State of Connecticut
Department of Developmental Services

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Governor

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Appropriations Health Subcommittee Workgroup: February 27, 2018

Co-Chairs: Senator Terry Gerratana, Senator Heather Somers and Representative Patricia Dillon

We appreciate the opportunity to discuss Governor Malloy's Recommended Budget Adjustments for FY 2019 as they relate to the Department of Developmental Services (DDS). We have included the following information in response to questions posed at the Appropriations Committee Public Hearing on February 16, 2018.

1. **How many employees have you seen leave the agency this year? Via retirement, transfers, separation, etc. (FY17, FY18 YTD)**

The following information was pulled from Core-CT as of February 1, 2018:

Department of Developmental Services Fiscal Year 17 Separations/Terminations	
Reason for Separation/Termination:	
Death	9
Discharge	2
Drop in Working Test Period	2
Layoff	10
Non-Disciplinary Termination	1
Non-Perm Appt End	2
Resignation	53
Retirement	212
Separated pending Retirement	3
Transfer out of Agency	71
Unclassified Position Discontinued	1
Grand Total	**366**

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Department of Developmental Services Fiscal Year 18 YTD - Present Separations/Terminations	
Reason for Separation/Termination:	
Death	2
Discharge	3
Resigned in Good Standing	12
Retirement	116
Transfer out of Agency	25
Grand Total	**158**

2. Five year history of the DDS Residential Waiting List

DDS has changed the way the Residential Waiting List data is organized and presented to more accurately reflect the needs of individuals and provide a more transparent representation that can be easily understood by families and other stakeholders. To support this effort, beginning in March 2017, Case Managers began working with individuals and families through the annual individual planning (IP) process to collect information through a Support Survey and Residential Request Assessment. The Support Survey identifies whether or not an individual has unmet residential or day service needs. If the individual is determined to have unmet residential needs, the Residential Request Assessment identifies what category of need the individual has (Emergency, Urgent or Future Needs). This information is being collected over the course of a year, during which time data is being updated in order to be presented in a new format that should be clearer and easier to understand for future Management Information Reports (MIRs). With this in mind, attached please find the data by year as requested.

3. Provider Direct Care worker salary ranges and responsibilities

Our most recent formal data regarding national Direct Support Professional (DSP) wage trends comes from the 2016 Staff Stability Survey Report issued in January 2018 by National Core Indicators (NCI), a collaboration of the National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. The survey is offered annually across all 50 states. DDS facilitates provider participation in the survey, but the data collection and analysis is conducted by the national group. Only 29 of 182 (15.9%) Connecticut providers replied to the most recent completed survey. This indicates a margin of error in the data of 16.7%.

With this data limitation in mind, here is some information for your consideration that we found pertinent. Nationally, across all service types, Direct Support Professionals (DSPs) received a median hourly wage of $11.41, compared to the survey reported median wage of $13.85 in Connecticut.

The following table is excerpted from page 31 of the report.

Table 21: Average Hourly Wage - All DSPs

	State Minimum Wage[6]	Avg. Hourly Wage	Std. Deviation	Median Hourly Wage	Minimum hourly wage	Maximum hourly wage
AL	$7.25	$9.53	1.74923	$9.20	$7.25	$14.00
AZ	$8.05	$10.53	1.45087	$10.25	$8.50	$17.72
CT	$9.60	$14.06	1.98704	$13.85	$11.43	$18.50
DC	$11.50	$14.27	2.11654	$13.86	$11.80	$25.00
GA	$7.25	$10.39	2.19995	$10.00	$7.50	$23.68
HI	$8.50	$12.10	1.97601	$12.50	$8.50	$15.17
IL	$8.25	$10.95	1.69754	$10.68	$8.25	$19.77
IN	$7.25	$10.73	1.20125	$10.60	$8.10	$14.00
MD	$8.75	$12.62	3.11125	$11.90	$9.50	$25.31

And from page 34,

Table 23: Average *Starting* Hourly Wage – All DSPs

	Avg. Starting Hourly Wage	Std. Deviation	Median Starting Hourly Wage	Minimum starting hourly wage	Maximum starting hourly wage	N
AL	$8.79	1.54802	$8.00	$7.25	$14.00	33
AZ	$9.78	0.99190	$10.00	$8.05	$15.00	80
CT	$12.73	1.28336	$12.50	$11.00	$15.89	25
DC	$13.87	1.71716	$13.85	$10.83	$21.91	60
GA	$9.80	1.97516	$9.50	$7.25	$23.68	130
HI	$10.93	1.57607	$10.54	$8.50	$14.00	12
IL	$10.07	1.52956	$9.98	$8.25	$19.77	180
IN	$9.91	1.05369	$10.00	$7.63	$14.00	87
MD	$11.66	2.11725	$11.08	$9.00	$21.92	72
MO	$9.71	1.63336	$9.50	$7.65	$17.00	84

As the NCI survey included only a 15% response rate for Connecticut providers, DDS has also consulted annual report information from all qualified providers. This more comprehensive data shows an average hourly wage of $14.50 for DSPs, as compared with the average hourly wage of $14.06 reported through the NCI survey.

4. Statistics on employment trends of private providers (Commissioner referenced Provider Stability Survey)

Our most recent formal data regarding provider employment trends comes from the 2016 Staff Stability Survey Report issued in January 2018 by National Core Indicators (NCI), a collaboration of the National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. The survey is offered annually across all 50 states. DDS facilitates provider participation in the survey, but the data collection and analysis is conducted by the national group. Only 29 of 182 (15.9%) Connecticut providers replied to the most recently completed survey. This indicates a margin of error in the data of 16.7%.

With this data limitation in mind, here is some information we found pertinent.

Across states, the turnover rate for Direct Support Professionals (DSPs) in 2016 ranged from 24.1% to 69.1%; the NCI average was 45.5%. According to the survey, Connecticut's turnover rate for the same time period was 31.5%, with 74.2% of Connecticut agencies reported having DSPs work for 12 months and longer. Again, please note that this information applies only to the 29 Connecticut provider agencies that replied to the survey.

Nationally, of the DSPs employed by respondents as of December 31, 2016:
- 19.1% had been employed for less than 6 months
- 15.7% had been employed between 6 and 12 months
- 65.2% had been employed for more than 12 months

Of the DSPs who left (separated from) employment between January 1, 2016 and December 31, 2016:
- 38.2% had been employed for less than 6 months
- 21.0% had been employed between 6 and 12 months
- 40.8% had been employed for more than 12 months

5. **How many individuals are at each Level of Need (LON) in public group homes and in private group homes?**

	Public CLA	Private ICF CLA	Private Non-ICF CLA	Private CRS
LON 1		6	7	
LON 2	1	12	28	4
LON 3	12	22	120	14
LON 4	14	30	244	79
LON 5	45	69	688	181
LON 6	57	81	954	226
LON 7	109	138	965	187
LON 8	3	1	103	30
Blanks			4	1
	241	359	3113	722

6. **$5 million for Emergency Placements: how many will be served? How will funding be used?**

The Governor's Recommended Budget Adjustments for FY 2019 include an appropriation of $5 million to assist with Emergency Placements. The initial intent was to provide emergency placement funding for a variety of situations, including instances of lengthy reliance on hospital emergency departments. When considering this funding in the context of our traditional service structures and using data on costs associated with individuals recently in these types of situations, $5 million would provide somewhat limited relief for permanent and ongoing placements. However, upon subsequent conversations with the administration, we have agreed to a better and more cost effective way to utilize this funding.

Our plan is to build capacity within the community to address some immediate concerns of individuals in crisis. In turn, the ability to offer enhanced supports will reduce reliance on hospitals for individuals with acute clinical needs. This funding would also allow DDS to provide some critical wrap-around services to de-escalate situations and offer enough stability to keep individuals in the most integrated community-based settings that best suit their ongoing needs. We have long understood that there are gaps in our continuum of supports and services. We are acutely aware of instances in which individuals have had to rely on emergency department care for extended periods of time, due to the nature of their crisis and the constraints of the current system. While this funding will not eliminate the problem immediately, or provide enough funding to place everyone in crisis who presents at an emergency department, it will provide us with resources to build new and unique capacity in our system. By building this capacity, we can create a system over time that delivers supports and services in a cost effective and timely fashion, and by doing so, lessen the need for long-term congregate care placements.

The DDS system currently lacks a number of pieces to address the needs of individuals with escalating or crisis-level needs. First, we do not have a mobile crisis response system. Other states have found that the old adage, an ounce of prevention is worth a pound of cure, is true in the manner in which we look to support individuals with intellectual disability and their families. In Connecticut, the Department of Mental Health and Addiction Services (DMHAS) has proven the efficacy of mobile crisis teams and their ability to respond to problems that might otherwise end in costly long-term placements, by intervening at the site of the issue ahead of a point of no return. This type of capacity is one portion of our plan.

In addition to mobile crisis response, we plan to bolster our continuum of care with increased capacity in the state's respite capacity. These respite opportunities must be safe, clinically sound, and time limited where

both the individual and the family can get some space and time apart, while the crisis team identifies the underlying issues and corresponding resources to correct those issues. DDS would be a part of these resources, but we hope to partner with others, including community mental health providers, local education agencies and other state agencies to build a full continuum of appropriate supports.

Moving beyond respite, the system also lacks 'step–up' and 'step-down' units. Here again, DDS is looking to the best practices implemented by DMHAS and other states. The step-up units would provide an alternative to the use of emergency rooms and other extreme measures where we can identify challenges early, before a family has made the painful decision that they can no longer support their loved one. The goal of these units is to fix problems before they reach that tipping point and provide both care and a plan to succeed at home, including identifying necessary wrap-around services. Sometimes, however; there are not obvious early signs. In those cases there is a role for hospitals to play. Simply returning the individual to the home they were in prior to emergency department stabilization is often unsuccessful. DDS does not currently operate step-down units, and there do not appear to be existing step-down units in the state well-suited for the individuals that DDS supports. These units would allow a team to work under clinical supervision to provide a planned, appropriate transition, inclusive of needed wrap-around supports.

While $5 million dollars will not fund the entire necessary expansion DDS contemplates, it could be a strong beginning of a proactive, therapeutic approach to handling these complex situations, for both children and adults eligible for DDS supports. If we replicate what we know already works in other states and in other state agencies, we can begin to use our traditional funding more efficiently and move the whole system towards a less costly and reactive approach.

7. Explain the net savings of $1 million from the ten FY 19 conversions. How have past savings from conversions been used?

The net savings of $1 million is based upon the department's analysis of ten public community living arrangements (CLAs) converting from public to private operation on October 1, 2019. Estimated gross savings from the conversions are $6.75 million; $6.3 million in the Personal Services account, $410,000 in Other Expenses and $40,000 in Clinical Services. The salary savings is made up of $5.7 million in salaries at the homes to be converted and $600,000 in overtime savings achieved by redeployment of public employees to vacancies within the public service system. The Department estimates that it will cost $5.2 million in the Community Residential Services account and $500,000 at the Department of Social Services to fund individuals for the remaining nine months of FY19 in privately-operated group homes.

Recent conversions of CLAs from public to private operation have been articulated in the context of budget reduction options. Therefore, savings from these conversions were used to reduce expenditures in the Department's Personal Services, Other Expense, and Clinical Services accounts to remain within available allocations.

8. How are Personal Services reductions impacting DDS's ability to provide services?

DDS has seen significant reductions to Personal Services in recent years. Some have been directly tied to the conversion of publicly-operated programs to private providers. However, this has represented a fairly small portion of the total reductions to the department's spending in that account, particularly if you take into consideration holdbacks and targeted lapses.

The chart on the next page lays out the department's Personal Services appropriations from FY16 – FY19 (proposed Governor's Budget Adjustments), in addition to the department's actual or projected spending after holdbacks and targeted lapses.

	FY16	FY17	FY18	FY19 - Governor's Budget Adjustments
Appropriation	262,989,799	214,679,415	207,943,136	194,793,871
Actual/Projected Expenditures	244,132,052	215,986,057	202,330,585	194,793,871

Savings measures have primarily included layoffs in late FY16 and deferred refills of positions vacated through retirements or other separations of employees. Certain key positions have been refilled during this time, but hiring has been held to a minimum. Overall, from July 1, 2014 to February 2018, the Department has reduced staff by more than 800 positions, shrinking from 3,683 to 2,860 employees.

Some of this attrition would be considered natural, as the Department has moved away from providing certain types of supports (e.g., public day programs). However, staff reductions in other areas have affected the department's ability to provide services. For instance, Supported Living Workers have been reduced from 85 at the start of FY15 to 69 today. These employees are now primarily members of our Individual and Family Support (IFS) teams, offering temporary assistance to individuals and families on an emergency basis. Case Management also has remained understaffed, shrinking from 369 case managers and supervisors in FY15 to 346 today.

Staffing reductions have been seen across the board in nearly every division and area of the department since FY15. In this fiscal year and moving forward, we hope to free up Personal Services funding to tackle some of the areas of need in staffing through reductions in spending for overtime.

9. What is the impact of the reduction in the rent subsidy program?

The Department has managed reductions in the Rent Subsidy account by restricting reimbursement of discretionary items like snow removal, lawn care and garbage removal. Finally, the Department reviews chronically high utilities and attempts to find remedial measures.

10. What is the impact of overall account reductions on the Employment and Day program?

Although the delay in passing the FY18 budget impacted DDS's ability to start FY18 high school graduates on time, there is enough funding to cover the day and employment needs of all current year grads for the remainder of this fiscal year.

The current FY19 budget for employment and day programs, as adjusted by Governor Malloy, includes enough funding to meet the needs of all projected FY19 high school graduates. Additionally, the Governor's proposed budget adjustment for FY19 also provides funding for projected case load growth for age outs and the Money Follows the Person (MFP) program.

11. Show DDS system today vs three years ago- has there been erosion in the system of care.

The DDS system has been challenged in recent years, facing the same fiscal constraints as the rest of the state. At the same time, increased demands at every level have required that the Department and its providers do more to ensure the quality of supports provided and the safety of individuals served. DDS and our provider community continue to be grounded in a commitment to the individuals and families that we support. DDS and our provider's resources are stretched to cover important and continually expanding responsibilities, however, we have seen the effects of rate decreases and staff reductions.

The DDS system of supports has seen numerous changes in the past few years, some driven by positive shifts in philosophy, some driven by fiscal pressures. We have continued to move toward community-based, integrated supports in both residential and day/employment. We have reduced capacity in our publicly-operated institutional settings and effectively closed down sheltered workshops. We have worked toward efficiencies in our public system, converting some programs to more cost-effective private operation, and applying Lean principles to administrative operations.

However, these positive changes have been balanced against challenges in nearly every program and service area of the agency. Staff reductions have impacted areas of direct support to individuals, families, and providers. As one example, in FY15, DDS employed or contracted with 65 clinicians in our psychological services divisions, providing not only direct support to individuals served in publicly-operated programs, but important consultation to private providers and individuals. As of today, we employ or contract with only 47 clinicians. Despite a shrinking census in publicly-operated programs, there is still an enormous need for clinical support in our Private and Individual and Family Supports divisions.

Our Behavioral Services Program (BSP), which serves children with co-occurring intellectual disability and behavioral health needs, also has seen significant reductions. In FY15, our appropriation was over $32 million and has fallen to just under $22.5 million in the current fiscal year. This has primarily resulted in a waiting list for the program, as savings have been removed with each child who ages out of BSP and transfers into Community Residential Services.

In addition, the rates of reimbursement to private providers have been reduced, in particular following the substantial reductions in FY13 to our Community Residential Services and Employment Opportunities and Day Services accounts. At a time of increasing costs in many areas for employers, this has left our private provider partners without the ability to raise staff wages to combat high rates of turnover. This is just a sampling of some of the areas in which the DDS system of supports has been affected in recent years.

12. Behavioral Services Program – what is your 5 year plan for this program and what priority is it for the agency.

Over the next five years, children at age 21 will continue to age-out of the behavioral services program (BSP) but they will continue to receive supports through DDS as adults.

Fiscal Year	Number of Age-Outs	Current Annual Cost
19	52	$2,890,916
20	47	$2,850,336
21	46	$2,529,590
22	41	$2,251,979
23	41	$2,360,138

As in all cases, DDS strives to provide supports to as many individuals as possible within available appropriations. As individuals age-out of BSP, and as the appropriation allows, new individuals will be taken off the BSP waiting list and will receive appropriate supports. DDS remains committed to supporting this program for children with intellectual disability and behavioral health or mental health needs. To ensure that DDS is able to support as many individuals as possible within available appropriations, we encourage families to explore other community resources and insurance-based supports which may be available to them. DDS will continue to build on the strong partnerships that have been developed with the Departments of Education, Children and Families, Mental Health and Addiction Services, Public Health and Social Services and a variety of other community and stakeholder groups to help better support the complex behavioral needs of individuals supported by DDS. This effort will focus on providing information to families on the implementation of effective positive behavior support strategies across the lifespan, beginning at an early age.