

Comments on DDS Draft Five Year Plan 2017 – 2022
Collette L. Bement, Ph.D.
80 Barstow Lane, Tolland CT 06084

Pursuant to Section 17a-211 of the Connecticut General Statutes, The Department of Developmental Services (DDS) is required to develop Five Year Plan for submission to the Public Health and Appropriations Committees in January 2017. The plan is required to:

- (1) Set priorities;
- (2) Identify goals and objectives and the strategies to be employed to achieve them;
- (3) Define the criteria to be used in evaluating whether the department is making progress toward the achievement of such goals and objectives;
- (4) Identify changes in priorities, goals, objectives and strategies from the prior plan;
- (5) Describe and document progress made in achieving the goals and objectives outlined in the prior plan; and
- (6) Estimate the type and quantity of staff and client services that will be needed over the life of the plan.

The draft DDS Five Year Plan (2017 – 2022) falls short of achieving these objectives because the plan does not clearly identify the priorities, goals and objectives of the department, specific parameters for evaluating progress are not provided, there is no substantive discussion about whether the goals of the previous five year plan were achieved, and if not, why not, and most important, there is no discussion about (1) how to reduce the many waiting lists that now exist for DDS clients, (2) increase funding to private providers, and 3) close all outrageously inefficient public institutions and group homes.

Specific Comments:

- A 1-2 page Executive Summary should be provided at the beginning which lists the priorities, goals and objectives of the department for the next five years. After reading the current 30-page plan, you should not still be guessing about what the department priorities, goals and objectives are for 2017-2022. The DDS Five Year Plan 2012-2017 specifically listed 25 “Goals for 2012 – 2017” (pages 24-27) and the anticipated time frame for implementation of each goal was specified (page 28). The current draft plan does not provide this information.
- Next, the plan should provide the Mission and Vision Statements of the department. These critical foundations for the department are alluded to in the draft plan, but are not provided in the draft document.
- The plan should list each of the 25 goals identified in the 2012-2017 Five Year Plan and then indicate if the goal was successfully implemented and if not, why not (as requested in part 5 of Section 17a-211). The discussion should also indicate if each goal was implemented within the

timeframe indicated in the plan, and if not, why not? Some of the information in the section “Celebrating Accomplishments Since 2012” on pages 12-16 in the current draft plan can be used for this discussion. I believe that it is critically important to revisit the last five year plan and determine whether or not the department achieved the goals it had laid out, and if it did not, why not. Did the department’s priorities, goals and objectives change during the five years? The draft five year plan for 2017-2022 seems to indicate that it did.

- Page 3: The age distribution bar graph uses unequal age integrals (2, 3, 8, 4, 4, 13, and 10 years) for the X-axis of the graph without providing a rationale. Why is there an 8-year interval for 6 – 13 year olds, and then a 4 year interval for 14-17 year olds? Why is there a 13-year interval used for 22-34 year olds, and then multiple 10-year intervals used for individuals after age 35?
- Page 4: The bar graph for residential supports should be expanded to include the percentage of the annual DDS budget which is used for each of the types of residential supports listed and the overall percentage of the budget used for public versus private provider supports should be clearly indicated.
- Page 5, ¶ 2: The plan states, “DDS continues to follow national trends, moving toward community-based residential supports and away from publicly-operated, institutional care”. The draft plan provides the recent closure of two Regional Centers as evidence of its commitment to community-based supports. In reality, these two centers were not closed because the department recognized the value of community-inclusion, but they were closed for financial reasons (state budget crisis) and most of the residents living in the two centers were simply relocated to one of the three regional centers still open. This paragraph confirms the department’s support of individuals who currently reside at STS, but it neglects to mention the financial burden to the state to keep this institutional facility open (over \$400,000/resident and increasing). The *Messier v. Southbury Training School* Settlement does not conclude that STS must remain open, nor does it prevent the governor from closing STS. The governor and department have consciously made the decision to keep STS and the Regional Centers open despite the financial burden to the state. The growing number of people waiting for residential supports (and, because of the budget crisis, day/employment and respite supports) do not seem to engender the same level of concern. Finally, the statement at the end of the paragraph, “Adhering to a person-centered approach, all transitions from STS and the Regional Centers occur in a thoughtful and purposeful manner.” The aggressive approach used for the recent closure of the two regional centers was neither person-centered nor thoughtful, although it was very purposeful.
- Page 5, ¶ 3: The draft plan summarizes that there are currently more than 2,000 individuals waiting for residential supports. Despite public hearings about the waiting list, numerous newspaper articles, editorials and Letters-to-the-Editor, there appears to be no urgency to the plight of these individuals. The only mention of the Waiting List concerned new definitions of what it means to be on the Waiting List and how to implement the new definitions.
- Page 8, Quality of Life: A link should be provided to the National Core Indicators survey so that legislators and the public can review the results of the survey themselves. This section only lists some areas where Connecticut ranked at or above the national average (health indicators, some

community inclusion indicators, and some day program/regular activity). There are many significant areas where Connecticut ranked below the national average. If the department is not going to provide all of the survey results, then this section should be deleted from the plan.

- Page 9, The Workforce: Please provide the number of full time and part time staff employed by the 196 qualified agency providers.
- Pages 12-16, Celebrating Accomplishments Since 2012: As indicated above, some of the text in this section should be used in the discussion of whether or not the department achieved the priorities, goals and objectives identified in the DDS 2012-2017 Five Year Plan. Is it possible to provide a link on the DDS website for reports listed in this section (i.e., SELN report)? There appear to be many accomplishments listed in this section which were not even mentioned in the 2012-2017 Five Year Plan.
- Page 12, Employment c: “Youth in transition” were identified as a demographic focus”. What does “youth in transition” mean? Are they “new grads”?
- Page 12, Employment e: DDS experienced a 77% competitive job placement rate working with Project Search. Using percentage rates can be deceptive. Exactly how many transitioning youth and recent graduate participated in this program?
- Page 13, Employment f: DDS is organizing referrals and funding for a cadre of high school graduates for the 2016 and 2017 school years. How many is a “cadre”?
- Pages 12-13: Several of the accomplishments concern employment benefits for new grads. How many of the 2016 new grads actually began active employment upon graduation? Does this mean that these 2016 new grads were not adversely impacted by the funding cut for Day and Employment Services last summer?
- Page 13, Mission-Drive: The draft plan states that, “A new department mission and vision statement were created in April 2012...”. Neither statement has been included in this draft plan.
- Page 13, Self-Directed: How many individuals self-direct their own day services and how many individuals self-direct their own residential services. These numbers should be reported separately.
- Page 14, Expanding Person-Centered Residential Options, a: When was the Shared Living committee established? Is the option of Shared Living currently being used in the state, and if so, by how many individuals?
- Page 14, Expanding Person-Centered Residential Options, b: When was the CCH committee to examine other states’ residential options established?
- Page 16, Dignity in Healthcare Decisions, line 1: Suggest that you replace the word “procedure” with the word “policy”, to clarify that DDS has not actually developed an “end-of-life procedure”.
- Page 16, Streamline Processes, b: The statement, “Planning and Resource Allocation Teams reduced the volume of requests by more than 50% by using rules-based decision-making.” What does this mean? Has DDS established another layer of qualifications before families can even request the option of residential supports?
- Page 16, Making Quality Transparent and Accessible to All: The statement, “Families can now access information about provider quality under the PROVIDER PROFILE information section of

the DS website.” I was unable to locate any information about provider “quality” on the DDS website. The only information available was an alphabetical list or a list by town identifying “qualified” providers.

- Page 17, A New Approach: Finally, the draft plan begins to discuss DDS’ plans for 2017-2022, but DDS’ priorities, goals and objectives are far from clear. From the first paragraph, “The plan, as presented in this document, encompasses the department’s goals for the next five years, creating a path for DDS to transform itself and continue to have a positive impact on the individuals and families it supports.” So does this mean that DDS’ priority is to “transform itself”? Paragraph 2 indicates that the “new Five Year Plan takes the foundational elements that we developed with stakeholders in 2012, and applies to them a project-based approach to implementation”, but what does DDS plan to implement? From the beginning of paragraph 3, we learn that “DDS’ 2012-2107 Five Year Plan described a paradigm shift” but from the last sentence in this paragraph we learn that “in our new 2017-2022 Five Year Plan, DDS is committed to continued work toward a new paradigm, focused on several overarching shifts”. So, now there is a newer paradigm shift? What does “overarching shift” mean? There are four bullets listed on page 17. Are these the priorities, objectives and goals for the 2017-2022 Five Year Plan?
- Pages 17, How This Approach is Different: “DDS is committed to a strategic approach for the 2017-2022 Five Year Plan, representing the next component of an overarching Lean-driven transformation program that began with the agency’s Strategic Vision Project. The strategic vision has given the agency a goal for how we would like to see our organization function in the future; this plan gives us the path to get there.” What does that mean? The draft plan then begins a presentation of a project-based approach which “invites stakeholders at all levels to take ownership of the future of our service delivery system. In return, this approach asks for accountability and work product delivery that will help drive us to achieving our mission and vision.” Still, the priorities, objectives and goals of this draft plan remain unclear.
- Over the next 9 pages, the draft plan presents no less than 30 specific projects, each which will have a defined set of related work products, and success will be measured by the production of a “work product” from each project. There is no timeframe provided for the completion of any of these projects. A five year program outline plans to focus on Building the Foundation → Early Progress → Active Evolution → Continued Adaptation → Agency Transformation. By following the project-based approach, in phase five, “DDS will be transformed into a responsive, modernized organization”! So, what are the individuals who are waiting for day and employment supports, residential supports, respite services, family support grants, or for a case manager to be assigned to them supposed to be doing while DDS transforms itself over the next five years?

I am specifically concerned that the draft plan does not include:

- a plan to reduce the Waiting List. More than 2,000 individuals are still waiting for residential support and only a single paragraph (page 23) describes DDS' plan to redefine the residential Waiting List definitions, but there is no plan to actually reduce the Waiting List. Apparently in 2022, these individuals and their families will still be waiting.
- a plan to deal with the waiting lists for Day and Employment Services, Behavioral Support Services, Family Support Grants, Respite Services and Case Management. These supports and services should not be subject to almost yearly cuts because of state budget deficits.
- a plan to increase funding to private providers. While a disproportionate amount of the DDS budget is currently directed to public-provided residential and day supports, the private providers have not received a significant increase in funding for more than 7 years. Private providers now deliver residential supports to approximately 92% of individuals. The employees of private providers are struggling to make ends meet and provide for their own families!
- a plan to eliminate the costly public services at STS, the Regional Centers and group homes, which cost 2-3 times more than the same quality services offered by private providers. The closure of STS is never mentioned as a solution. In FY2016, states expenditures at STS included \$61 million for earnings (including \$13 million in overtime) and \$20 million for fringe benefits to care for approximately 260 residents, and this does not include any of the costs for heat, electricity, food, medical services, etc.! The current census at STS is approximately 240, but the draft plan still does not even mention closure of the institution. How much is the state willing to pay per resident for STS to remain open over the next five years? \$500,000/resident? \$1 million/resident? Two Regional Centers have recently been closed, but the majority of these residents moved to other public facilities. And yet, in this draft plan, DDS states that it "continues to follow national trends, moving toward community-based residential supports and away from publicly-operated, institutional care." There is no evidence of this commitment in the draft plan? Privatization of some public group homes has occurred, but privatization of the remaining group homes appears to be on hold for political reasons. In FY2016, the overtime costs at all state-run facilities exceeded \$45 million!
- When residential Waiting List Initiative funding became available in 2014 for individuals with a care giver over the age of 70, it took DDS several months to interview eligible families before they could determine how many families actually qualified and sought residential funding support. The department blamed its antiquated computer system for some of the delay, along with the fact that many IPs didn't even include the ages of the caregivers. Since that time, has DDS established a procedure for this type of information to be updated annually at each individual's IP?

In conclusion, the draft DDS Five Year Plan 2017 – 2022 lists more than 30 "projects" the department intends to undertake, but the plan fails to clearly identify the priorities, goals and objectives of the department. Other than completing each project by producing a project-related document, specific

parameters for evaluating progress are not provided. There is no substantive discussion of whether the goals in the 2012-2017 Five Year Plan were achieved, and if not, why not. Additionally, as noted immediately above, the draft plan lacks any substantive discussion about how to (a) reduce the residential Waiting List, as well as the other waiting lists that now exist; (b) increase funding to private providers; and (c) close costly state-run institutions and group homes. Significant revision of the DDS draft Five Year Plan 2017-2022 is necessary to conform to the specific requests outlined in Section 17a-211 of the Connecticut General Statutes.