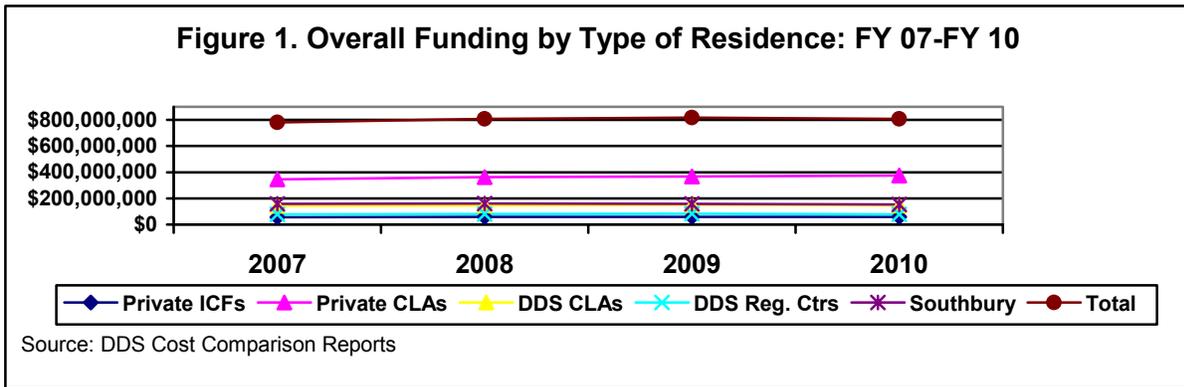


PROVISION OF SELECTED SERVICES FOR CLIENTS WITH INTELLECTUAL DISABILITIES

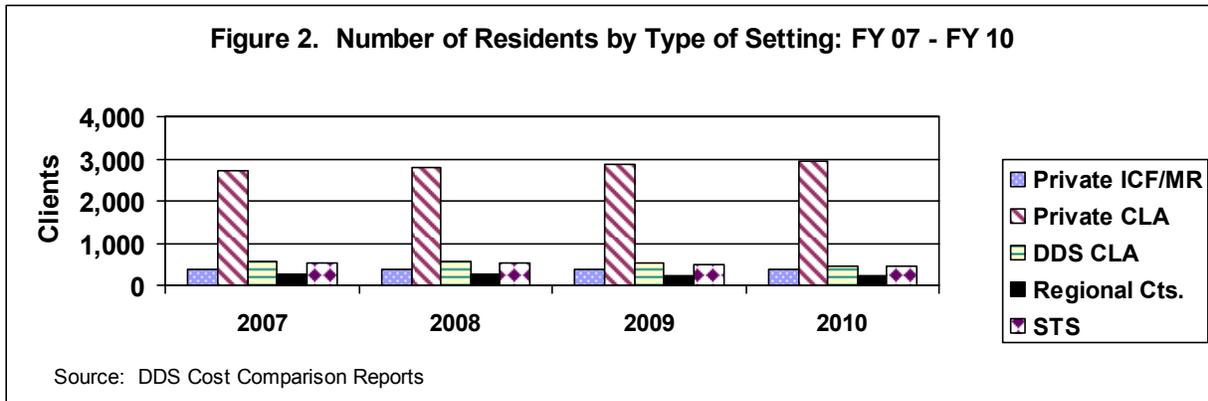
Scope of Study

- Examine the DDS funding structure for providing residential and day/work programs for clients in 24-hour residential services
- Compare the costs of providing these services in private and public settings and determine the factors that impact costs
- Examine the costs of providing services to clients by level of need
- Assess the quality of care in providing services in various 24-hour residential settings
- Propose recommendations that ensure a cost-effective, quality-driven system for residential care for DDS clients with intellectual disabilities

Overall Funding and Clients Served in Residential Programs

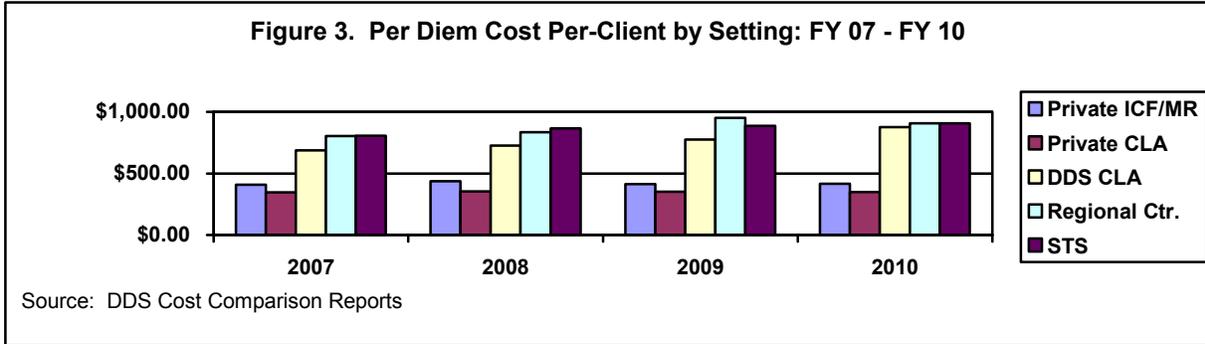


- Total expenditures for clients in 24-hour residential care grew from \$781.8 million in FY 07 to \$807.7 million in FY 10, a 3.3 percent increase (**Figure 1**).
- The total number of clients in 24-hour residential settings has declined slightly over the same period. However, the number of clients in public settings has declined to 11 percent from 21 percent while the number in private CLAs has grown by 7.5 percent (**Figure 2**).
- Overall about half the funding goes to DDS public settings to take care of 25 percent of all clients.



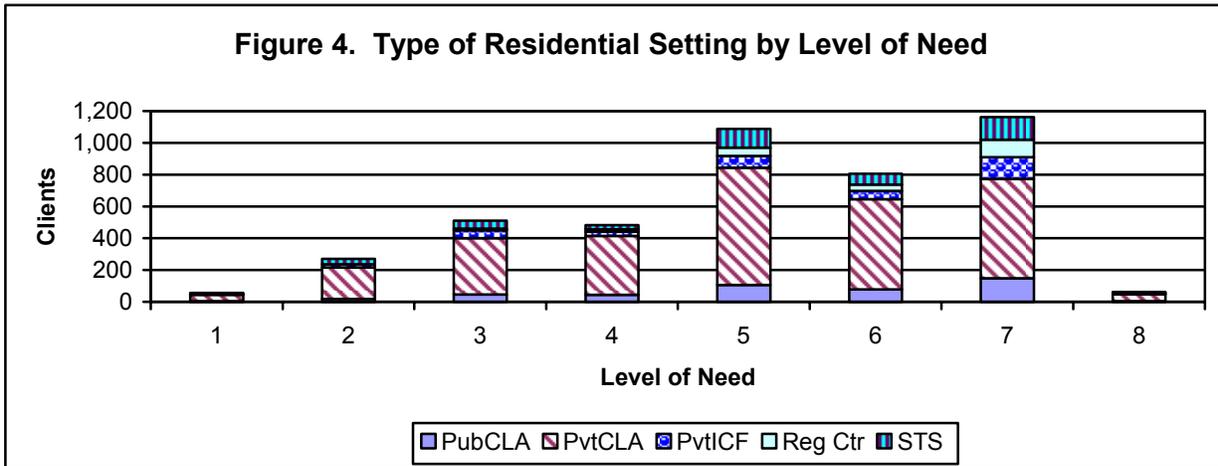
Per Client Costs in Residential Programs

- The declining numbers of clients and increasing costs in public settings have resulted in significant differences in costs between private and public residential services. As **Figure 3** shows, the daily per-client costs are less than half in private settings, and the per diem costs in public settings have increased an average of 17 percent over the period FY 07 to FY 10.



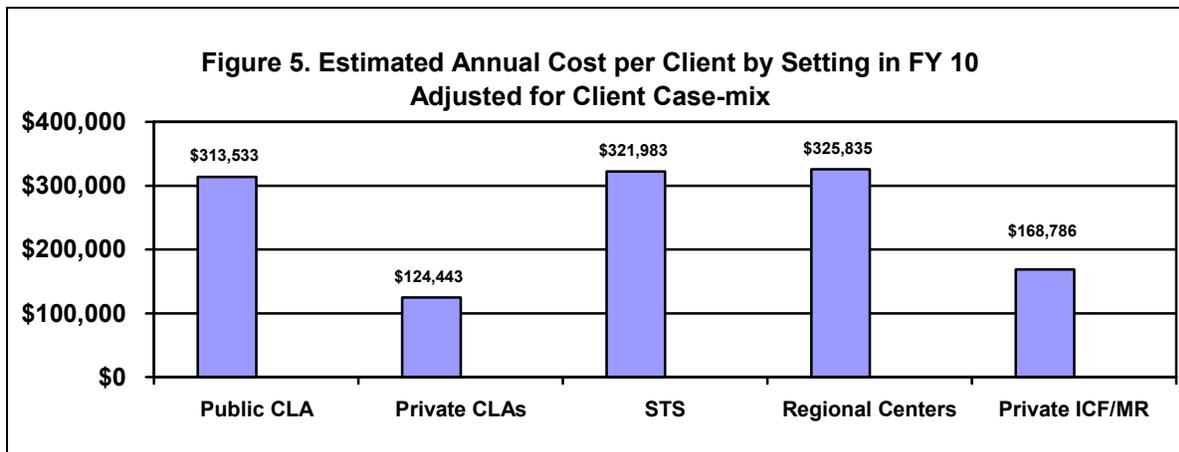
Residential Setting by Client Level of Need

- Client need is assessed using a tool that measures need on a scale of 1 to 8, with 8 being the most intensive. Most clients at the lower levels do not need 24-hour care; the majority of clients in residential settings are assessed at 5 to 7. **Figure 4** shows the type of residential settings by client level of need.
- The figure also shows that clients at any level of need are living in private settings as well as public.



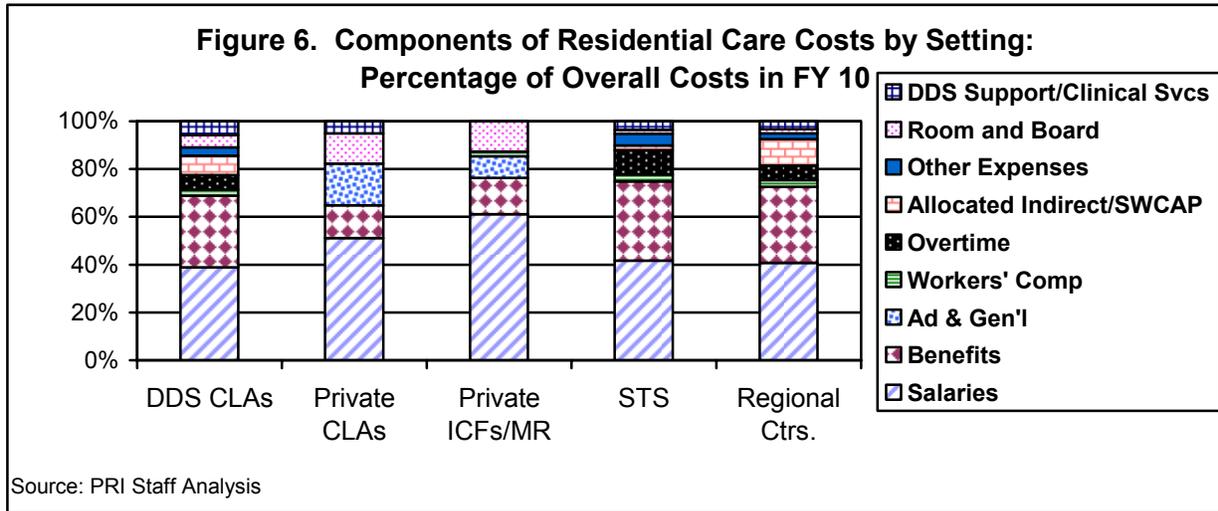
Costs by Setting Adjusted for Client Level of Need

- Even adjusting for client level of need, annual costs are about double in the public settings over the private (**Figure 5**).



Components of Costs

- Providing 24-hour care is labor intensive, thus the greatest contributor to costs is staffing no matter what the setting. **Figure 6** below shows the contributors to costs in the various settings.
- Benefits also can be a significant contributor to costs, especially in the public settings.
- Overtime contributes to about 6 to 10 percent of overall costs in public settings.
- Salaries make up a greater percentage of overall costs in private settings than the public but benefits contribute a lower portion than public residences.



Moving to a New Rate Structure

- DDS has had residential funding guidelines in place to guide client resource decisions since 2006 but they apply only to private CLAs serving new clients or clients changing placements.
- Many clients exceed the DDS-established funding guidelines as indicated in **Table 1**.

Table 1. Number and Percent of Clients Exceeding Residential Threshold for Private CLA.

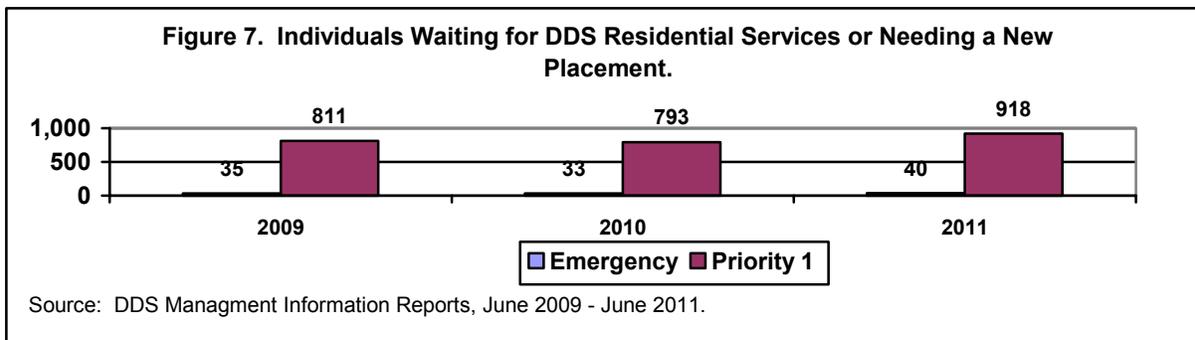
<i>LON Score</i>	<i>Classification</i>	<i>Reg. Director Approval Threshold</i>	<i>Total Clients with Cost Data</i>	<i># over Threshold</i>	<i>Percent Over Threshold</i>
1-2	Minimum	\$33,000	237	222	96%
3-4	Moderate	\$69,000	707	476	67%
5-7	Comprehensive	\$139,000	1,892	392	21%
8	Individual Program Budget	n/a	n/a	n/a	n/a

Source: PRI staff analysis of DDS databases

- DDS is moving to a rate structure that will apply to all clients, but will phase it in over 7 years
- Given the percentage of clients over the guidelines, it will take a long phase-in period in for providers and clients to adjust to rate restructure without funding shocks.
- The new rate structure will not apply to DDS facilities or homes, or private ICFs/MR.
- DDS is aggressively downsizing its residential and day programs – DDS serves only 25 percent of clients in 24-hour care, a decrease of 16 percent since FY 07.
- DDS is hampered from downsizing more quickly due to labor agreements the state has with its employee unions.

Waiting List

- In addition to the inequities of per client funding among settings, a perhaps greater inequity is the growing number of clients who receive no services. **Figure 7** shows that in June 2011, there were 958 people on the wait list. Of those, 549 were receiving no services, and 25 were considered an emergency.



Quality Assurance

- There is no consensus around a set of measures that could assess or rate quality.
- This study focused on the results of licensing and certification inspections at residential facilities as those were the most available data.
- Inspections are conducted by the Department of Public Health for ICFs using federal regulations similar to those used for nursing homes; DDS inspects private and public group homes using state regulations.
- Based on the number of deficiencies per home or facility for FY 10 inspections, the results were better in the private facilities than in the public as shown in **Table 2** below.

Table 2. Profile of Licensing Reviews Conducted in FY 10 for Public vs. Private Facilities

CLAs	Public CLAs (n=42 inspections)	Private CLAs (n=401 inspections)	Total (N=443)
Average # of Deficiencies	10	6.4	7
ICFs	Public ICF n=36 inspections	Private ICF n=67 inspections	Total (N=103)
Average # of Deficiencies	3.5	2.9	3.1

Source: PRI Staff Analysis of DDS and DPH Inspection Results

PRI Committee Key Findings and Recommendations

Based on the findings that it is on average about twice as costly for residential care in public settings, and inspection results show on average no better quality, the PRI committee recommends:

- *An accelerated pace of moving away from a dual service system to a private sector service model*
- *DDS use the provisions of Southbury settlement agreement offering choice to current residents of regional centers*
- *Use DDS CLAs only as residential placements for clients from Southbury or regional centers*
- *DDS LON assessment tool be used to gauge staffing levels needed and where they are higher than would be in private sector, staff should be redeployed to serve clients on wait list*
- *DDS should not refill any vacancies in residential or day/work programs*
- *Ultimately, DDS should provide direct services only for extremely hard-to-place clients or where directed by the courts*
- *DDS should examine the salaries paid to private provider direct care staff using several factors to assess adequacy*
- *A centralized utilization review process be established clients exceeding funding guidelines with results published annually*
- *Each client's day/work program be reviewed to ensure they are participating in the most meaningful program and in the most inclusive environment*
- *Share results of quality inspections with clients' teams and families or guardians*