Department of Developmental Services
Residential Transition Workgroup
Minutes
September 19, 2013

Attendees: Len Cipolline, Stan Soby, Pauline Bouffard, Peter Mason, Mark Kovitch, Katie Rock, Chet Fischer, Shannon O'Brien

I. Minutes of the August 15th, 2013 meeting were reviewed and approved

II. Committee Updates:

Implementation Committee – Peter distributed a handout, "Transition Process" which clarifies day rates. It gives a very detailed explanation on how funding is handled for internal changes and portability of funds. When does a provider lose money and when does it get recycled. It gives a variety of examples of possible moves. Portability is when an individual moves to another agency and not for internal moves. A suggestion was made to send this information to all providers so they can understand the process.

- Providers prefer the term "over the rate" instead of "overfunded."
- It was noted that the State continues to try to make URR efficient and consistent. It was noted that conditional approvals are causing issues and in the future it will be either approved or disapproved.
- Even though there is no official waiting list, there is a significant number of individuals waiting for services.
- Commissioner Macy was looking for suggestions on how to reorganize the PRC process by presenting "White Papers". The reader group has not published the result of this project.
- Some concerns presented was if a sampling of PRC packets are reviewed from each provider, how much will be missed when it comes to restraints, HRC issues and over usage of medications.
- Qualifications for program authors need to be tightened up.
- In the past, Dr. Hanley and Dr. Hanson provided training for program authors and this is something that needs to be reconsidered.
- Right sizing not allowed at this time.
- Too many budget summary forms floating around and regions are not consistent with this process. It would be nice to have one standard form. However, if we are going to the LON rates, why does there need to be a budget summary sheet?
- Previous budget summary form had cells locked so providers could not enter numbers.

B. Residential Issues: Committee members are having a difficult time showing up for meetings. This group will become part of the Community of Practice committee. Pauline did discuss some assistance technology that

they will be using in a home in Meriden. The individual does not need 24 hours support but will be able to live with minimum supports thanks to technology.

C. CCH – Policy being revised regarding rates and it will be going to a reader group for review.

D. IHS- Peter has received some feedback on current rates. Listed below are a few:

1 .Too many changes in a short period of time
2. Program is too complicated
3. Behavioral hours to low
4. Spread sheet to complicated
5. Reserve and emergency hours very helpful
6. Keeping funding whole for the first year a good thing.
7. How does personal support differ from I.H.S.?
7. Healthcare and Nursing coordination need to be clarified.
8. What is the role of the provider?
9. What is the role of the Health Care Coordinator?
10. What is the role of the VNA?
11. L. Hyatt will be asked to attend a future meeting to address questions regarding roles of everyone.
12. Authorization for Health Care Coordinator can't be sub-contracted out.
13. Teams will have to oversee health care for individuals.
14. DDS does not want to be the payer of first resort and how does VNA come into play?

E) Data Management

1. Not much to report at this time.
2. Committee will be asked to review "Providers detail reports". Can they be made user friendlier. Can committee members add anything to the format or should items be deleted.

F) Sustainability - Done

III. Community of Practice Update

1. Look at the current system and how can we make if more person centered?
2. If someone lives in a family home there is no safety net for the agency. If staffing is canceled for whatever reason, agency can't be paid.
3. For individuals that live in rural areas, they do not have the ability to network and resources are not there.
4. DDS would like to see a broader source of resources beside themselves.
5. This committee has not met at this time.

IV. Continue Discussion of Residential Clinical supports - Katie Rock

1. Review of Provider Survey for Residential Care Nursing and Behaviorist.

2. Very poor response to survey. The committee realizes everyone is very busy but these surveys are only as good as the response they receive.
3. Please review highlights from graph. Please see attached graph for more detailed information.
    a. Residential Care Nursing and Behaviorist average in-house vs. consultant coverage.
        1. 68% of agencies use a consultant service for RN's.
        2. 60% of agencies use in-house behaviorist.
    b. Residential Care Nursing – RN's, In-house vs. consultant rates
        1. RN's average rate was $31.75 an hour for in house and $58.23 for Consultants. Please review graph for other comparisons.
    c. Residential Care Behaviorist in House vs. Consultants rates
        1. Average hourly rate for in house behaviorist was $35.67 compared to $88.27 for a consultant. See graph for more comparisons.
    d. Residential Care Nursing - % of time spent on primary care vs. administrative.
        1. 62.5% of RN's spend at least half of their time on primary care/care coordination.
        2. 37.5 of RN's spend at least half of their time on administrative task.
        3. 86% of LPN's spend at least half of their time on primary care/care coordination
        4. 14% of LPN's spend at least half of their time on administrative task.
    e. Residential Care Nursing & Behaviorist – average hours per client per week.
        1. RN's 2.19 - LPN's 11.43 - Behaviorist 1.77
        2. Several providers commented that they no longer use LPN's due to the need for RN oversight.
    f. Average Hours for a 4 bed home, LON 5
        1. Average hours for RN's 5.57
        2. Average hours for LPN's 5.38
        3. Average hours for behaviorist 3.76
    g. Lakisha Hyatt and Dan Micari will be invited to the next meeting to discuss nursing duties and QSR expectations.
    h. DDS nurses and agency nurses can have conflicting ways of doing things.
    i. VNA's are not allowed in CRS's even though this may be happening.

V. Other State Rate Research - Massachusetts Rates – Len Cipolline - Handout
1. Difficult to compare Massachusetts rates to Connecticut's LON.
2. The committee questioned what the daily rate actually includes.
3. Fringe benefits and tax set at 21.7%. Is this part of the rate?
4. Three basic service models

a. Basic – With 9 model options with different staff intensity level and rate.

b. Intermediate Program model with 24 categories

c. Medical/clinical program models with 12 categories.

d. Hourly rates:

- DC workers level 1- hourly rate $15.63
- DC workers Level II- hourly rate $16.72
- Relief level 1 - $13.64
- Relief Level II – $14.59

VI. Public comments – None

VII. Adjournment – 3:30

VIII. Next meeting will be held on October 17th at 1:00 at CAN.

Respectfully submitted,
Chet Fischer