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Legislative Program Review and Investigations Committee  
Connecticut General Assembly  
State Capitol Room 506  
Hartford, CT 06119

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**Agency Responses to Implementation Questions for Study Entitled  
*Provision of Selected Services for Clients with Intellectual Disabilities*  
(completed January 2012)**

Part of the Legislative Program Review and Investigations Committee's (PRI) authorizing statutes provides:

*In any instance in which a program review cites inadequate operating or administrative system controls or procedures, inaccuracies, waste, extravagance, unauthorized or unintended activities or programs, or other deficiencies, the head of the state department or agency or the appropriate program officer or official to which the report pertained shall take the necessary corrective actions and when the committee deems the action taken to be not suitable, the committee shall report the matter to the General Assembly together with its recommendations. (C.G.S. Sec. 2-53h(a))*

For two years after the completion of a program review, the committee through its staff queries each agency that has been the subject of a review as to what actions the agency has taken to implement the PRI recommendations.

**2013 and 2014 Department of Developmental Services (DDS) Responses to PRI Staff  
Follow-Up Questions Re: Study Entitled  
*Provision of Selected Services for Clients with Intellectual Disabilities (January 2012)***

**2012 Legislative Session**

After the study was completed in January 2012, in the 2012 legislative session, PRI raised HB 5036, *An Act Implementing Recommendations of the Legislative Program Review and Investigations Committee Concerning the Provision of Selected Services For Persons with Intellectual Disability*. The bill included several of the study recommendations based on study findings that operating a dual system of care for DDS clients residing in 24-hour staffed residential settings was costly, and that the provision of care in the more expensive public settings offered no better quality. The recommendations in the bill were to:

- accelerate the pace for phasing out DDS-operated services, except for a very small segment of the client population;
- apply the same provisions contained in the Southbury Training School settlement agreement to residents currently living at regional centers;
- establish a centralized utilization review process for high-cost client services; and

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- require DDS to consider certain factors when contracting or renewing contracts with private providers.

The committee held a public hearing on the bill on February 22, 2012. No further action was taken on the bill, with the committee deciding instead to follow up with DDS next year on the agency's progress in areas reviewed by the study.

### **2013 and 2014 Agency Responses to Follow-Up Questions**

In both early 2013 and 2014, the committee through its staff asked DDS a number of questions related to the department's implementation of the committee recommendations. The PRI questions and the DDS responses for each year are included in this document.

2013 COMPLIANCE QUESTIONS FOR THE  
DEPARTMENT OF DEVELOPMENTAL SERVICES  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE REPORT:  
*Provision of Selected Services for Clients with Intellectual Disabilities (January 2012)*

Please respond to the following questions concerning the Legislative Program Review and Investigations Committee's study on *Provision of Selected Services for Clients with Intellectual Disabilities* by February 6, 2013. For each question below, the number corresponds to the number of the recommendation contained in the Executive Summary of the full report. If you have any questions, please call Maryellen Duffy or Cathy Conlin at 240-0300.

1. Since January 2012, what steps has DDS taken to evaluate all residents receiving 24-hour care at the five regional centers for possible placement in the community? How many residents have been evaluated? What were the overall results of those evaluations? Were any regional center residents recommended for a community placement and if so, how many? Have any regional center residents moved to a community living arrangement? Are there residents that are planning to move but have not yet?

DDS North Region has been discussing portability at each individual's quarterly and annual meeting. The only residents not seriously considered yet for portability are some of the residents who are more medically involved or individuals needing a 24-hour nursing (LPN) presence. Dozens of referrals have been made to vacancies in the private provider community for the individuals living at Hartford Regional Center. Seven residents have moved to Community Living Arrangements (CLAs) in 2012 and four more are scheduled to move.

Since January 2012, each individual residing in one of the three West Region regional centers has had their annual Individual Plan meeting. At each one of these meetings, the option of community placement is discussed with the team and evaluated for appropriateness. The West Region currently has 138 individuals residing in the three regional centers, and all have been evaluated. Of those evaluated, 17 individuals have been identified as being appropriate for community placement, and guardian consent has been received. Since January 2012, two individuals have moved from the West Region regional centers into community placement. The 17 individuals noted above are planning moves that have not yet occurred.

The South Region has conducted quarterly reviews of all individuals who reside at the Meriden campus and current and future placement is discussed. Staff continues to work with families to educate them on the variety of residential options that are available to their family member(s). Of the 13 individuals in the ICF/ID program in Meriden, four of these individuals reside in the Transitional Unit, where a return to community living is always the goal. Two of these individuals are currently looking for community placement. Additionally, there is currently one person residing at the campus who has a guardian who wants him to reside in the community, if the appropriate medical supports are in place. Two individuals moved out of the Transitional Unit in the fall of 2012, one to public and one to the private sector, and one individual on long-term respite moved in December 2012 to a public placement).

The PRI committee in January 2012 recommended that, for residents of Southbury and the regional centers, a rejection of a community placement should be revisited periodically. Since January 2012, how many recommendations have been made for community placement and how many were rejected? Have any of those rejections of community placements been reviewed and if so, were the community placement options again offered to the clients and families?

The professional teams at Southbury Training School (STS) have been making a recommendation regarding community placement during each Individual Plan meeting since November of 2011. During 2012, 100% of all the residents at STS have had a professional recommendation made and presented to the guardian. In 98% of the cases, the professional team has recommended that the resident could receive community based services. In 2% of the cases, the team recommended that services should continue be provided at STS. During 2012, 24 individuals moved out of STS and are receiving community based supports. Eighteen of these individuals are receiving supports from the private sector and six are receiving community based supports from the public sector. There are 30 more individuals at STS who are currently having community services developed for them. Twenty-six of these individuals will have services provided by the private sector and four of these individuals are requesting public sector services. The professional team reassesses each person at least annually regarding the recommendation for community services and presents/revisits this recommendation with the guardian. STS currently has a population of 370 residents. Its population at the start of 2012 was 419 individuals.

The committee had also made several recommendations to accelerate the pace of the public to private service transition. Please provide the current numbers of residents in the public settings -- Southbury, regional centers and public CLAs -- and those being served in private sector residences.

Public 24 hour Programs	
Residential Type	Nbr. Individuals
CLA	374
Regional Centers	199
Southbury Training School	370

Data as of 2/1/2013

Private 24 hour Programs	
Residential Type	Nbr. Individuals
CLA	3364
CRS	528
CTH	396

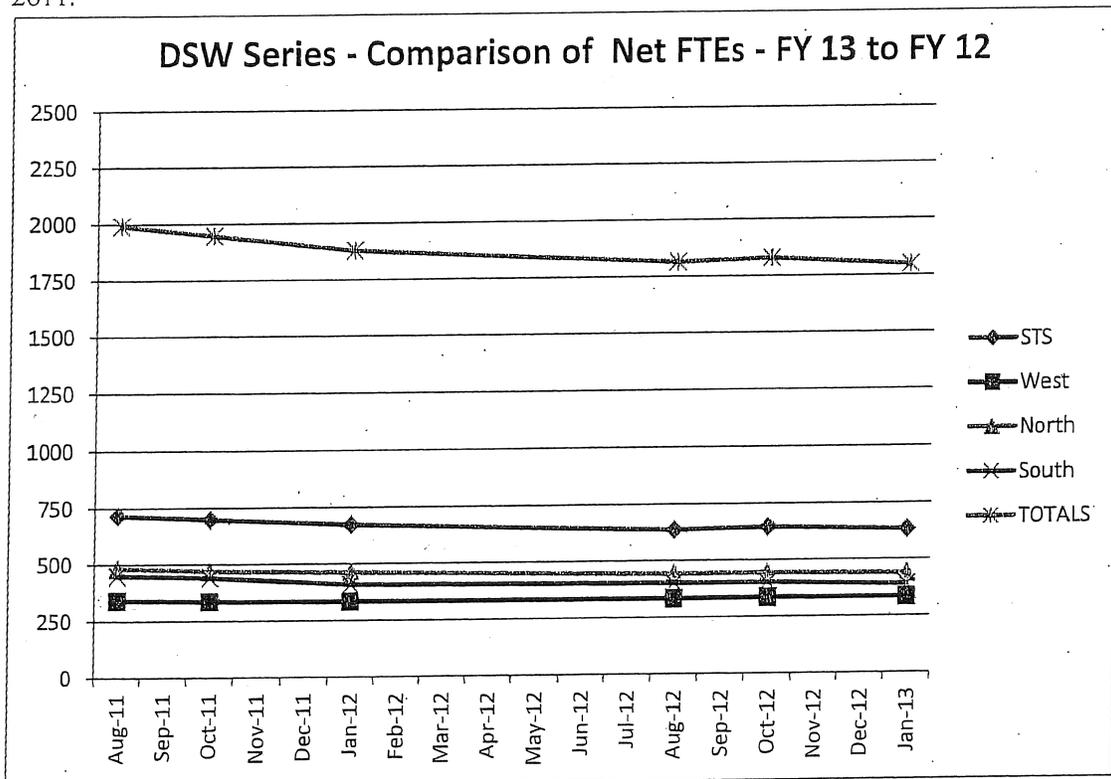
Data as of 2/1/2013

2. Has DDS conducted a staffing assessment at its residential settings in light of the 16 percent reduction in public sector clients that the committee found had occurred between FY 07 and FY 10? If an assessment was done, was the LON assessment tool used to determine the level of staffing needed (as it would in contracting for private placements), and what did the assessment results determine?

If the assessment determined staffing levels are higher than comparable settings in the private sector, what actions has the department taken to redeploy DDS staff to serve clients on the residential care waiting list in their homes or to provide respite care?

Please provide numbers for current DDS direct care or direct service filled positions in residential care settings. Were any of these refilled positions (of previously vacant positions) in FY 11 through the end of calendar year 2012? Please provide that number.

The number of current DDS direct care employees/direct service filled positions in residential care settings as of January 1, 2013 expressed as full time equivalents (FTEs) was 1,951.28 adjusted to reflect the number on leave status (e.g. workers' compensation, medical leave, etc.) the number was 1,798.76 FTEs – this includes durational/temporary staff as explained in the next paragraph. Still, this is a reduction of 192.45 FTEs since August 1, 2011.



DDS has not refilled any direct care/direct service positions vacated during FY 11, FY 12, or FY 13 YTD on a permanent/regular basis other than licensed practical nurse (LPN)

positions. Between July 1, 2012 and December 31, 2012, 42.5 FTEs were filled on a durational basis or in temporary positions as part of our overtime reduction plan submitted to the Office of Policy and Management (OPM) in October 2011 in order to replace staff who were on long term leave or to fill gaps in staffing schedules that were being filled on an overtime basis. We plan to continue to use of durational/temporary staffing of this nature to help us control overtime costs without hiring permanent replacement staff.

Has DDS been able to close any public residential settings in the past year? Where have any new residential clients been placed?

No homes were closed in the North Region in 2012. One home closure that was delayed in 2012 will occur in 2013 along with an additional three homes. Any new residential clients in the north region have been placed in the private sector.

Since January 2012, the West Region has not closed any public residential settings. One unit/apartment is slated to be closed this fiscal year at the Lower Fairfield Center. All new residential placements have occurred in the community with the private sector.

The South Region closed Ellsworth Avenue in New Haven on June 1, 2012 and 100 Lowe Avenue in Meriden on October 23, 2012. All individuals moved into homes supported by the private sector. 227/229 Camp Street in Norwich was closed in February 2013 and 251 Rogers Road, Norwich is scheduled to close in 2013. Three of the individuals in these homes went into vacancies in the public sector and the rest of the individuals are now supported by the private sector.

During 2012, six residences closed at STS (3 cottages and 3 Personal Village (PV) residences). As consolidations continue and residents continue to explore community placement options, it is expected that there will be one additional PV closure in 2013.

3. What efforts has DDS made to reduce its overtime? Was the department able to reduce its overtime by at least 10 percent in FY 12 as required by the Office of Policy and Management? Please provide the overtime usage and cost figures for FY 12.

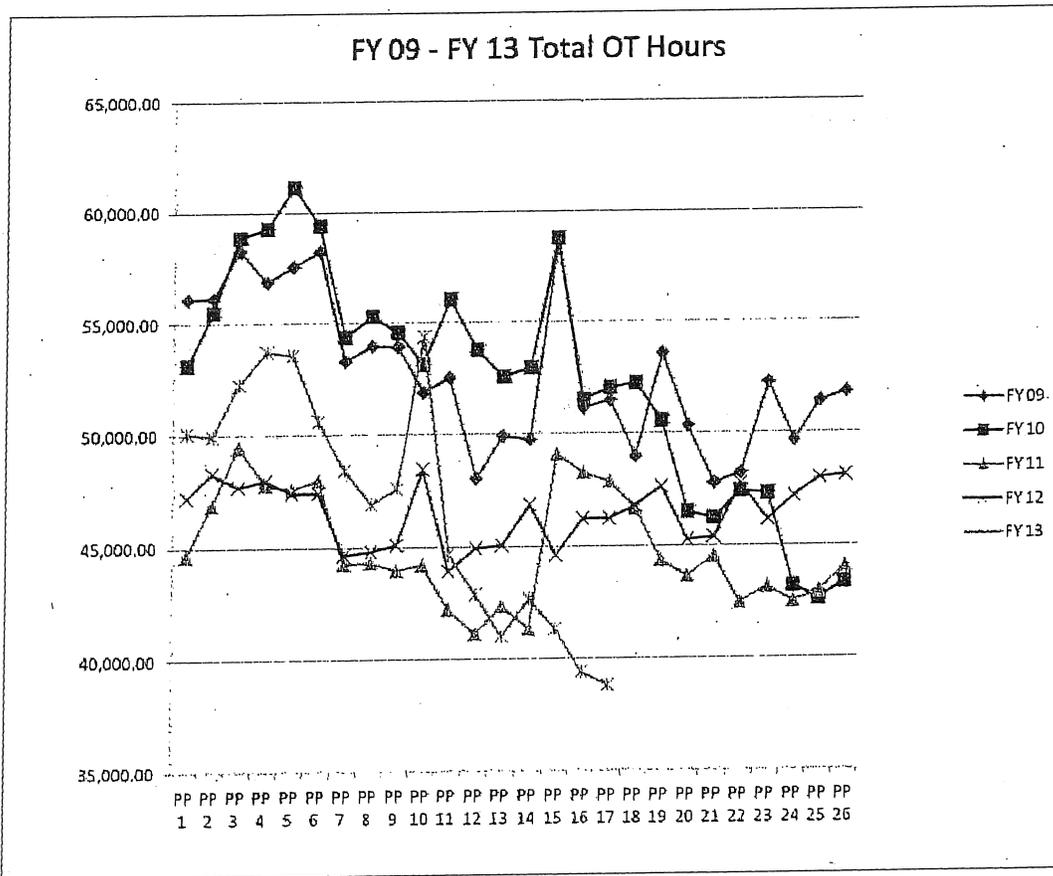
DDS efforts to reduce overtime in FY 2012 included the closure of six additional residential programs operated by the public sector and the hiring of 42.5 FTEs on a durational/temporary basis, as proposed in the Overtime Reduction Plan submitted to OPM in October 2011. In addition, staffing ratios and schedules were reviewed and revised in many programs.

Despite these efforts, the continued attrition of direct care staff and the 24/7 nature of our operations prevented us from achieving the 10% reduction in overtime that OPM asked us to achieve. For FY 2012 (after adjusting for the 27<sup>th</sup> pay period that occurred), we experienced a 3.35% increase in overtime hours (total overtime hours were 1.25 million an increase of 40,660 hours) and a 5.54% increase in overtime costs (total overtime costs were \$41.2 million an increase of \$2.28 million). The percent increase in cost was greater than the increase in hours because less of our total overtime was paid at "straight time" – in FY 11, 52.03% of total overtime was paid at straight time while in FY12; only

50.8% was paid at straight time. More importantly, mandatory overtime which is paid at double time increased 32.55%.

We continued to experience increases in overtime in early FY13. But, we have recently seen marked improvement for the last six pay periods as a result of the continued use of durational/temporary staff and adjustment of staffing ratios and schedules.

It is important to note that overtime is significantly lower than it was in FY 2009 and FY 2010, and due to the dramatic improvements realized in the last six pay periods, total overtime hours are at a historical low.



4. What steps has DDS taken to review contracts it has with private providers, especially examining the salaries paid to direct care workers considering:

- what they are paid relative to the agency's executive director's salary;
- relative to wages needed for self-sufficiency standards as calculated periodically by the Office of Workforce Competitiveness and the Office of Policy and Management and those that may be developed by the DDS Sustainability Subcommittee; and

- income levels that qualify persons and families for eligibility for state Medicaid and other assistance.

Please provide the overall results of any contract reviews, and indicate if DDS took any subsequent action.

As previously explained, the comparison of the salary paid to direct care workers relative to the agency's executive director's compensation does not provide the clear benchmark requested by the committee. To compare the direct care worker's wage to an amount over the \$ 100,000 cost allowance would not be a fair comparison since the overage would not be an allowable state funded expense and one that was privately funded by the provider. To compare the direct care worker's wage to the maximum allowable executive salary amount of \$100,000 would only result in a standard measurement from the salary allowance for more than half of the providers.

As part of the Residential Transition Work Group, the Sustainability Committee was formed to focus on sustainable wages for residential direct care staff. The committee members include providers, a self-advocate, family members and DDS staff. The committee has met three times and will issue a finding by the end of the fiscal year.

DDS is a member of the Non-Profit Cabinet, a collaborative of state contracting agencies and private providers. The Cabinet's goal is to focus on achieving the best possible outcomes for consumers and ensuring the most effective utilization of state resources. This includes maintaining an overall provider network that, in addition to being cost-effective, is viable and sustainable. The Cabinet has identified adequate direct care wages and benefits as one of the key pieces in maintaining viable and sustainable non-profit agencies.

5. PRI recommended that the Department of Developmental Services ensure that private providers comply with the requirements of cost reporting, including the submission of forms on executive director's salary, before issuing a new contract. Please indicate what steps DDS has taken during the past year to ensure compliance, and what the results have been.

DDS revised the FY12 annual report requiring all providers to report the executive director's salary. The FY12 annual report is currently being reviewed by DDS staff and, as part of the review, any provider that failed to disclose the executive director's salary will be contacted to amend their submission to include the executive director's salary disclosure form.

6. What steps did DDS take in 2012 to continue to phase out the provision of public day/work programs, with the overall goal to implement a single private delivery system for day/work services? Did DDS close any public day/work programs during 2012? Please provide the current client numbers for public and private day/work programs.

During the past two calendar years (January 2011 – December 2012) there has been a gradual shift from public to private day programs. The percentage of individuals in public day programs has changed from 5.32% in January 2011 to 3.94% in December 2012 while in private day programs the percentage has shifted upwards from 94.69% to 96.06% between

those two dates, a difference of 1.36%. Public day program enrollment went from 493 individuals enrolled in January 2011 to 378 enrolled in December 2012 while private day program enrollment increased from 9287 in January 2011 to 9584 in December 2012.

Please provide the current DDS staffing levels in public day/work programs. Were any of these refilled positions (of previously vacant positions) from FY 11 through the end of calendar year 2012?

DDS currently (as of January 25, 2013) employs 133 staff (130.22 FTEs) in public day services or employment programs. There was no new staff hired to work in public day programs during FY 11 or FY 12.

7. PRI had also recommended that DDS should conduct a staffing assessment of its current staffing levels for its public day programs, using the day/work LON scores in the private programs as a guide for level of resources needed, and redeploy staff resources over those levels to other services. Did DDS undertake that assessment, and if so, what were the findings? Did the department redeploy any public day/work staff as a result?

Given the department's emphasis on downsizing public day programs, it did not engage in a staffing assessment. Redeployment is occurring based on individuals leaving public day programs and staff retiring or accepting jobs in other parts of the agency.

8. PRI recommended DDS adopt a centralized utilization review process for clients exceeding the day/work program funding guidelines and receiving 24-hour staffed residential services, so that the results could be electronically tracked among regions and the department could compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. PRI recommended the results be included in the Management Information Report at the end of each fiscal year. Has the process been centralized, are the results tracked, and is this information contained in the report?

As DDS indicated last year, implementing such a centralized system would be a hardship on private providers, especially small and medium-sized providers who serve people with intensive support needs in only one region. DDS continues to use a uniform Utilization Resources Review (URR) process in each region for residential and day services, which is overseen by the Regional Director's designee from each DDS division, including Public Residential and Day Services, Individual and Family Services, Private Administration and Self-Determination. The URR process is consistently reviewed jointly by the Waiver and Planning and Resource Allocation Team managers in each region in order to ensure continuity and consistency of practice. The URR process needs to remain a regional process with centralized coordination as explained last year. In the June 2013 Management Information Report (MIR), we will start providing data on the number of individuals participating in the URR process for day services.

9. What efforts have been made to review each client's day program relative to his/her LON, with the objective being that each client should participate in the most productive, meaningful work or day program in the most inclusive environment as possible? How many

reviews have occurred over the past year? Have any clients changed work or day programs as a result?

Have any steps been taken to ensure that outcomes of day programs are being measured? What are some of those performance and outcome measures being reviewed?

We periodically review our LON and program MIR data to determine whether people we serve are moving from non-vocational to vocational programs, or whether individuals are moving to more integrated community-based work settings. Unfortunately, the number of people who are employed, or who are in work-based programs continues to decline across all LON levels. This decline mirrors the national employment figures for people with disabilities. Our consumers report that they are often the last to be hired and the first to be fired and the national data confirms a worsening employment situation for people with disabilities.

We continue to provide training and technical assistance for our case managers so they can effectively promote employment at individual planning meetings. We have created regional job developer networks to provide ongoing trainings and technical assistance to the staff who are seeking jobs for our consumers. All day service providers are now required to have a goal to increase the employment outcomes for people who participate in their day programs. DDS closed admissions to sheltered workshops on October 26, 2012. DDS is working with providers to develop individual transition plans to employment.

10. PRI recommended that DDS adopt a centralized utilization review process for clients receiving 24-hour staffed residential services whose costs for services exceed funding guidelines. Please indicate if that process has been implemented. Who are the members of that review panel? What have the results of the review been by region? Have the results been reported in the department's most recent Management Information Report?

As DDS indicated last year, implementing such a centralized system would be a hardship on private providers, especially small and medium-sized providers who serve people with intensive support needs in only one region. DDS continues to use a uniform Utilization Resources Review (URR) process in each region for residential and day services, which is overseen by the Regional Director's designee from each DDS division, including Public Residential and Day Services, Individual and Family Services, Private Administration and Self-Determination. The URR process is consistently reviewed jointly by the Waiver and Planning and Resource Allocation Team managers in each region in order to ensure continuity and consistency of practice. The URR process needs to remain a regional process with centralized coordination as explained last year. In the June 2013 Management Information Report (MIR), we will start providing data on the number of individuals participating in the URR process for residential services.

11. Has DDS reminded its case managers of the importance of keeping client automated records up to date, in light of the PRI study findings that client records sometimes did not reflect accurate and current information?

Yes, DDS sent a memorandum to Case Managers and Case Management Supervisors in February 2012 to remind them that as information changes, automated records need to be updated in a timely fashion.

12. PRI recommended that DDS conduct audits of sample cases in its client demographic database to determine the accuracy of client information. Has this been done and if so, what were the results?

DDS currently performs a variety of audit functions focused on compliance with waiver requirements. If in this process issues with demographic information are identified they will be corrected. DDS believes that a continued focus on auditing related to federal waiver requirements is the best use of limited resources. We continue to perform ongoing internal audits regarding data accuracy, waiver enrollment and reevaluation, and integration of data to decrease inaccuracies.

13. Have the results of quality inspections on homes and facilities been shared with all clients' Planning and Support Teams, which would include guardians and families?

Quality Service Reviews (QSR) and Community Living Arrangement (CLA) licensing results are currently posted on the DDS Website. QSR results are located within each Provider Profile. CLA licensing results are located under Quality Management and Licensure-CLA Licensing/Inspection reports. Additionally, quality measures will be reviewed by department stakeholders in the near future, as addressed in the department's Five Year Plan.

14. Have DDS staff and clients been involved and participated in the planning for the Integrated Care Organization model being undertaken by the Department of Social Services for clients who are eligible for both Medicare and Medicaid, especially those clients who are under 65? Please describe what role, if any, DDS has taken to ensure that any health care delivery model reduces duplication, prioritizes preventive care, incorporates a data reporting system that easily tracks and reports on preventive care and screening clients have received, and can be used as part of a performance measure.

The Department of Social Services has been awarded a contract from the Centers for Medicare and Medicaid Services (CMS) to design a system to integrate care for individuals eligible for both Medicare and Medicaid (dual eligible). DDS has been participating as a stakeholder in the planning and development phases of this initiative. A key element of the system focuses on promoting health neighborhoods, consisting of clusters of medical and non-medical providers that would offer a team-based approach to serving the dual eligible population. This model would focus on integrated care management that incorporates the coordination of medical, behavioral, and social support needs. To identify and address health and wellness issues for dual eligible persons with intellectual disability, DDS, with the University Center for Excellence in Developmental Disabilities (UCEDD) at the University of Connecticut, facilitated three focus groups comprised of consumers, families/guardians, case managers, nursing staff and providers. DDS and other stakeholders continue to contribute to the development of performance quality measures for the demonstration project

that will examine the quality and cost outcomes for the target population. DDS has shared information about our person-centered planning process that incorporates health services within the broader context of the person's life and goals. DDS's Waiver Director presented to the Complex Care subcommittee of the Connecticut Council on Medical Assistance Program Oversight in December 2012 regarding DDS services, waivers, health care disparities and the integration of individuals who are dually Medicare and Medicaid eligible into health neighborhoods. DDS is working with other stakeholders to develop a proposed care coordination plan for individuals who are dually eligible. As the integrated plan model becomes more fully developed, DDS will advocate for clear and useful reports that will allow the department to utilize this information as part of its quality assurance efforts.

2014 COMPLIANCE AREAS FOR THE  
DEPARTMENT OF DEVELOPMENTAL SERVICES  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE REPORT:  
*Provision of Selected Services for Clients with Intellectual Disabilities (January 2012)*

Please inform PRI about what progress DDS has made during the past year in the following recommendation areas concerning PRI committee's study on *Provision of Selected Services for Clients with Intellectual Disabilities* by March 28, 2014. Each proposed area is followed by a summary of DDS' reported implementation as of February 2013 (italicized), and some specific questions about what has occurred during the past year. If you have any questions, please call Maryellen Duffy or Cathy Conlin at 240-0300.

**I. Evaluation of residents at Regional Centers and community placements.**

*DDS reported last year that as of 2/1/2013 all persons living at the regional centers had been evaluated for residential placement. DDS reported there were 199 people residing at the regional centers, which was a reduction from the 236 people who were living at the regional centers in 2010 when the study was done. Last year, the department indicated that several more individuals at regional centers in each of the three regions were scheduled for a move to a community placement and others had been referred for vacancies in the community. (Rec. #1)*

Since your last response – February 2013 – how many regional center residents have moved to community placements? *See chart below.* What is the current total number of residents in regional centers? *As of Dec. 31, 2013 there were 188 residents in regional centers.* Are any of the residents scheduled for a placement in the community last year still living at a regional center? *See chart below.* What is the current vacancy rate at private community living arrangements, and what is the typical amount of time for a placement to be filled once a vacancy occurs? *There are currently 50 vacancies for which vacancy information has been submitted. At any time there are also a number of short term vacancies associated with people in hospitals or nursing homes who are expected to return to their community home. For vacancies since 7/1/12 the average length of time until the vacancy was filled was 118 days. It should be noted that DDS has created a secure area where providers may view people who have been assigned funding to identify potential referrals. The regions also continue to initiate referrals based on people who need that type of home and have been assigned funding.* How does DDS track those vacancies? *DDS tracks vacancies as well as the number of referrals. Since July 1, 2012 the providers have received an average of 5.6 referrals.*

How many current regional center residents continue to reject the option of a community placement? *See chart below.*

	North	South	West
# of Regional Center residents who have moved into the community (1/1/13 – 12/31/13)	6	2	4
# of residents currently in Regional Centers	44	13	ETG - 34 LFC - 59 NW - 38
# of residents scheduled for community placement	5	0	3
How many regional center residents reject community placement?	37/44	1	ETG – 32/34 LFC – 55/59 NW – 23/38

**Evaluations of Southbury residents and community placements.**

*In its 2013 compliance response, DDS indicated that evaluations regarding community placements had been done for all Southbury residents during the previous year and that 98% had resulted in a recommendation for community placement. (Rec #2)*

*Did the families and/or guardians agree with the recommendation in all cases? No, however 46 families or guardians have agreed with the team’s recommendations and are currently actively pursuing placement.*

*DDS reported last year that during 2012, 24 Southbury clients had moved to the community – 18 to private homes and 6 to public homes, and 30 more individuals had plans being developed for community placements. Overall, DDS reported that 370 people remained at Southbury as of 2/1/2013, a significant reduction from 450 persons when the PRI study was done in 2010.*

Please provide the number of Southbury residents who have moved to community residential settings during 2013, and the number still awaiting a placement.

*During calendar year 2013, three residents of Southbury Training School (STS) moved to the community and are being supported by private providers. Forty-six additional residents are currently having community placements developed for them. There are currently 341 residents at STS as of April 4, 2014.*

Please provide the number of residents in public settings -- Southbury, regional centers and public CLAs -- and those being served in private sector residences.

*As of the December 2013 Management Information Report (MIR), there were 887 individuals living in public settings including Southbury Training School (STS), Regional Centers and Community Living Arrangements (CLAs). As of the same date, there were 4,371 individuals living in private CLAs, Continuous Residential Supports (CRSs) and Community Companion Homes (CCHs). The breakdown is as follows: STS- 350; Regional Centers- 188; public CLA-349; Private CLA-3,395; Private CRS- 585, private CCH- 391.*

Please provide the number of current vacancies that exist in private sector residences. *There are currently 50 vacancies for which vacancy information has been submitted.*

## **2. DDS Staffing Assessments and Reductions.**

Last year DDS did not indicate whether it had conducted a staffing assessment at its residential settings as PRI proposed. (This recommendation was made in light of the 16 percent reduction in public sector clients that the committee found had occurred between FY 07 and FY 10.) If an assessment was done, was the LON assessment tool used to determine the level of staffing needed (as it would in contracting for private placements), and what did the assessment results determine? *The census of DDS Public settings has continued to decline. At the same time DDS has experienced a reduction in its workforce. In June of 2011, DDS provided residential supports to 1,064 people in Campus and CLA settings. There are now 872 served in those settings. This is an 18% drop in less than two years. Because of this rapid change we have relied on the Utilization Resource Review process to help ensure that staffing for the individuals with intense staffing needs were reviewed in a similar fashion as occurs with private providers. Regional management also reviews staffing patterns and considers the Level of Need (LON) information as part of that process. It should also be noted that at this time the Residential LON rate development has not fully addressed the issue of how many hours should be associated with residential service for LON level. When the residential rates are completed, DDS will review how that information can be used to further inform management of public services.*

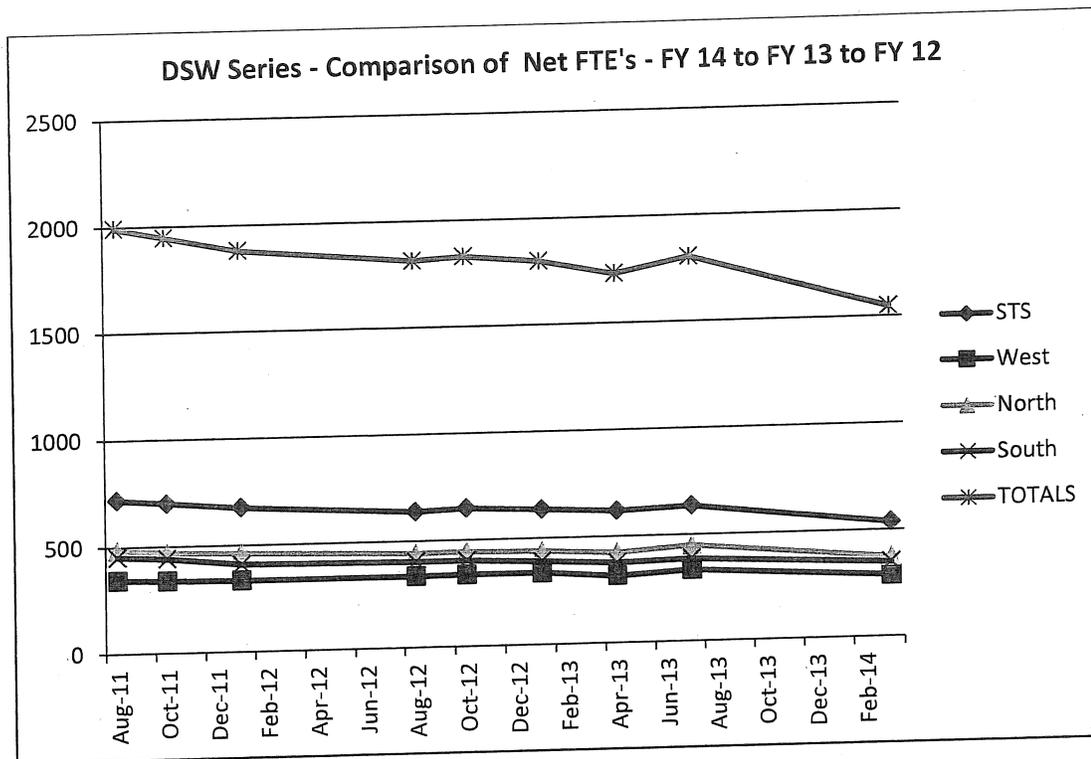
If the assessment determined staffing levels are higher than comparable settings in the private sector, what actions has the department taken to redeploy DDS staff to serve clients on the residential care waiting list in their homes or to provide respite care?  
(Rec. #2)

*DDS has collaborated with 1199 to create specialized training for people who have worked in traditional residential services to prepare them for supporting people living with their families. This extensive training is often referred to as "The Academy." 235 employees applied for this opportunity and 37 were admitted. The group will be completing their training in June. DDS anticipates adding people to our Family Support Teams across the state in the next year.*

*DDS reported in early 2013 that it had reduced direct care staff by about 192 FTEs since August 2011.*

Please indicate the numbers for current DDS direct care or direct service filled positions in residential care settings. Has DDS filled any new positions or previously vacant positions?

*The number of current DDS direct care employees/direct service filled positions in residential care settings as of March 21, 2014 expressed as full time equivalents (FTEs) was 1,675.1. Adjusted to reflect the number on leave status (e.g. workers' compensation, medical leave, etc.) the number was 1546.33 FTEs. This includes durational/temporary staff. Still, this is a reduction of 257.43 FTEs since July 2013 and a reduction of 444.88 since August 2011. DDS has filled 66 positions in the direct care series through hire, transfer, or promotion since June 14, 2013. Of those, only 13 were non-supervisory direct care staff assigned to work in DDS operated Community Living Arrangements. More importantly, 35 of the positions filled were Supervising Developmental Services Worker positions, many of which were vacated through retirement. DDS must have a supervisor for each of its functional units. Another eight positions filled were Lead Developmental Services Worker positions and 10 were Developmental Services Supporting Living Worker positions which are assigned to provide supports to individuals living in their family homes.*



Has DDS been able to close any public residential settings in the past year? If so, how many? *See chart below.* Where have any new residential clients been placed? *Disregarding internal movement within public programs, DDS placed nine people into DDS operated CLAs or regional centers. Placements were made into a variety of settings and were typically for people who had an urgent need for placement. Most were previously living in another residential setting but could not remain there and at that time there was not a suitable vacancy available with a private provider.*

	North	South	West
# of public residential settings closed (1/1/13 – 12/31/13)	4	2	1
	555 Pomfret Street	227/229 Camp Street	LFC, Apt. K
	85 Mountain Road	Rogers Road	
	2955 Main Street		
	40 Village Dr. #116		

*Pursuant to a Memorandum of Understanding with District 1199, Job Fairs were held to allow affected staff to select reassignments based on seniority to other residential settings where there were holes in the schedule or staffing shortages. This helped to reduce overtime. Staff from closed public homes were re-assigned to vacant positions.*

### 3. DDS Efforts to Reduce Overtime

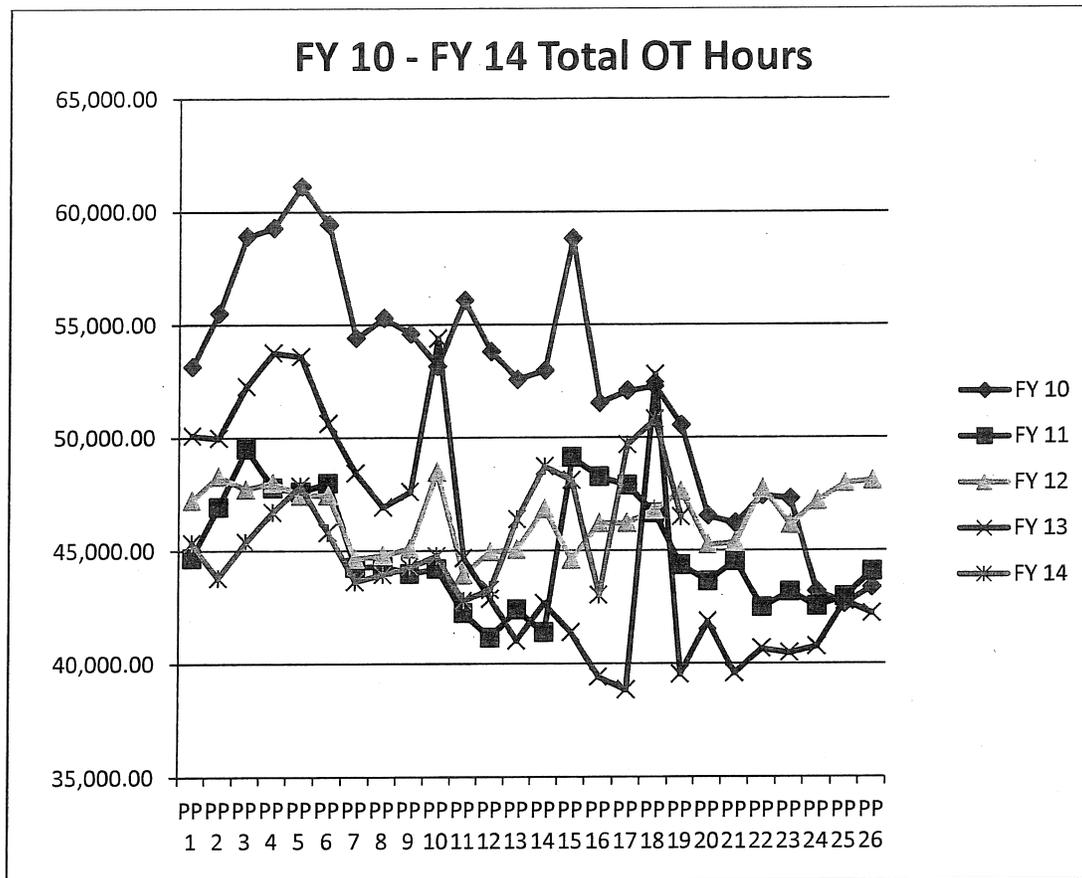
*Last year DDS reported that efforts had been employed aimed at reducing overtime, including closing six public residential programs and hiring 42.5 FTEs on a durational/temporary basis. However, DDS reported that, despite its efforts the agency's FY 12 overtime hours increased by 3.35% and its overtime costs rose by 5.54%. DDS indicated that it had not met OPM's goal of a 10% reduction, but that the early months of FY 13 appeared to show some improvement as a result of rescheduling and the hiring of durational employees. (Rec. #3)*

Please provide what progress DDS has made in 2013 in reducing its overtime hours and costs. Has DDS met the OPM goal of a 10 percent overtime reduction?

*DDS efforts to reduce overtime in FY 2013 were more successful. For the fiscal year as a whole, overtime hours were down 2.68% and overtime costs were down 2.98%. However, for the last half of FY 13 (thirteen pay periods) the total overtime hours were down 10.05% compared to the last thirteen pay periods of FY 12. Overtime costs were down 11.17%.*

*In addition, as a result of residential program closures and consolidations and pursuant to a Memorandum of Understanding with District 1199, Job Fairs were held to allow affected staff to select reassignments based on seniority to other residential settings where there were holes in the schedule or staffing shortages. This helped to reduce overtime.*

*Positive results continued for the first eleven pay periods of FY 14 – overtime hours were down 9.47% compared to the first eleven pay periods of FY 13 and overtime costs were down 9.51%. But since then, due primarily to the significant decrease in the number of direct care staff and to a lesser degree the severe winter weather, in the last eight pay periods overtime hours have increased 10.62% over the same eight pay periods in FY 13 and overtime costs have increased 17.11% (costs have increased more sharply because more of the overtime is mandatory and paid at double time). Year to date for FY 14, overtime hours are down just 2.45% and costs are up .06%. Overtime continues to be lower than it was in FY 10. See the chart below for a comparison of overtime hours for the past five years.*



**4. DDS review of private provider contracts, especially examining the salaries paid to direct care workers considering several measures.**

*DDS indicated in in response last year that it disagrees with measuring what direct care workers are paid relative to the agency's executive director's salary. The department stated last year that a Sustainability Committee was formed to focus on sustainable wages for direct care staff and that it was expected to issue findings by the end of FY 13. (Rec. #4)*

Please indicate if the Sustainability Committee issued any findings during the past year and if so, please attach them to your response. Has the department examined the issue in any other ways during 2013, or arrived at any benchmarks for measurement that it believes are more appropriate than those proposed by the PRI committee?

*The Sustainability Committee held several meetings during FY2013. There was much discussion regarding the definition of sustainability. While the committee believed that the rates paid for supports should be based on current appropriations, there should also be a system put in place to index staff wages in order to maintain quality supports for individuals with intellectual disabilities. The committee reviewed data prepared from FY11 Annual report data that showed that the*

*majority of residential support costs were wages and benefits that represented 60-75% of total residential service line.*

*The group reviewed and agreed with the Day methodology for determining a sustainable wage. The committee recommended to the Full Residential Rate Transition committee that the following Residential methodology be approved.*

*A “sustainable” wage provides economic self-sufficiency to meet basic life needs including provisions for comprehensive health benefits coverage. Since wages and benefits constitute approximately 80% of the “costs of doing business”, the committee recommends the following:*

- The DDS waiver rate reimbursement formula should be based at a minimum on an hourly sustainable wage for a family of three.*
- The DDS health insurance calculation should be based on the average employee benefit cost as a percentage of total compensation as reported by the Employee Benefit Research Institute analysis.*
- A mechanism should be developed for annual rate review and adjustments tied to the Social Security index to ensure rates are not eroded by inflation.*

*The full rate committee has not yet voted on the recommendation. A provision for sustainable wages is expected to be part of the final report issued at its conclusion. DDS believes the issues involving contracting and direct care wages are not isolated to our department and should be resolved on a statewide basis. DDS participates and supports the goals of the State Human Services Purchase of Service (POS) Workgroup to standardize the contracting process for all private providers. The department continues to work with the non-profit Cabinet to review issues related to contracting and wage levels. Through this coordination with the other state human services POS agencies, DDS provided guidance to private providers for the required use of the cost-of-living increase for staff salaries and benefits included in Section 27 of Public Act 12-104.*

## **5. Reporting of Providers Executive Director Salaries**

*DDS indicated that it had revised its FY 12 annual report requiring that all providers report the salary of each executive director’s salary. At the time of its response last year, DDS was still reviewing the annual report and indicated that any provider that had not filed the information would be contacted. (Rec. #5)*

Did all providers report the salaries of executive directors for the FY 12 report? Is that information published as part of DDS’ annual report? Is that available on DDS’ website?

Is the same information available for the FY 13 annual report?

*DDS revised the executive director salary page beginning with the FY2012 annual report to more accurately reflect the director's salary for all contracted Connecticut programs. For FY2012, all contracted providers required to complete an annual report reported the salary of the executive director. The information is available but it is not information that DDS has published. DDS is completing the reviews of the FY2013 annual report and anticipates that all contracted providers required to submit an annual report will complete the executive director's salary page.*

**6. Phasing out the provision of public day/work programs, with the overall goal to implement a single private delivery system for day/work services**

*DDS reported last year that the percentage of individuals in public day programs had declined from 5.32% to 3.94%, while the percentage in private programs had increased from 94.69% to 96.06%. DDS also provided the number of individuals in each sector's programs as of December 2012. The department indicated the number of DDS staff employed in public day services as of January 2013 was 133 (130.22 FTES) and that no new staff had been hired in either FY 11 or FY 12. (Rec. #6 and Rec. #7.)*

Please update the numbers and percentages of individuals in public and private day services since your report to PRI last year.

***Breakdown of people in Primary Day Programs as of 12/31/2013 (includes Self Determination (Private Hire) as well as Public and Private.***

Public/Private/Self Determined Breakdown of Day Programs as of 12/31/2013		
Public/Private/Self Determination	Number of Individuals	Percentage of Total
Private	4847	93%
Public	103	2%
Self Determination	235	5%
Total	5185	100%

Have any public programs been closed? Please also provide the most recent DDS day services staffing levels. Has any staffing assessment occurred during the past year? Has there been any redeployment of DDS day staff to other programs? (Rec. #6 and Rec. #7)

*DDS has reduced the number of people supported in Public Day from 457 in June of 2011 to 334 as of December 2013. Most of the people remain in Public Day Services with 97 (96.24 FTE's) Day Service Instructors. Given the rate of decrease in instructors, there has been no formal redeployment initiative. However, some of the decrease is a result of Day Service Instructors accepting other positions.*

7. **Centralized utilization resources review (URR) process for clients exceeding the day/work program funding guidelines.**

*DDS indicated last year that it continued to believe URR should be done at the regional level but did not comment on what type of tracking was being done. DDS did indicate it was going to begin reporting on individuals participating in URR in the June 2013 MIR.*

Does the department continue to conduct URR on a regional basis? How is tracking of that done? Did DDS report on URR for day services in the June 2013 MIR report? (Rec. #8 and Rec. #10) *DDS continues to conduct Utilization Resource Reviews (URR) on a regional basis. Data is entered into an access database based on the results of the review. DDS did not report on URR for the June 2013 report. Resource limitations in our planning area forced us to delay several changes we had hoped to make with our reporting. We will be adding URR Management Information Report (MIR) data to our March 2014 publication.*

8. **Review each client's day program relative to his/her LON**

*DDS indicated that it periodically reviews LON and MIR report data to ensure people are working in the most integrated work settings, but that the numbers of clients in work related settings was declining due to the poor economy. DDS indicated that it had begun requiring all private day service providers to increase employment outcomes for people participating in their programs. Also, DDS indicated that it had closed admissions to sheltered workshops in October, 2012.*

Please describe the department's progress to enhance employment outcomes for individuals in day service programs. How are private providers being measured on these outcomes? (Rec. #9)

*DDS has seen a steady increase in the number of individuals receiving employment related supports since the rate methodology for the Individual Supported Employment (ISE) program was introduced in February 2012. The number of participants with an ISE authorization has increased from 382 in FY12 to 531 in FY13 and currently 608 in FY14. In addition, we have seen an increase in the number of providers providing the service. In February 2012 there were 43 providers with an authorization to provide Individual Supported Employment supports to DDS participants. As of April 2014, this has increased to 60 providers. DDS initiated the funding of Career Plan development and a one week "working interview" that allows the employer to see how a person's skills and abilities match a job. DDS also provides incentives for employment benchmarks relating to job acquisition and number of hours worked. The use of these employment tools and incentives has been increasing. DDS continues to work with all stakeholders through leadership forums and through other formats to seek feedback on how to increase employment for individuals with intellectual disability.*

**9. Importance of keeping client automated records up to date**

*DDS indicated it had sent a memorandum to case managers about the importance of this in February 2012.*

Has DDS checked to see if the case managers are updating client automated records?  
If so, what did DDS find? (Rec. # 11)

*Case Management Supervisors complete audits of eCAMRIS as part of their Quality Service Reviews (QSR) of case managers. eCAMRIS data is input upon intake into DDS, upon case transfer and ongoing as needed during a calendar year. DDS Central Office conducts regular runs on Individual Plan dates, Level of Needs (LON), case notes and QSR completions and this information is given to Case Manager Supervisors for follow up with their staff. In 2013 DDS removed two screens from eCAMRIS, the Medical and Functional Profiles, to help eliminate incorrect or duplicate information. The information on those screens is contained in the LON which is updated annually or more.*

**10. DDS conduct audits of sample cases in its client demographic database**

*DDS indicates that it performs a variety of audit functions to comply with CMS waiver requirements, and that the department believes this is the best use of limited resources.*

Does DDS continue to conduct the database audits to comply with the federal waiver?  
Have there been any independent CMS audits of DDS data and if so, what were the findings? (Rec. #12)

*DDS continues to conduct internal audits: Spectrum Audits at each DDS regional office (random sample). DDS continues to conduct Quality System Reviews for waiver participants (random sample each year). DSS conducts waiver assurance audits for a predetermined number of individuals by waiver and reports findings to DDS waiver assurance committee. DSS conducts Medicaid billing audits. CMS conducts annual PERM Audits via an independent contractor for waiver participants.*

**11. Quality Service Reviews should be shared with families**

*DDS indicated that licensing results are posted on its website in each provider's profile. In addition, DDS indicated that quality measures will be reviewed with department stakeholders as addressed in DDS's Five Year Plan.*

Please indicate if there are any other steps that DDS has taken in this area during the past year. (Rec. #13)

*A DDS LEAN Event was held during the week of November 18 -22, 2013 to review the Quality Service Review Process. Team membership included DDS and private provider participants. A Quality Service Review (QSR) Project Plan was developed, including a LEAN Team Plan - Tasks and Activities and Participant Assignments. Initial subgroup project meetings are underway. Full LEAN Team meetings are scheduled monthly, through August 2014. The focus of this process is on eliminating inefficient components of the QSR, significantly reducing Corrective Action Plan (CAP) backlogs, and preparing for implementation of real time electronic caseload reporting and access. These activities will promote and enhance individual health and safety, and quality of life. One of the outcomes of the LEAN initiative is to have more accessible reports and data available for families and consumers.*

## **12. Participation in the Integrated Care Organization model**

*DDS indicated last year that it and other stakeholders were working with DSS on its demonstration model to integrate care for individuals eligible for Medicare and Medicaid*

Please briefly provide a status update on the integrated care model and DDS' role during the past year. (Rec. #14)

*DDS was officially added to the membership of the Council on Medical Assistance Program Oversight Complex Care Committee. Two DDS staff represent DDS on behalf of the Commissioner at these meetings. DDS participated in the development of the white paper on Care Management and provided the Committee with an overview of DDS waivers.*