

DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS
QUALITY ASSESSMENT

DIVISION OF DEVELOPMENTAL DISABILITIES

3.1 HISTORY

The Department of MHRH, Division of Developmental Disabilities has transitioned from a system of care predominated by a large institutional base, sole service provider, to a service system which is person centered, community-based, dispersed, and focused on providing the necessary supports to promote personal choice and valued membership in the community.

The evolution of services for individuals with developmental disabilities has been paralleled to the civil rights movement. Sociologist Bernard Farber has used the idea of “surplus” populations to describe this kind of fatalistic view of retarded people.

retarded citizens, like the ill, the disfigured, the aged, the poor, or racial minorities, are perceived as marginal, and therefore expendable people.”

-Rhode Island History, Days of Darkness Days of Hope, The Care of Mentally Disabled People

Institutionalization became the prescription from health care professionals to parents. There were no other options. The Ladd Center was so distant for most families, that once their son or daughter was placed there, they became isolated from society. On a local and national level, institutional life was chronicled and photographed showing the horrible conditions that were forced on many individuals – overcrowding, abuse, inadequate food and shelter, lack of personal property, no privacy, and lack of opportunities to participate in any meaningful activities. Parents wanted another option.

In 1951, the Parents Council for Retarded Citizens was formed. Armed with knowledge gained through a commitment to educate themselves about mental retardation, they advocated for change. In 1952, the Council voted to become affiliated with the national Association of Retarded Children. Local groups were created throughout the state and in 1962 they created a state association, the Rhode Island Association for Retarded Citizens. By 1968, RIARC included ten regional chapters with almost 1,000 family memberships. Arthur Trudeau, a charismatic leader and parent, enlisted the help of Congressman John Fogarty. Mr. Fogarty states in a speech:

My long-time friend, J. Arthur Trudeau gave me my first real insight into the hell-on-earth that so recently represented existence for mentally retarded children. In 1954, I was asked to address a small organization in Rhode Island composed of the parents of mentally retarded children. I didn't know much about mental deficiency, so I listened more than I talked. I had heard the familiar statistics about there being five million mental defectives in the country and three hundred more born each day to American families, but I had never before looked into the eyes of parents to whom these children had been born. They told me of the hopelessness of the treatment outlook, of the difficulties of getting these children into any kind of school, of the tragic air of rejection and defeatism which seemed to engulf all professional and public

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discussion of the plight of these children.

-Rhode Island History, Days of Darkness Days of Hope, The Care of Mentally Disabled People

At the national level, in 1963 the President's Panel on Mental Retardation presented a national plan that recommended community-based programs, and a reduction in the number of individuals who lived in institutions. This report, along with champions at the national level such as Congressman John Fogarty, as chairman of the House Appropriations Committee, resulted in a shift in national policy with regard to services for individuals with retardation. Laws such as *Mental Retardation Facilities and Community Mental Health Centers Construction Act*, amendments to the *Vocational Rehabilitation Act*, Mental Retardation Amendments, and changes to the *Social Security Act* resulted in the ability of states to access federal funding to develop community-based programs and services. The Americans with Disabilities Act (ADA) passed in 1990 eliminated many of the barriers that existed in accessing community sites.

No doubt many of you can recall, as I can, when the retarded child was each family's private – often even its secret – problem. Individually, every parent tried his best to solve the problem. Doctor after doctor was called upon, institution after institution was tried, until at last hope sunk into desperate resignation. There was only one ending to that private, secret road: failure. It has been little more than a decade that a newer way has been tried on a nationwide scale – the way of cooperation, the way of banding together. Instead of the intermittent pushes of an individual parent against the hard wall of prejudice and apathy, there is now the mighty push of millions. And the wall is crumbling.”

-Congressman John E. Fogarty, 1961

In Rhode Island, Arthur Trudeau and other leaders used their talents to rally the community and raise funds to develop and implement programs and activities for individuals with disabilities in their communities. Through the grassroots action of families, the Office of Mental Retardation was established in Rhode Island law in 1967. Initially vetoed by the Governor, parent advocacy and support from key members in the House and Senate resulted in the veto being overturned.

Other leaders such as Paul Sherlock and Jim Healey galvanized support in the State Legislature resulting in Rhode Island being the first state first state to enact legislation requiring that all handicapped children are entitled to an education. The concept of a community-based system received significant support from Rhode Island citizens, through the passage of several bond issues to purchase property and/or construct homes and day program sites, as well as state general revenue to fund services. Access to federal funding through the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Program provided the financial support for operation of residential and day programs. This was by its nature a medical-based model for long-term care that included significant regulation and oversight to ensure that individuals had access to quality

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services. Rhode Island was again the leader as the first state to obtain approval for the use of federal ICF/MR funding for residential settings of six persons or less, and the first group home was opened in 1975. A statewide zoning law was enacted in 1977 which compelled local communities to accept community residences for six or fewer unrelated individuals as a single family home.

The parents movement influenced local politics as well. The successful passage of bond issues for services for the retarded, and the legislative establishment of the Office of Mental Retardation are examples of the influence of the parents on state policy.

-Rhode Island History, Days of Darkness Days of Hope, The Care of Mentally Disabled People

Despite all of the support, the population at Ladd Center was still very high, over 1,000 people in 1975, and the environment had not significantly improved. In 1975 *The Providence Journal* exposed the conditions at Ladd Center in a provocative series of articles. In 1977 a class action lawsuit was filed by the Ladd Center Parents Association, *Iasimone vs. Garrahy et al.* A *Stipulation Agreement* was signed in 1982 with a plan to move people into the community. This led to the most successful deinstitutionalization process in the country gaining national recognition because Rhode Island's deinstitutionalization plan incorporated the individuals who lived in the institution, the people who lived in the community who needed residential services, and the public employees at Ladd Center. As the community system grew over the years, it created community-based living arrangements not only for those individuals who were leaving the institution but also those in need of residential services in the community. In an unprecedented effort, Robert L. Carl, as Executive Director of the Division, Ladd Center leadership, and the AFSME labor union leadership for the workforce at Ladd Center, fashioned an agreement that there would be no job loss or layoffs as a result of the movement of individuals into the community. This Memorandum of Understanding was fundamental to the support of the unionized workforce of the deinstitutionalization process. The MOU and its provisions helped ensure a smooth, well-supported transition to community life for people who had been living at the Ladd Center. On July 30, 1986 the Governor held a press conference at Ladd Center, where he announced that Rhode Island would close its institution for the mentally retarded, making Rhode Island the first state to publicly declare its policy that it would close the state institution. Ladd Center officially closed in 1994, the third state in the nation to close its institution.

In order to expand services and create flexible options within the community-based system, the State applied for the Medicaid funded *Home and Community-Based Waiver*. The Waiver allowed the state the flexibility to expand services and access federal funding for Early Intervention Services, family support services (Homemaker, Respite, Specialized Medical Equipment, Adaptations to the Home), Semi-Independent Residential Services, and Shared Living Arrangements (also known as Adult Foster Care). Approved in 1982, The *Waiver* continues to be the main funding source for program services.

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In 1987 the *Right to Service* legislation changed the eligibility criteria for individuals who could receive funding from the Division by incorporating the federal functional definition of “developmental disability.” This broadened the population meeting the eligibility criteria from only individuals with mental retardation to also including individuals with developmental disabilities. As a result of the passage of the *Right to Service* legislation, a state general revenue appropriation was established which allowed individuals with developmental disabilities to request funding that they could receive directly to purchase services. Most significantly, this program made the concept of self-directed services a reality. This expansion in the scope of the population served by the Division led to the statutory name change from the Division of Retardation (DOR) to the Division of Retardation and Developmental Disabilities (DOR/DD); later to become the Division of Developmental Disabilities (DDD).

In 1991 the Rhode Island became one of only eight states to receive a five-year grant from the Federal Government called the *Community Supported Living Arrangement (CSLA)* Program, a unique “limited option waiver”. The establishment of the federal CSLA limited option waiver can be linked to the work of Rhode Island Senator John Chaffee’s efforts in Congress, to stimulate creating thinking and create responsive changes in the Home and Community Based Waiver Program. This special waiver allowed the state to expand the opportunities for individuals to direct their services to anyone who was eligible for Division funded services. Very importantly, *CSLA* also introduced the concept of individualized funding. There were no contracts between the state and service provider agencies. Individualized Plans formed the agreements between the state and the person relying on supports. Individuals received the funding directly and could purchase the supports and services they needed. When this grant ended, the individuals were enrolled in the *Home and Community-Based Waiver*, and the concept of self-directed services was incorporated into the *Waiver*. To continue the spirit of self-direction and control of resources, the *Waiver* was amended to include the means for self-direction and management of their services through an intermediary service organization or “fiscal intermediary.” Over time, the *Waiver* was amended to include other services, such as Supported Employment and Personal Emergency Response Systems.

There is a new way of thinking about how, where and with whom people with developmental disabilities can live, learn and work. This new way of thinking has involved a shift from a preoccupation with preparation, care and treatment to a concentration on supporting participation, building on capabilities, adapting environments and building relationships. The old way of thinking meant offering individuals and families a limited number of options. The new way of thinking means assisting individuals and families in identifying what is important to them, and empowering them with decision-making and spending authority to act upon those choices.

- “A New Way of Thinking,” Governor’s Planning Council on Developmental Disabilities, MN

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In 1994 Rhode Island submitted a Medicaid 1115 Waiver called *CHOICES* (*Citizenship, Health, Opportunities, Interdependence, Choices, Environments, Supports*). This was a research and demonstration waiver as it incorporated more flexibility and personal control by the individual and family in the choice of their long-term care supports, and a managed care model to improve access to acute medical care for individuals with developmental disabilities. Rhode Island withdrew the five-year demonstration waiver application, in favor of incorporating the long-term care system change concepts of *CHOICES* into the Home and Community Based Waiver. These concepts became the basis for the evolution of services in Rhode Island.

A shift in thought and practice was necessary to create an environment that enabled individuals and families to make choices and direct their future. The emphasis needed to more clearly expand to include people and their friends and families in the decision-making, rather than the primary dialogue for contracted services occurring between the state and service providers. Person-centered planning and individualized funding was at the core of this shift, as initiated first under CSLA. Person-centered planning focuses on capacity thinking and looks toward a positive possible future, engaging the support of allies, considering community membership and contribution, and identifying all supports including needed services to reach goals that have been set. Individualized funding recognizes the funding as unique to the individual. The individual receives information from the Division about the funding that will be available to the person to design and develop supports, and once funding is authorized, the individual is notified of the funding that the Division expects to spend, the types of services and supports selected by the individual, and the licensed and certified agency who will provide the supports. The individual may also choose to manage their own supports using the services of a Fiscal Intermediary as a conduit for the Medicaid *Waiver* funding.

Some of the existing processes needed to change to support this evolution. An assessment process is utilized; the Personal Capacities Inventory (PCI) and Situational Assessment is completed and a program level determined. From the 'program level' a level of funding is assigned. A Support Agreement was also developed that documents the discussions and conversations between the individual/family and service provider(s) chosen by the individual to provide support. It provides information regarding the expectations of the parties (the individual and the provider agency selected by the individual), health and safety concerns, and the means for continued communication. Once signed by both parties, this document is reviewed and approved by the Division and becomes the vehicle to authorize funding. In addition, the Division and the licensed and certified agencies developed a *Certification Document* that supports this shift in thinking and practice. It includes processes/practices such as the PCI, Support Agreement, movement to individualized funding and the fundamental values at the foundation of the approach to supports and services for people with developmental disabilities who rely on the Division and its agents.

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Rhode Island has always sought to improve the quality of its services. “In 1983, the Service Quality Network was established focusing dialogue and learning together around values common in all our lives: sharing places in community; making choices; developing valued competencies; building positive reputation and increasing status and valued roles; and community participation/building relationships.” (Presentation by Parents and Friends for Alternative Living) In 1988, the first Facilitator’s Forum was held. This forum provides opportunities for any interested stakeholder in the state to increase their skills and capacities in values-based problem-solving and creative thinking (described in “Implementing Person Centered Planning,” O’Brien and O’Brien).

In 1998 legislation was passed prohibiting aversive procedures in the area of behavior management. This legislation, along with *Licensing Regulations*, became a catalyst for increasing the use of positive approaches in providing supports and assistance to individuals with developmental disabilities.

Throughout the 1980’s and 1990’s people from The Netherlands, Japan, the United Kingdom, Germany, Belgium and Australia visited Rhode Island to learn of its deinstitutionalization process and the building of its community-based system. A long-term partnership was developed with staff from the Netherlands, coordinated by Ms. Lynda Kahn. These visits became a kind of “external review process”, creating an opportunity for the DD service network to look at its own programs and services through the eyes of another...an opportunity for review and growth. This international exchange initiative stimulated dialogue that strengthened coherency with value and mission, and focused efforts to support and celebrate community membership for people with disabilities.

In 1984 Parents and Friends for Alternative Living (PAL) was incorporated providing advocacy and support for families. Self advocates organized as the Rhode Island Coalition of Self Advocates and in 1996 incorporated as “Advocates In Action.” Both groups developed a partnership for advocacy for individuals with developmental disabilities and their families. The self-advocates sent delegations to National Self-Advocacy Conferences and in 2000 Advocates in Action and PAL hosted the national “Ride the Wave” self advocacy conference in Rhode Island. Advocates in Action provide leadership training opportunities, offer information about the adult service system to students who are graduating from school, testify at hearings before the State Legislature, listen to individuals who are receiving services and help them to advocate for themselves.

Thirty-five years ago parents revolted and protested the neglect and exclusion of their children with mental retardation. The most significant progress since that time has been the emergence of individuals with mental retardation as persons in their own right, as fellow human beings claiming their place in our society.

-Gunnar Dybwad, 1985

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The attached chart (Attachment A) displays the evolution in services, supports, and service delivery approaches over the past 50 years. All of the stakeholders in the DD network in Rhode Island continue to have the shared vision of providing opportunities and choices so that individuals with developmental disabilities can have full participation in community life. We must remember where we have been and what we have learned so that we will never regress. We must continue to listen to individuals with developmental disabilities and their families, challenge each other, “push the envelope,” and find new resources and partnerships that will support people to lead integrated and connected lives in their communities. We continue to strive for genuine *community membership vs. community presence*. John O’Brien

*Our goal should be clear. We are seeking nothing less than a life surrounded by the richness and diversity of community. A collective life. A common life. An **Everyday Life**. A powerful life that gains its joy from the creativity and connectedness that comes when we join in association as citizens to create an inclusive world.*

-John McKnight

References:

“A Rhode Island Timeline for Services for People with Developmental Disabilities,” A presentation created by Parents and Friends for Alternative Living

A New Way of Thinking, Minnesota’s Governor’s Planning Council on Developmental Disabilities, January, 1987

Days of Darkness Days of Hope. The Care of Mentally Disabled People, Rhode Island Historical Society, Volume 40, Number 4, November 1981

Everyday Lives, Pennsylvania Department of Public Welfare, 1991

Implementing Person Centered Planning: Voices of Experience. Edited by John O’Brien and Connie Lyle O’Brien. Inclusion Press. 2002

“The Evolution in Services and Supports,” adapted from “The New Service Paradigm” (Bradley, 1994), Rhode Island Department of Mental Health, Retardation and Hospitals, 2002.

Rhode Island’s *CHOICES* 1115 Waiver Proposal

Real Lives, A series on contemporary support to people with mental retardation, Amy Hewitt, Susan O’Neill, August, 1998

MHRH/DDD: 10/2006

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3.3 CURRENT SNAPSHOT

The Division of Developmental Disabilities' statutory requirement, through RI General Law 40.1-21-2, is to plan, develop, coordinate and administer a complete, comprehensive and integrated program for adults with developmental disabilities. Individuals receiving services in the developmental disabilities system have the opportunity to choose services that best meet their needs, and support their capacity to live in their homes in the community. The Division's fundamental goal is to support individuals in genuinely taking more personal control over their own lives, and to build and enhance meaningful community membership.

In carrying out this mission, the Division of Developmental Disabilities upholds these principles:

- Each individual is unique; supports and services shall be responsive to the individual and his/her particular situation;
- All of us develop and grow within a community of relationships; supports and services shall be designed to help build relationships;
- Each individual is deserving of respect; the Division strives to meet the highest standards of personal and professional integrity.

The eligibility criteria for DDD services is included in RI General Laws 40.1-21-4.3 and is as follows:

(1) "Mentally retarded developmentally disabled adult" shall mean a person eighteen (18) years old or older and not under the jurisdiction of the Department of Children, Youth and Families, with significant sub-average, general intellectual functioning two standard deviations below the norm, existing concurrently with deficits in adaptive behavior and manifested during the developmental period. For purposes of funding, it is understood that students enrolled in school will continue to receive education from their local education authority in accordance with 16-24-1 et seq.

(2) "Developmentally disabled adult" shall mean a person, eighteen (18) years old or older and not under the jurisdiction of the Department of Children, Youth and Families, who is either a mentally retarded developmentally disabled adult or is a person with a severe, chronic disability which;

- (a) is attributable to a mental or physical impairment or combination of mental and physical impairments;*
- (b) is manifested before the person attains age 22;*
- (c) is likely to continue indefinitely;*

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- (d) *results in substantial functional limitation in three or more of the following areas of major life activity:*
- (i) *self care*
 - (ii) *receptive and expressive language,*
 - (iii) *learning*
 - (iv) *mobility*
 - (v) *self-direction*
 - (vi) *capacity for independent living,*
 - (vii) *economic self-sufficiency; and*
- (e) *reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated. For purposes of funding, it is understood that students enrolled in school will continue to receive education from their local education authority in accordance with 16-24-1 et, seq.*

Attachment B is included which describes the support structure necessary for the Division to carry out its statutory requirements. It also describes the organization by functional area and the distribution of positions.

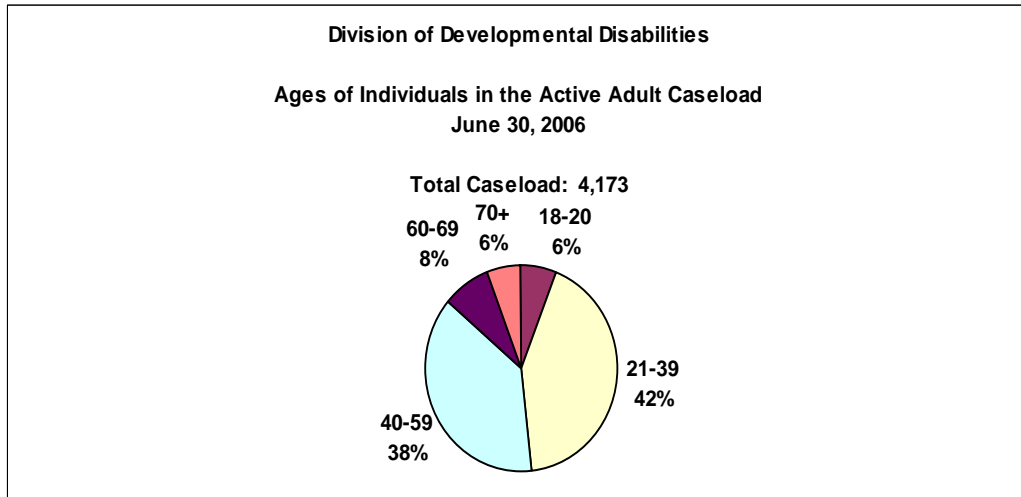
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3.3a POPULATION SERVED

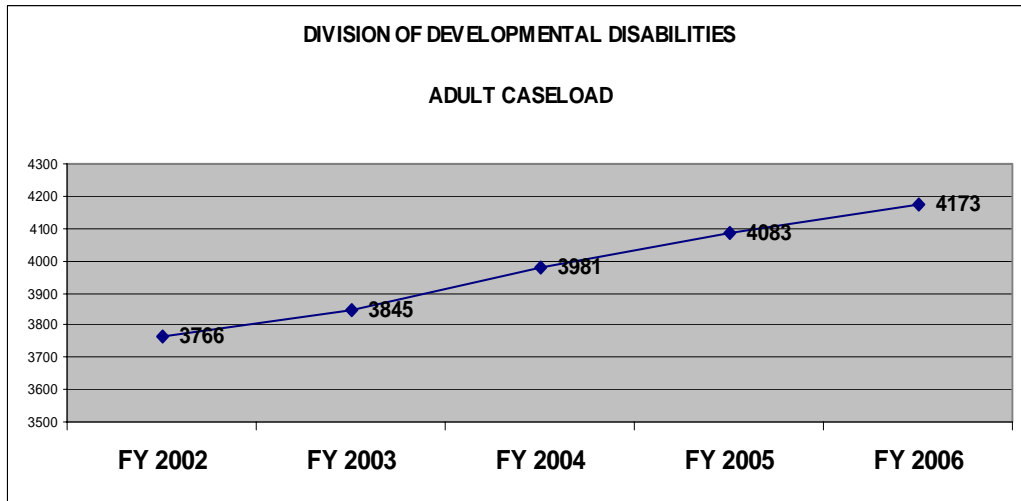
As of June 30, 2006, there were 4,173 individuals who were eligible for services from the Division. Approximately 3,000 individuals are eligible for the Title XIX Home and Community-Based Waiver.

The chart below provides information related to the ages of the individuals who are eligible for services.



As of June 30, 2006 RICLAS supported 287 individuals (7% of the eligible caseload). Their bed capacity is 304.

The caseload is increasing each year. The following chart indicates the growth in the caseload over the past five years.



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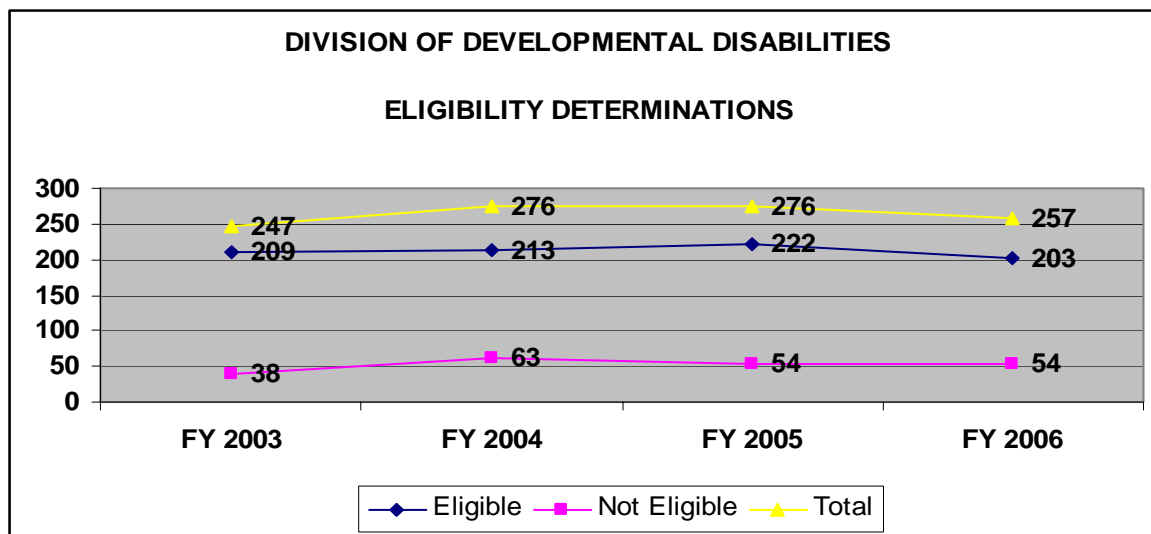
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CASELOAD GROWTH

	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>
Beginning Caseload	3,766	3,845	3,981	4,083
Determined Eligible	209	213	222	203
Cases Closed	<u>130</u>	<u>77</u>	<u>120</u>	<u>113</u>
Ending Caseload	3,845	3,981	4,083	4,173

Rhode Island's statutory definition of persons eligible for service through the MHRH Division of Developmental Disabilities has changed and expanded over the past 15 years to include persons who meet the federal, functional definition of developmental disabilities in addition to mental retardation *per se*. This expanded definition requires the Division to provide services to an increasing number of individuals, some of whom have minor support needs, but many who require intensive, specialized and expensive supports. We are planning and providing services for many more people who have involvement with the criminal justice system, psychiatric hospitals, and acute care hospitals. These individuals require increasingly complex, and intensive therapeutic services. In addition, some of these individuals are requiring structured 24-hour residential supports immediately upon entering the adult service system.

The chart below indicates the total eligibility determinations made per year, the number of individuals determined eligible, and the number of individuals who are not determined eligible. A significant amount of staff time is spent referring individuals who are not eligible to other programs/funding sources.



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3.3b SERVICES PROVIDED TO POPULATION

A critical point to be understood about this service system is that the services are life-long. Services are described within three general categories of service. Residential services and family supports are mutually exclusive. The categories of Service are:

Residential Services,
Day/Employment Services, and
Family Support.

Residential Services:

Residential services include periodic support to assist an individual to live in the community (non-24 hour), supports whenever the individual is in the home (including overnight support), and Shared Living Arrangements (also known as Adult Foster Care). Requests for residential services are prioritized based on criteria from the *King* court case into three categories:

- **Priority 1** which means that there is an critical need for residential services immediately or within six months (i.e. individuals in medical and psychiatric hospitals, individuals who have turned 21 and are in an under-21 residential setting, situations of abuse, neglect or mistreatment, etc.). There are 150 individuals on this list.
- **Priority 2** which means that there is no critical need at the current time, but it is important to track these individuals due to the age or health care needs of the individual or primary caregiver (i.e. single parent, aged caregiver, caregiver who is ill, etc.). There are 87 individuals on this list.
- **Priority 3** which means that the individual/family has requested a residential service, but there is no immediately need for services. There are 63 individuals on this list.

Day/Employment Services:

Day/employment services include a broad range of supports based on each individual's abilities and interests including, but not limited to: personal skill development, health and life education, socialization, prevocational services, community integration, volunteer opportunities, supported employment, and transportation. These services usually occur Monday through Friday, during the day, however, as individuals become more involved in the choice in services, some individuals are using their funding in a more non-traditional way (i.e. employment supports for second/third shift, community integration activities, etc.)

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Family Support:

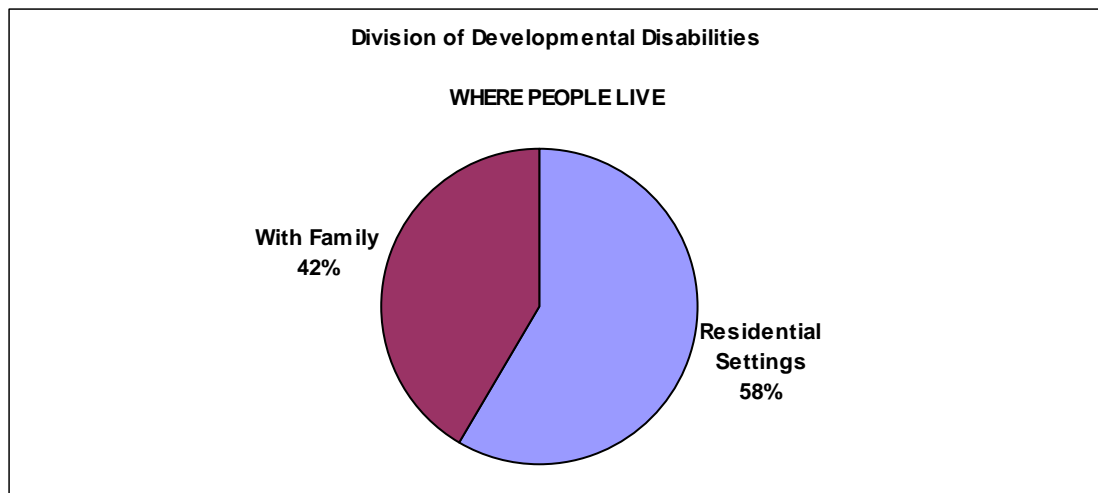
The Division's focus is to support families so that their son or daughter can remain in the family home for as long as possible. Supports can include, but not be limited to: in-home supports, community integration activities, respite, homemaker/home health aide services, assistive technology, home modifications, and Parent Subsidy.

Program Eligibility:

All individuals are eligible to be funded for day/employment services; however, in order to receive most residential services or family support, the individual must be eligible for the Home and Community-Based Waiver.

Where people live:

Approximately 2,416 individuals do not live with their family. They live alone, with others with developmental disabilities, with others who do not have a disability, in nursing homes, shelter care facilities and in out-of-state schools. Some are homeless. 1,757 individuals live with their family.



Residential Settings:

- 1,628 individuals (67%) receive 24-hour services funded by the Division. They receive services from private agencies and RICLAS.
- 45% of the individuals who receive 24-hour supports are aged 50+. These individuals are facing the same health care issues as the general population, and some individuals have a more vulnerable health status due to their disabilities.

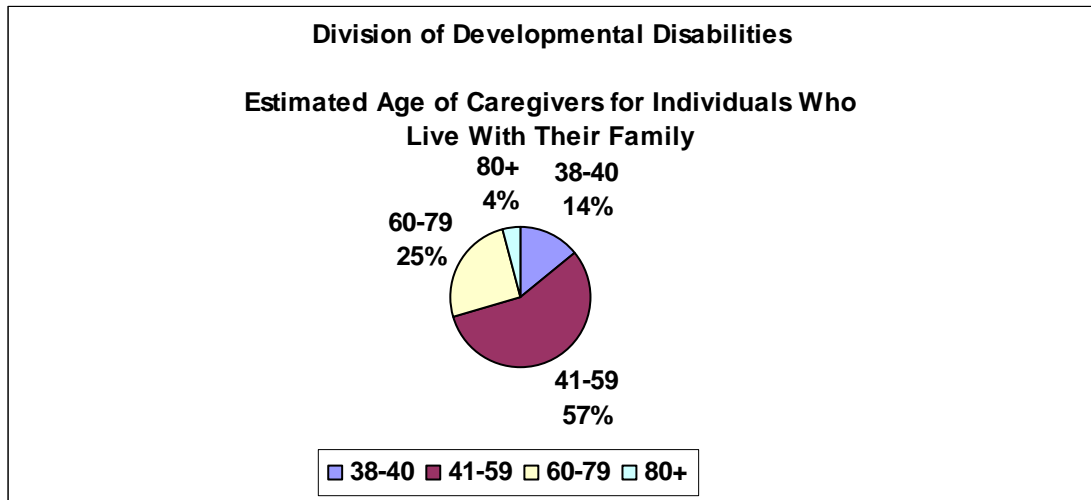
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- 68% of the individuals supported by RICLAS are aged 50+. This has a significant impact on RICLAS Medicaid revenue as there is a higher mortality rate (resulting in vacancies), more individuals are in hospitals (services cannot be billed to Medicaid), and overall the individuals need more support with medical issues as they age (there is no ability to increase FTE's and RICLAS currently does not have sufficient Community Living Aide FTE's to meet minimum staffing requirements).

Family Settings:

- Approximately 550 individuals are aged 40+. By conservatively adding 20 years to the age of the individual with developmental disabilities, 29% of the people in the adult caseload who live at home live with caregivers who are over 60 years old.
- This statistic is significant as there will be a **strong demand** from these families for residential services in the coming years.



Providers

There are 36 licensed agencies providing supports to eligible individuals. All agencies are also certified by the Division. There is one publicly operated provider and the remainder are private agencies.

Most agencies provide residential services, day/employment services and family supports. Some agencies provide only one or two categories of service.

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Contracting process

The Division does not enter into contracts with individuals or provider agencies. The *Certification Document* identifies the Division's program and financial requirements of the agencies. The Licensing Regulations stipulate other provisions that the agency must follow.

The Division has shifted the service system from one where the major service relationship was between the Division and the provider, to one where the major service relationship is between the individual and the agency chosen by the individual. The current process is described below.

Once an individual is determined eligible, a Social Worker is assigned. For newly eligible individuals and individuals requiring an new category of service or change in their current services, the following process is used. The Social Worker or agency currently providing services meets with the individual and those who know him/her best to complete a Personal Capacities Inventory (PCI) and a Situational Assessment (SA).

Division decisions to make funding available for the purchase of service in one or more of the categories of service are based on the existing need of the individual and/or the Individual's family/support system. Information sources for these decisions include:

- Application for Services
- Assessment Tools (Personal Capacities Inventory and Situational Assessment)
- Conversations with the Social Worker and other staff in the Social Services Unit
- Other evaluations/assessments as appropriate/available

The Division will make a determination as to the support level needed by the individual in each category of service requested, based on similarly situated individuals currently receiving services. The support level corresponds to a funding amount that the Division will make available to the individual to purchase supports. The individual is notified of their available funding and can use this letter in discussions with provider agencies. They negotiate the supports that they will receive and document their conversation on a Support Agreement. On a broad level, this document identifies the person's interests, the services that the agency will provide, the agency's expectations of the individual/family, any health and safety concerns, and the means of review services between the parties. In addition, the individual signs a form indicating that they have chosen the agency to provide services. The Support Agreement is reviewed by the Division and is the basis for funding to begin. Within 90 days of the authorization of services, an Individualized Plan is developed which is more detailed than the Support Agreement.

The individual can choose to manage their own supports, based on an Individualized Plan submitted to the Division for approval, using the services of a DDD Certified and MHRH licensed Fiscal Intermediary for the receipt and disbursement of funds.

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Unmet needs for services

The Division and the provider agencies attempt to meet each individual's need for support by developing services that the individual/family have requested based on the individual's capacities and interests. However, there are unmet service needs, or a delay in meeting service needs based on the following:

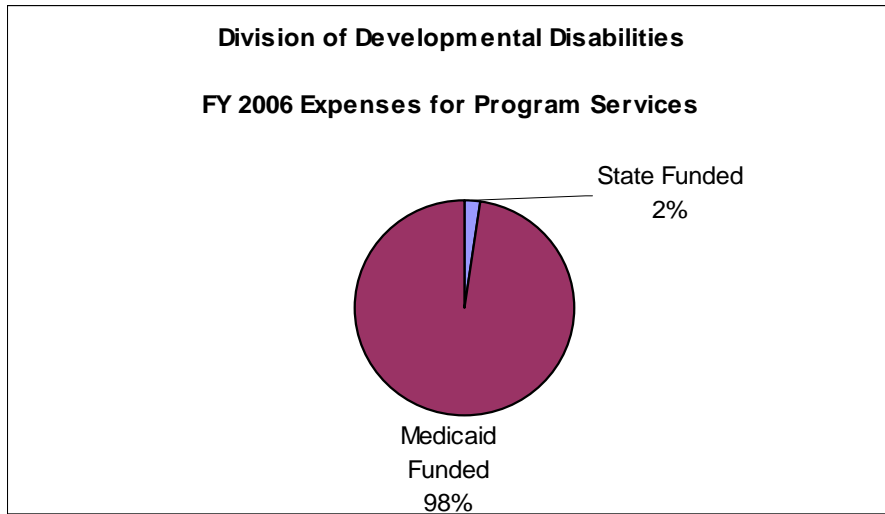
1. Insufficient residential settings to meet the needs of those individuals who have been identified as having a Priority 1 need for residential supports.
2. There can be a significant delay for individuals accessing day program services
3. Workforce issues, especially the ability to recruit and retain direct support staff.
4. Shortage of physicians, psychiatrists and dentists who will accept individuals with developmental disabilities
5. Shortage of routine preventative mental health services
6. Crisis services, hospital, diversion and hospital step-down
7. Emergency respite network
8. Supported Employment
9. Affordable, accessible housing/apartments
10. Knowledge about available technology to facilitate activities of daily living
11. While often eligible for DD services, the network of services is not really geared to the needs of individuals whose TBI occurred in the late teenage years. These individuals may better be served by the adult TBI network
12. Some individuals not eligible for DD services, may "fall through the cracks" and need some level of support (i.e Aspergers, some individuals with autism).
13. Coordinated approach to services for parents with developmental disabilities.

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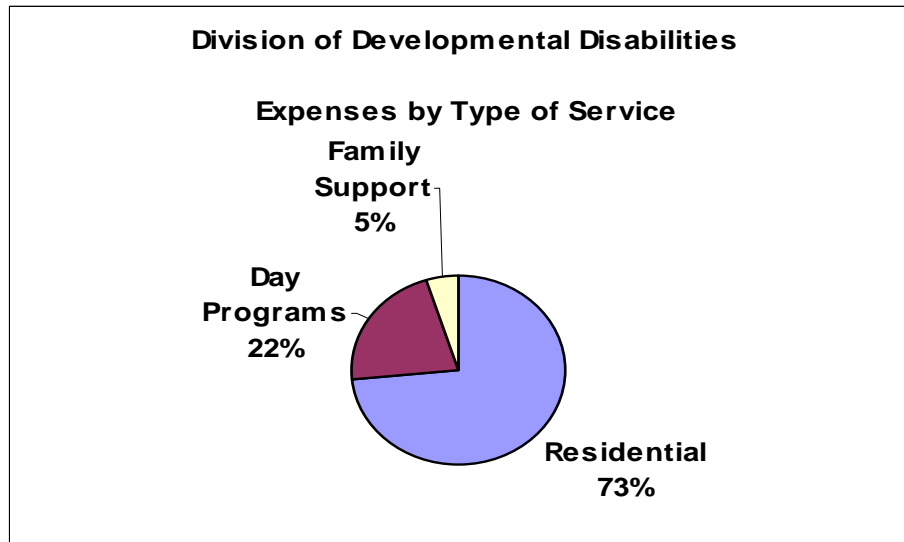
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2.3c EXPENDITURES/REVENUE

Medicaid is the main funding source for Division funded services and supports. Medicaid funding through the Home and Community-Based Waiver and the Rehab Option of the Medicaid State Plan comprise approximately 98% of the funding for program services.



The chart below indicates how the FY 2006 expenses were distributed by type of service/support: Residential, Day/Employment Programs, Family Support.



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2.3e BEST PRACTICE DISCUSSION

Rhode Island is in the interesting position of having a history of being on the cutting edge, but we have lost our momentum, and as a result, our leading status. For years, people would come from far and wide to see what Rhode Island was doing. It has been at least three years since we have hosted visitors from other countries, and with only few exceptions, from other states.

Different people attribute this change to different causes. Several internationally recognized DD experts have observed that the generosity of Rhode Islanders in making this one of the best funded service systems in the country has fueled our reliance on hourly staff and money to pay them as opposed to thinking creatively about other solutions and alternatives.

People in the Rhode Island service system would vehemently disagree with this observation, considering ourselves to have a long history of creative and out of the box thinking. These stakeholders would be more likely to point to the approach and attitude of the recent past MHRH administrations as stifling of innovation, and overly expectant of accountability, rules and regulations.

Some of us will acknowledge that we may have become complacent. We still think of ourselves as pioneers, and take great pride in being one of a minority of states that have closed their institution. It is not, however, something that we can point to indefinitely as evidence of our being in the forefront. Continuous change can become exhausting, particularly when so much effort and energy must be expended year after year to fend off proposed budget cuts to simply maintain the financial status quo.

Thus, our best practice section takes three parts:

- BEST PRACTICE currently happening in Rhode Island
- BEST PRACTICE historic to Rhode Island, but not happening much anymore
- BEST PRACTICE recognized as such nationally, but not currently happening on any great scale in Rhode Island.

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BEST PRACTICE current to Rhode Island

- There is a strong set of values that is shared by all stakeholders
- Strong self-advocacy network who are increasingly at the table, and listened to by other system stakeholders
- Comprehensive Leadership Training program run by and for Self Advocates
- Standardized assessment tools are used to determine a program support level for similarly situated people, yet allowing the flexibility to acknowledge individual support needs
- The opportunity for individuals to manage their own supports using a fiscal intermediary
- Use of a Support Agreement which documents the conversations and expectations between the individual/family and the agency selected by them. It also serves as the vehicle to authorize funding.
- Individuals and families can choose the agency (if the agency has the capacity at the time) to provide their supports
- There is a sharing of training resources among agencies. For example, the various RICLAS clinics and Special Care Facilities are available to the entire network of providers, agencies collaborate around training such as Human Rights, Medication Administration, Management Training, etc.
- Some individuals in the DD network of services have individualized funding which allows them to see and understand the funding available to them and how they choose to use these resources to meet their needs.
- The DDD staff is accessible and involved and knows individuals and families personally
- The program and fiscal staff within DDD communicate regularly with each other to foster and understanding of the support needs of the population served
- There is an excellent training program for direct support professionals
- Ongoing relationships with community organizations such as: Transition Councils, Hospice, the Alzheimer's Association, etc.

BEST PRACTICE historic to Rhode Island

- The leadership of the Division had the authority to make decision, set standards, and work with the stakeholders to improve services for individuals with developmental disabilities
- A “safe environment” where agencies worked with DDD to think creatively and experiment with new ideas/concepts/approaches, pilot them, and support each other through the process.
- Active and deliberate fostering of a climate that encourages new thinking and flexibility

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- Organized efforts to share stories of success and inspiration, and celebrate accomplishments of individuals supported
- Strong emphasis and dedicated resources to promote supported employment
- Ability to reconfigure resources to fund new approaches and pilot programs
- Ability to fund programs and services appropriately which allowed agencies to be financially stable
- Continuous discussions with stakeholders resulting in changes in the structure of the DD system to support new ideas and approaches to service delivery.
- Development of new DD agencies that were supported by the larger DD agencies in order to improve access to services. Having both small and larger agencies offers the best of both approaches.
- External reviews by DD professionals from other states and other countries stimulated dialogue that strengthened Rhode Island's value and mission, and its focused efforts to support community membership for people with disabilities.

**BEST PRACTICE recognized Nationally,
but not happening in RI on any sort of a large scale**

- Closure of sheltered workshops
- Incentives for supported employment over segregated settings
- Policy that expects the pursuit and maintenance of employment for all working age adults with developmental disabilities
- Portability of budgets
- Ability to pay stipends to co-workers and neighbors for agreed upon natural support
- Bottom-line budgets that enable flexibility across life-areas
- External case management and support coordination (Individual Plan facilitation and monitoring) for individuals receiving residential services from agencies
- Reserving some state only funds enabling more flexible programs that may not be possible under waiver assurances
- Use of technology to enable individuals to spend more time alone
- Citizen advocacy programs
- End-user accountability (resources enabling individuals receiving services to be the party to whom providers are accountable to, rather than a state bureaucracy)

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3.4 INITIAL FINDINGS

Over the course of the past month and a half, we have met with various stakeholders of the work accomplished through the Division of Developmental Disabilities. Participants have included all segments of the DDD staff, written comments, as well as four community meetings, representing people served, families, community service providers and advocates. Our questions have focused on those suggested in the departmental letter to the community in late August: What does DD do well? Where is there need for more? How is the population changing? and What resources are needed? We have chronicled all feedback, even when veering from identified inquiries. We have compiled notes from each meeting, organizing emerging trends and common themes. With over 35 full flipchart sheets and over 55 pages of written notes we have endeavored here to include all feedback.

In compiling our initial findings into a meaningful report, while honoring the volume of heart-felt input, we realized that the emerging issues could be categorized in three tiers: root concerns, concurrent structural or process issues, and then indicators of health or breakdown within the system. Using the analogy of a tree, root issues are identified as feedback offered in almost every encounter. Structural or “trunk concerns” indicate process or systemic items that are apparently a result of the root issues, and were presented as such in our encounters. And the health or disease of the “DD organism” is indicated by the abundance or lack of leaves/the fruit-bearing aspect of the tree, and most often relate to answers to the question, “Are DD services on the cutting edge?”

The most prevalent, or root concerns, expressed in our assessment were:

1. Communications
 2. Leadership
 3. Staffing
 4. The life-long nature of developmental disabilities, yet the need for linkages
1. The struggle with insufficient communications, deteriorating relationships and mistrust within and outside DDD was apparent throughout every conversation. The resulting process challenges were reported as:
 - o The severe lack of linkages and cooperative ventures among MHRH Divisions (Behavioral Health, access to Slater Hospital) and other state agencies (i.e. affordable and accessible housing, Elderly Affairs, RIPTA, RI Housing, Transition Councils, Departments of Education, Children Youth and Families, Health, Human Services)
 - o Supporting up-to-date information technology to provide ease of electronic communication/data among parties; more use of trends analysis, cost-benefit analysis, and calculations of “social capital”

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- Delays in getting funding level information from DD; agencies not getting enough background information from social workers or people they support
- A reported loss of vital technical assistance from the Office of Health Care; the Office is currently completely un-staffed.
- The need for bi-lingual/interpreter resources in both written and verbal communications

One of the indicators of breakdown in communication was the loss of candid dialogue about successes and failures, such as through the Service Quality Network, the International Institute, etc., bringing stakeholders together for brainstorming and resource sharing.

Another suggestion is the use of technology to link stakeholders together.

Also, sparsely located DDD staff among the state grounds, hindering the opportunity for “spontaneous collaboration” and convenient access to co-workers/leadership.

An example of a positive indicator, consistently stated in several meetings, was the fact that when contacting DDD from the community, individuals and families report connecting with a person who is willing and able to help them. People report great satisfaction in the personal “heart” in the face-to-face, person-to-person communications with DD.

Regarding this assessment, participants expressed repeated gratitude for being asked to contribute to the process, and reported a desire to continue the dialogue with the department. One suggestion would be to distribute copies of the assessment/feedback shared at community meetings.

2. DDD leadership must be expanded and include strong, dedicated visionaries grounded in the principles specified in Attachment C "Our Common Ground". Summing up frequent commentary regarding leadership, one participant said, "The Division needs its own torch carrier." The resulting systemic concerns that emerge due to a perceived lack of leadership were:
 - A decision as to the role of RICLAS in the DD network of services and supports and once that decision is made, to provide the necessary resources so they are “right-sized” for their role.
 - DD staff operating “in the dark” without a perceived alliance with MHRH/DD leadership, as they have experienced in the past.
 - The State bureaucratic processes create obstacles for managers, e.g. transitioning to a new payment system for finance staff. The goal should be to simplify processes, build linkages for inter- and intra-departmental collaboration for efficiency and cost-effectiveness, but

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avoid an amalgamation of all human services into one giant, layered, complex human service department.

- The state processes (processes both within and outside of the department) for the filling of vacancies result in a significant delay in filling necessary positions that enable the manager to meet service requirements and expectations.
- Many decisions/processes are made outside of managers' program area that significantly impacts their ability to meet their goals and objectives in a timely way.
- Managers must be able to make decisions, set standards and have sufficient resources to accomplish their tasks.

One of the indicators of breakdown is the "hot button issue" of the Health and Wellness Standards, which significantly raise the scope and intensity of regulation related to healthcare and medication administration. Providers have also described a fear of risk-taking due to the climate resulting from a highly publicized series of investigations at one agency. The current environment seems increasingly reliant on regulation rather than providing sufficient resources at the state level for active monitoring. Said one participant, "The DD network always took the road that the person has the right to make choices and supported the person to make choices." It was okay for people to make decisions that involved risk, obviously within certain guidelines. "We shared the risk, and learned from mistakes together." Another person reported, "We are at a place where blame is the solution to the problem." The Office of Quality Assurance and Licensing should be re-directed to focus less on holding agencies accountable to regulations, and more on assisting agencies to make appropriate changes to be better organizations.

There is also an erosion of advocacy at various levels, from legislative to grassroots.

One suggested and critical positive indicator is the need for a DD strategic plan, with a clear and articulated vision about the next phase in the evolution of services.

3. Sufficient and appropriate staff within DD as well as within provider agencies is the backbone of the service delivery system. Structurally, the quality of the service system depends on a strong foundation of direct support professionals. Indicators of structural decay were reported as:
 - Prolonged (up to a year or more) vacancies and uncertainty about frontline staff positions within DD, including Social Caseworkers and Direct Support Staff in RICLAS. DD Social Caseworkers have caseloads that include 140-170 people, in contrast to a national average of 50 among DDD systems in other states.
 - In the community, difficulty in recruiting and retaining the caliber of staff needed to provide quality services.
 - There was a strong need reported to professionalize the career path of direct support staff and pay them appropriately for their level of

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responsibility, including adequate benefits and regular cost of living increases.

Signs of strength that were suggested in our conversations include regular access to professional development opportunities and options for “growing in the job”, staff longevity, and innovative management/leadership practices, such as self-directed work teams.

4. DD eligibility is life-long and the nature of this service means that supports to an individual are very likely to increase as circumstances change over time. DD cannot be treated the same way an acute medical condition can. Supports can be provided to allay the secondary effects of a disabling diagnosis, empowering an individual and family to fulfill their greatest potential to be a contributing member of their community. There is a need however to build carefully crafted linkages to other state and private networks to access additional expertise, share best practices, and provide the comprehensive support plan that the people DD supports need.
 - Individuals entering the service network are requiring increasingly complex and intensive therapeutic and clinical interventions and/or different approaches in service delivery on a continuing basis (individuals involved with criminal justice system, transitioning from psychiatric hospitals, are dually diagnosed (DD/Mental Health), with Traumatic Brain Injury, with technology dependency, with Autism, with Asperger’s Syndrome, non-English speaking individuals and families)
 - As more services have been available to support children with disabilities in both the home and school setting, families have come to depend on that level of service and expect it to continue in the adult service system. Relationships with the Department of Education and Local Educational Agencies need to be cultivated to build better transitional planning and communications with families.
 - As individuals age, their need for support often increases (i.e. loss of skills, medical issues, move from semi-independent supports to 24-hour supports). There are approximately 300 people awaiting residential options.
 - Several hundred caregivers are also aging (approximately 550 primary caregivers over the age of 60), resulting in the need to increase supports to the family or placement outside of the family home (residential services). There is a strong need to implement other residential options (i.e. rent subsidies, Shared Living Arrangements).
 - The lack of capacity within the DD network for crisis intervention to avoid more costly hospitalizations and step-down program from hospitals to avoid prolonged hospitalizations or nursing home placements
 - The need for more and better transportation options,
 - The need for accessible, affordable housing options,

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- The restoration of capital and facilities funds, e.g. Access to Independence

Some indicators of breakdown in this area were the alienation of RICLAS from the other DD community providers. They are expected to operate similarly, but are “stuck” within the bureaucracy of the state system.

Similarly, RI ranks poorly in the area of supported employment for people with disabilities; though rather highly for people with behavioral health concerns. As one participant stated, “Community based employment is neither prioritized nor provided to the majority of working-age DDD customers. Based on current funding, a higher priority seems to be placed on non-employment day services and sheltered employment services.”

And, a term used in describing the situation that people with disabilities face as a result of incomplete linkages among state departments is “forced oppression”. People get the support to be safe in the community, but are unable to thrive. Rather than just “filling beds or slots, we need to support people.”

A sign of network strength may be indicated by better understanding/“marketing” about people with DD, and the services provided within the DD network to the greater community. And, perhaps a stronger alliance with the business community would be beneficial. Essentially, DDD provides investments in the citizen, with rippling returns to the community, e.g. social capital. One participant asked, “What it would cost without DD?”

Another positive indicator, apparent in RI, is the presence of strong self-advocacy groups.

Based on our conversations with DD staff, people and families served by the system, advocates, community providers, we offer the following summary of answers to the questions posed by the department:

- **What does DD do well?** The answers to this question were often provided in the past tense “We used to...”. The culture of experimenting with new approaches and services with people, families, and agencies, challenging each other, “pushing the envelope,” with a collaborative spirit have been denigrated over the past few years. However, the system remains rooted in a strong commitment and principles set forth over decades of service evolution. As one participant stated, “We have retreated to bunkers over the past few years. We have begun to peek out, and are hoping for an all-clear signal.” Within the community and DDD, from finance and administrative staff, to Program Review, facilities, quality assurance and social services, there was a strong alignment behind purpose and people. It appears critical to continue the work that has been started, and keep leading the system down the path of person/family-focused control and choices.
- **Where is there need for more?** This report covers myriad examples of need and setbacks in progress. However, it is our belief that initial and immediate focus on

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the root issues, improving communications, establishing visionary leadership, building a strong direct support foundation, and preserving DD uniqueness yet forming necessary linkages, will yield naturally emerging improvement in the more systemic and symptomatic concerns. One suggestion is to continue this dialogue with the community into the planning and implementation phase.

- **How is the population changing?** People and caregivers are aging...young families are coming up through an ever-evolving educational system, carrying forth similar expectations of DDD...as people experience less structured living options, some may encounter issues with criminal justice, substance abuse, etc...new diagnosis such as Asperger's and Autism Spectrum are challenging traditional support approaches. DDD needs to remain flexible to meet the ever-changing needs of the people "knocking on the DD door". And, DDD needs to remain responsive to the changing needs of the people already inside.
- **What resources are needed?** Again, examples of needed resources are generously presented throughout this document, offered by the various stakeholders who participated in the process. However, we believe that focusing efforts to relieve the root issues, communications, leadership, staff resources and linkages, the indicated structural concerns and symptomatic indicators will have the nurtured base from which to address needed resources.

Just as a tree requires strong roots to deliver nourishment through the conduit of its trunk and into the leaves and fruit-bearing parts, so does the network need grounding in a communicated, common vision, beliefs and shared practice. With strong roots, the network can weather heavy storms, evolve to meet changing climates, and provide bounty to the community. Powerfully yet simply stated by one participant who receives support through DDD told us,

"All I want is to contribute to and be valued by my community."

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ATTACHMENTS

Reference: Section 3.1, HISTORY

- Attachment A, Evolution of Services and Supports

Reference Section 3.3, CURRENT SNAPSHOT

- Attachment B, Division Structure

Section 3.4, INITIAL FINDINGS

- Attachment C, Our Common Ground
- Attachment D, Tree Image

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- ATTACHMENT B (Reference Section 3.3, Current Snapshot)

DIVISION STRUCTURE

To fulfill the Division requirements, it needs a structure that:

- ❑ responds to individuals that apply for services in a timely way,
- ❑ assists individuals in negotiating the service system, assesses the individual and family's need for support, provides case management services and crisis intervention services,
- ❑ has the ability to make judgments of clinical necessity and clinical appropriateness for the services being requested,
- ❑ has the ability to make judgments regarding the level of support an individual requires based on similarly situated individuals,
- ❑ authorizes services for individuals in a timely way,
- ❑ supports individuals in having a voice in the determination of the supports to be provided,
- ❑ responds to individuals with developmental disabilities and their families as their needs change,
- ❑ provides opportunities to develop creative options in meeting individual's needs,
- ❑ ensures the most effective use of resources,
- ❑ ensures that our processes, policies, practices and agreements are respectful and as person-centered and directed as possible,
- ❑ ensures individual satisfaction with the supports received and related quality outcomes,
- ❑ provides for quality assurance and quality improvements in service delivery,
- ❑ promotes the health of the individuals and their access to the acute care system,
- ❑ monitors the medical services provided to individuals who have complex medical diagnoses,
- ❑ certifies new agencies who apply to be providers of service in Rhode Island,
- ❑ provides the ability to upgrade and modify existing technology to meet the needs of funding sources, staff, management, etc.,
- ❑ monitors service provision for all individuals receiving services,
- ❑ ensures that individuals receiving supports in day and residential settings have facilities that meet health, fire and life safety standards,
- ❑ maintains Medicaid and Waiver compliance, and
- ❑ updates payment and other record systems per HIPAA.

In FY 2007, the Division has total full-time equivalent (FTE) positions of 598. This is divided between the central office/private operated services (74 FTE) and RICLAS (524 FTE). The Division is administered by an Executive Director's office (3 FTE) and is divided into functional areas that include:

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- Eligibility,
- Agency Certification,
- Services and Resource Development,
- Service Coordination/Case Management,
- Health Care,
- Quality Assurance, and
- Fiscal Management
- RICLAS (Rhode Island Community Living and Supports)

RICLAS is considered a provider of service and represents the publicly operated program for individuals with developmental disabilities.

ELIGIBILITY:

Approximately 180-200 individuals with developmental disabilities apply for services each year. The primary referral source is the individual with developmental disabilities' family (45%).

The application is reviewed by a clinical team of DD staff including: a psychologist, nurse, social worker, social casework supervisor, administrator, and any other clinician that the team feels is necessary in order to make an eligibility determination. The eligibility determination is made based on the promulgated *Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult*, dated January, 2002. Approximately 10%-15% of applications are clear cut as to eligible/not eligible. The remaining 70% require significant clinical review and data in order to make the determination.

Approximately 80% of these individuals are determined eligible for Division funded services, based on the above criteria.

There are four FTE assigned to this function.

AGENCY CERTIFICATION:

Any agency that wishes to provide services funded by the Division must apply for Division Certification. Staff from the Division review the application and a site visit may be made to programs operated by this agency in Rhode Island or another state. Once the Division agrees to certify the agency, the agency must sign a *Certification Document* that indicates their agreement to comply with the Division's program and financial requirements. The agency must then be licensed by the Department.

There are approximately six staff that participate in this function.

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SERVICES AND RESOURCE DEVELOPMENT:

Staff work collaboratively with agencies, individuals, families, and advocates to develop systems of support and information for those seeking and using services. They also rate assessment tools, notify individuals of the funding available to them, make programmatic recommendations regarding requests for services at an administrative level, assist in the development of residential options, assure fire and life safety compliance, and provide technical assistance to improve quality of services. The Access to Independence Program is administered by staff in partnership with RI Housing.

While there are five FTE's assigned to this function, this is a component part of every person's job responsibility in the Division.

SERVICE COORDINATION/CASE MANAGEMENT:

All individuals eligible for Division funded services are assigned a Social Worker in the Division's Social Services Unit. The Social Worker guides the individual and their family through the service system; makes recommendations on service requests, authorizes some services, and monitors services as required by the Home and Community-Based Waiver; provides crisis intervention support; and provides assistance to them throughout their lives. In addition, the Social Worker completes assessment tools. These tools are rated and form the basis for the funding that the individual can receive to purchase supports.

In addition to the above, this office coordinates residential services. The Social Services Unit identifies individuals in critical need for residential supports, collaborates with other Division staff and agencies to develop new residential programs, matches individuals with similar needs, and coordinates referrals of individuals to fill residential vacancies.

This office also completes evaluations of individuals with developmental disabilities in nursing homes, and offers day program supports should the individual request them per PASARR regulations.

There are 42 FTE's assigned to this unit including Social Workers, Casework Supervisors, clerical and administrative staff. The average caseload per Social Worker is approximately 150. National standards suggest caseload averages of 40-50. Some New England states have worker to consumer ratios at this level or lower.

HEALTH CARE:

The Division's Office of Health Care establishes policies to promote best practices for health care related long-term supports, reviews individual plans that include significant health care supports and make recommendations, provides technical assistance to individuals with disabilities, family members, and agency staff, provides oversight of the

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implementation of the *DDD Health and Wellness Standards*, and tracks mortality statistics.

There are two FTE assigned to this function.

QUALITY ASSURANCE:

The Office of Quality Assurance was established through legislation. This office establishes reporting requirements for instances of abuse, neglect or mistreatment, and provides training and technical assistance to agencies. Staff are involved in bi-weekly Incident Management Reviews and follow-up, and they investigate reported incidents of significant abuse, neglect, mistreatment. This office works collaboratively with the Office of the Attorney General, Sexual Assault and Trauma Resource Center and local police.

There are nine FTE assigned to this function

FISCAL MANAGEMENT:

This office provides all financial management functions for the Division. This includes the developing the budget, monitoring and projecting of expenditures, processing of payments, maintaining accounting records, authorizing services, collecting attendance information for all services, monitoring of enrollment and expenditure caps of the Home and Community-Based Waiver, participating in the monitoring of agencies, and providing technical assistance to staff of the Division and private agencies.

There are nine FTE assigned to this function.

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ATTACHMENT C (Reference Section 3.4, Initial Findings)

“OUR COMMON GROUND”

- It is important that there be equity and fairness in our system.
- Our capacity to accommodate new people coming into the service system without waiting lists is highly desirable to maintain.
- We are personally and publicly accountable to people with disabilities and their families, the citizens of this state, and to one another.
- The system belongs to all of us – and all means ALL.
- We value our partnership.
- We have built the extraordinary accomplishments of supports and systems for people with disabilities through our collaboration.
- We need to work together with respect and civility.
- It is important to us that there is security and stability for people, including those people we serve and those who support and assist them.
- Direct service staff should have a good working wage to ensure continuity, stability and quality in support for people.
- It is important that there be continued investment and responsible management of growth and stability in the system for people with disabilities.
- Fiscal solvency of provider agencies is important to the continuity and stability of supports provided to people.
- Predictable cash flow helps support stability and fiscal solvency. Monthly payments in twelfths, are desirable over per diem/attendance payment structures.
- It is important to ensure, as we have in the past, that we will take care of individual people with extraordinary or emergency needs.
- We are focusing on the shift to increasing control to people with disabilities and their families
- Our practice and policy need to support the above-referenced shift and this requires new ways of thinking, including adaptive changes in our practice and organizational structures.

GOALS

~responsive

~stable fiscal base

~competent, committed staff

~transition to CHOICES

~making the system more understandable to people

~gives income/fiscal predictability

~ensures systems accountability, security and stability

For the people we support

~well-funded

~well-managed

“What we Agree On” discussion points
Transition/Stabilization
September 23, 1997

MHRH-DDD/Provider
Discussions
Revised October 31, 1997