individuals were relocated to community residences within the six regions. The region of relocation is generally the area in which the client resided prior to being housed in a state facility or the current location of his or her family.

Relocations from institutions account for only a portion of the client population growth in any one region. The largest contributor to growth has been new clients residing at home. This category accounted for roughly 1,100 of the 1,400 increase.

Staff Resources

Figure I-4 shows the distribution of DMR staff by program function. Between FY 86 and FY 89 total staff grew by 15.2 percent. The function having the largest percentage increase was management services, growing almost 50 percent during the period. Virtually all of this increase took place within regional offices.



Approximately 55 percent of DMR staff is allocated to residential services. Although the proportion of staff accounted for by residential services remained stable during the period, there was a significant shift in its location. In FY 86, 81 percent were assigned to large state-run facilities, but by FY 89, the figure was down to 72 percent.

Table I-1 shows the distribution of staff by geographic location. The numbers reflect permanent full time and part time positions that were filled as of June 30, 1989. Note that the two training schools account for nearly half (44.6 percent) of the department's total filled positions.

Table I-1. Distribution of DMR Filled Positions by Location
- June 30, 1989.

<u>Location</u>	<u>Permanent Full Time</u>	<u>Permanent Part Time</u>	<u>Total</u>
Region 1	502	152	654
Region 2	555	212	767
Region 3	388	133	521
Region 4	442	142	584
Region 5	473	181	654
Region 6	577	221	798
Mansfield	1,059	137	1,196
Southbury	1,889	225	2,114
Central Office	128	1	129
TOTAL	6,013	1,404	7,417

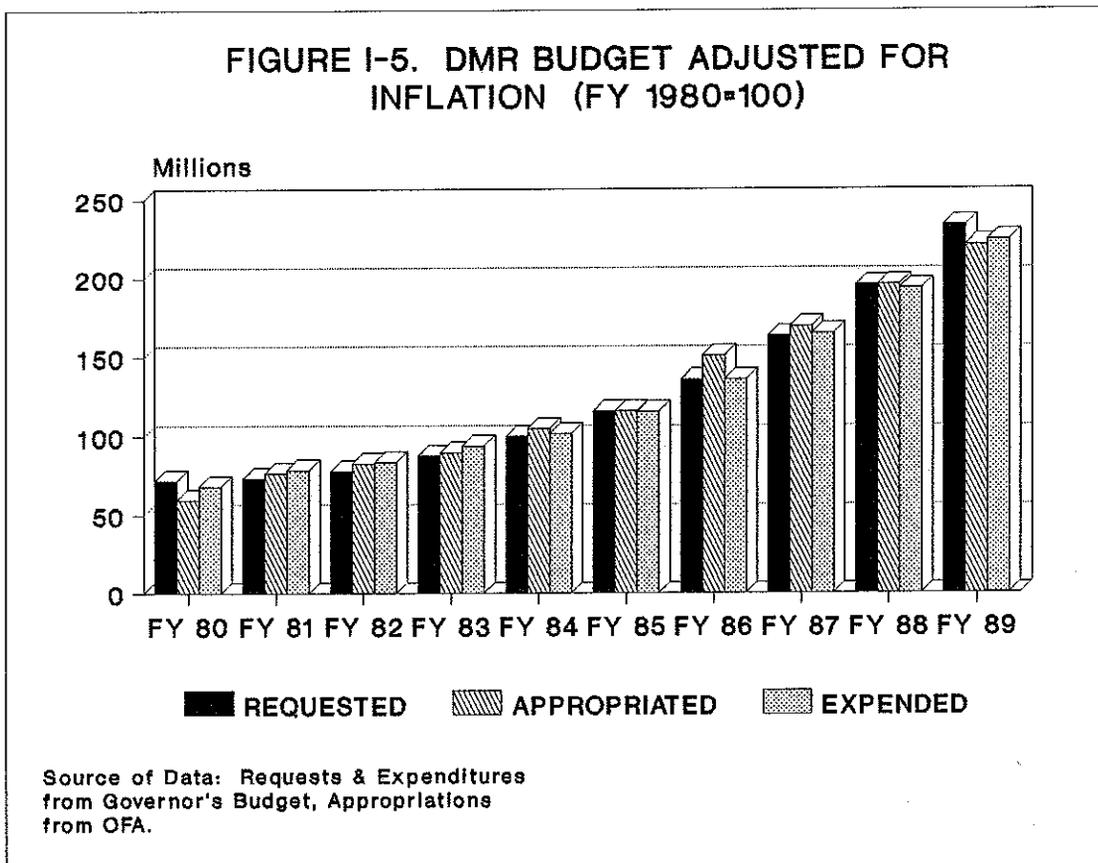
Source of Data: Department of Mental Retardation.

Financial Resources

During the past 10 years, the Department of Mental Retardation General Fund budget has increased from \$68.6 million to nearly \$356 million. Even after being adjusted for inflation, the budget has increased 328 percent. During the same period, the overall state budget adjusted for inflation grew 148 percent.

Figure I-5 presents inflation adjusted data on the amounts requested by the department, appropriated by the legislature, and actually expended since state fiscal year 1980.

In all but FY 80 and FY 89, the legislature has appropriated an amount equal to or greater than the dollars requested by DMR.



Funding within DMR is categorized in four major program areas. The total agency expenditures for each program for the past four fiscal years are included in Table I-2. Three of the program areas and the overall agency budget have nearly doubled, while the fourth area has increased 50 percent.

Funding from those program areas is disbursed to the six regions, two training schools, and the central office. The total expenditures for each location for the past four years are shown in Table I-3.

Table I-2. Total Department of Mental Retardation Expenditures by Program Area, State FY 86-89.

	FY 86	FY 87	FY 88	FY 89 (est.)
Day Management	42,319,368	56,745,781	71,486,443	84,392,077
Residential	18,090,153	23,402,153	32,281,091	35,077,362
Resource	105,819,522	132,139,943	160,201,844	204,416,780
	24,739,163	29,211,788	33,500,214	37,128,823
TOTAL	\$190,968,206	\$241,499,665	\$297,469,592	\$361,015,042

Source: Office of Fiscal Analysis Connecticut state budget books.

Table I-3. Department of Mental Retardation General Fund Expenditures, State FY 86 - FY 89 (in millions).

Location	FY 86	FY 87	FY 88	FY 89
Region 1	\$14.5	\$19.6	\$23.7	\$28.2
Region 2	13.5	19.2	24.7	27.8
Region 3	9.0	13.2	16.6	20.5
Region 4	10.9	15.3	19.9	23.1
Region 5	12.8	17.1	22.1	24.7
Region 6	15.2	19.0	24.0	27.5
Mansfield T. Sch.	35.8	36.5	36.5	37.0
Southbury T. Sch.	39.4	47.1	54.5	65.4
Central Office	35.2	48.7	70.0	97.0
TOTAL	\$186.3	\$235.7	\$292.0	\$351.2

Source: Department of Mental Retardation budget documents submitted to the Office of Policy and Management.

During the 4-year period, central office expenditures nearly tripled, while the regional budgets doubled. Expenditures for Southbury Training School have increased 166 percent, primarily due to staffing and other changes required by

the U.S.A. consent decree. Despite a significant decline in the resident population at Mansfield Training School, total expenditures there have remained relatively stable.

Since FY 86, DMR has lapsed \$35 million out of its \$1.1 billion General Fund allocations. However, the size of the lapses has consistently decreased over the period. The department has indicated that the largest lapse, \$20.8 million in FY 86, occurred when DMR first became responsible for developing group homes and overestimated its capability to do so. The FY 89 lapse was approximately \$1.8 million or .005 percent of the total budget. Table I-4 shows the amount of the lapses.

Table I-4. Department of Mental Retardation Budget Lapses, State FY 86 - FY 89.

Year	Budget	Lapse	Percent
FY 86	\$207,096,802	\$20,767,526	10.0%
FY 87	244,116,960	8,135,078	3.3%
FY 88	296,221,263	4,289,158	1.4%
FY 89	358,124,016	1,784,929	0.005%

Source: Department of Mental Retardation & State Comptroller.

SECTION II: DESCRIPTION OF SELECTED OPERATIONS

Budget Process

Annual request. Like all state agencies, DMR is required to submit its annual budget request to the Office of Policy and Management (OPM) in late summer. Options are due one month later. Instructional materials from the governor and OPM regarding development of the budget are sent to the commissioner of mental retardation in early summer; these are shared with regional and training school staff.

At that point, a current expenses budget must be developed showing the cost of ongoing expenses plus a percentage allowance for inflation. (The percentage is established by OPM for use by all state agencies.) Personal services data are based on a specific payroll from the month of June that is designated by OPM. Computer programs that automatically calculate the new cost have been provided by OPM for the FY 91 budget process.

In order for the DMR central office to receive the information it needs in time to prepare the consolidated agency document, the regions and training schools are required to complete their budget materials by early August. These data are then combined with the central office costs under four program categories -- day, management, residential, and resources -- for submission to OPM.

The process of compiling regional information, particularly for the options component of the budget, actually begins in the spring. Regional meetings are held to obtain input from parents, providers, and other interested parties about the programs and services that are needed. These ideas are considered in the context of the goals of the department as a whole, which are spelled out in the agency's five-year plan.

In at least some of the regions, the number of meetings and the detail of the discussion at them has declined in recent years. This was attributed by some of the regional directors to a desire to avoid building up expectations in the community at a time when state agencies are discouraged from submitting expansion options.

In the mid-1980s, when agencies were allowed to submit options requesting new funding, a multi-layered process involving citizen input and regional and central office staff was used by DMR to identify specific new programs and equipment for each region and school. The regions and schools would identify their particular needs and submit them to the

central office where staff would compare the requests for similarities. Cost estimates would then be developed, and further discussions were held between the directors, the deputy commissioners, and the commissioner. Top priorities for each region and school were then included in the options request.

During the past couple of years the submission of expansion options by state agencies has been limited by OPM to those presented in the form of a reallocation of resources. As a result, a less comprehensive process for identifying options has been used by the regions in recognition of the fact that few if any such options will be submitted by the department.

The current process relies more heavily on DMR staff comment than the community. Within the various regions and schools, the directors and their assistant directors discuss future needs as part of the planning process, and this information is provided to the central office. Annualized costs of expansions, such as new community beds, are prepared by central office staff. The final decision on the agency options, including the 10 percent reduction required of all agencies, is made at the central office by the commissioner and the two deputy commissioners.

Internal allocation. Once the legislature approves a state budget and the governor signs it, OPM informs individual agencies what their specific allocations will be. By law, overall state appropriations can be reduced 5 percent by the governor if a deficit is forecast for the upcoming year. If such a reduction is being made, OPM will deduct that from the allocation given to an agency.

Once OPM notifies DMR of its allocation, the total dollars must be distributed among the central office and the various regions and training schools. The actual share of many line items in the budget is not determined until after the final budget has been set.

To facilitate development of the internal allocation plan, DMR uses formulas based on factors such as the number of staff, the number of clients, and the square footage of physical space. Specific formulas used for the different accounts are based on experience, meetings with the assistant regional directors for the different program areas, and discussions among the regional and training school directors and the commissioner and his deputies. Contractual obligations and other mandatory expenses are also factored into the plan.

Before a final allocation plan is agreed upon, several drafts may be prepared. After the regions and schools have had a chance to see the impact on their own area, further

discussions will be held about which, if any, categories need to be refined and recalculated.

A final spending plan scheduling expenditures throughout the year by quarter for each location in the agency must be submitted to OPM before any money will be released to DMR. Following approval of this plan, quarterly allotments are made. The DMR central office must then produce an allotment schedule for the comptroller so the dollars will be posted to the appropriate central office, individual regional, and training school accounts.

Spending decisions. As mentioned previously, DMR relies on a decentralized structure of management for most decision making in the agency. In the area of budgeting, the central office closely controls disbursement of funding in certain accounts throughout the year, while the regional and training school directors have great flexibility in the administration of other accounts. In the latter case, the funds designated at the beginning of the fiscal year for the regions and schools become a guide for how money should be spent, but the directors have discretion to manage the money as they judge appropriate for their areas.

Table II-1 shows the DMR appropriation for state FY 90. Just over half of the \$381 million in the budget covers "Personal Services." Those dollars are used to pay for state employees and are allocated based on the assigned location of the employees. Management has no discretion to use this money for any other purpose.

Money in the "Other Expenses" line is allocated to the regions and training schools after a deduction is made for the central office and special new expenses. The remaining funds are distributed among major and minor subcategories based on each entity's projected share of those costs. Items such as travel, food, professional fees, utilities, and postage are included in this category.

The regional and training school directors have the greatest amount of spending discretion with respect to the "Other Expenses" category of the budget. They are allowed to redistribute the total money allotted to them by the central office for all subcategories as they deem appropriate during the course of the year.

The "Equipment" category is the smallest line item in DMR's budget. After deductions for items such as new telephones and computers and adaptive equipment for clients, the remaining funds are distributed to the regions and training schools. The allocation is based on the number of full-time equivalent staff.

Table II-1. State FY 90 Appropriation for the Department of Mental Retardation.

<u>Funding Category</u>	<u>Dollars Appropriated</u>	<u>Percent of General Fund</u>
Personal Services	\$194,203,495	51.7%
Other Expenses	29,150,015	7.8%
Equipment	715,368	0.2%
Other Current Expenses	6,922,935	1.8%
Grant Payments - Other Than Towns	<u>144,954,403</u>	38.6%
Total General Funds	\$375,946,216	
Federal Contributions	5,338,405	
Carry Forward	<u>50,000</u>	
AGENCY GRAND TOTAL	\$381,334,621	

Source: Office of Fiscal Analysis, The State Budget for the 1989-90 Fiscal Year.

Funds in the "Other Current Expenses" line are used for specific, targeted items that are short-term in nature, such as pilot programs or areas of concern to the legislature. Money in this category cannot be used for expenses outside of the specified purposes.

The "Grant Payments - Other than Towns" category contains funding for specified types of ongoing programs. Funding for all of the various DMR day and residential programs are contained in 14 designated accounts that comprise the Grants category. Among the individual accounts are: Community Sheltered Workshops, Community Residences, Community Training Homes, Private Residential Schools, Adult Programs, Respite Care, and Family Deinstitutionalization Support. Money cannot be transferred from one program account to another without approval by OPM and the Finance Advisory Committee. However, within DMR itself, money can be shifted from one region to another if it is for the same program purpose.

Within DMR, funds in the Grants category are controlled by the central office. Money is allocated to the regions to cover the cost of contracts for clients in existing programs. Additional funds to be used for new program services are apportioned based on the total number of clients living in the region.

The money for residential placements in each type of program setting is divided among the regions based on the average cost of such placements, the number of clients to be placed, and the length of time during the initial placement year. The actual cost of the placements can be higher or lower and cover different periods of time as long as the region stays within its overall funding allocation for that category and meets its minimum placement goal.

Oversight. The budgeting process at DMR is based on the philosophy that if the regions are given a fair share of the available resources allocated to the department, then it is the responsibility of the regional and training school managers to live within their allocation. However, the central office does recognize that unforeseen events during the year may result in the need for allocation realignments.

Each region and training school is assigned a liaison within the fiscal coordination unit at the DMR central office. These individuals are in frequent contact with region and training school fiscal staff to answer questions, review contracts and staffing requests, and monitor overall spending patterns. The regional and training school assistant directors for administration also meet on a regular basis with central office staff to discuss budgetary issues.

Regions and training schools must report their expenditures by categories on a monthly basis to the central office. This report is called the Comprehensive Financial Status Report (CFSR). The individual reports are consolidated with central office expenditure data into one report, the "LOFA Report," for submission to the legislature.

If a report from a region or training school projects a deficiency in any account based on the current spending pattern, the central office will ask the region to explain how they plan to finish the year within their original allocation. Alternatives for trimming costs will be discussed, and the situation will be monitored by the central office.

When an individual report contains an error or appears to be overly optimistic about the entity's ability to control costs for the remainder of the fiscal year, the central office liaison will ask that the numbers be corrected or that additional information will be provided. If the region or training school disagrees, the issue will be brought to the attention of the chief of the Division of Fiscal Administration. If the matter still cannot be resolved, the regional or training school director and the deputy commissioner for administration may become involved.

If a CFSR shows a region or training school is underspending in a particular category, an explanation will also be requested. If it appears that excess funds have been al-

located to that area, the money will be transferred from that region to one with greater needs in the same account category.

When a region or training school is making large changes within the major and minor categories of the "Other Expenses" account, they may be asked to submit a revised spending plan for that account to the central office. Often at midyear, each region and training school is asked by the central office to re-examine the "Other Expenses" account and update spending projections for the year.

Within the individual regions and training schools, in order to prepare the CFSR for central office, more detailed information is compiled for local use. Depending on the region, the information is shared with various managers to make them aware of the spending patterns within their areas of jurisdiction. These individuals are then responsible on the regional level for ensuring that overspending does not occur in a particular category. The degree to which accountability for subaccounts is dispersed within the individual regions or training schools varies around the state.

When the initial budget allocations are established, regions may also identify particular accounts they believe might develop problems because the dollars available are lower than projected need. These accounts are closely watched during the year to ensure that costs are kept in line with funding.

If a region or training school identifies allocation categories that need to be revised during the course of the year, they must inform the central office of the amount of the money they wish to transfer between accounts. If the central office is not already aware of the possible need for a transfer based on the information provided in the CFSR, then the region will be asked to explain the reason for the change. If the central office concurs with the need, an attempt will be made to transfer funds in the desired account category from another region. If this is not feasible, then the central office must prepare an FAC request.

Day-to-day fiscal activity affecting the operation of the central office itself is handled by staff in the Business Office Unit of the Division of Fiscal Administration. They process purchase orders and contracts as well as prepare the central office component of the budget.

Contracts. Regional staff are responsible for negotiating the costs to be included in contracts with private providers. One master contract covers the costs of all residential programs in the state operated by each provider. Day programs are contracted for utilizing master agreements covering all the programs a provider offers in a region.

The central office makes all payments for these contracts. Residential payments are based on one-twelfth of the total of all of the negotiated rates for the individuals served by a provider's master contract. When a new group home is opened, the provider is paid the first 30 days of program staff salaries up front; all other costs are paid retrospectively on a monthly basis. Payments for day programs are made prospectively on a quarterly basis.

Personal services agreements are monitored by the fiscal staff of the region or training school where the contract is issued. As part of the annual budget preparation process, ongoing contractual relationships involving client services are reviewed to determine how much of the previous year's estimated cost was actually incurred and what the future needs for the service are likely to be. At the time new or renewal contracts are entered into, central office staff review the terms and price, and the commissioner or deputy commissioner for administration must sign the contract.

Policy Development

In 1988, the Department of Mental Retardation released its first five-year plan. The document spelled out the broad mission, operating principles, and goals of the department. Within four major service areas (administrative, day, residential, and resource services), detailed goals and objectives were specified. In odd numbered years, the plan is updated; in even years, a new plan is produced.

The content of the agency's plan discusses information from the six regions and two training schools. In the spring, meetings and forums with various individuals and groups interested in the mentally retarded are held in each of the regions to solicit comments on the goals and priorities for the future. In the fall, another round of meetings is held to discuss the budget allocation process and its effect on the department's ability to meet the goals identified in the plan.

The five-year plan serves to focus the department on the future. Likewise, the DMR mission statement, provides guidance on the direction DMR is heading.

The major policies defining the overall direction and strategies the Department of Mental Retardation will pursue to attain the goals set forth in the plan and the mission statement are formulated at the top of the organization. They are primarily established by the commissioner and the two deputy commissioners.

The ideas for the policies come to them from a variety of sources, including national events, DMR staff, pressure by

the court monitors, and conflicts between the basic philosophy of the commissioners and the current operation of the department.

Initially, the commissioner and one or both deputies will discuss an idea among themselves. Depending on the nature of the idea, the commissioner may also discuss it with other selected DMR staff and persons outside the department. If the idea survives, at some point it is turned over to the DMR planning unit to explore further and provide appropriate statistics and documentation.

Once that information is compiled, the commissioners will review it. If they approve the formalized concept, the next step involves DMR staff from the program development area who prepare an implementation plan. As part of that process, they further refine the concept using work groups of agency staff and outside individuals, the number and make-up of which depend on the topic. Finally, a detailed implementation plan is developed and set in motion.

Residential Services

The Department of Mental Retardation provides a variety of residential services for approximately 6,000 individuals. This represents about 60 percent of the department's clients.

The residences encompass a multiple of settings including: campus units consisting of Mansfield and Southbury Training Schools and the regional centers; community living arrangements (CLA) such as group homes and supervised apartments; community training homes (CTH), which are a variation of a foster care system; and other private treatment facilities such as nursing homes for the elderly and residential schools and nurseries for infants, children, and young adults who have serious or chronic medical conditions requiring 24-hour care.

Table II-2 shows the distribution of clients by type of residential program. The shift away from large state-run facilities toward community residencies is clearly apparent. During the four-year period covered by Table II-2, the campus population decreased by nearly 600, while community placements, as measured by the CLA and CTH population, increased by close to 1,000. The increase above the number accounted for by relocations from state-run facilities can be attributed to direct placements from family homes.

The budget process sets the direction the department wishes to proceed in residential programming and the residential models it wants to support. In making these determinations, advice is sought from regional directors and resi-

dential staff. However, the final decision with regard to the department's position is made at the commissioner level.

Table II-2. DMR Clients by Type of Residential Program (FY 86-FY 89).

FY	Campus	CLA	CTH	Priv.Treat. Facility	Ind. Living	Family Home	Other	Total
1986	2,391	1,687	500	796	207	3,004	158	8,743
1987	2,258	1,885	500	739	274	3,115	166	8,927
1988	2,094	2,232	476	691	291	3,607	159	9,550
1989	1,812	2,675	469	647	260	4,105	172	10,140

Source of Data: DMR Monthly Statistics.

At the end of the budget process the availability of funds for the various residential models is specified through a system of accounts. These accounts are the means by which desired models are advanced and undesired ones discouraged.

Implementation of the department's residential program is the responsibility of the regional offices. While a standard method for developing a residence is not required by the department, there are only minor differences in the strategies followed by the regions in establishing residences and making client placements.

Residential development. Figure II-1 outlines the basic approach followed in developing CLAs, which represent the largest category of community placements. Community living arrangements include homes, apartments, and condominiums, and generally serve two to six clients.

Like the CLA model, the strategy used for developing community training homes does not differ substantially among the regions. Essentially, the approach consists of a recruitment phase in which efforts are made through the media, public speaking engagements, and individual contacts, to interest persons in using their own homes to provide a family setting for up to three department clients. Those expressing an interest are provided additional information about the program.

The next phase in the CTH development process is reserved for those submitting a formal application. Applicants must provide letters of reference, a certificate of good health from a physician, and undergo a police background

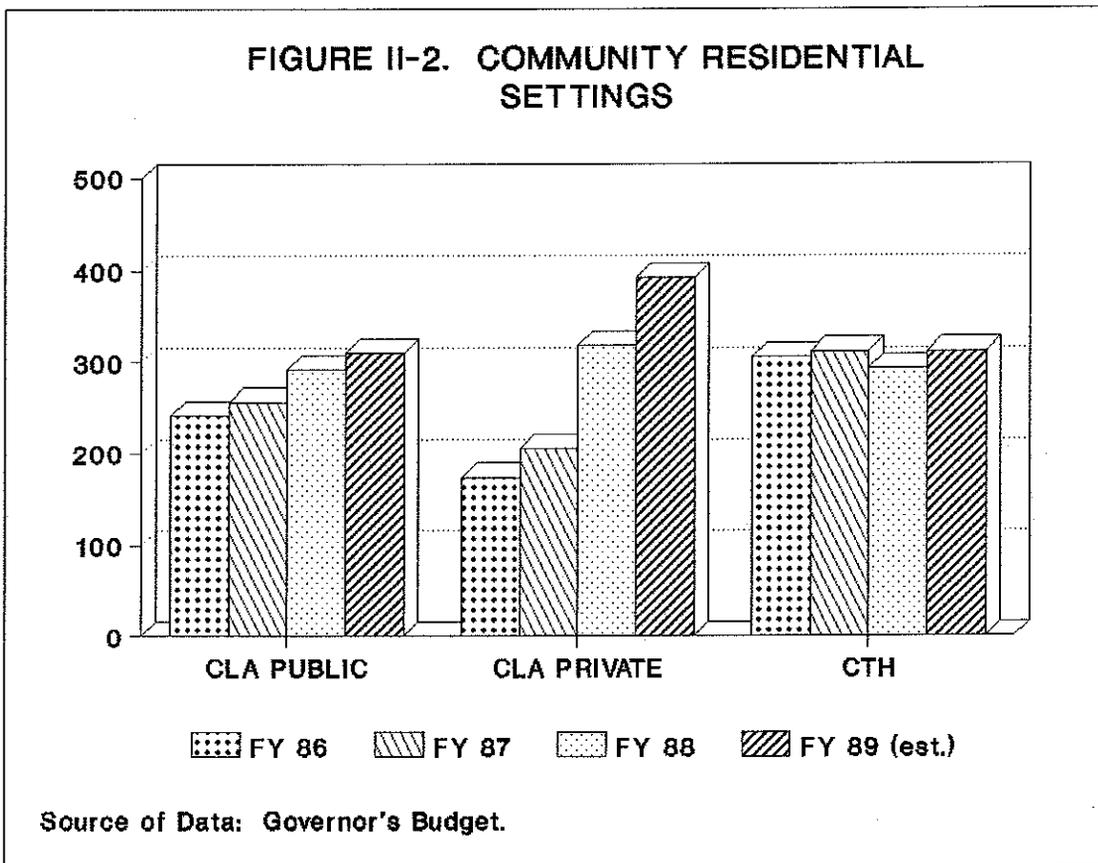
Figure II-1. Community Living Arrangement Development Process.

- Step 1. Notice of Availability of Funds
 - A. DMR central office informs regions regarding resource allocations and target priorities
 - B. Region meets with all interested parties
 - Step 2. Interested Providers Submit Letter of Intent
 - A. Provider agency describes what it intends to do
 - B. Provider describes history of organization, other programs it may operate, financial records
 - Step 3. Region Meets Provider to Review Letter of Intent
 - Step 4. Region Selects Providers
 - A. Letter of Agreement is sent to provider
 - B. Type of program to be developed is specified (e.g., number of beds, level of care, etc.)
 - C. Names of residents are assigned to provider
 - Step 5. Provider Develops Residential Services Plan
 - A. Provider meets prospective residents, DMR staff
 - B. Budget, staffing pattern, and support services are specified
 - Step 6. Region Reviews Residential Services Plan (RSP)
 - A. RSP is finalized, including the budget
 - B. Letter of Commitment is sent to provider
 - Step 7. Property Development Phase
 - A. Provider finds suitable property
 - B. Region approves site and cost estimates
 - C. Property renovations begin
 - 1. Certificate of occupancy (town)
 - 2. Sanitation report (town)
 - 3. Fire Marshal approval (town)
 - Step 8. Provider Hires and Trains Staff
 - Step 9. Licensing Inspection (DMR Central Office)
-

check. Applicants are interviewed by regional office staff, and their homes are given a health and safety inspection. If no problems are identified, an applicant is issued a license.

In developing new community residences, DMR has favored CLAs over CTHs. This is apparent in Figure II-2, which shows that the number of CLAs has steadily increased over time, while the number of CTHs has remained fairly constant.

As a group, CLAs are considerably more expensive than CTHs. Based on the data available to the program review committee the average CLA rate in FY 89 was calculated to be \$158 per day, per resident. DMR estimated the average cost per client residing in a CTH to be \$39 per day.



The CLA rate noted above includes both the room and board component, which is paid by the Department of Income Maintenance (DIM) and the service part paid by DMR. Table II-3 shows the average amount paid by each agency statewide and by region.

Statewide, DMR's daily rate averages \$121.39 and ranges from \$0.20 to \$659.63. Region 4 has the highest at \$150.58 and region 5 the lowest at \$102.44. On an annualized basis, the difference between the two regions amounts to \$17,571 per client. DIM's statewide average is \$36.55, and ranges from a low of \$32.99 in region 2 to a high of \$42.29 in region 3.

Projections based on these rates indicate that on a daily basis DMR spends approximately \$217,540 and DIM \$53,973 to house clients in privately operated CLA's.

Table II-3. Average Rate Per Resident in a Privately Operated CLA.

<u>Region</u>	<u>Funded Beds</u>	<u>DIM's Avg. Daily Rate</u>	<u>DMR's Avg. Daily Rate</u>
1	360	\$37.35	\$135.45
2	334	32.99	111.82
3	220	42.29	149.09
4	275	39.69	150.58
5	470	34.77	102.44
6	193	34.82	132.04
Statewide	1,792	\$36.55	\$121.39

Source of Data: DMR's June 1989 CLA Expense Reports.

A major component of the room and board rate is the cost of purchasing and renovating property. Data on these two costs were obtained from the Corporation for Independent Living (CIL). The corporation is a private nonprofit organization that has financed the purchase and renovation of over half the CLA's supported by DMR.

CIL uses proceeds from tax exempt bonds it markets through the Connecticut Development Authority, to purchase and renovate residential property. Once the property is ready for occupancy, it is leased to a private nonprofit organization that has received approval from DMR to operate a residence.

The operating agency's lease agreement with CIL entitles the agency to obtain ownership of the property at the completion of the lease. Money to meet the agency's financial obligations to CIL is included in the daily rate paid by DIM.

Since 1983, the Corporation for Independent Living has financed the acquisition and renovation of 228 properties at a cost of approximately \$70,000,000. Included in the total is \$35,000,000 to purchase property, \$25,000,000 to renovate it, and \$5,000,000 in fees and expenses.

Renovation costs tend to be high relative to the purchase price because it is CIL's policy to make virtually all its homes accessible to handicapped people. This frequently means that extensive changes must be made to such things as stairs, doors, cabinets, and plumbing. Also, if people incapable of self-preservation are to live in the house, it must meet life-safety code requirements.

Table II-4 shows the average cost per CLA financed by the Corporation for Independent Living. The relative low costs in region 5 are in part a reflection of the fact that over half the purchases in region 5 occurred prior to January 1987. The same could explain the relative high costs reported for region 6, where all CIL financed residences were purchased after January 1987.

Table II-4. Property Acquisition Costs.

Region	Avg. cost Purchase	Avg. cost Rehabilitation	Total	N= Properties pre / post 1987
1	\$189,663	\$117,505	\$330,335	21 / 25
2	157,296	125,019	307,747	18 / 30
3	158,376	124,173	304,138	9 / 28
4	213,050	93,398	328,388	18 / 16
5	149,973	81,268	249,575	29 / 24
6	192,526	149,398	367,520	0 / 10
Statewide	\$172,159	\$109,549	\$303,896	95 / 133

Source of Data: Corporation For Independent Living.

Residential Placement. In each region, some form of a team is used to make individual placement decisions. The team generally consists of key members of each of the disciplines included in the region's organizational structure. Although the team makes the final placement decision, it does so in consultation with the client, the client's family or guardian, DMR staff responsible for the client, the provider of the residence, and, if appropriate, the court monitors.

Potential placements are identified through a variety of means. First and foremost are class members. Annually, the central office assigns each region a quota of class members that it is expected to place in the community during the year. In addition to class members, regions maintain a list of clients who have been identified as needing a placement at some point. The method used to prioritize nonclass members varies, but is generally centered around the regional staff's judgement as to how well those responsible for the client can cope financially, emotionally, and physically with continuing to care for the person.

Nonemergency placements are made on the basis of the team's determination as to the client that could most benefit from the specific residence that is available or is to be developed. Priority is given to class members. New residences are usually developed around a specific person with other clients selected based on their perceived compatibility.

Figure II-3 shows the proportional distribution of DMR clients by residential program for each of the regions at the end of FY 89. Clearly, the regions vary widely in terms of where their clients reside. Most notable is region 3, which has the highest proportion of its clients in DMR supported community residences and the lowest residing at home, and region 4, with the exact opposite.

In FY 89, 911 DMR clients were moved from one residential setting to another. This was an increase of nearly 200 over the previous year's total. However, an examination of the data contained in Table II-5 and Table II-6 reveals that most client movement occurs between CLAs; that is, transfers from one CLA to another. In FY 89, such actions accounted for nearly 30 percent of all client moves and in FY 88, 27 percent of the moves were of this type. The two most commonly cited reasons for such moves are incompatibility among clients, and the need of an individual client for increased or decreased supervision.

As Tables II-5 and II-6 indicate, the largest source of community placements, defined here as placements in CLAs and CTHs, are from Mansfield Training School (MTS), Southbury Training School (STS), and regional centers (RC). Combined, they accounted for 298 such placements in FY 89. These facilities were the source of 202 CLA and CTH placements in FY 88.

Despite the volume of community placements generated by the state-run facilities, a significant number still came directly from family homes. In FY 89, CLA and CTH placements from family homes totalled 91; in FY 88 the number was 101.

If the effects of intra CLA and CTH transfers are removed, clients from family homes accounted for 18.8 percent

of all new community placements in FY 89, while those from institutions accounted for 61.6 percent. In FY 88, the proportions were 25.5 and 51.8 percent respectively.

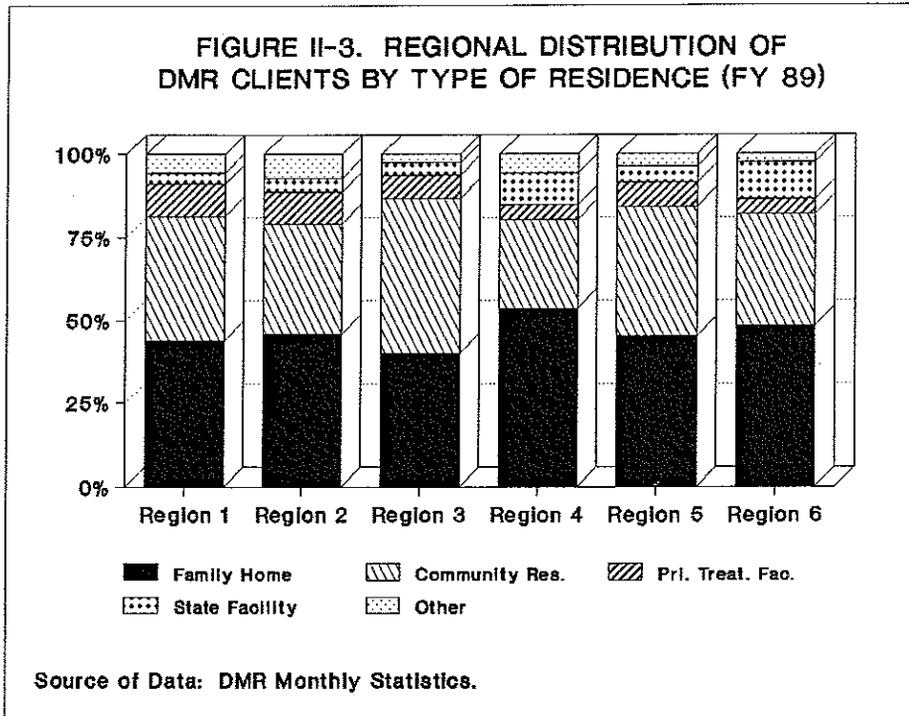


Table II-5. Client Placements by Source (FY 89).

Source	CLA	CTH	RC	LTC*	Other	Total
CLA	268	9	6	3	18	304
CTH	14	32	4	1	2	53
HOME	73	18	15	1	4	111
LTC*	44	0	2	10	1	57
MPS	166	3	0	0	1	170
SPS	30	4	1	0	0	35
RC	89	6	28	1	0	124
OTHER	41	10	2	0	4	57
Total	725	82	58	16	30	911

*LTC= Long-Term Care Facility

Source of Data: Department of Mental Retardation.

Table II-6. Client Placements by Source (FY 88).

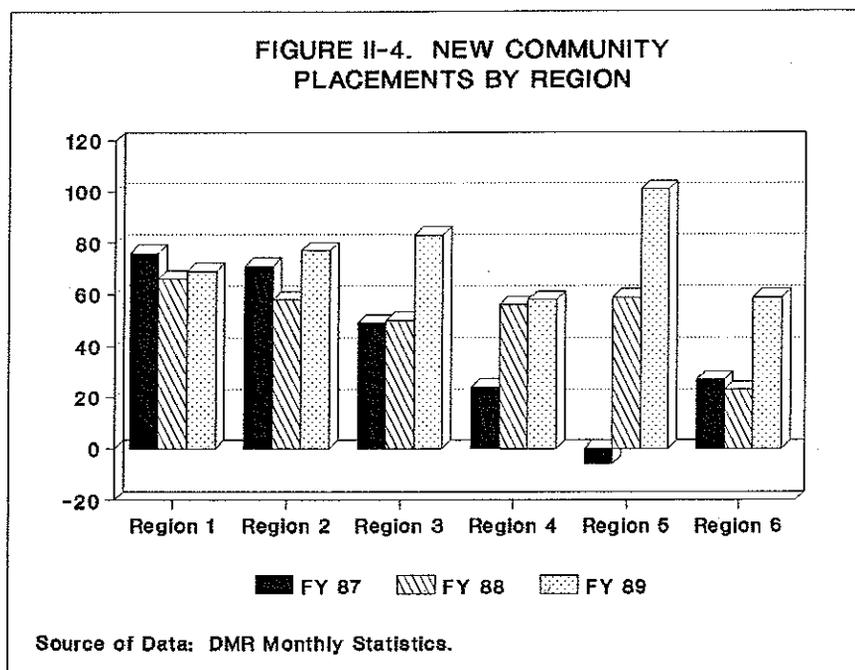
Source	CLA	CTH	RC	LTC*	OTHER	TOTAL
CLA	194	5	3	6	7	215
CTH	24	30	5	0	7	66
HOME	80	21	11	0	6	118
LTC*	37	2	1	9	1	50
MTS	83	0	0	0	0	83
STS	32	1	2	0	0	35
RC	82	4	3	1	2	92
OTHER	<u>49</u>	<u>1</u>	<u>3</u>	<u>0</u>	<u>0</u>	<u>53</u>
Total	581	64	28	16	23	712

*LTC=Long-Term Care Facility

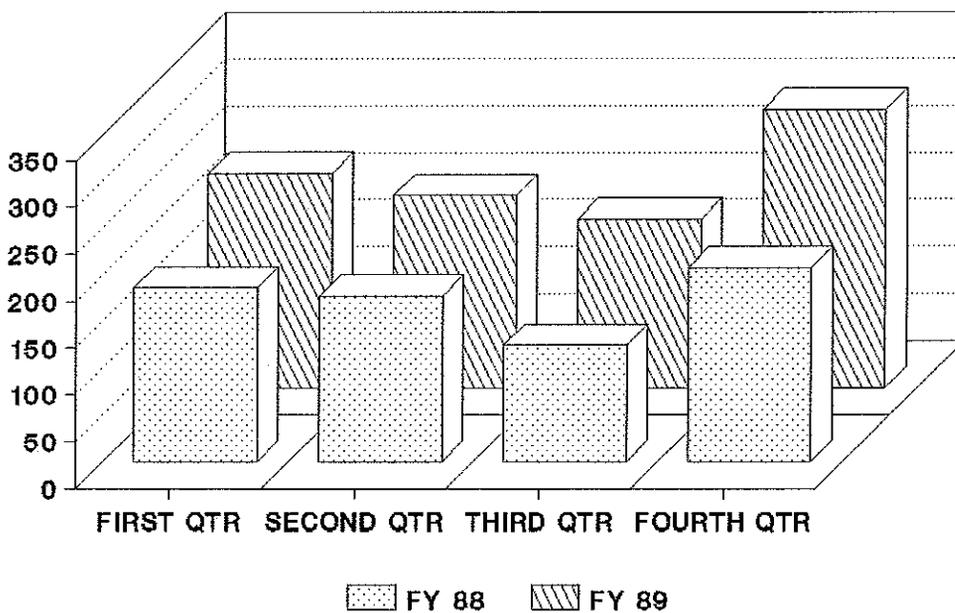
Source of Data: Department of Mental Retardation.

Figure II-4 shows the increase in the number of community placements by region in each of the last three fiscal years. The absence of a pattern among regions is apparent, as is the volatility in region 5.

Figure II-5 shows that in terms of time, placements are concentrated in the last quarter of the state fiscal year. They appear to be very cyclical in nature, falling from the first to the third quarter then rising sharply in the last quarter.



**FIGURE II-5. PLACEMENTS BY TIME OF YEAR
(FY 88 and FY 89)**



Source of Data: DMR Monthly Statistics.

Day Programs

The Department of Mental Retardation provides vocational and nonvocational day services to approximately 6,500 individuals with mental retardation. Over 70 percent of them are placed in privately operated programs in the community. The remaining number attend DMR operated programs on the grounds of state-run facilities.

The department provides or purchases services in two major categories: Unified School District #3 (USD #3) and adult services.

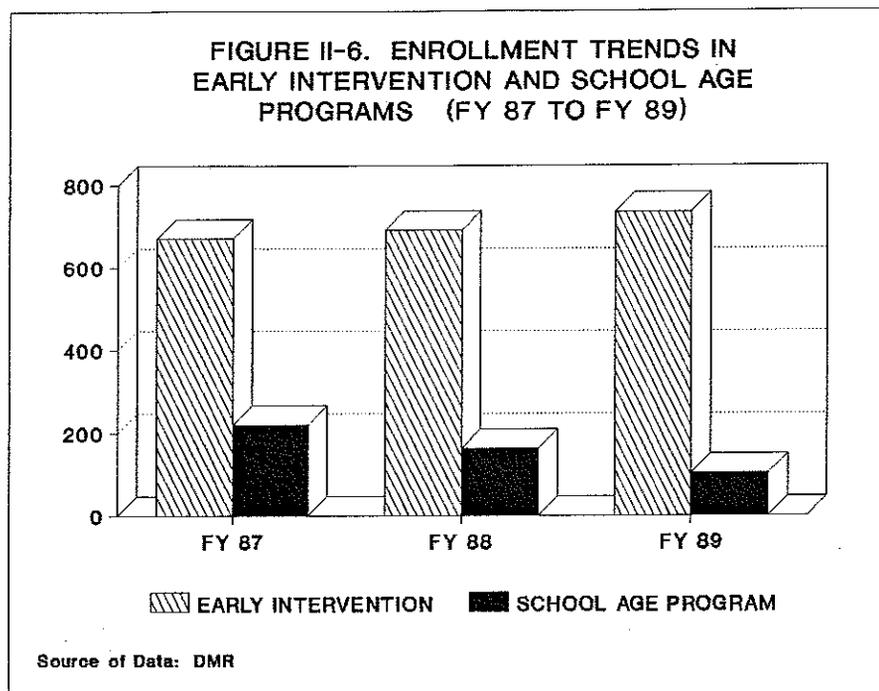
Unified School District #3. USD #3 includes an early intervention program for developmentally delayed infants age birth to 3 years old and an educational program for school age clients (3 to 21 years old) living in DMR facilities.

Early intervention. The early intervention program provides educational services to infants up to three years old who have genetic or medical conditions commonly associated with mental retardation or who manifest cognitive learning delays that could impede intellectual development. Regional

special education staff train parents at home and teachers in day care centers and nursery schools to develop the child's basic physical, language, and social skills. The department pays pre-school tuition and, when necessary, assigns medical support staff to work at the child's home or learning center.

The School age program. Unified School District #3 was established within DMR by statute in 1978 to provide classroom instruction on a 12 month basis to severely or profoundly retarded children requiring functional education. The curriculum is supported by speech therapy, physical and occupational therapy, behavior management services, and nursing services. Children residing in DMR facilities are those educated in the district.

Figure II-6 compares the number of clients in the early intervention and school age programs over the last three years. The data show an expansion of the early intervention program and a decrease in the school age program. During this period, the number of infants receiving intervention services at home, day care centers, or nursery schools rose by 65, while the number of school age children educated in DMR facilities dropped by 116. These opposite movements are both results of the department's shift from institutional based learning to special education in public schools. Also, the early intervention program has allowed developmentally delayed infants to enter their local public school systems, which, under federal law, are responsible for educating disabled children three years of age and older.



Adult Services. Services for adult clients consist of vocational and nonvocational programs. The vocational category includes sheltered workshops and four different supported employment models. Under the nonvocational category are adult day treatment, community experience, and opportunities for older adults programs.

Sheltered workshops. Sheltered workshops are large work forces of DMR clients who work in a fixed segregated location, performing tasks like assembly, labeling, or sorting. This is the oldest vocational program model still being funded.

Supported employment. The supported employment program enables mentally retarded individuals to enter the regular business or industry work force. Clients are assigned job coaches who develop the job opportunity, place and train clients, assist and supervise them, and provide necessary ongoing support.

The department recognizes four models of supported employment, which differ according to the number of clients working together, the degree of support given, and the level of integration with nondisabled co-workers. The four models are:

Individual Placement Model - places individual clients in their own jobs with the support of a continuously available coach who trains them and provides, as long as necessary, work supervision. Clients in this model work at a variety of locations, including department stores, supermarkets, and manufacturing companies.

Enclave Model - places small groups of clients in integrated work settings where they receive support and supervision from a job coach. The clients in this model generally require more continuous supervision than those in individual placement. Enclaves are typically situated in small business settings like car washes and bakeries.

Mobile Work Crew Model - allows a small group of clients to work in the community, providing services like building and grounds maintenance, housekeeping, and janitorial work to businesses or organizations that contract with the department or provider agency for the services.

Small Enterprise Model - places a small number of clients, generally those with severe disabilities, in a small business operated by a

provider agency. The company pays the workers' wages and provides full-time supervisory staff.

Adult day treatment. Adult day treatment provides medical support services and special education in a segregated setting to profoundly retarded or medically complex individuals. The department is trying to change existing models to ones encouraging more integration into community life.

Community experience. An outgrowth of adult day treatment, became a recognized program in FY 88. This program emphasizes community participation and personal development for severely disabled individuals. Clients, under the supervision of program staff, learn basic social, educational, and physical skills at the program site and visit the community. Many participants require significant medical or psychological support services including physical and occupational therapists, behavioral problem specialists, and special education staff.

Opportunities for older adults. This program, operated much like a typical community senior citizen center, allows mentally retarded adults 55 years old or over who choose to retire from work the opportunity to develop relationships in the community and pursue educational and recreational interests. These programs are typically located at recreational centers, community senior citizen centers, and volunteer work sites.

Day Program Development. Figure II-7 shows the basic steps regions take in developing adult day programs with private providers. This process is closely aligned with residential development so that clients can begin day programs as soon as they move to a new home.

The strategy DMR uses to develop private day programs is similar throughout the regions. The central office begins the process by notifying regions and providers of available day development funds. Attached to this notice is an outline of the contract process and a schedule of informational sessions with regional directors. Prospective providers attend these meetings and if interested submit a formal application. The department requires providers to submit certain information such as letters of reference, a table of organization and by-laws, and other information they consider necessary to process the application. Regional staff meet with providers, select one, and assist the chosen provider in completing a detailed day service proposal. Contracts are then negotiated, signed, and sent to central office for final approval.

Figure II-7. Private Adult Day Program Development Process.

Step 1. Notice of Availability of Funds (NOA)

- A. DMR central office informs regions and providers regarding resource allocations and target priorities
- B. Region formally notifies interested providers
- C. Region holds meetings with interested providers

Step 2. Interested Providers Submit Letter of Intent

- A. Provider agency describes types of programs it can operate
- B. Provider describes history of organization, other programs it may operate, and financial records

Step 3. Region Meets Provider to Review Letter of Intent

Step 4. Region Selects Providers

- A. Letter of Agreement is sent to provider
- B. Type of program to be developed is specified
- C. Individuals receiving service are identified

Step 5. Provider Develops Day Program Proposal

- A. Provider meets prospective clients
- B. Client-specific budget, staffing pattern, and support services plan is completed

Step 6. Region Reviews Day Program Proposal

- A. Proposal's programmatic and fiscal accuracy are verified
- B. Negotiations are finalized
- C. Contract is signed by all parties.
- D. Funding begins

Step 7. Provider Hires and Trains Staff

- A. Region provides technical assistance staff if necessary
 - B. Client begins program
 - C. Soon after provider launches program, regional staff begin quarterly reviews of provider's compliance with contract guidelines.
-

Day Program Placement. Other than giving regions a list of class members who will be placed in the regions and require a day program, the central office does not play a direct role in the placement process. Each region's day program director develops a process that reflects management style and specific regional needs. In spite of this decentralized approach, all regions follow three basic steps.

The three fundamental stages of the placement process consist of the client's case manager filing an official day services referral, a day program placement team selecting an appropriate program and identifying potential providers, and an interdisciplinary team (IDT) ensuring clients make an easy transition to their new day activity.

Every request for a day program originates in the case management unit. The case manager submits a referral containing pertinent psychological, physical, and historical information about the client to the day services director. It is the case manager's responsibility to serve as a liaison between all of the groups involved in the process, including the client and his or her family, day program staff, the IDT, and the provider.

Each region has a day placement team consisting of the assistant regional director of day services and his or her staff. This group meets to discuss which clients needing day programs will receive them. When the team decides to place a client, it notifies the case manager of prospective programs. The case manager visits the programs, usually with the client, meets the program's personnel, and recommends the program which seems to best serve the client's needs.

Of the factors that day staff use to place clients, residential placement most directly guides the decision. When the residential division receives its list of required placements, it is the day staff's responsibility to develop appropriate programs for those individuals moving to the community. Priority placements not involving class members are also generally accommodated by the team. These include new residential placements resulting from the death or serious illness of a client's primary caretaker, or a severe mental stress on a client that necessitates a residential and day program change. After these special cases, school graduates are generally the next priority.

Table II-7 shows the total number of clients in all adult day programs for the last three fiscal years. Clearly illustrated is the department's shift toward privately provided programs. In this period, the number of clients in private day programs increased by 684, while the size of DMR operated on-campus programs decreased by 368 clients.

Table II-7. Number of Clients in Private Adult Programs
(FY 87-89).

	<u>FY 87</u>	<u>FY 88</u>	<u>FY 89</u>	<u>Net Change</u>
Privately Provided	4,337	4,724	5,021	+684
DMR Operated	<u>1,831</u>	<u>1,631</u>	<u>1,463</u>	<u>-368</u>
Total	6,168	6,355	6,484	+316

Source: Department of Mental Retardation.

Table II-8 shows the number of clients in the different types of privately provided program models and the net change for the same period. The significant growth of the community experience and supported employment models underscores the department's transition from segregated to community based vocational and nonvocational programs.

Table II-8. Number of Clients in Private Programs by Type of Program.

<u>Program Model</u>	<u>FY 87</u>	<u>FY 88</u>	<u>FY 89</u>	<u>Net Change</u>
Shelt. Workshop	2,637	2,615	2,613	-24
Supp. Employment	958	1,156	1,283	+325
Adult Day	455	378	299	-156
Community Exper.	0	288	456	+456
Opp. Older Adults	<u>287</u>	<u>287</u>	<u>370</u>	<u>+83</u>
Total	4,337	4,724	5,021	+684

Source: Department of Mental Retardation.

Table II-9 shows each region's total private adult day service budget and the average cost per client for FY 89. The data indicate that the funds appropriated to the regions for day services vary widely. Region 1, with the largest private adult day program budget, spends nearly \$2.5 million more than region 6, although their per client costs differ little. On the other hand, region 4, with the highest per client expense allocates over \$2,500 more per client than

region 3, with the lowest per client expense. These cost variations may reflect significant differences in how regions allocate day resources or may suggest that the cost of purchasing day services from private providers largely depends upon the economic forces of the geographic area.

Sheltered workshops, unlike all other day programs, are paid through DMR's central office under a cost reimbursement system. Consequently, regional cost data on this program is not shown in Table II-9.

Table II-9. Total and Average Cost of Adult Day Programs by Region FY 89.

<u>Region</u>	<u>Average Cost Per Client</u>	<u>Total Cost</u>
1	\$11,303	\$6,521,856
2	11,531	4,672,344
3	10,574	3,701,743
4	13,103	5,069,475
5	12,185	5,167,535
6	10,865	4,065,712
Statewide	\$11,593	\$29,198,665

Source: Department of Mental Retardation.

Table II-10 shows the lowest and highest cost per client paid by DMR in FY 89 for each type of program, also included is the average cost per program statewide. The data show broad variation in the amount the department spends per client on each program model. Most notably, is a more than \$45,000 difference between the least expensive and most expensive individual adult day treatment program in the state.

Table II-10. Range and Average Per Client Cost Statewide, FY 89.

<u>Program</u>	<u>Lowest Per Client Cost</u>	<u>Highest Per Client Cost</u>	<u>Average Cost</u>
Adult Day Treat.	\$9,286	\$54,761	\$18,620
Community Exper.	10,716	31,103	16,818
Opp. Older Adult	3,657	12,125	8,535
Supp. Employment	4,710	20,554	10,698

Source: Department of Mental Retardation.

Respite Care Program

The Department of Mental Retardation defines respite care as temporary care of a person with mental retardation for the purpose of offering relief to the family or community training home provider. It is a service that allows for time to re-energize, deal with emergency situations or engage in personal, social, or routine activities and tasks that otherwise might be neglected, postponed, or curtailed due to the demands of caring for a person who has mental retardation.

Respite care is provided in a variety of settings, including a family's own home, group homes, community living arrangements, day care centers, camps, recreational facilities, and institutional settings. To be eligible for respite funds, one must be either a natural or adoptive family having a son or daughter who is a client of the department, or licensed by the department under its community training home program.

Respite care is not an entitlement program. The amount of respite funds available to families is based on individual family needs. These include the severity of the retardation, family stresses, composition of the family, and extra care needed (for example, medical care).

Two methods are used to fund respite care. The most visible is a line item in DMR's budget. Details of this funding is shown in Table II-11. Of note, is the fact that from FY 86 to FY 88 the appropriated amount significantly exceeded what the department requested and expended.

A second means of supporting respite care is through the operating budgets of state institutions and public and private group homes that provide beds for out of home respite placement. This type of support is difficult to identify because it is contained within each facility's accounts.

Early in the program (FY 86), DMR was responsible for recruiting care providers for families and community training homes. This proved to be difficult. Consequently, services were not well provided and monies were not fully utilized. When the guidelines changed and allowed families to arrange for their own respite providers, it became easier to find providers. As a result, more families requested respite care, and budgeted monies were utilized and extended to many more families.

Table II-11. DMR Respite Care Program Financial Data.

<u>Fiscal Year</u>	<u>Requested</u>	<u>Appropriated</u>	<u>Expended</u>
1986	0	\$300,000	\$141,003
1987	315,900	413,200	331,472
1988	433,000	836,228	796,560
1989*	1,304,350	685,757**	630,260
1990	725,851	805,276	N/A

* In FY 89, funding for respite was changed from a pilot program to a permanent funded program. In addition to the appropriated figure shown, \$407,148 was transferred to the CTH account for inclusion within the rate payments.

** In response to a request to reduce the overall DMR budget by 3% the department revised the respite allocation downward by 7.3% leaving \$635,757 available to be expended.

Source of Data: State comptroller's annual reports and governor's budget books.

The program is administered at the regional level. Each region is allocated a portion of the funds appropriated to the department. The allocation is based on a formula that takes into consideration the number of family and community training homes in the region. The amounts received and expended by each region for FY 88 and FY 89 are outlined in Table II-12.

Table II-12. DMR Respite Care Program Financial Data by Region.

Region	FY 88		FY 89	
	Allocated	Expended	Allocated	Expended
1	\$203,317	\$202,235	\$139,957	\$139,957
2	133,979	133,549	116,975	116,975
3	111,535	111,524	78,745	78,745
4	100,711	69,723	90,535	90,535
5	167,721	166,055	120,700	115,203
6	116,058	113,445	88,845	88,845

Source of Data: Department of Mental Retardation.

Each region has at least one respite coordinator to administer the program. When a family or a community training home requests respite care, an evaluation takes place. In some regions, need is evaluated by a case manager and reviewed with the respite coordinator. In other regions, an interdisciplinary team approach is used to evaluate need. A point system is used by some regions to evaluate needs.

At the present time, regions make contractual agreements with families for respite funding. Needs are evaluated, using the process previously described, and monies are agreed upon. The DMR guidelines state that families arranging for their own respite must take full responsibility for the safety of the arrangements.

Families pay for respite directly. Standardized DMR forms are subsequently sent to the respite coordinator in the region, indicating the amount of time and type of care received. The forms are signed by the provider and the family. The family is then reimbursed.

The regions utilize a logging and tracking system to monitor use of respite care by families who have requested services. The level of funds available to individual families may change from quarter to quarter, depending upon emergencies and new family requests in the region.

The percentage of families with DMR clients residing at home that received respite care services in FY 89 is shown in Table II-13. The proportion of eligible families receiving respite assistance varied considerably among the regions.

Table II-13. Proportion of Eligible Families Receiving Respite Services, FY 89.

Region	Total No. Families	No. of Families Receiving Support	Percent of Families
1	746	131	17.6%
2	869	122	14.0%
3	406	179	44.1%
4	814	78	9.5%
5	726	294	40.5%
6	<u>544</u>	<u>124</u>	<u>22.8%</u>
TOTAL	4,105	928	22.6%

Source of Data: Department of Mental Retardation.

Funding for community training homes is arranged differently. A set amount is allocated for each individual in a community training home. During FY 88 the amount was \$600; in FY 89, \$400 was allocated.

Community training homes may also arrange for their own respite provider. An invoice is submitted for reimbursement and subtracted from the individual's yearly allowance. To receive reimbursement, community training home providers must submit documentation including the dates of respite service, the rate paid, and verification by the providers that service was rendered.

In Table II-14, a detailed regional breakdown of the respite care spending for community training homes is shown. As with the funding for families, there is considerable variation among regions.

Table II-14. Percentage of Community Training Homes (CTHs) Receiving Respite Services, FY 89.

Region	Total CTHs	No. Receiving Respite Service	Percent of CTHs
1	133	99	74.4%
2	51	32	62.8%
3	79	79	100.0%
4	59	28	47.5%
5	81	54	66.7%
6	<u>66</u>	<u>44</u>	<u>66.7%</u>
TOTAL	469	336	71.6%

Source: Department of Mental Retardation.

Quality Assurance

The Quality Assurance Division is located within the Department of Mental Retardation's central office and consists of three units. Its purpose is to assure that the services licensed, funded, and operated by the department comply with policies and regulations, further the department's mission, and protect individuals from jeopardy. The department was required to add several components to its quality assurance system as part of the CARC v. Thorne consent decree agree-

ment. A contempt motion, filed in February 1988, alleging that the quality assurance requirements of the consent decree had not been implemented was settled in August 1988.

There are currently 41 staff employed in this division, an increase of 33 employees since January 1987. As Figure II-8 depicts, the division includes an Incident Unit, a Regulatory Compliance Unit, and a Program Enhancement Unit. A description of each of the units is presented below.

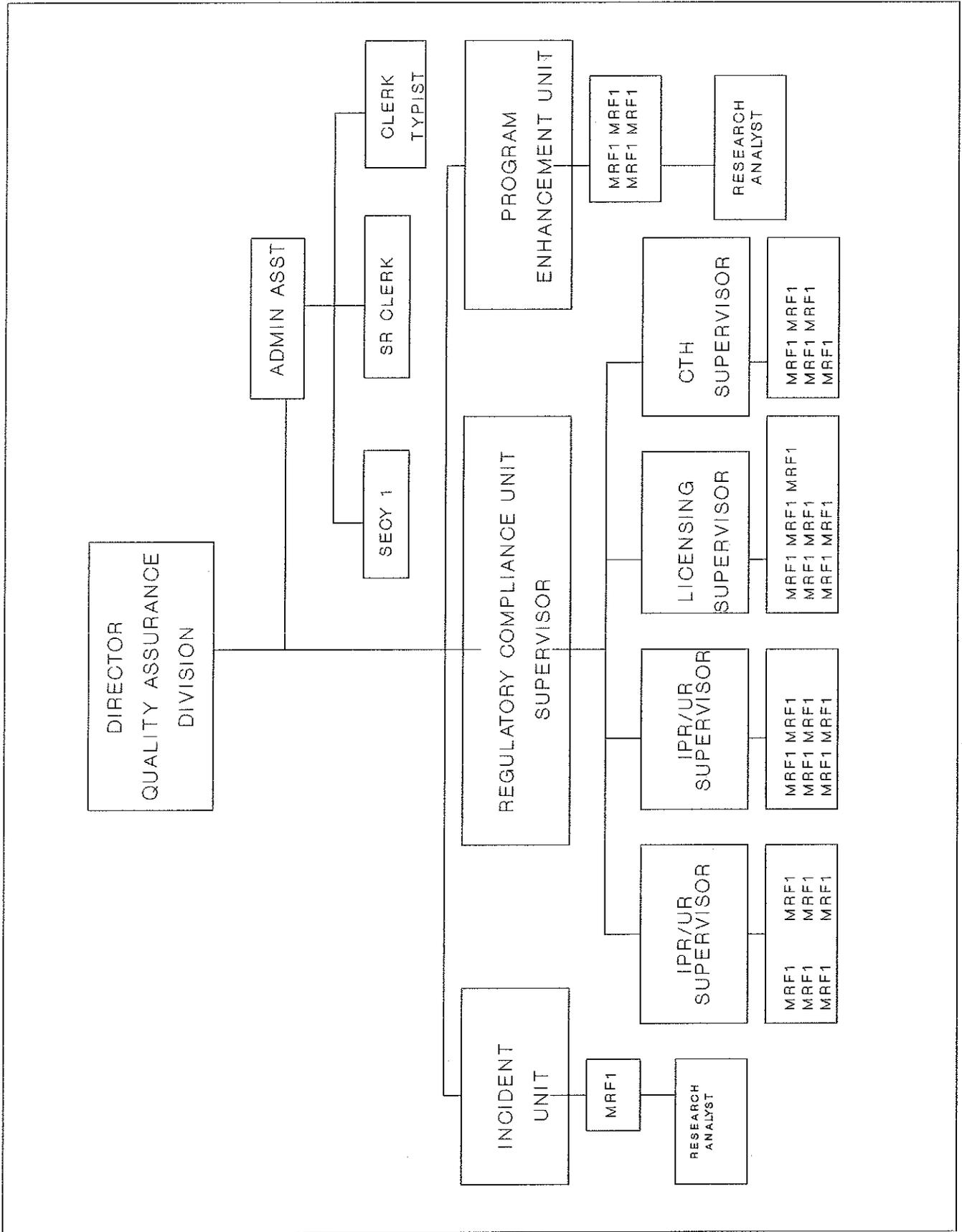
Regulatory Compliance Unit. The Regulatory Compliance Unit monitors services provided or purchased by the department against minimum standards outlined by both federal and state regulation. As Figure II-8 shows, the unit is divided into four subunits. The two subunits titled IPR/UR are responsible for conducting reviews so that the Department of Income Maintenance can receive federal medicaid reimbursement. The Licensing subunit issues licenses to all new and existing private facilities and has begun certifying public community-based facilities. The CTH subunit, which was only recently established, will be responsible for licensing all community training homes in the state.

In general terms, the Regulatory Compliance Unit measures the services being provided against specific federal or state standards. The processes followed by all four subunits are similar. Inspections are conducted by regulatory compliance staff after which deficiency reports are issued by inspectors, if appropriate. If deficiencies are cited, providers are required to submit a plan of correction to ensure they are remedied.

One function of the Regulatory Compliance Unit is to conduct Independent Professional Reviews (IPR) annually and Utilization Reviews (UR) semiannually for those facilities that are certified as Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and for those clients, eligible for medicaid, who reside in ICF/MR facilities. The federal government requires the Department of Income Maintenance to have an independent review conducted so that it may receive medicaid reimbursement for those clients. DIM subcontracts this function to DMR and pays all staffing and related expenses.

The purpose of the Independent Professional Review is to ascertain whether the client residing in an ICF/MR facility is receiving active treatment and adequate services. The purpose of the Utilization Review is to determine whether a client needs to continue staying in an ICF/MR facility.

FIGURE II-8



As of June 30, 1989, there were 128 public and private ICF/MR facilities with 1,593 clients requiring review. Reviews are conducted at Southbury Training School, Mansfield Training School, regional centers, and other public and private community residences with ICF/MR status. Table II-15 lists the number of such facilities as of June 30, 1989, and the total ICF/MR bed capacity by region. Full capacity may not always be reached on a day-to-day basis.

Table II-15. Regional Breakdown of ICF/MR Facilities.*

Region	No. of Facilities	No. of Certified Beds
Region 1	24	197
Region 2	29	277
Region 3	13	129
Region 4	9	186
Region 5	16	162
Region 6	6	60
Mansfield Training Sch.	23	369
Southbury Training Sch.	8	213
TOTAL	128	1,593

* As of June 30, 1989.

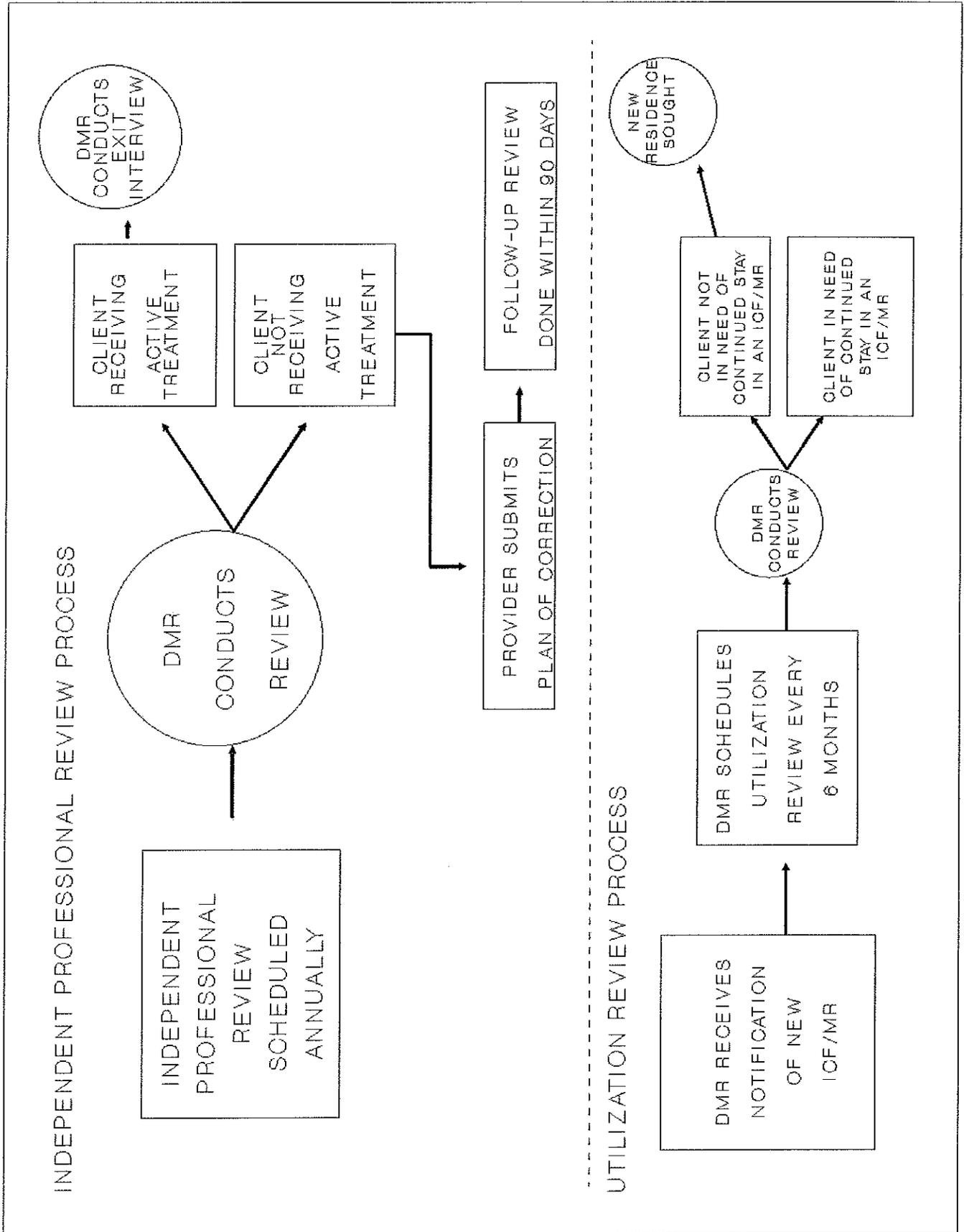
Source: DMR Quality Assurance Division.

Inspectors are assigned as teams, which ideally consist of three people per team, for both the Independent Professional Review and Utilization Review. A registered nurse is the team leader. Figure II-9 depicts the process that quality assurance staff follow when conducting these reviews.

For the Independent Professional Review, teams examine records, observe clients, and confer with facility staff to determine whether active treatment and adequate services exist. The review focuses on the client's Overall Plan of Service (OPS) which outlines the services a client should receive. In order for DMR staff to determine that a client is not receiving active treatment, staff must find that the client either has no OPS or the existing OPS is not being followed.

If the team determines a client is not receiving active treatment, it issues a deficiency report to the facility, and the provider must respond with a plan of correction within 10 days. The correction plan, which is submitted to the team, must indicate how active treatment will be implemented.

FIGURE II-9



The team will follow-up to ensure the plan has been implemented within 90 days. If it has, the client is reclassified as receiving active treatment. If not, the client's status remains nonactive, and applicable documentation is submitted to DIM.

The Utilization Review is conducted semiannually: once at the time of the Independent Professional Review, and again six months later by the same team. Generally, the criteria inspectors use for these reviews are based on direct observation and interviews with staff involved with the client.

There are three possible determinations that a team may make at the time of the Utilization Review: 1) the client is in need of continued stay in an ICF/MR facility; 2) the client is not in need of continued stay in an ICF/MR facility and should be moved to a nonICF/MR facility/residence; or 3) the client should be transferred to another ICF/MR facility that can better meet his or her needs. If a client does not need the level of services offered by an ICF/MR facility or the present facility is inappropriate for his or her needs, a new residence will be sought. Since March 1989, seven individuals have been classified as not in need of continued stay.

Another function of the Regulatory Compliance Unit is to license new private residential facilities and annually relicense all private existing facilities receiving DMR funds. There are four types of licenses a facility may receive : 1) initial; 2) annual; 3) provisional; or 4) short term.

Currently, there is one supervisor overseeing seven licensing inspections. Licensing inspectors conduct inspections individually and are assigned by provider. Thus, one inspector would inspect all facilities owned by a specific provider.

All private facilities (approximately 460) must be licensed by DMR. All public facilities (about 60) that have 24 hour staffing and are community-based must be certified by DMR. During the inspection, the inspector examines the provider's application packet, samples client's records, and conducts an environmental inspection of the residence. Table II-16 provides a breakdown of licenses issued over the last two fiscal years.

The program review committee sampled the licensing records of 76 facilities to ascertain the types of deficiencies that appeared most frequently among providers. Table II-17 shows each facility's deficiencies by type and number for selected categories. For example, the table shows that 39 of the facilities sampled had no deficiencies in the licensing category, 24 facilities had 1 deficiency in the policy area and 7 had 4 deficiencies each in the physical category.

Table II-16. Licenses Issued for Private Residential Facilities.

<u>Fiscal Year</u>	<u>New Licensure</u>	<u>Annual Licensure</u>	<u>Totals</u>
FY 88	138	171	309
FY 89	148	309	457

Source: DMR Quality Assurance Division.

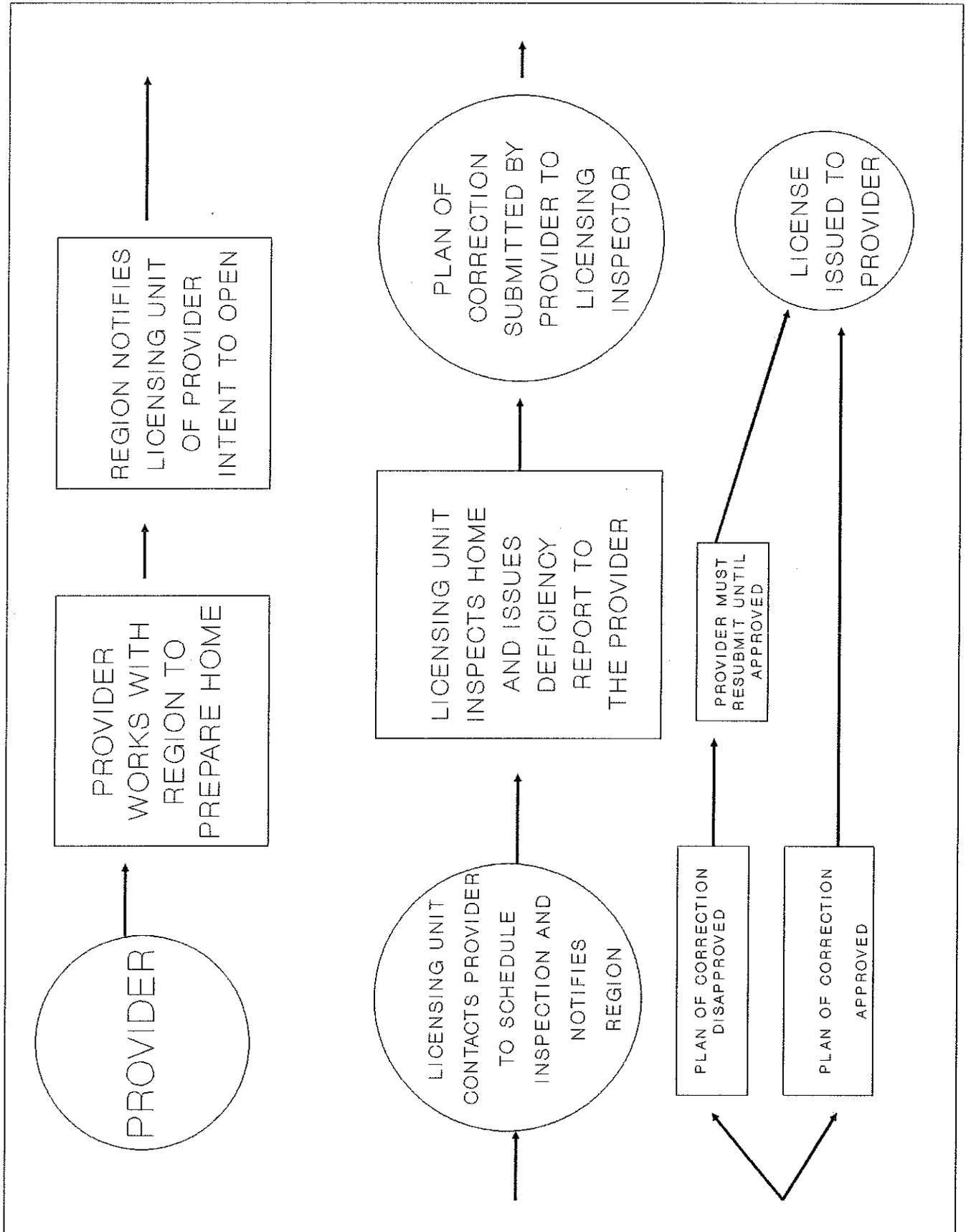
Deficiencies in the licensing category involve submission of an incomplete application packet to operate a residential facility. Deficiencies in the administrator area include lack of a qualified administrator for the facility, inadequate staff training, and failure to adhere to specific reporting requirements. Policy deficiencies include insufficient internal operating procedures. Physical deficiencies consist of substandard building characteristics and/or improper maintenance of the facility. Finally, medical deficiencies include inappropriate medical care, and a lack of client and staff training.

In the sample taken, an average of 44 days elapsed between the date a facility was inspected and a deficiency report was mailed to the provider. On average, it took an additional 35 days from the time the report was mailed until the provider's plan of correction was received and accepted by the division.

The top portion of Figure II-10 shows the processes a provider must follow to have a new residence licensed. Regional DMR staff assist the provider in developing the residence and then contact the quality assurance licensing staff once the home is ready for initial licensure. If deficiencies exist upon initial inspection of a new residence, a license will not be issued. Any deficiencies found must be corrected prior to licensure.

Figure II-10 also displays the processes a provider must follow for annual relicensure. An inspector will contact a provider approximately four months prior to expiration of the residence's license to schedule an inspection. After the inspection, a report will be issued to the provider. According to state regulation, if the report identifies deficiencies, the provider has 10 days to develop a plan of correction for the deficiencies identified. The inspector reviews the plan

FIGURE II-10



of correction, and if it is not satisfactory, it will be returned to the provider. The region may then assist the provider in writing an acceptable plan of correction. Once the plan is accepted, a license is issued by the commissioner of mental retardation.

Table II-17. Number of Deficiencies Per Facility by Category.

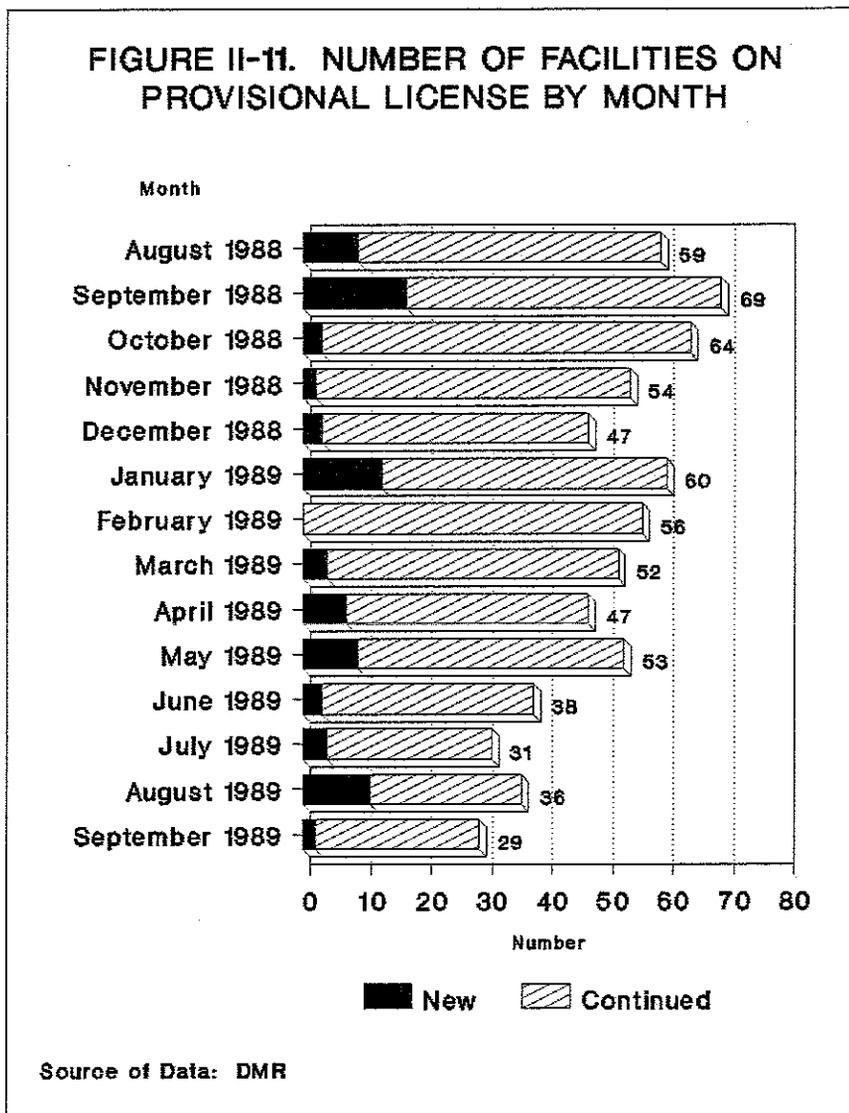
Type of Deficiency	Number of Deficiencies										
	0	1	2	3	4	5	6	7	8	9	10+
Licensing	39	21	10	3	0	1	0	0	0	0	0
Administrator	39	6	10	2	1	1	1	3	5	5	1
Policies	28	24	8	5	3	3	2	2	0	2	2
Physical	18	19	16	6	7	1	2	2	1	2	0
Medical	24	12	5	5	8	7	5	6	1	0	1

A provisional license may be issued for no more than 30 days and indicates major health/safety issues may exist in the home. There are several reasons that a home may be issued a provisional license, including: 1) the application packet is incomplete; 2) a plan of correction was not developed; 3) the provider's license expired prior to an accepted plan of correction being submitted; or 4) serious health/safety issues need to be addressed by the provider. The provider has 30 days to correct the deficiencies, but this time period can be extended.

Figure II-11 gives a monthly breakdown of the number of facilities on provisional license from August 1988 through September 1989. There were a total of 137 facilities placed on provisional license status during this time period. The figure shows that the total number of facilities on provisional license has declined over the 13 month period from a high of 69 facilities in September 1988 to a low of 29 facilities in September of 1989.

Figure II-12 provides a breakdown of the reasons why providers have been placed on provisional licensure. It is important to note that facilities may receive this type of license for multiple reasons. The figure shows that the most common reason a provider is placed on provisional license is

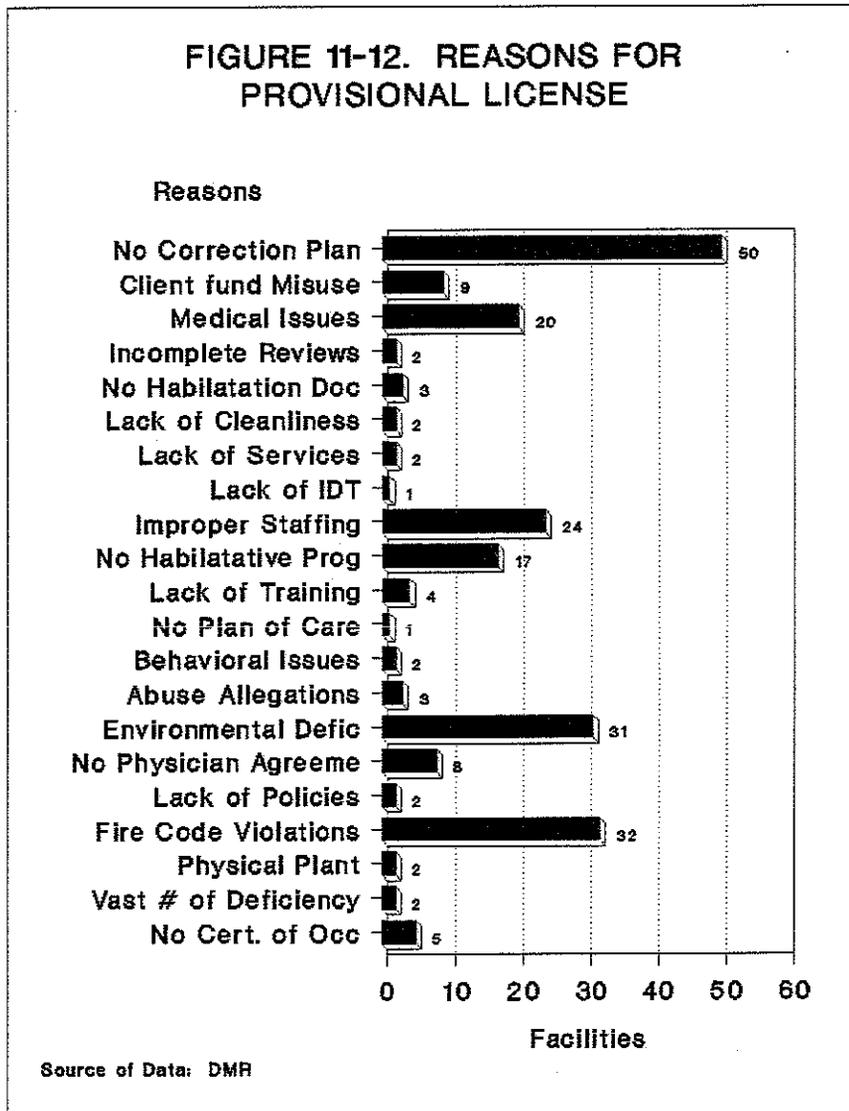
for failure to submit an acceptable plan of correction, followed by fire code violations which account for 32 facilities being on this type of license. Environmental deficiencies and violations of staffing patterns were also frequent reasons for provisional status.



The average length of time a facility remained on provisional licensure was 243 days. However, the median time was 151 days, while fully 25 percent of the facilities held a provisional license for 365 days or more.

Licensing inspectors also may place a facility on short-term licensure. This occurs if a home has a vast number of

deficiencies that have an effect on services, and the provider has submitted an acceptable plan of correction, but the inspectors are not sure the plan will be implemented.



The provider is granted an annual license when an inspection is done prior to the expiration date of the short-term license and information received from the provider indicates that any needed corrective action has been taken.

A facility may request the department grant a waiver for any licensing regulation. The commissioner has complete authority in granting or denying a waiver, but this is typically done on the recommendation of a licensing inspector. Any regulation may be waived, but it cannot negatively impact on clients, and health/safety issues are scrutinized closely prior to issuance. If a waiver has been issued, inspectors must identify the deficiency when conducting an inspection of the home, but also must note in the deficiency report that a waiver was granted.

Currently, community training homes are licensed by the region in which the home is located. The region develops the CTH, conducts inspections, forwards the results, and verbally states to the Quality Assurance Division if deficiencies are found. If everything is in order, a license is granted. Standards for licensure of CTHs are less rigorous than for private group homes.

A community training home operator may house up to three individuals and receives a license for each. There are three types of licenses an operator may qualify for: 1) adult; 2) children; or 3) respite. Each home is assigned a level of care ranging from less than 24-hour supervision to intensive 24-hour supervision.

In the future, all CTH licensure will be done in the Quality Assurance Division. The community training home process, while still in development at this time, will be similar to other licensing done within the Regulatory Compliance Unit.

Five individuals and a supervisor have been hired by the Quality Assurance Division to carry out the CTH licensure function. At the close of fiscal year 1989, there were 350 homes operating in the state with a total bed capacity of 487. During FY 89, 58 new homes were developed with a capacity of 159 beds. However, 43 homes providing 143 beds were closed. Thus, the net gain for FY 89 was only 15 homes with a total capacity of 16 beds.

Individual Reviews. In addition to reviewing facilities, the Quality Assurance Division is also responsible for conducting client-based reviews. There are three types of individual reviews that the department conducts or tracks to guarantee fundamental individual rights are protected, individual progress is evaluated, and efforts are directed toward enhancing an individual's quality of life. These reviews include: 1) the individual program quality review that is under the Program Enhancement Unit, 2) the individual red flag review that is conducted by a client's case manager, and 3) a longitudinal study of class members, which is being done by an outside consultant.

Individual Program Quality Review. The Program Enhancement Unit is a separate group in the Quality Assurance Division and is staffed by five employees. This unit recruits, trains, and assists volunteers who conduct individual reviews on quality of life issues. These reviews are done on a biennial basis. The reviews are designed to go beyond federal and state regulatory compliance standards and attempt to measure the quality of life being experienced by the client. The department's mission statement is used to define what is meant by quality of life.

Volunteers undergo two days of training on how to evaluate programs in relation to their impact on an individual client's quality of life. Included in the training is a video that depicts favorable and unfavorable treatment of clients, as well as ideas on what constitutes a good or bad program. Volunteers are grouped into four-person teams. The program enhancement unit has four staff people who act as facilitators for the volunteers.

Participation of providers in this process is strictly voluntary, but participation is close to 100 percent. Following the review, the provider meets with the volunteers and regional staff to discuss the findings. The provider has 30 days to write a Quality Improvement Plan if deficiencies are found. The Program Enhancement Unit receives a copy of the plan, but the region has the responsibility to make sure that the plan is implemented. There are no punitive actions involved, rather a cooperative atmosphere exists in trying to improve client's quality of life.

Red Flag Review. As mentioned above, case managers are responsible for completing an individual red flag review. These reviews are done on a quarterly basis, following a client's annual Overall Plan of Service. The review consists of a 25-question checklist in which a negative response constitutes a red flag and indicates a client may be in jeopardy. For example, a red flag would appear if a client did not have a current Overall Plan of Service or necessary transportation services were not being provided. Figure II-13 shows the processes followed by a case manager in carrying out a review.

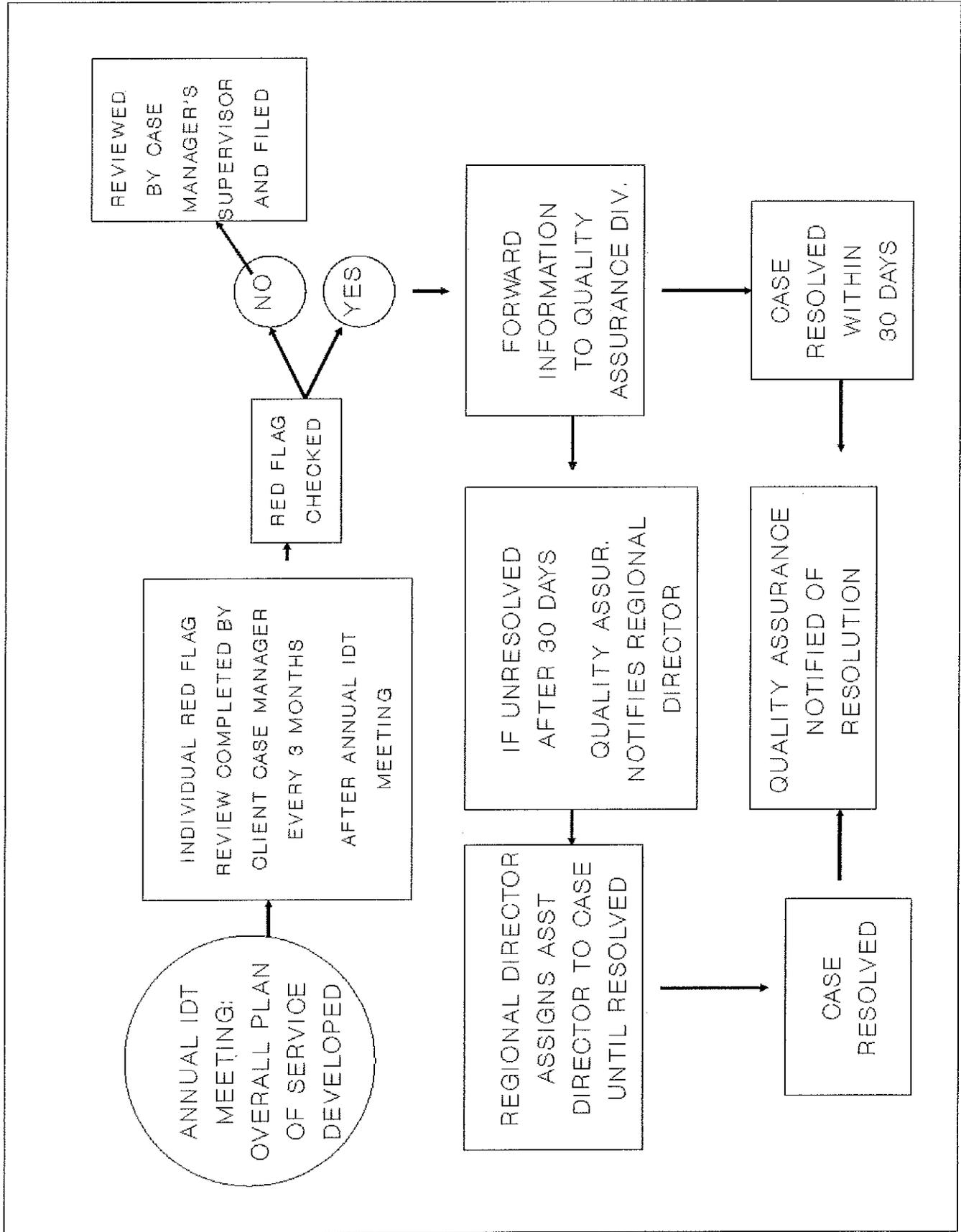
The responsibility to resolve a red flag rests with the region, however, the quality assurance staff is notified when a red flag appears. An analyst in the Quality Assurance Division generates a report every 30 days identifying red flags in both the aggregate and by individual. These reports are then given to the director of the division, who meets monthly with the commissioner. Recurring red flags may be discussed at the weekly regional directors' meetings or directors may be contacted directly. At this time, the director of quality assurance or the commissioner may question the regional director on the resolution of the red flag.

Longitudinal Study. As part of the settlement agreement, the department engaged an outside consultant to conduct a longitudinal study by collecting and analyzing data on class members. One part of the study includes an annual red flag component identical to the one completed by the case manager. The Quality Assurance Division monitors the red flag component and if a class member is identified as being in serious jeopardy, the quality assurance director is immediately notified and a response from the provider is required within 24 hours.

The Incident Unit. This unit in the Quality Assurance Division, tracks information through incident reports received from the regions and the training schools and generates reports on various topics of concern. For example, the Quality Assurance Division requires that an incident report be filed on abuse/neglect complaints, restraint use, administration of behavior modifying medication, mortality rates and reviews, and other special concerns. Information is compiled and analyzed by the unit, and forwarded to the director of quality assurance.

It is the region's responsibility to investigate most complaints or concerns and report the results to the Quality Assurance Division. By statute, the Office of Protection and Advocacy must be notified of any suspected incidence of abuse or neglect. Likewise, that office may refer a complaint to the Quality Assurance Division and require DMR to implement a protective service plan. The Quality Assurance Division would then track the outcome of a regional investigation.

FIGURE II-13



SECTION III: RECOMMENDATIONS

One of the most striking aspects of the Department of Mental Retardation study has been the intensity of the feelings exhibited by the various advocacy groups involved in the field. Views on major issues are all too frequently personalized. Instead of reacting to the merits of an idea, people react to the individual presenting it.

It is the belief of the legislative program review committee that there is considerably more agreement about the options that should be available to mentally retarded citizens of Connecticut than is readily apparent from listening to the various advocacy groups in the state.

The original issue was whether mentally retarded individuals would benefit from living and working in the community. That question has been answered resoundingly in the affirmative. There is vast agreement that most mentally retarded people should live in some type of community setting.

The remaining disagreement arises over individuals with severe retardation or multiple handicaps requiring a wide array of services and a large amount of direct care. The issue is one of where to draw the line with respect to how much effort should be made and at what financial cost to the state to enable these mentally retarded persons to live in the community.

Top management in the Department of Mental Retardation has made great progress in moving the department in a single direction. The mission statement, adopted in 1986, focuses on the participation of persons with mental retardation in community life, providing them with choices, and offering them an opportunity to experience respect and dignity. This mission is accepted as a long-term goal for mentally retarded residents in Connecticut, and agency staff are unified in their efforts to implement programs that will achieve that mission.

At the same time, oversight of the changes associated with the integration of increasing numbers of individuals with mental retardation into the community has not been well managed. No clear delineation of the roles and responsibilities of the central office versus the regional offices exists. As a consequence, variations within the six regions have occurred, resulting in confusion about agency criteria and the specific application of policies. The decision-making process within DMR has frequently been based on individual cases rather than a systematic approach to problems.

Until recently, no recognition has been given to the impact of the program costs of one client on the availability of services for other clients. Day and residential programs are developed on an individual basis without consideration of the extent to which provision of a particular program for one person may prevent the offering of programs to other clients.

Top managers within DMR have also exhibited an unfortunate tendency to judge events in the context of winning and losing and to take actions aimed at rewarding supporters and punishing critics. This approach can subordinate the best interests of the clients to the inclinations of top managers.

A further complication has been the federal courts. Through the Mansfield and Southbury consent decrees, the department has agreed to make a number of changes affecting the program offerings of certain groups of clients as well as the internal operations of DMR. Managers are expected to respond promptly and directly to any issue raised by the courts. This has led to a situation where individual client interests drive the activities of the department. Thus, DMR's ability to apply a systematic approach to its operations is diminished.

The recommendations adopted by the program review committee address inadequacies and inconsistencies found in the current system of management at DMR. The proposed changes are intended to facilitate the department's ability to continue moving toward achievement of its mission.

Mission Statement

The Department of Mental Retardation's mission statement is a broad declaration of policy with respect to what the department seeks to accomplish for mentally retarded individuals. It commits the department to work toward the inclusion of mentally retarded individuals in community life and increase their opportunities to make choices and friendships. The statement provides employees with a clear direction and purpose.

In the opinion of the program review committee, the department's leadership has excelled in conveying and publicizing the mission to employees, providers, and advocates. Within the department, there is virtually no disagreement about the merits of the mission. It was apparent throughout the course of this study that department employees knew the major elements of this statement, and most embrace the mission whole-heartedly.

The program review committee commends the department and its leadership for having a mission statement that is under-

stood and accepted by employees and advocates. However, the committee believes that it is the type of policy statement that is the prerogative of the legislature as the state's primary policy-making body to, if not initiate, at least approve. Therefore, the program review committee recommends:

The current mission statement of the Department of Mental Retardation should be adopted into statute with a provision requiring it to be reconsidered by the General Assembly in 1992 and every four years thereafter.

The mission of the department to be included in statute is "to join with others to create the conditions under which all people with mental retardation experience:

- Presence and participation in Connecticut town life;
- Opportunities to develop and exercise competence;
- Opportunities to make choices in the pursuit of a personal future;
- Good relationships with family members and friends;
and
- Respect and dignity."

By incorporating the mission statement into statute, the legislature will have an opportunity to assert its policymaking responsibility and allow for public discussion of the statement. It will also give more permanence to the department's direction, not permitting modification without legislative action. Thus, a clear signal will be given to the department and the public that the legislature is committed to the goals set forth in the mission statement.

The program review committee believes that a policy of this type should be reviewed periodically to allow for modification. Although the mission may be reconsidered at any time, legislative review at least every four years, beginning in 1992, is proposed. This schedule places the re-evaluation one year following the beginning of a governor's term of office and allows for a newly appointed commissioner of mental retardation to have one year to contemplate and suggest changes to the legislature if necessary.

Annual Plan

The Department of Mental Retardation formulates a detailed five-year plan that outlines priorities, identifies goals, and assesses progress in four major service areas

(administrative, day, residential, and resource services). A new plan is produced in even years and updated in odd numbered years.

The plan is used as an internal document and aids the department in the long-range planning function by setting direction. The program review committee believes the five-year plan is a useful document that outlines the policies the Department of Mental Retardation intends to pursue, and provides information on the department's overall direction and achievements. It also provides guidance to employees in terms of the policy orientation of top management.

The program review committee believes the department's long-range plan should be brought to the attention of the legislature because it is a statement of policy that sets and prioritizes objectives, and summarizes accomplishments. The committee believes that given the legislature's policymaking responsibilities, it should have the option to consider and establish alternative policies. Therefore, the program review committee recommends:

The Department of Mental Retardation shall be required to annually develop a five-year plan. The department shall hold public hearings on a full draft of the plan and, beginning in January 1991 and annually thereafter, submit the final plan and a transcript of that public hearing to the committees of the legislature having cognizance over the department's operations and finances. The committees may hold a public hearing on the plan. The plan shall:

- set priorities;
- identify goals and objectives, and the strategies to be employed in achieving them;
- define the criteria to be used in evaluating progress;
- identify changes in priorities, goals, objectives, and strategies from the prior plan;
- describe and document progress made in meeting goals and objectives outlined in the prior plan; and
- estimate the type and quantity of staff and client services that will be needed over the life of the plan.

Requiring a public hearing on a draft version of the complete plan provides the public a forum in which to review and comment on the goals set forth in the plan. It also informs the public on the overall direction of the department.

Requiring the final plan and a transcript of the public's testimony to be submitted to the legislature's committees of cognizance automatically makes available the public's views to the General Assembly. If the contents of the plan are controversial, the legislature may hold a hearing and appropriately become the body where the conflict will be debated.

The plan should focus the department's efforts and alert the legislature of the department's intent. Under the proposed process, the department will have the opportunity to state its direction and how the goals and objectives in the plan will be reached. The legislature will have the means to decide if the direction the department is taking is appropriate. Finally, the plan will provide a mechanism to hold the department accountable.

Role of Cost in Decision Making

The program review committee believes that cost has not played a significant role in the Department of Mental Retardation's decision making. In the opinion of the committee, the department is so focused on the individual client that it has lost sight of the fact that money expended to obtain a benefit for one client reduces the resources available to obtain benefits for others.

Examples supporting this view include: 27 individuals each having residential service expenses in excess of \$110,000 per year; day programs for two individuals that yearly exceed \$54,000 each; a \$16,500 per year expense to transport a person on a daily basis from Hartford to a school in New Haven; and a \$14,560 annual expenditure to transport an individual from Rocky Hill to Hartford.

Admittedly, these are isolated instances well above the average expenditures for similar services provided by the department. However, in the view of the committee, such extremes are possible because the department places so much emphasis on enhancing an individual's skills and maximizing his or her integration into the community that cost has been reduced to a marginal consideration.

Even in terms of the basic models used to implement its policies the department has not demonstrated a real cost awareness. For example, in the community residential area, the department has chosen one of the most expensive models, the community living arrangement (CLA), to be the cornerstone of its program. In addition to utilizing an expensive model, the department has increased its use of the most costly versions of the model.

In FY 89, three-bed and four-bed residences, which are the most expensive CLA versions, comprised 40 percent of the department's CLAs compared to an estimated 5 percent in FY 86. In explaining this shift the department's staff cited the belief that smaller homes are more representative of a family setting and thus provide the client with a more typical environment.

Exactly how much more of a family environment can be created in a three-bed than a six-bed residence is difficult to measure. However, in terms of price, the average cost per bed in the three-bed residence is \$193 per day, which is double the \$96 daily average for the six-bed version.

Another example of the low importance of cost in the department's decision making concerned a change in the model used to provide medical services in one of the department's service regions. As a result of the change, medical costs increased \$55,000 in FY 89 and could increase by \$160,000 per year when the new model is fully implemented. Yet, a review by the committee staff concluded that conflicts and philosophical differences with the original providers, not quality of service issues, led to the change.

A final example of the department's attitude toward cost can be found in data provided by the Corporation for Independent Living. A review of these data show the average cost of developing a new residence rose from \$170,480 in FY 86 to \$400,120 in FY 89. Despite these increases, the department did not take any significant action to hold down costs until the fourth quarter of FY 89. At that time, it instituted a policy limiting private residential development costs to those submitted for review and approval by regional office staff prior to work commencing.

A tougher policy was developed in the first quarter of FY 90. However, this occurred only after the Department of Income Maintenance, the agency actually paying the development costs, strenuously objected to the increases. It should be noted that, under current procedures, development expenses are capped at rates based on draft guidelines produced by the U.S. Department of Housing and Urban Development.

The program review committee believes the cited examples typify the department's approach toward spending. In the opinion of the committee, the department does not seem fully cognizant of the fact that the state and each of its entities must operate under a budget constraint.

Rather than put its energy into the difficult task of allocating resources and benefits, the department's leadership has chosen to advocate for more money. This was illustrated several times during the study when committee staff observed DMR staff advising parents and advocates that the

best way to obtain additional services was to pressure the General Assembly or the governor to provide more money.

Despite the fact the department spends a considerable amount of its funds on purchasing services directly for clients, it does not track the total cost of the services provided to each client. In the committee's opinion, such information is critical if cost is to become a factor in decision making. Therefore, the program review committee makes the following two recommendations:

The Department of Mental Retardation should develop a system for tracking the cost of services purchased for individual clients.

Annually, each of the Department of Mental Retardation's regional offices should calculate and compare the total cost of services provided to each client residing within the region. The comparisons should also include projected cost with actual cost. The results should be circulated among assistant directors, case managers, and others responsible for making decisions concerning the provision of services to clients.

The purpose of the latter recommendation is three-fold. First, it would enable the department's staff to see the cumulative cost of all decisions affecting an individual and the resulting decrease in the resources available for all other clients. Second, it will provide the staff with a measure of how accurately it projects costs. Lastly, knowledge of the information will further encourage the department to identify and seek ways to correct inequities and inefficiencies in client expenditures.

In an effort to provide a mechanism to automatically trigger a review of exceptionally high expenditures, the program review committee recommends:

Whenever the proposed cost of providing a specific service to a client (e.g., day, residential, support, etc.) exceeds by more than 30 percent the average cost of providing that service to all other clients within the region, the regional director shall make a formal finding on the need and appropriateness of providing the service. For the service to be provided or continued, the finding must be either:

- a. the service is necessary to maintain the client's health, safety, or existing skills; or
- b. the anticipated improvement in the individual's skills or quality of life can reasonably be

judged equal to or greater than the benefits other clients must forego in order to provide the service to the recipient.

The intent of this recommendation is to force the department's staff to treat client-related decision making as a process involving the allocation of the finite resources available to all clients. The program review committee believes that by confronting this reality, the department will develop greater sensitivity to its responsibility to efficiently allocate resources and maximize benefits for the total client population not just selected clients.

The recommendation would apply to a limited number of persons and, therefore, should not become an unreasonable burden. For example, in the area of community residential services, only 261 clients would meet the threshold criteria.

For those identified, the conditions for making expenditure decisions are clearly spelled out. Costs related to maintaining a client's basic health, safety, and skills would be acceptable at any level. However, expenses associated with enhancing a person's skills or quality of life would face a bureaucratic hurdle. Such expenditures would have to be justified on the grounds of their relative contribution to all client benefits.

Selection Criteria

Over the course of the study, the program review committee found widespread confusion among the public about the criteria the department uses in making decisions. Of particular note, the criteria used to select clients for services and to select private providers for contracts is not readily available or identifiable to individuals outside the department.

With regard to clients, the primary reason this lack of criteria poses a problem is that simply meeting the statutory definition for mental retardation does not automatically entitle anyone to the department's services. Rather, once eligibility for a service has been established, the department must then exercise its discretion as to which eligible client will actually receive it. The department's discretionary power was affirmed in an opinion issued by the state attorney general in October, 1983.

According to the attorney general, once eligibility criteria are met, the statutes allow the commissioner of mental retardation to "exercise his discretion in approving applica-

tions for placement." It is important to note that the attorney general limited this conclusion to individuals not yet within the DMR system.

The fact that these discretionary powers are usually exercised by regional staff intensifies the need for regulations that define the criteria used in making eligibility decisions affecting the rationing of services.

Another problem found by the program review committee, during examination of DMR's regulations for selection criteria, was that certain sections of the regulations inadequately detailed department policy while others were not followed. When questioned about the latter, DMR asserted that certain provisions of the Mansfield consent decree conflicted with existing regulations. Committee staff was told that documentation supporting this opinion would be forthcoming. However, it was not produced.

The program review committee accepts the argument that the consent decree has rendered the regulations inoperable. But leaving these regulations as part of regular agency regulations adds further ambiguity to what should be a clear blueprint of department policy for the public record.

By not adopting regulations and keeping them current, the department has failed to inform the public about how decisions are made. The department's inability to maintain detailed and accurate regulations has caused confusion about department policy and decision-making criteria. Therefore, the program review committee recommends that:

The Department of Mental Retardation shall adopt regulations that define the criteria to be used in:

- a. determining if a person is eligible for services provided by the department;
- b. determining which clients will and will not receive a specific service; and
- c. selecting private sector service providers.

The Department of Mental Retardation shall repeal all existing regulations conflicting with the Mansfield Consent decree or otherwise not legally binding.

Requiring the department to place in regulation the criteria used in decision making accomplishes several important objectives. It allows for public comment on the regulations prior to adoption, provides a sense of permanence to the criteria, and places the department's policy in one source where

the public can easily identify whether the rationale for a decision is legitimate.

Procedural Guidelines

Another area of concern for the program review committee is that the DMR central office has not ensured procedural uniformity among all the regions. Moreover, the central office has not delineated the decision-making authority of the regional and central office personnel.

Due to the decentralized structure of the department, decisions affecting everyday processes are generally made at the regional level. For example, regional staff select and negotiate contracts with private providers. Although, in the opinion of the program review committee, the regional approach works well for the department, the lack of forceful direction from the central office has permitted some variation in the way clients and providers are treated. For example, procedures used to rank clients' residential needs and methods used for notifying families about the availability of respite care vary among regions.

Although not required, most regional offices have written procedural guidelines concerning many of their key activities. However, the level of detail and the degree to which these guidelines are followed also differ among regions.

The absence of clearly defined decision-making authority was frequently cited as a problem by regional office personnel in interviews with committee staff. It has allowed aggrieved providers and clients to bypass the formal appeal procedure and directly contact the commissioner or other central office staff. The result is that occasionally regional decisions are overturned, thus alienating staff and encouraging relationships to develop between the department's constituents and central office staff.

As mentioned in the preceding section on regulations, the commissioner has broad discretionary powers. The fact that much of this power is in the regions, and not in the commissioner's office, heightens the need for written department guidelines outlining how regional staff should apply discretion.

Specifically, the two procedures most in need of written guidelines are the selection of private service providers and the determination of which clients eligible for department services will actually receive them. These are generally the first processes providers and clients undergo when they begin their involvement with the department.

Providing equal and consistent treatment to all clients and providers should be the cornerstone of the department's

service delivery system. Since it appears that DMR has not made statewide uniformity a top priority, the program review committee recommends:

The Department of Mental Retardation should develop guidelines that will ensure that the processes followed by the regional offices in selecting service providers and determining which clients will receive services are uniform. The guidelines shall specify the decision-making authority of the department's central and regional offices and set the parameters within which each shall operate.

This recommendation is intended to encourage the central office to take a more active role in ensuring department policy is applied consistently throughout the regions. Furthermore, with clearly outlined decision-making authority, decisions made by regional staff within the bounds of their authority cannot be easily overturned as the result of informal appeals to central office staff.

To promote central and regional office coordination in developing these procedures, and to have a written outline of the procedures developed by the department, the program review committee also recommends:

Each regional office, following a format developed by the department's central office and taking into account regulations and guidelines adopted by the department, shall prepare written procedures outlining the processes to be followed in selecting private sector service providers and determining which clients will receive services. The procedures shall be reviewed and approved by the department's central office.

The committee believes these recommendations will lead to a greater role of the central office in managing the regions and establishing procedural uniformity that minimizes the possibility or perception that bias, favoritism, or caprice play a significant role in DMR's decision making.

Management Practices

Analysis. In the view of the program review committee, the department lacks sufficient management controls to ensure it is operating in a uniform, efficient, and effective manner across all regions. Information related to the operational aspects of regional offices such as procedures followed, staff-to-client ratios, and the cost of various program models is either not collected or not analyzed on a regular basis.

The information on regional offices that is collected and analyzed is almost exclusively directed at ensuring the department's goals and fiscal requirements are met. As a result, the department's top managers know which regions are good at making community placements, but not why some do it more cheaply than others. They know which regions are good at developing supported employment opportunities, but not if the criteria used to select clients for those programs are uniform and applied consistently among regions.

The committee believes the department's top managers must take on more responsibility for overseeing the operational aspects of the department. A system should be put in place that ensures not only that goals are being met, but that they are being met in an efficient and fair manner. Therefore, the program review committee recommends:

The Department of Mental Retardation should develop a management oversight capability and submit reports at least annually to the legislature's committees of cognizance that:

- a. evaluate each region's adherence to its approved procedures for selecting service providers and determining which clients will get services; and
- b. identify and explain discrepancies between regions with respect to such things as staff-to-client ratios, cost-per-program models, cost per client for each type of service provided, gaps between clients served and those requesting services, etc.

The intent of this recommendation is to direct the department's top managers to assume a more active oversight role. The committee believes that by placing an emphasis on identifying and explaining discrepancies between regions, operational aspects of the department should be better understood. The knowledge gained should improve the overall management of the department. It should also encourage the central office, which has the clearest view of the department as a whole, to play a stronger role in promoting management ideas between regions.

Management Training. The program review committee believes that DMR has until recently done an inadequate job of identifying training needs and developing appropriate training programs for its management level employees.

In the past, the department has emphasized training designed to orient new and current employees to the goals of

the department. That aspect of training has been executed notably. The staff development unit facilitated one of the department's biggest challenges following the Mansfield consent decree by changing the way employees viewed individuals with mental retardation and how they should be served.

Whether intended or not, values and mission training has been one of the department's most effective management tools. The clearest evidence of this is that although central office allows the regions to conduct their affairs independently, they all move in a singular direction. This unanimity of goals has eased the department's implementation of challenging initiatives and changes.

However, training designed for management and supervisory level employees has been neglected, particularly when technical in nature. To cite an example, when the department's service delivery system changed to one based on contracting with private providers, no specific, mandatory training was developed to assist regional employees in negotiating these contracts. Some regional managers initiated programs, but it was the central office's responsibility to identify this need and implement appropriate training.

To DMR's credit, the department's staff development unit has recognized this deficiency and has begun identifying management training needs. Recently, the department surveyed its management force to find out what types of training its managers consider most useful. This survey is a positive first step towards the identification and development of necessary management training.

To ensure the department continues to view management training as an essential part of its training network, the program review committee recommends:

The Department of Mental Retardation should identify management needs on an ongoing basis and develop appropriate training programs.

The program review committee believes the staff development unit is fully capable of organizing and implementing these changes. To date, the problem has been an overemphasis on philosophical training and a neglect in management training. This recommendation will require the department to establish, and continue providing, training designed to improve the performance, efficiency, and supervisory skills of its management staff.

Quality Assurance

The review of the Quality Assurance Division in the Department of Mental Retardation revealed a system that is fragmented and poorly defined. The system was created by the

federal court monitors, plaintiffs, and department staff as a result of the CARC v. Thorne lawsuit. It tries to meet the needs of all these groups and as a result lacks focus and is too ambitious for the available resources.

The current system has 12 separate components, including 9 that are client-based, and 3 directed at program. Three of the components are performed directly by the Quality Assurance Division. The division is responsible for monitoring the others, which are carried out by either other department staff or contracted consultants.

Currently, a typical client may be reviewed under 8 of the 12 quality assurance components. A red flag review, identifying possible jeopardy situations, is done for each client three times a year. At least one annual licensing review of private residences is performed, and if a client resides in an intermediate care facility, there are two additional reviews conducted.

Client-specific behavior programs involving the use of restraint are reviewed by both the DMR Program Review Committee and the Human Rights Committee. A quality enhancement review of a client's day program is done biennially, and if a client is on psychotropic medication, an annual review is conducted. Each review focuses on a different aspect of the program or individual, however, overlap does exist.

In the view of the program review committee, the department's quality assurance efforts could be improved in three ways. First, efforts of the Quality Assurance Division should be directed at a single objective, namely problem identification. Second, the division must utilize its resources more efficiently. Finally, the division needs to produce analyses directed at identifying systemic problems.

Focus. The program review committee believes that quality assurance should be used strictly as a management tool, solely for the identification of problems, not their resolution. The current quality assurance system is designed to do both. Aside from the issue of not having sufficient staff resources to both provide information and ensure resolution, the committee views those as separate functions that are incompatible for the same staff to perform.

The program review committee believes the appropriate level for resolution of a problem is in the region where a program is located. Regional staff are closer to the problem and, therefore, should be able to resolve it more quickly. Also, the added authority should increase their sense of responsibility for the operation of programs in their region. Therefore, the program review committee recommends:

The Quality Assurance Division should only identify problems. Once uncovered, the division shall notify the applicable region. It shall be the responsibility of the regional office to oversee the resolution of any problem identified by the Quality Assurance Division. The regions shall report to the Quality Assurance Division when there is resolution.

The Quality Assurance Division shall issue a monthly report listing unresolved problems. The report shall identify the location, nature, and number of months since the problem was first identified. The Quality Assurance Division shall follow-up by conducting a sample of those problems reported as resolved by the region. If the region has reported a problem resolved and the Quality Assurance Division judges otherwise, the regional director and the commissioner shall be notified.

The intent of this recommendation is to give the Quality Assurance Division a single purpose -- identifying problems. As a result, the division should be more focused. The recommendation also shifts responsibility for resolving problems to a level much closer to where they occur. However, requiring the quality assurance staff to verify reported resolutions, provides a mechanism by which regions can be held accountable.

Resource Efficiency. The Program Enhancement Unit in the Quality Assurance Division reviews and evaluates whether programs that DMR funds or operates are performing in ways consistent with the mission. The department's mission statement is used to define what is meant by quality of life. Quality enhancement teams, which may consist of department staff, private citizens, and clients, conduct reviews of day and residential programs identifying areas of strength and weakness.

The committee believes that this is an inappropriate function for the Quality Assurance Division to be performing. To operate this program, finite staff resources are diverted from other quality assurance functions. In the view of the committee the focus of the Quality Assurance Division should be on assuring that basic, minimum safety and health issues are addressed. The regions should address quality of life issues.

More importantly, the committee found that although the program was originally designed to recruit volunteers to conduct quality reviews, in reality, of the 91 individuals conducting the day program reviews, 46 were paid employees of the department. In the opinion of the program review committee, scarce staff resources could be better used. Therefore, the program review committee recommends:

Program quality enhancement reviews should be administered in the regions. To enhance community awareness/-involvement, recruitment efforts for volunteers should be centered in the community. Employees of DMR should not be allowed paid state time to participate as volunteers.

Information should be provided from the regions to the Quality Assurance Division regarding the results of the reviews. The Quality Assurance Division should then compile and analyze the information from the regions.

There are 462 private residential homes that require annual licensure. The Quality Assurance Division has seven licensing inspectors who conduct licensing inspections. However, two of these inspectors have recently been hired and, therefore, do not have their own case loads. For the five remaining licensing inspectors, case loads range from 78 to 100 facilities per inspector.

Deficiencies issued to private facilities under the current licensing system fail to differentiate between serious problems that require immediate correction and more technical deficiencies that do not threaten clients well-being. Given their current case loads, inspectors have little time to re-inspect facilities that may have serious inadequacies and should have both scheduled and unscheduled inspections performed.

To enable inspectors time to perform more frequent inspections of facilities with a history of problems, the program review committee recommends:

The Quality Assurance Division should develop a weighting system for categorizing deficiencies. This system should be used to determine the frequency of inspections.

- a. Residential facilities that have undergone two consecutive inspections with no deficiencies shall be inspected biennially.
- b. Residential facilities that have undergone two consecutive inspections and the deficiencies received have been categorized as noncritical shall be licensed on an annual basis.
- c. Residential facilities that have undergone two consecutive inspections and the deficiencies received have been categorized as critical or the facilities that hold a provisional license shall be inspected at least semiannually.

This recommendation would allow inspectors to concentrate their efforts on residential facilities that exhibit problems, while still ensuring that all facilities are inspected at least every two years. By moving to a different licensing schedule based on the number and type of deficiencies found, inspectors will now have the opportunity to conduct unannounced visits and target problem facilities.

Information Analyses. The program review committee found the Quality Assurance Division failed to perform analyses that would lead to identification of systemic issues and highlight regional variations. Although several reports are generated by the division, most contained only raw data.

For example, the reports generated by the division focus on individual facilities or clients and as a result are rarely aggregated, so regional comparisons cannot be drawn or systemic issues identified. Furthermore, regional directors have complained they receive information by individual client or facility for all six regions and the training schools, making meaningful analysis too time consuming to perform.

The committee believes it is vital that the Quality Assurance Division produce data so top management can address systemic issues and measure regional performance. Therefore program review committee recommends:

The Quality Assurance Division develop a capacity to analyze data and issue reports identifying system problems and reporting regional variations.

The sort of analyses the Quality Assurance Division should be performing include: identifying problems by type, by region, by case manager, by inspector, and by average time taken to resolve, as well as comparing other relevant measures. This can be used to hold individuals and regions accountable, to reassess usefulness of criteria, to identify training needs, and to formulate policy.

Appointment of Commissioner

Under C.G.S. Sec. 19a-460, the commissioner is appointed by the governor "on recommendation of the council on mental retardation." The appointee must be "a person whose background, training, education and experience qualify him to administer the care, training, education, treatment and custody of persons with mental retardation."

The program review committee believes the statutory role of the council in the selection process for the commissioner

of mental retardation is currently confusing. It is unclear whether the governor is required to choose only from among the individuals whose names are proposed by the council, or if he or she must merely consider its recommendations along with any other names that may be suggested.

Likewise, the nature of the direct mental retardation experience that is required of the nominee appears to be ambiguous. Whether a nominee with broad work and educational experience outside the mental retardation field could qualify for the position based on the administrative qualification requirement of the statute is arguable.

The committee believes clear qualifications for the commissioner of mental retardation should exist. However, the selection process should not differ markedly from that of any other commissioner. As with all of the governor's appointments, the selection should be based on the skills and training needed to handle the responsibilities and problems of the particular agency.

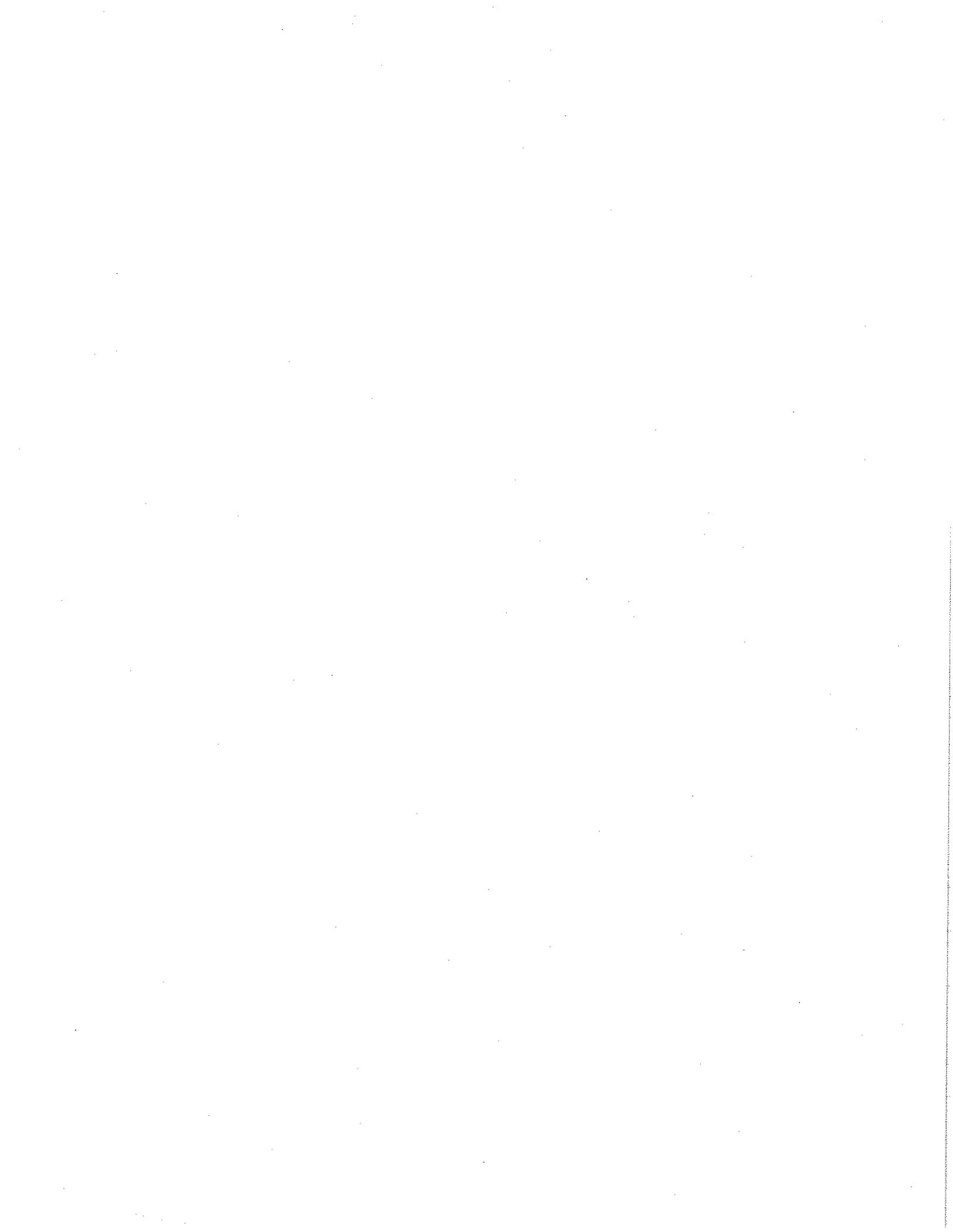
Therefore, the legislative program review committee recommends:

C.G.S. Sec. 19a-460 shall be amended to require that the commissioner of mental retardation be required to have "background, training, education or experience in administering the care, training, education, treatment, or custody of persons with mental retardation." In addition, the role of the Council on Mental Retardation with respect to the appointment of the commissioner shall be clarified. The council shall be allowed to advise the governor on the selection, but the governor shall not be required to appoint a person recommended by the council.

Under the revision proposed by the committee, the governor will still be able to utilize the knowledge and expertise of the council in evaluating candidates for commissioner. However, the governor will be free to select the person he or she believes combines the best mix of managerial skills and philosophical compatibility.

A further check on the background and training of nominees will be provided by the legislature. The qualifications of nominees for all commissionerships are scrutinized through the formal approval process, including public hearings by the Executive and Legislative Nominations Committee.

APPENDICES



APPENDIX A

Details Regarding Selected DMR Contracts

A study conducted by the Legislative Program Review and Investigations Committee of the Use of Professional Consultants by State Agencies in 1988 revealed that the Department of Mental Retardation had awarded a total of 16 sole source contracts to three consultants or their firms from distant geographical locations. The total contract value involved was \$1,137,179.

Graphic Futures, whose president is Elizabeth Mount from Georgia, received a total of three contracts valued at \$89,345. Joseph Patterson from Arizona received four contracts with a \$85,359 value. In addition, a company headed by Dr. Patterson, Desert Survivors, received a separate \$62,550 contract. Ralph Wetzel, also from Arizona, was awarded seven contracts totaling \$117,925. Finally, Common Green Corporation, of which Joseph Patterson is president and Ralph Wetzel is secretary, had a contract with the department extending through July 1989 for \$782,000. The department has recently signed a new contract with Common Green for \$419,361 for fiscal year 1990.

In the fall of 1988, as part of the study of consultants, program review committee staff inquired into the reasonableness of the sole source contract awards. At that time, Deputy Commissioner Terry Roberts, Elizabeth McArthur, Director of the Division of Service Development and Support, and Marijke Kehrhahn, Director of the Training and Staff Development Unit, were interviewed. They provided program review committee staff with the following three reasons for the sole source contract awards:

1. The department was under pressure from the court monitors and the plaintiffs in the CARC v. Thorne lawsuit to quickly develop and implement methods to respond to clients with challenging behaviors;
2. Prior to the sole source awards, a national search for consultants had been conducted by the department, but none of those solicited were available. (An RFP had been issued under Acting Commissioner Amy Wheaton for \$10,000 worth of consultant services); and
3. The consultants hired by the department had national reputations, and, therefore, were uniquely qualified for a sole source award.

Because two of the three consultants were from Arizona, a state in which DMR Commissioner Lensink had served as director of the Division of Developmental Disabilities, committee staff specifically asked whether the commissioner was personally acquainted with any of the consultants. At the

fall interview, department staff unequivocally denied any relationship, personal or otherwise, existed between the commissioner and any of the consultants.

In January 1989, the Legislative Program Review and Investigations Committee authorized a management study of the department. One facet of the study was to examine in-depth the circumstances surrounding the contract awards to these consultants. The committee staff outlined three areas that warranted further scrutiny: the relationship between the original RFP issued under Acting Commissioner Wheaton and the subsequent sole source contract awards; the affiliation between each consultant and top management in the department; and the professional reputations of each consultant.

In May, June, and August of 1989, program review committee staff conducted a broad range of interviews with DMR personnel who were involved in procuring the consultants as well as awarding later contracts. Department personnel interviewed included Commissioner Lensink, Deputy Commissioner Charles Galloway, Deputy Commissioner Terry Roberts, and Division Director Elizabeth McArthur. Formal interviews were also conducted with Dr. Elizabeth Mount and Dr. Joseph Patterson, two of the consultants involved. A phone interview was held with Dr. Ralph Wetzel, the third consultant.

In the round of interviews conducted in the spring of 1989, Commissioner Lensink, Deputy Commissioner Galloway, and Division Director McArthur stated that the initial hiring of these consultants was in response to pressure from the court monitors to develop methods to train department staff in managing behaviorally challenging clients.

At Deputy Commissioner Galloway's suggestion, the department contracted with Elizabeth Mount. Dr. Galloway said that he knew of Dr. Mount through a network of professionals with whom he associated and was aware of Dr. Mount's work in developing planning methods for helping mentally retarded individuals. Deputy Commissioner Galloway also noted that he had met Dr. Mount at a conference in Georgia in the 1970s.

The hiring of Joseph Patterson was suggested by Commissioner Lensink. In an interview with committee staff, Commissioner Lensink said he had been aware of Dr. Patterson's work with mentally retarded individuals who exhibit challenging behaviors. Commissioner Lensink also told committee staff that he had been an acquaintance of Dr. Patterson's when they both lived in Arizona.

The hiring of Ralph Wetzel was suggested by Dr. Patterson, who was a former student of Dr. Wetzel. Although both Commissioner Lensink and Deputy Commissioner Galloway indicated they were familiar with Dr. Wetzel's work through his publications, only Commissioner Lensink had personally met him. Commissioner Lensink said that he had met Dr. Wetzel once when he had toured programs for the mentally retarded offered at the University of Arizona.

Program review committee staff found several inconsistencies between the explanation for hiring the consultants put forth in the fall of 1988 and the spring of 1989.

In the fall of 1988, committee staff was given a copy of a Request for Proposal (RFP) issued in the spring of 1985 by Acting Commissioner Amy Wheaton. Department staff said that the RFP was mailed to four nationally recognized experts and requested consultant services for a \$10,000, two-month period. The RFP involved curriculum development and on-site training of selected staff located in a particular unit at Mansfield Training School. The department told program review committee staff that none of the consultants were available at the time. However, no documentation could be provided by DMR to confirm the unavailability of the consultants solicited under the RFP.

The scope of consultant services sought in the fall of 1985 when Dr. Patterson and Dr. Mount were hired was significantly broadened under Commissioner Lensink's new leadership. Dr. Patterson and Dr. Mount were awarded contracts to train regional staff in techniques and methods for working with behaviorally challenging clients, while Dr. Wetzel was to provide services at the institutions. The total contract value was in excess of \$162,175. Yet at the fall interview with program review committee staff, department personnel kept citing the initial \$10,000 RFP as evidence that the department attempted to obtain competitive bids.

In the spring interview with committee staff, Elizabeth McArthur again attempted to establish a link between the original RFP issued and the later sole source awards to these consultants. When questioned further by committee staff, she admitted that there was little connection between the original RFP and the subsequent sole source awards.

Another area where contradictions between the fall and spring interviews exist concerned the relationship between the commissioner and the consultants. Committee staff initially were told by department personnel in the fall 1988 interview that none of the consultants were personally known to the commissioner. However, in the spring, committee staff were informed by both Commissioner Lensink and Dr. Patterson that they were acquainted through a mutual friend. Furthermore, Dr. Wetzel indicated to committee staff that he had served on the Arizona Governor's Commission on Mental Retardation when Commissioner Lensink headed the Developmental Disabilities Division in the state and had met the commissioner at that time. Dr. Wetzel also indicated that he was contacted by Commissioner Lensink to discuss programs for the mentally retarded offered at the University of Arizona.

Also in the fall interview, committee staff was told that each of the consultants were awarded contracts because they were "national experts" in their fields. However, it appears that only Commissioner Lensink knew of Dr. Patterson's work with behaviorally challenging mentally re-

tarded individuals. Dr. Patterson acknowledges that he had a regional reputation, mostly limited to the Arizona area, when he was initially hired by the department.

Within the department only Deputy Commissioner Galloway knew of Dr. Mount's work. Dr. Mount provided committee staff with her resume and a list of other states in which she has been a consultant. According to this list, Dr. Mount has worked extensively in other states and has had her work referenced in at least one national publication.

Both Commissioner Lensink and Deputy Commissioner Galloway were familiar with Dr. Wetzel's work. Dr. Wetzel has been a professor at the University of Arizona for a number of years and has also published fairly extensively.

Elizabeth McArthur was unable to provide an explanation for why she had previously characterized all three consultants as national experts. Commissioner Lensink acknowledges that he may have used the term "national expert" too freely and stated that "expert" would have been a better phrase.

Conclusions

Program review committee staff finds that the DMR staff interviewed in the fall of 1988 misled the committee by: 1) trying to establish a relationship between the original RFP and the subsequent sole source awards; 2) indicating that no personal relationship existed between the commissioner and any of the consultants; and 3) attributing the hiring of these consultants to their national reputations.

Committee staff finds that the original RFP issued by the department had no relationship to the sole source selection of the consultants subsequently hired. The department's attempt to establish a link was deliberately misleading. A practice the department is continuing by citing, in a form that must be sent to the Office of Policy and Management, the original RFP as sole source justification for the latest Common Green contract.

Although committee staff was told that the commissioner did not personally know any of the consultants hired, it became clear in the spring interviews that Commissioner Lensink was acquainted with Dr. Patterson and had met Dr. Wetzel at least once. Furthermore, Deputy Commissioner Galloway also had met Dr. Mount at a conference they both attended.

Committee staff finds that the department's depiction of the consultants in the fall as "national experts" was untrue. In the spring interview, Dr. Patterson acknowledged that he does not have a national reputation, but rather a regional reputation in the Arizona area. Only Dr. Wetzel appears to have national name recognition, one criteria that may be necessary to characterize an individual as a "national expert". Even Commissioner Lensink concedes that he used the term too freely.

Elizabeth McArthur, who was present at the fall interview, accepts the responsibility for misinforming committee staff. However, neither she nor Deputy Commissioner Roberts were able to explain the discrepancies between what committee staff was told in the fall and what was stated in the spring interviews.

Commissioner Lensink indicated that he was unaware that his staff had been interviewed in the fall of 1988 about these contracts and that questions had been raised about the relationship between DMR staff and Dr. Patterson, Dr. Mount, and Dr. Wetzell. However, Deputy Commissioner Roberts believes she had informed the commissioner about the questions asked by committee staff immediately after the fall 1988 interview.

Program review committee staff believes it is doubtful that any of these consultants would have received contracts from the department on the basis of their national reputations. It is the opinion of committee staff that these consultants were selected because they were known to the commissioner and the deputy commissioner, who believed that their methods reflected the philosophy of the department.

In a related area, program review committee staff is also concerned about the contract award to Dr. Patterson that led to the establishment of the Common Green Corporation. In this instance, Dr. Patterson was given a \$46,560 contract on a sole source basis to develop a proposal outlining how DMR should serve clients with both mental retardation and mental illness who exhibit challenging behaviors. Dr. Patterson proposed that a cadre of people skilled in dealing with behaviorally challenging clients be developed rather than creating a center where individuals would be admitted for treatment.

The department then awarded a \$1.3 million contract to Common Green, Dr. Patterson's firm, for a 15 month period to provide such services. The contract was later amended to \$782,000 because of reductions in the department's budget. Common Green was just awarded another \$419,361 sole source contract for FY 90. Elizabeth McArthur told committee staff that it was clear when Dr. Patterson developed the proposal, that he would head the project that would be proposed.

The committee staff is particularly disturbed that department staff gave different responses in the fall of 1988 and the spring of 1989 regarding the reasons for the selection of these consultants and that no effort was initiated by the department to correct the resulting misconceptions. Although the department did not violate any laws, committee staff believes that the pattern of repeated sole source awards to these consultants and the appearance created by awards and subsequent statements by DMR staff showed poor judgement on the part of department managers.

APPENDIX B

Region 6 Medical Services Contract For Seaside

Chronology

Since 1978, the Niantic physicians group composed of Doctors Linden, Thompson, Cooper, and Goldberg has been providing health care services to residents of DMR facilities in southeastern Connecticut. In 1988, the physicians group was serving approximately 200 people at Seaside and Mystic centers.

During the spring of 1988, the doctors were informed by the Department of Mental Retardation (DMR) health services coordinator for Region 6 that their contract would only be extended for six months and that the regional office planned to issue a Request for Proposals (RFP) in July 1988 for more comprehensive medical services. The doctors were told they could respond to the RFP if they wanted.

Reasons for change. According to the director of Region 6, Kathryn duPree, the decision to change the medical services model was made by her, but discussed with the commissioner and his deputies prior to the change being made. She indicated that she considered the clinic model of physician services that was in place when she arrived in Region 6 in 1986, and which was still in place in 1988, too fragmented an approach to medical service.

Under that system, Doctors Linden, Thompson, Cooper, and Goldberg conducted clinics on-site at the Region 6 facilities in Mystic and Waterford during preset hours of the week, were on call for emergencies, and handled inpatient care for DMR clients at Lawrence and Memorial Hospital in New London. For many years the clients saw whichever doctor was handling the clinic on a given day. Recently, efforts had been made to schedule the clients so they would see the same physician on a regular basis.

Ms. duPree said one of the reasons for deciding to change the medical services contract was increasing conflicts with the current physicians group about implementation of DMR policies. Of particular concern were disagreements about the ability of clients to attend day programs away from their residences, the use of psychotropic drugs, and the identification of possible cases of client abuse.

She also noted that under the existing clinic system, interdisciplinary teams, which are responsible for the development of individual client plans of service, have raised concerns about communication, particularly the flow of information about medical related issues. Communication with psychiatrists treating clients has also been a problem.

The director said she was also concerned about access to generic health care in the community for clients still in DMR facilities who will be moving out of those settings, as well as for mentally retarded individuals already living in the community. She believed efforts to identify the availability of such services needed to begin.

Request for proposals. In late June 1988, Region 6 issued an RFP for the provision of primary health care to approximately 200 DMR clients. The goals of the new system as stated in the proposal were to:

- provide health services through a primary physician model consistent with the department's mission;
- provide health services in the context of an interdisciplinary team approach;
- educate community practitioners to the needs of clients with mental retardation; and
- assist clients moving to community homes in locating generic health providers.

Services were sought for the six-month period from January 1, 1989, through June 30, 1989. The RFP indicated a continuation of service in subsequent years was anticipated, but would be contingent on future appropriations.

Organizations or individuals wishing to respond to the RFP had to submit a letter of intent to Region 6 by July 30, 1988; the application itself had to be submitted by August 30. Region 6 was to complete its review of the proposals by September 30, 1988.

Selection process. Notification of the RFP was given to the Niantic physicians group, the New London chapter of the American Medical Association, Columbus Medical Services, Liberty Healthcare, and Pennhurst. The latter three firms had previously expressed interest to DMR staff about working in Connecticut.

A letter of intent dated July 6, 1988, and a proposal for services dated August 1988 were submitted to DMR by Columbus Medical Services. A letter of intent dated July 15, 1988, was submitted by Liberty Healthcare; their proposal for services was received by DMR on August 30, 1988. On July 27, 1988, Region 6 received a letter from Doctors Linden, Thompson, Cooper, and Goldberg that was titled "Proposal for Medical Services for Clients of Seaside Regional Center." A synopsis of the three proposals is included at the end of this appendix.

On September 30, 1988, Liberty Healthcare and Doctors Linden, Thompson, Cooper, and Goldberg were sent letters informing them that the contract for medical services had been awarded to Columbus Medical Services. On October 3, Columbus was sent a letter indicating that its contract with DMR would begin January 1, 1989.

According to the Region 6 director, Columbus Medical Services was selected because of its combined nurse practitioner and physician model of service, which only its proposal included, and the fact that its references were stronger.

Contracts. During the fall of 1988, full implementation of the contract with Columbus Medical Services was postponed. Columbus was having difficulty finding a full-time physician to work at Seaside as outlined in its RFP response.

In December 1988, Region 6 extended the clinical services contract with Doctors Linden, Thompson, Cooper, and Goldberg to cover the provision of medical services for January 1 - June 30, 1989. This extension cost \$46,200, an increase of \$6,200 over the previous six months.

Region 6 also signed a modified contract with Columbus Medical Services for a needs assessment of the region and the services of a full-time nurse practitioner starting February 1, 1989. The original \$120,000 cost of the six-month contract was reduced to \$65,000.

If the Niantic physicians' contract had been renewed for state FY 89 without any change in services as originally forecast in the Region 6 budget, the cost would have been \$80,000. The cost of the two six-month contracts with the Niantic doctors plus the payments to Columbus for coordination and nurse practitioner services for six months resulted in actual expenditures of \$135,100. The \$55,100 over the original budgeted cost was obtained from savings in the food and office supplies categories of the region's "Other Expenses" account.

Current situation. Columbus Medical Services was expected to have a full-time physician available to begin working July 1, 1989, when a 12-month contract for \$239,500 was to begin. By June 30, Columbus still had not hired a full-time physician. To fulfill the July 1 contractual requirement for a doctor, Columbus made arrangements for two Connecticut physicians (a family practitioner and a neurologist) to temporarily provide medical care and handle on-call services for Seaside and Mystic Center residents.

The family practitioner is also responsible for in-hospital care at Backus Memorial Hospital in Norwich. Major emergencies are handled at Lawrence and Memorial Hospital, utilizing its voluntary, on-call system for inpatient care, if needed.

Throughout the summer, Columbus Medical Services continued interviewing candidates for the full-time physician's job. Several times Columbus thought it had found someone, but each time the physician subsequently changed his mind. It is now expected that the part-time neurologist will assume the full-time position on October 1, 1989.

As a result of the delays in fully implementing the primary care model of service originally envisioned in the contract drawn up with Columbus Medical Services, Region 6 is reassessing the tasks to be required in state FY 91. A new RFP will be issued this fall, and responses will be solicited from other groups in addition to Columbus.

Findings

1. The decision to change the manner of delivering medical services to residents of Seaside and other DMR clients in Region 6 was made by the regional director and was within her authority.

2. The impetus for changing the medical service model was the increasing number of philosophical differences between the Department of Mental Retardation and Doctors Linden, Thompson, Cooper, and Goldberg.

3. Once the decision to change the model was made, a number of medical service models could have been chosen, depending on the services desired and funding available. The model selected for the RFP was based on the regional director's previous educational and work experience.

4. The ability of Region 6 to identify an additional \$80,000 (and actually spend \$55,100) of its state FY 89 budget allocation for the revised medical services model at a time when increased money was unavailable for other services raises questions about the manner in which funding priorities are set by DMR.

5. The two-page letter submitted by Doctors Linden, Thompson, Cooper, and Goldberg in July 1988 constituted a response to the Request for Proposals. However, the information in the document did not address all of the elements specified in the RFP.

6. There is no evidence to suggest Region 6 did not follow proper procedures in awarding the initial contract to Columbus Medical Services in October 1988.

7. DMR's continued contractual relationship with Columbus Medical Services, despite its repeated failure to hire a full-time physician as specified in its original proposal, suggests Region 6 staff thought implementation of the medical services model represented by Columbus in the long term was more important than the firm's ability to perform in the short term.

Legislative Program Review and Investigations Committee Staff
 Summary of the Proposals for Medical Services Received by Region 6

	Drs. Linden, Thompson, Cooper, and Goldberg	Columbus Medical Services	Liberty Healthcare
PROPOSAL RECEIVED BY DMR	July 27, 1988	August 1988	August 30, 1988
TYPE OF FIRM	group practice private physicians (internal medicine)	interdisciplinary group of professionals w/ extensive experience serving individuals w/ developmental disabilities	full-service medical management company
STAFFING TO BE PROVIDED	15 hrs/wk of physician services at 5 wkly clinics emergency care 24 hrs/day in-hospital care to clients admitted to Lawrence & Memorial Hosp.	one full-time medical director one full-time nurse practitioner 24 hr/day primary care coverage (includes nurse practitioner utilization)	20 hrs/wk primary care physician services for wkly clinics 10 hrs/wk physician consultation and education for in-house and community based providers 24 hrs/day on-call primary care physician services 10 hrs/wk psychiatric consultation services

NATURE OF SERVICES PROVIDED

<p>provide primary health care at clinics</p> <p>provide in-hospital care</p> <p>meet with other interested parties during usual clinic hours on a scheduled basis, if time consumed does not interfere w/ patient care</p> <p>utilize existing working relationships with specialists to gain care for clients</p> <p>provide info about physicians in the area to DMR and info to physicians about clients (could not solicit physicians)</p> <p>will get the specialty care needed for clients</p>	<p>primary responsibility for care of ~200 clients</p> <p>primary care evaluation, diagnoses, and treatment</p> <p>develop/implement a preventive health services program</p> <p>develop long-term treatment plan for chronic medical conditions</p> <p>evaluate, diagnose and treat acute medical conds.</p> <p>develop/follow-through on medical referrals to outside consultants</p> <p>complete 30 day physicians' order and medication review</p> <p>participate in interdisciplinary team process</p> <p>develop/participate inservicing center staff</p> <p>review psychotropic medication practices</p> <p>increase capacity of community health services</p>	<p>daily rounds to living areas and/or clinics; medical exams; follow-up treatment; periodic reviews/evaluations</p> <p>develop/implement long-term treatment plans for chronic medical conditions</p> <p>develop, coordinate and follow-up on appropriate medical referrals to hosp.s and other providers</p> <p>attend individual annual team reviews</p> <p>participate in developing behavior management plans</p> <p>utilize ancillary services</p> <p>meet with parents and guardians on request</p> <p>complete medical summary on death/transfer/discharge</p> <p>ongoing orientation and training to physicians + other health providers in the community</p>
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Dr. Linden et al	Columbus Medical	Liberty Healthcare
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OTHER COMPONENTS

recruitment of highest quality personnel avail.	Quality assurance program	
ongoing mgt. of professional staff, including continuing ed	Recruitment and screening of professional staff	
ongoing client centered systems development	contract oversight by sr. management staff person	
quality assurance activities		
quarterly progress reports/meetings		
malpractice ins.		

COST

\$42,000 for 6 months (1/1/89-6/30/89)	\$239,500 for first year, based on an ongoing project relationship	\$240,000 per year (12 installments); annual increase = CPI med. component physician index
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NOTE: The information contained in this summary was obtained solely from the materials submitted to the Department of Mental Retardation in response to the RFP.

6/30/89

APPENDIX C

Personal Service Agreements

The Department of Mental Retardation contracts for a variety of personal services. These services range from having a professional consultant design a data processing system to providing routine medical services for clients.

Based on the state comptroller's records, the department entered into 356 personal service contracts in fiscal year 1988 and 374 contracts in fiscal year 1989. The face value of the contracts for FY 88 was \$6,905,381. In FY 89 the face value of the agreements totaled \$7,040,538.

All personal service contracts in the state comptroller's active file were categorized by program review committee staff into types of services provided. Table C-1 shows the number and face value of contracts for each category of service in FY 88 and FY 89.

Table C-1. Personal Service Agreements by Type of Service Provided.

Service	FY 88		FY 89	
	No. of Contracts	Contract Face Value	No. of Contracts	Contract Face Value
Counseling	23	\$1,514,099	13	\$ 332,460
Day Program	2	61,011	3	19,320
EDP	3	240,405	2	37,800
Management	5	95,547	7	179,207
Medical Services	103	2,056,925	121	2,963,734
Personnel	59	490,087	11	51,061
Pharmacy	7	18,544	10	35,434
Planning/Research	7	217,990	14	331,656
DMR Program Rev. Comm.	11	128,840	21	239,142
Recreational	26	83,826	30	108,777
Religious	2	14,745	3	24,944
Residential	1	112,760	3	818,915
Respite	14	547,107	14	520,818
Staff Training	58	506,526	94	709,284
Tech Advice	6	268,820	4	21,740
Transportation	6	13,931	5	52,800
Other	20	487,502	16	520,188
Unknown	3	46,716	3	73,258
Total	356	\$6,905,381	374	\$7,040,538

Source of Data: Office of the State Comptroller.

As the table shows, medical services had the greatest number of contracts and the largest contract face value for both years. This category includes physician care, dental care, speech therapy, physical therapy, and other medical related services.

The personnel category, which consists of individuals or organizations that provide direct care services for a specific client of the department, ranked second in number of contracts in FY 88. However, it decreased dramatically in both the number of contracts and their face value in FY 89.

The increase in value for the residential category from \$112,760 in FY 88 to \$818,915 in FY 89 can be attributed to one contract awarded to the Shrope Foundation for \$773,355. This contract required that full residential services be provided to a maximum of 14 clients.

Personal Service Agreements categorized as "other" services are extremely diverse. For example, services range from security guard coverage to video production. The high face value for "other" involved the distribution of grants by the department for compliance with the Developmental Disabilities Assistance Act. Contract values for that purpose were \$395,764 in FY 88 and \$377,068 in FY 89.

Table C-2 displays actual expenditures in FY 89 for contracted services. Expenditures may be made on contracts that were entered into in a prior year, but services either were not performed or paid for until FY 89. Thus, expenditures may be greater than the face value of the contracts for a given year. For example, expenditures in FY 89 exceeded the face value of the contracts by \$207,761, for a total expended amount of \$7,248,299. This was 2 percent of the department's FY 89 expenditures.

The table shows that medical services was the largest expenditure, followed by staff training. As noted previously, the high expenditure in the residential category can be traced to a single contract.

Table C-3 provides a breakdown of the service recipient or end product received by the department. The vast majority of the services contracted for by the department are client-based. Of the total expended in FY 89, fully 71.1 percent was for direct services for clients of the department.

Table C-2. Expenditures For Services For FY 89.

Service	No. of Contracts	FY 89 Expenditures
Counseling	28	\$ 506,213
Day Program	4	68,415
EDP	5	227,885
Management	11	130,586
Medical Services	202	2,736,153
Other	25	625,291
Personnel	27	113,296
Pharmacy	16	27,007
Planning	17	309,227
Program Review Comm.	29	167,349
Recreation	34	90,506
Religious	6	30,969
Residential	4	737,119
Respite	20	480,177
Staff Training	121	750,581
Tech Advice	8	135,047
Transportation	6	48,281
Unknown	6	64,197
Total	569	\$ 7,248,299

Source of Data: Office of the State Comptroller.

Table C-3. Service Recipient Or End Product Delivered.

Product	No. of Contracts	FY 89 Expenditures
EDP	4	\$ 213,875
Report, Manual, etc.	12	219,910
Service to a Client	327	5,152,943
Service to Department	79	748,371
Staff Training	126	778,901
Other	15	77,704
Unknown	6	56,595
Total	569	\$7,248,299

Source of Data: Office of the State Comptroller.

APPENDIX D

Provider Survey

The Legislative Program Review and Investigations Committee surveyed 111 organizations having contracts to provide day or residential programs to DMR clients to obtain data on provider perceptions of the department. Completed questionnaires were submitted by 87 entities, for a response rate of 78.4 percent.

Information about the size and program offerings of the survey respondents is presented in summary form. The responses to the opinion questions on the survey have been grouped by region.

The regional responses represent the answers of all survey respondents who operate programs in a specific region. Provider agencies working with DMR may offer services in more than one region, thus the total of the regional responses is greater than 87. The number of providers who had contact with each region is shown in Table D-1.

Survey of DMR Service Providers

1. Type of Organization 2. Number of years organization has:
6% For Profit (a) been in existence _____ median=13
94% Nonprofit (b) contracted with DMR _____ median=5

3. Does your organization, or its parent, currently operate in states other than Connecticut?
78% No 22% Yes (If yes, how many states? _____)

4. Identify each region within which your organization provides services for DMR.

N=27 Region 1 N=17 Region 4
 N=21 Region 2 N=30 Region 5
 N=16 Region 3 N=17 Region 6

Note: providers may operate in multiple regions, so numbers total more than 87

5. Approximately, what was your organization's total budget for its last fiscal year?

Range: \$42,000-30.3million \$ _____ expenditures
 median=\$1.6m

\$ _____ revenues
 Range: \$30,000-\$40 million
 median=\$1.6m

6. Estimate the percentage of your organization's total expenses devoted to providing services to DMR clients. _____ %

median=94%

7. Estimate the percentage of your organization's total revenues from all sources that are received for providing services to DMR clients. _____ %

median=95%

8. Please indicate whether your organization provided the types of services listed below to DMR during the fiscal year ending June 30, 1989. For each yes response, please supply the data requested.

(Range of all responses indicated)

Service	Service Provided (yes/no)	No. of Separate Projects	Total No. Persons Served	No. years since first service provided to DMR
Residential	yes no 66%	(1-40) median=4	(4-192) median=20	(1-23) median=6
Supported Employment	yes no 52%	(1-45) median=2	(3-211) median=23	(1-17) median=3
Sheltered Workshop	yes no 33%	(1-6) median=1	(9-300) median=44	(4-30) median=10
Day Services (Excluding Employ.)	yes no 39%	(1-6) median=1	(1-130) median=18	(1-25) median=3
Other (Specify)	yes no			
Other (Specify)	yes no			

Table P-1. LPR&IC Provider Survey Responses to Selected Questions.

Region	Number of Responses	9. Rate Job Performance during past year as Adequate or Better:		10. Characterize Accuracy of Information as Adequate or Better:	
		Central Office	Region	Central Office	Region
1	27	70%	85%	56%	78%
2	21	67%	71%	57%	71%
3	16	63%	92%	75%	88%
4	17	47%	71%	35%	53%
5	30	57%	80%	60%	80%
6	17	53%	71%	71%	77%

Table P-2. LPR&IC Provider Survey Responses (continued).

Region	11. Characterize your relationship as Adequate or Better with:		12. Overall Believe Organization treated fairly by:		13. Compared to other organizations, believe your organization not treated as well by:	
	Central Office	Region	Central Office	Region	Central Office	Region
1	85%	89%	63%	78%	26%	15%
2	71%	86%	52%	81%	19%	5%
3	69%	94%	63%	88%	19%	0%
4	65%	77%	47%	71%	29%	18%
5	83%	90%	57%	90%	17%	3%
6	59%	77%	47%	71%	35%	29%

APPENDIX E

DEPARTMENT OF MENTAL RETARDATION

RESPONSE
TO THE
PROGRAM REVIEW AND INVESTIGATION COMMITTEE
MANAGEMENT STUDY
OF THE
DEPARTMENT OF MENTAL RETARDATION

January, 1990

INTRODUCTION

In response to pressures from advocates, the court, the federal government, and citizens of the State of Connecticut, the Department of Mental Retardation has made a dramatic number of changes to revamp our service delivery system over the past four and a half years. Generally, these changes have been well-managed and have propelled Connecticut into a position of national leadership in the field of developmental disabilities. Yet, we will be the first to acknowledge that there is much unfinished work. Areas such as quality assurance, management information services and fiscal accountability will require continued refinement to improve further their effectiveness and efficiency. We must also continue to expand the variety of supported living arrangements to ensure that the development and safety of individuals with mental retardation are protected in the least restrictive settings with the most efficient use of costly staff resources. And we must also assure that neglected and underserved groups garner a share of new, community-based programs.

The department realizes that sometimes both we and our constituents have suffered the side effects of massive, rapid change. These side effects include uneven learning and competence, mistakes that are only recognized in hindsight, resistance to ideas based solely on their unfamiliarity, and frayed feelings even among people who basically agree.

While the department welcomes constructive criticism from all quarters and applauds the efforts of the Legislative Program Review and Investigation Committee and their staff for their efforts in producing this report and its recommendations, we are understandably cautious about making further changes that may be a response to (a) issues that arose out of isolated circumstances rather than a systemic problem, or (b) systems that are still evolving, or (c) may demand additional personnel in an era of scarce resources. We are also constantly reminded that we work in a fluid and dynamic system, where changes in one area may result in unforeseen repercussions in another. It is in this spirit of openness, tempered by caution, that we respond to the recommendations of the committee.

MISSION

Recommendation of the Program Review and Investigation Committee

The current mission statement of the Department of Mental Retardation should be adopted into statute with a provision requiring it to be reconsidered by the General Assembly in 1992 and every four years thereafter.

The mission of the department to be included in statute is "to join with others to create the conditions under which all people with mental retardation experience:

- . Presence and participation in Connecticut town life,
- . Opportunities to develop and exercise competence,
- . Opportunities to make choices in the pursuit of a personal future,
- . Good relationships with family members and friends, and
- . Respect and dignity."

Response

The department is justifiably proud of its articulation of a mission and its widespread acceptance by staff. We are pleased that the committee recognizes the mission and endorses it so strongly that it recommends that the legislature adopt the mission statement verbatim in state law.

Our only concern with the recommendation is that our mission statement not be weakened or modified in the process of debate and adoption. The legislature also needs to review other statutes to remove any underlying inconsistencies with the mission. In the interest of consistency, we suggest that this recommendation should be applied to all other state human service agencies that have adopted official missions over the past several years.

ANNUAL PLAN

Recommendation of the Program Review and Investigation Committee

The Department of Mental Retardation shall be required to annually develop a five-year plan. The department shall hold public hearings on a full draft of the plan and, beginning in January, 1991 and annually thereafter, submit the final plan and a transcript of that public hearing to the committees of the legislature having cognizance over the department's operations and finances. The committees may hold a public hearing on the plan. The plan shall:

- . set priorities;
- . identify goals and objectives, and the strategies to be employed in achieving them;
- . define the criteria to be used in evaluating progress;
- . identify changes in priorities, goals, objectives and strategies from the prior plan;
- . describe and document progress made in meeting goals and objectives outlined in the prior plan; and
- . estimate the type and quantity of staff and client services that will be needed over the life of the plan.

Response

The current five year plan that operationalizes the department's mission is also a product that reflects input from the public obtained in regional and training school forums that are held annually. The final plan is widely disseminated, both to other agencies and to legislators, particularly those who serve on committees of cognizance. One of the original purposes for the plan was to signal to the legislature, the Office of Policy and Management, and others, the direction that the department intends to take.

We believe that our system of local forums reaches towns, neighbors, town selectmen, and families better than formal public hearings, which tend to be dominated by professional representatives of various advocacy and provider organizations. We have been pleased that many legislators have felt free to

participate with their constituents in our forums. We would not wish to substitute a formal hearing for this valuable process.

Another option would be for the legislature itself to hold hearings on the DMR five year plan every other year. This might be the most cost effective way to directly involve legislators in the process.

COST OF SERVICE

Recommendation of the Program Review and Investigation Committee

The Department of Mental Retardation should develop a system for tracking the cost of services purchased for individual clients.

Response

The department does track the cost of programs on an individual client basis, an activity critical for understanding the elements of cost in individual client programs and for the department's effort to capture maximum federal reimbursement for our programs. However, our capacity to accurately track costs for individuals is limited by the department's current computerized accounting systems. We expect that the adoption of a new financial accounting system as part of the Connecticut Automated Mental Retardation Information System (CAMRIS) will greatly improve our ability in this area. Caution must be used, however, not to put undue focus on the exceptional costs of any individual's program or to portray those costs as representative of the department's overall resource deployment or need. The tasks of long range cost projection and resource allocation are best served by use of averages and profiles.

Recommendation of the Program Review and Investigation Committee

Whenever the proposed cost of providing a specific service to a client (e.g., day, residential, support, etc.) exceeds by more than 30 percent the average cost of providing that service to all other clients within the region, the regional director shall make a formal finding on the need and appropriateness of providing the service. For the service to be provided or continued, the finding must be either:

- a. the service is necessary to maintain the client's health, safety, or existing skills; or
- b. the anticipated improvement in the individual's skills or quality of life can reasonably be judged equal to or greater than the benefits other clients must forego in order to provide the service to the recipient.

Response

The department does not agree to the use of an artificial cost threshold to trigger a review of individual clients' programs for appropriateness for the following reasons:

1. The cost of an individual's program alone is not a measure of its appropriateness or effectiveness. A program that falls well under the average may still provide far more support to a client than he or she needs to be successful. At the other end of the spectrum, some clients require a level of support that brings the cost of their program far above the average. Attempting to serve these clients at a lower cost and with less supports, would negate the value of the entire effort and constitute a true waste of resources.
2. The use of only a limited segment of the department's service delivery system, such as only purchased services as the source of cost data, would not produce appropriate comparison of costs. The exclusion of the cost of other program delivery options such as state operated day programs from the calculated averages would misrepresent the actual costs of total service delivery and significantly reduce the value of any resulting comparisons.
3. If we calculate the average cost of residential services for all clients who receive state support, then the costs of almost everyone who lives in the DMR training schools and regional centers will exceed the state average for purchased services. Enactment of the committee's recommendation would have us "justify" those costs on the basis of the two test questions the committee proposes. In almost every case, we could not justify the costs.
4. A number of factors over which the department has little or no control affects the costs of individual programs across the entire service delivery spectrum. These factors include collective bargaining agreements, regional economic variations, facility age and size, federal funding requirements and changing labor markets.

The department is committed to delivering the most appropriate and cost effective programs possible to each and all clients possible within the constraints of available resources. These decisions are made after weighing many variables in a context of legislative, judicial, and other externally imposed requirements. Any effort to impose a formal review process must recognize the impact of these external mandates in the decision-making process.

REGULATIONS

Recommendations of the Program Review and Investigation Committee

The Department of Mental Retardation shall adopt regulations that define the criteria to be used in:

- (a) determining if a person is eligible for services provided by the department;
- (b) determining which clients will and will not receive a specific service; and
- (c) selecting private sector services providers.

Response

- a. Determining eligibility for services has always been a difficult issue for the department. Eligibility based on the statutory definition of mental retardation (Sec. 1-1g C.G.S.) is clear when applied to most individuals. There are, however, other individuals who have been given access to the department through state and federal legislation, such as early intervention and the federal Nursing Home Reform Act. Therefore, the department agrees that regulations should be adopted that outline specific criteria for eligibility, including an appeal process for those who are denied eligibility. It should be noted that current state law does not provide that eligibility for services entitles or guarantees the availability of services.
- b. The determination of which clients will and will not receive a specific service is made based on priorities and factors outlined in the department's five year plan and in light of available resources. To place a priority listing in regulation would not allow for changes to be made based on unanticipated priorities for target populations made by the governor, the legislature (collectively through the budget act or individually through constituent advocacy), the federal government, or court mandates.

The department feels that the development of guidelines and procedures that include a process for their review and update on a biannual basis will satisfy the concerns of the committee.

- c. Regions select private service providers based on a standard process that takes into account the availability of funds, target priorities, and the provider's ability to address these areas. To date, the department has rarely been confronted with an abundance of providers seeking contracts for any one program. Therefore, the department feels that the development of guidelines and procedures for the selection of private service providers would better accomplish the recommendation of the committee. As stated earlier, a process for review and update on a biannual basis would be developed in the guidelines and procedures.

Recommendation of the Program Review and Investigation Committee

The Department of Mental Retardation shall repeal all existing regulations conflicting with the Mansfield consent decree or otherwise not legally binding.

Response

Court orders, including consent decrees, do not generate a requirement for regulations, only a statute can do that. However, we will review existing regulations that govern department activities and propose to the legislature changes that will bring a regulation into consistency with the CARC v. Thorne consent decree if those changes do not also violate the original intent of the statute that spawned the regulation.

PROCEDURAL GUIDELINES

Recommendation of the Program Review and Investigation Committee

The Department of Mental Retardation should develop guidelines that will ensure that the processes followed by the regional offices in selecting service providers and determining which clients will receive services are uniform. The guidelines shall specify the decision-making authority of the department's central and regional offices and set the parameters within which each shall operate.

Response

The department agrees to develop guidelines that include procedure for review and update on a biannual basis to ensure consistency among the regions and clearly outline decision-making authority at the regional level. The guidelines will include a management reporting system.

Recommendation of the Program Review and Investigation Committee

To promote central and regional office coordination in developing these procedures, and to have a written outline of the procedures developed by the department, the program review committee recommends that each regional office, following a format developed by the department's central office and taking into account regulations and guidelines adopted by the department, shall prepare written procedures outlining the processes to be followed in selecting private sector service providers and determining which clients will receive services. The procedures shall be reviewed and approved by the central office.

Response

As previously stated, the department agrees to develop guidelines and procedures, including procedures for review and update on a biannual basis that are responsive to this recommendation.

MANAGEMENT PRACTICES - Analysis

Recommendation of the Program Review and Investigation Committee

The Department of Mental Retardation should develop a management oversight capability and should submit reports at least annually to the legislature's committees of cognizance that:

- a. evaluate each region's adherence to its approved procedures for selecting service providers and determining which clients will get services, and
- b. identify and explain discrepancies between regions with respect to such things as staff-to-client ratios, cost-per-program models, cost-per-client for each type of service provided, gaps between clients served and those requesting services, etc.

Response

The department has already developed some management oversight capability. The commissioner and deputy commissioners meet weekly with the regional and training school directors to ensure regular and frequent communication. Periodic management retreats have been held to enhance management and problem solving skills. The new automated information system (CAMRIS), will further enhance local and central office management's ability to analyze agency operation and performance.

- a. As stated earlier under Procedural Guidelines, the department will develop the procedures including management reporting systems that respond to this recommendation. From these, the department will develop and submit appropriate annual reports to the legislature's committees of cognizance.
- b. The department is at the early stages of being able to conduct this level of analysis repeated under part "b" of this recommendation. With the implementation of the new automated information system (CAMRIS), we will be able to move toward more sophisticated analyses of operations. From these data we will develop management reports to identify and explain differences between regions.

MANAGEMENT PRACTICES - Training

Recommendation of the Program Review and Investigations Committee

The Department of Mental Retardation should identify management needs on an ongoing basis and develop appropriate training programs.

Response

As the committee's report mentions, the department's management training needs assessment is an important first step in developing management training strategies. The central office staff development unit has conducted a preliminary analysis of the survey results and will develop a plan to address the identified needs. The department has set aside funds this fiscal year to cover the cost of appropriate DMR sponsored workshops and tuition costs for individual managers' training needs identified in personal learning contracts. The results of the survey indicate that both mid-managers and executive level managers prefer that training in the highest priority areas be provided through workshops, guest speakers, or specialists who attend regular local meetings or discussion groups.

The development of management training is identified as a new objective in the current five year plan. Based on the results of this year's training initiative, the department will institute an ongoing process to identify and respond to the training needs of managers to improve their performance, efficiency, and supervisory skills.

QUALITY ASSURANCE

The department recently received the results of an audit of the quality assurance division that was conducted concurrently with the Legislative Program Review and Investigation Committee's study. The audit was commissioned as the result of a 1988 court order and was conducted by a nationally known consulting firm that used a dozen mental retardation experts to assess the performance of every aspect of this important department function. The following is an excerpt from the audit report:

Prior to a critique of the quality assurance system, the state must first be commended for creating a multi-faceted, values-driven quality assurance system. Indeed, the Connecticut system may be one of the most comprehensive in the country. Indeed, some aspects of the system have only just become fully operational . . . we found that DMR staff anticipated and/or were able to identify many of the same problem areas that also were identified in the audit [and] as often as not, were already addressing them in some fashion.

Finally, it is important to note that the audit did not uncover a service system in crisis or circumstances that required pervasive systemic overhaul. In all, the service system is in step with and in some instances ahead of state-of-the-art in quality assurance relative to other states. For the most part, the findings and recommendations should be viewed as fine tuning a system that is already largely meeting its mandate.

Department staff concur with most of the committee's specific recommendations regarding the quality assurance system, and we are pleased to report that we have been working toward refinements in the identified areas.

Recommendation of the Program Review and Investigation Committee

The quality assurance division should only identify problems. Once uncovered, the division shall notify the applicable region. It shall be the responsibility of the regional office to oversee the resolution of any problem identified by the quality assurance division. The regions shall report to the quality assurance division when there is resolution.

Response

The department questions the committee's conclusion that the quality assurance division strives to solve problems. The quality assurance division was developed in close coordination with the CAMRIS mainframe computer system precisely so it could collect comprehensive data, analyze it, and feed it back with recommendations to department managers who would identify and implement solutions to problems. The Division of Quality Assurance endeavors to cooperate with regional managers, and training, program development, and planning groups to feed information to the appropriate resources in response to their expressed needs for data. We have received criticism from litigants in CARC v. Thorne for not taking a more active role in problem resolution. The department's stance has always been that it is not the domain of quality assurance to resolve problems.

Recommendation of the Program Review and Investigation Committee

The quality assurance division shall issue a monthly report listing unresolved problems. The report shall identify the location, nature, and number of months since the problem was first identified. The quality assurance division shall follow-up by conducting a sample of those problems reported as resolved by the region. If the region has reported a problem resolved and the quality assurance division judges otherwise, the regional director and the commissioner shall be notified.

Response

The committee's recommendation for a system that identifies problems and the length of time it takes to resolve them is congruent with the department's present course. We are also refining our capacity to use current and emerging resources to analyze data and report systemic deficiencies and regional variations.

Recommendation of the Program Review and Investigation Committee

The quality assurance division should develop a weighting system for categorizing deficiencies. This system should be used to determine the frequency of inspections.

- a. Residential facilities that have undergone two consecutive inspections with no deficiencies shall be inspected biennially.
- b. Residential facilities that have undergone two consecutive inspections and the deficiencies received have been categorized as noncritical shall be licensed on an annual basis.
- c. Residential facilities that have undergone two consecutive inspections and the deficiencies received have been categorized as critical or the facilities that hold a provisional license shall be inspected at least semiannually.

Response

The department is committed to the objective of categorizing and weighting licensing deficiencies. The committee's recommendations to reward quality service providers with fewer licensing inspections have merit, but require some legal research and certainly will have to be sanctioned by statutory and regulatory revisions.

Recommendation of the Program Review and Investigation Committee

Program quality enhancement reviews should be administered in the regions. To enhance community awareness/involvement, recruitment efforts for volunteers should be centered in the community. Employees of DMR should not be allowed paid state time to participate as volunteers.

Information should be provided from the regions to the quality assurance division regarding the results of the reviews. The quality assurance division should then compile and analyze the information from the regions.

Response

The aforementioned audit of quality assurance activities actually praised the department for including program enhancement as a component of our quality assurance efforts, but recommended that the function be relocated to the training division of central office.

The department will study recommendations from the external quality assurance audit and the committee to determine the most appropriate placement of the program enhancement function.

Recommendation of the Program Review and Investigation Committee

The quality assurance division should develop a capacity to analyze data and issue reports identifying system problems and reporting regional variations.

Response

We concur with this recommendation, and we are currently assessing reporting mechanisms along with the stated needs of field managers for information. Improvements to data analysis capability will be dramatically improved when the CAMRIS system is fully operational. Nevertheless, reports are currently being redesigned to be more useful to all concerned.

APPOINTMENT OF THE COMMISSIONER

Recommendation of the Program Review and Investigation Committee

C.G.S. Sec. 19a-460 shall be amended to require that the commissioner of mental retardation be required to have "background, training, education or experience in administering the care, training, education, treatment or custody of persons with mental retardation." In addition, the role of the Council on Mental Retardation, with respect to the appointment of the commissioner, shall be clarified. The council shall be allowed to advise the governor on the selection, but the governor shall not be required to appoint a person recommended by the council.

Response

The department agrees that clarifying the qualifications for the commissioner would be helpful. We do not feel that we can comment on the political process to be used in selecting the candidate.