STRATEGIC PLAN FAQ & ANSWERS
2000 & 2002

The following are answers to questions raised at the stakeholder forums held during the Autumn of 2000 for the rollout of the Department's Strategic Plan. The answers below represent the best thinking of the plan's crafters at the time the questions were asked. The work of the Implementation Groups, now in progress, may dictate changes to some of the answers as a result of their thoughtful consideration and work. Some questions have been assigned to these groups for examination as part of the planning process and will require further work to answer.

This concludes the question and answers from the initial rollout forums. As additional questions arise throughout the implementation of the strategic plan, we will look for opportunities to widely broadcast the answers for all to see. We thank you for your time and input.

Strategic Objective #1:

- **Will DMR re-determine one's eligibility through life?**

  In most instances, DMR will determine adult eligibility only once. If sufficient assessment information is available at the time of assessment, we will not normally re-look at adult eligibility. There may be rare exceptions, (which is why our current regulations allow for the possibility of redetermination), but in most cases adult eligibility will be done only once. Children change throughout their developmental period, and it is possible that we will look at eligibility multiple times prior to the age of 18. The Eligibility Group, however, is looking at the issue of how this process will occur for anyone eligible for the Department's services.

- **What happens to current consumers with IQ over 70 when new eligibility begins? How do we plan to stop serving those with IQ between 70-74? What will happen to an individual in the system now who, on reevaluation, is found to have an IQ over 70?**

  These questions have been assigned to a strategic planning work group for discussion and further proposal development. For the time being, all current consumers will be assumed to be eligible. The Department's first and primary goal is to make sure everyone it supports, is supported well and safely. Protocols will have to be established to handle redeterminations and changes in eligibility status.

- **Who will support those with developmental disabilities *whom* we currently support?**

  DMR has and will continue to support those individuals with developmental disabilities within our system. Given that our expertise and mandate are to serve individuals with mental retardation, the question of whether it is appropriate to serve people with developmental disabilities, in the absence of mental retardation, is a fair one. DMR will work with the Executive Office of Health and Human Services (EOHHS) and other agencies to address this question.

- **Will we be kept up to date on inter-agency agreements as they develop?**

The Department expects to be an integral partner in the discussion and crafting of interagency agreements. As agreements are made, we will ensure that their content and nature are appropriately disseminated and applied.

- **How will we ensure that other agencies abide by their agreements?**

  We will be working collaboratively with EOHHS and the other agencies to construct agreements that work for everyone involved. This is the best way to make sure that the agreements are effective and implemented.

- **Who will decide which diagnosis is primary, and if a person is better suited for service by DMR or the Department of Public Health (DPH), Department of Mental Health (DMH), etc?**

  Clinicians are expected to indicate which diagnosis is considered the principle one and we will rely heavily on their judgments. Reasonable people will disagree on these judgments, and we anticipate some interagency forum and conflict resolution mechanism to be developed to resolve disputes.

  It is important to point out that in most instances, individuals with dual diagnosis (Mental Retardation/Mental Illness) will remain the primary responsibility of DMR, established by a previous interagency agreement. The instances when the principal diagnosis issue will change this will be carefully detailed in a protocol that will have to be developed.

- **What will be the responsibility of area staff if all decisions are made at the regional level? Isn't this an insult to area office staff?**

  The decisions we anticipate making at the Regional level are eligibility decisions, which will include clinical assessment relative to level and intensity of support needs and individual resource mapping. The critical functions of individual service planning and design will continue to be done at the Area level. The assignment of eligibility to the Regional level is designed to provide greater clinical consistency regarding eligibility decision-making. It will help to free up Area office staff for service coordination activities by removing a time-consuming function. We value the work of our area staff and clearly no insult to area staff was intended.

- **Where will current intake staff go? What will be their functions?**

  We have not yet determined what current Intake and Eligibility staff will do. We anticipate some role for Area staff in the intake process, although it is likely to be significantly delimited. We have not yet developed details of this, but will keep everyone informed as we clarify these issues. One thing is certain, there is plenty of work in the Areas to do.

- **After a determination is made, does the area office have any say in final decision?**

  The actual eligibility decision will be made at the Region. The Area Office will not have a say in that decision.

- **What is going to be done to train appeal officers to be in sync with new plan?**

  We will have appropriate people designated by Central Office meet with appeal officers to explain our new eligibility standards.

- **Who will do the assessment and how often or when will reassessments be done?**

  The assessments will be done by the Regional eligibility teams for new people and by service coordinators with staff assistance from clinicians who either work in Area Offices or at the regional level for existing consumers. For existing consumers with Individual Service Plans (ISP), it would be done as part of the ISP process.

- **What assessment tools will be used? Who will administer the tools?**

  The work group assigned to this objective will survey existing instruments in use in other states and recommend a particular instrument, adapt an existing instrument or (less likely) create a new one for Massachusetts. At that time we will be better prepared to determine who should apply the tool.

- **Will all vendors use the same assessments to determine support needed?**

  This will be a DMR Assessment that will be done with information shared by the person, vendors, and others who know the person (friends, family guardians)

- **Does this apply to children?**

  No decision has been made yet concerning the application of a standard clinical assessment to children nor have we made a decision about whether the assessment of the tool should be the same for adults and children. This is an area which will require a good deal of exploration

- **Will currently eligible DD kids continue to keep family support allocations when they are not found eligible as adults?**
  We intend to use our children and transition surveys to help us figure out how many DD children we are currently serving. This will help DMR and EOHHS to sort out how best to support these young adults. Although it is not our intention to discontinue family support it should be understood that all of our family support allocations are based on an annual need prioritization and subject to legislative appropriation.

- **Will a mechanism to approve movement between intensity of need levels restrict the ability to quickly respond to changing needs of an individual?**

  No, whatever we put in place should not be a cumbersome process. It will simply create a method to "check" for accuracy to maintain fairness given resource decisions that may follow.

- **Where will pool of flexible funds come from?**

  We already have some flexible funds that we use, for instance, to address emergencies throughout the year. The pool funds, like emergency funds, are all reprogrammed base funds.

- **Will individuals <u>currently</u> in service be assessed for intensity of need and will resources be reallocated based on those assessments over short and long term?**

Those currently in services will be reassessed and information from the assessments will serve as a basis for dialogue to shift resources (reduce or increase) but at this time we do not see such shifts being "automatic."

- **What type of data will be used to make decisions?**

  The status and changes to individuals and their needs, as reflected in the application of a standard clinical assessment tool, may provide one source of data to help make decisions. We intend to use our work groups to help think through and design what data elements are important to consider as we move to create standard assessment tools and practices in general.

- **Will people get a determined level of support on an annual basis?**

  A review of the person's situation will lead to decisions being made as to the need to reassess in any given year. If not much has changed in a person's life then it would make sense to continue to use the existing assessment.

- **What will be done with existing contracts?**

  Once we have determined the direction our contracting system will take, all contracts will follow that course. Recent RFR's have been designed to yield contracting agreements that recognize the contract vehicle may change during the life of the procurement.

- **What will be the standards for cost corridors?**

  These have not been developed. However we have discussed the need to "price" our system in a manner that is similar to the methods used in the DD system across the country. This is not simply taking our current costs and producing averages. Instituting cost corridors will need to be done incrementally. The current prevailing view is that cost corridors should first be used with new services and services associated with expansion funding.

- **How does cost corridor fit into self-determination?**

  Funding for self-determination has been produced via reprogrammed base funds and for individuals with new funds (such as Turning 22). However, since real self-determination efforts involve new program planning, the cost guides used should fall within the funding system that is developed for the Department. Cost corridors need not be inconsistent with individualized program planning. The whole basis for cost corridors is to build in consistency with funding decisions throughout the department.

  The use of a standard clinical assessment leading to a level and intensity of support need will support self-determination efforts by giving the individual and his family a sense of what resources might be available to meet the individual's needs. This may in turn lead to the use of non-traditional providers as individuals make decisions about how to best meet their needs with the support of DMR.

- **Will there be an increase in state operated residential sites?**

  That will be taken up by the work group.

- **How does the department prepare to embrace the idea of a legitimate role for the facilities? How does this square with those who believe it is counter to the mission of the department?**

  Facilities exist now and people live there, which means for those individuals and their families they are "legitimate" and part of DMR's operating responsibility. The real question for the work group is what should be their future role. We need to be thoughtful about this issue and wait for the outcome of deliberations from the group, rather than anticipating a particular response before the question even has the opportunity for consideration.

Strategic Objective # 2

- **How will salary increases be incorporated to assist in recruitment and why doesn't the plan address salary levels? (the vast majority of questions related to Objective #2 were related to salary issues)**

  The Department will continue to incorporate annual salary increase dollars, when available. The plan calls for recruiting and retaining qualified staff at all levels. Salary is but one of many components that need to be considered. The planning process will consider salary as well as the other components.

- **Where will we get the money to implement these goals? Will there be new funds to support training and other staff supports?**

  New funds for some of the workforce initiatives sponsored by the Department have already been made available. Some of these new funds have already been allocated to this initiative; for example we have funded programs with UMass and the Community Colleges. DMR will take a very close look at how it uses existing training resources and determine if these resources are being used in the best way possible. We will need to examine what approaches need to be taken - a reallocation of some current resources, the addition of some new resources, or perhaps both.

- **Will the Department work with Human Resources Division (HRD) to substantially streamline the hiring process re posting, checking CORI, and having physicals in order not to lose potential employees?**

  The Department has arranged to meet with HRD on a regular basis to discuss both broad and specific hiring issues. Items such as CORI and diversity are continuing to evolve resulting in some uncertainty in the overall hiring process. HRD is in the process of giving agencies the authority and responsibility to take over certain actions, which had previously required HRD involvement. We need to focus on doing our end of things more efficiently - such as the time we take to get a job posted; the length of time a committee takes before starting and ending interviews; decisions on the candidates, just about all aspects of the process. If ways can be found to improve the human resources functions of the department they would be implemented where possible.

- **Will people's jobs be changed or will there be new staff hired?**

  Some of the work or tasks that we are currently doing will stop and some new initiatives will start. That may require peoples' jobs to change or call for additional staff. We don't yet know what those tasks or activities are but it is clear that changes will occur and, as they do, we will need to evaluate positions and peoples' skills against the new activities, in accordance with collective bargaining agreements.

- **What will the rulebook include?**

  This will be a fairly broad look at the overall administrative and operational functions in the department. The emphasis will be on standardization and consistency of activities and approaches throughout the organization. Expectations will be clearly expressed and guidance given to employees and contractors to help achieve a consistent standard of quality and to assure that individuals and families across the state have similar and constructive experiences with DMR.

- **What is the APD?**
  The APD is a federal Health Care Financing Administration (HCFA) acronym that stands for Advanced Planning Document. It is the vehicle the federal government uses to financially support the Medicaid Management Information System at the Division of Medical Assistance, (DMA). DMR is working with the DMA to develop a module MMIS that will serve the DMR business and program needs in the future. Essentially we are using the federal financing to develop a new management information system. This system will be a subsystem of DMA's MMIS. The goal is for DMR to develop an MIS system that protects privacy and can be accessed by families, individuals, public officials and others interested in Department information and data.

<u>Strategic Objective # 3</u>:

- **What will be done to ensure that supports are provided in a culturally competent manner?**

  The Department has made a commitment to ensure equal access to services across the Commonwealth. This would include the need to be sensitive to differences and experiences of the many diverse cultures that may want to access supports. Managers are encouraged to receive and provide training in diversity so that they may be effective in supporting consumers from different cultures. Strategies would include hiring staff directly from the communities in which supports will be provided; contracting for services with providers who have established effective cultural networks; and reaching out in partnership with other community organizations who presently provide supports to respective cultures in an area.

- **Will there be more clinical supports located in area offices to respond to needs?**

  Resources will need to be allocated so that area staff has accessibility to medical and clinical staff to assist them in addressing the needs of their consumers. It has not yet been determined whether these staff will be assigned and supervised at an area or regional level, or a combination of the two. Initially, it is unlikely that there will be sufficient resources for each Area office to have a full complement of clinical and medical staff. Perhaps this might occur over time as priorities are determined and resources are allocated. It is also likely that some medical and clinical support may be contracted. Partnerships and collaborations could be developed with generic providers. Some of our collaborations may involved the use of DMR resources to supplement supports for our consumers.

- **Will we use clinical resources at the facilities or will they be contracted from elsewhere?**

We are not intending to replace the generic health care system, but rather to enhance and support it through the use of DMR resources. DMR resources include staff, funding, consultation, collaboration, and joint initiatives/partnerships. It is important that the generic health care system be utilized and supported. Our facility staff has much expertise that can be utilized strategically in the areas and regions; it will also be necessary to contract for some services given the numbers of consumers needing clinical supports, as well as geographical considerations.

- **Behavioral supports are often provided through a contracted agency – do we see this happening for health and clinical services now?**
  Behavioral and clinical supports can be provided in a variety of ways. Each way has its benefits. There will likely be a combination of DMR clinical staff and contracted supports. The roles may vary depending on the nature of the services.

- **Given the increasing numbers of individuals, who are medically involved, can we not afford to "group them" together in terms of efficiency?**

  A person's medical needs are just one consideration for why people might live together. There are many other factors that go into living arrangements: choice, interests, compatibility, relationships etc. Medical and clinical supports need to be flexible. A person's home should be preserved as their home.

- **Will we be standardizing computer systems in order to enter health, clinical, behavioral data – and if so, who will be entering this data?**

  If we are to benefit from data management, systems should be uniform. Who enters data has not yet been determined. There may be different methods to enter the data, but there should be consistency in what is entered, and how it is utilized. The APD, referred to earlier, will take these issues into account as the project moves forward.

- **Will there be a difference between how the department and providers look at the needs of individuals?**

  Over time there should be much consistency between how the Department and providers look at the needs of individuals. Differences should be minimized as resources become more available, more equitably distributed, and more consistently utilized from area to area, region to region. Consistent systems need to be developed in each of the areas and regions. Providers will be included as these systems are developed and become operational.

Strategic objective # 4:

- **What are the foreseeable changes to the survey and certification process?**

  Right now that is hard to say, given that we have yet to embark in designing an integrated, comprehensive Quality Management (QM) system. What we can say at this point in time is that Survey and Certification will be a piece of an overall QM system that will review all the DMR services and supports. We know that nationally there is a move towards developing outcome-based systems to evaluate the quality of supports individuals receive. Massachusetts has been ahead of the curve in developing such a system and many states are interested in our process and have contacted us to find out more about our certification system. Given the national trend, the core of the certification process, one that reviews service outcomes, from the perspective of the individual, will remain the same.

- **Will the goal of survey and certification be to have one set of standards and measurement criteria for everyone receiving federal funding?**

  Again, that will be an important piece to be discussed when the workgroup for Strategic Objective #4 convenes. The group will need to consider what services are being billed under the federal Waiver and ensure that the requirements from HCFA are met. However, our goal would be to create a unified QM system, one that would apply all the services DMR provides, regardless whether they are billed under the waiver or not or whether they are provided in a facility or in the community.

- **Why not improve the current QUEST rather than change the S + C?**

  Over the years we have made changes in the survey instrument (QUEST) and survey process. We would expect to continue in this effort, especially to build upon the aspect of service enhancement and technical assistance. In addition, improvements may be made in Survey and Certification so that is fits well within the whole QM design.

- **Will the new quality management system cover all services DMR offers including family support, individual supports and transportation?**

  Yes, but this does not mean that all DMR services will be subject to certification. Some services will naturally lend themselves to an individually based review such as we currently use in Survey and Certification. Other types of services may require a different type of review process, perhaps where we evaluate the "systems" used by the provider that support individuals. Ideally, however, the information we collect about services should all have the same core elements so that we will be able to report on our entire system of services and supports in a comprehensive and integrated fashion.

- **How will the plan to integrate all quality management programs happen in the area offices?**

  A good question. This will be an important task for the workgroup, one that must be developed in conjunction with the QM system design. It will also require that the QM workgroup collaborate with the other three workgroups to ensure that Area Office roles that may change as a result of strategic planning are well coordinated, are provided training and technical assistance where needed, and have adequate resources to do all the tasks. Currently all Areas have some systems and deploy different staff to monitor the quality of the services provided to individuals. Therefore, we will need to confer with Regions, Areas and Facilities to see the systems they are using and what they see as important information to gather. But, since we want to create a unified, integrated QM system, we will, by necessity, need to have the system be the same within the Areas and Facilities.

- **What will be the timeline for implementation of these goals?**

  A plan for implementation will definitely be developed by the workgroup. Some aspects of the QM system are more time sensitive and will be implemented sooner. But we will not develop the specific pieces of the QM system until we have developed a set of outcomes and process measures that can be applied across settings and services.

- **How will the department support agencies with staff competencies to meet the new expectations?**

We would need to ensure that, before the new system roles out, DMR staff and providers participate in training and orientation sessions. One strategy would be to use the "train the trainers" approach so that there is local expertise within Providers, Regions, Areas and Facilities. Regardless of the format for training, this will be included in the work plan that is developed by the group.

- **Will we have parallel systems for a while?**

  While we would not want to stop monitoring systems currently being used, our goal would be to avoid parallel systems that go on for a long period of time. Otherwise we may confuse people and potentially overload them with too much work.

Spring 2002 Strategic Planning
Frequently Asked Questions

On the following pages, the Department has attempted to provide answers to questions raised by participants in a series of statewide forums regarding DMR Strategic Planning. The forums contained presentations on those workgroups who had achieved either significant milestones or completion of their assigned tasks. Additional summaries of the work on the remaining objectives will be published shortly.

The workgroup responses to these Frequently Asked Questions reflect the different stages of completion for each of the objectives. As further progress is made or information is learned or obtained, some of the answers may change. The Department will provide updates through bulletins or updates to the DMR web page.

FORUM Q&A's
JUNE, 2002

A. FACILITY RELATED QUESTIONS:

1. What are the criteria for facility admission? How were they determined?

   Admission to the Department's large, intermediate Care Facilities for the Mentally Retarded ("ICF/MRs") is restricted to individuals with mental retardation who have attained the age of 22 and are eligible for DMR services, meet the level of care for an ICF/MR and need active treatment. DMR must make a determination that, the individual's needs cannot be met in another setting, that the absence of facility residential services will pose health and safety hazards to the individual or others, and that the facility residential services are the least restrictive and most appropriate for the individual.

2. If today someone wanted to be admitted to Hogan could they be?

   Admission to a facility is not determined by choice only. There are admissions criteria that must be met, including a determination by DMR that the facility is the least restrictive and most appropriate setting for the adult with mental retardation.

3. Has there been any thought of making a reverse integration model which would create a diverse community on the grounds of those institutions?

   A reverse integration model was one, amongst a number of options, discussed by the facility work group. Guidelines for the use of facility properties will be developed.

4. Are there other integrated community models for group residential home-sites in addition to single family or apartment housing?

   The Department is looking at various types of housing that might be available, affordable, accessible, and appropriate to support individuals living in the community.

5. Why don't families have options and knowledge?

   Getting people the information they need in order to make plans and decisions is one of the Department's greatest challenges. There is a work group developing recommendations on how DMR can improve communications and access to information on services, supports and other subjects that are important to individuals and families.

6. Do community facilities depreciate?

   Yes, generally the owner of the house may depreciate the cost of acquiring and improving the house by deducting the cost of the home, for accounting and tax purposes, over the number of years that the house will be used.

7. Will "choice" people be given same funding in institutions and community?

   The types and amount of supports that individuals are offered will be based on their assessed needs. The costs of providing those services in different settings must be taken into account in offering the services.

8. Are facilities subject to a quality assessment process other than the current federal Title 19?

   No. Title XIX of the Social Security Act sets the standard that DMR facilities must meet to be certified as intermediate care facilities for people with mental retardation. The facilities are subject to an annual survey that is outcomes-based, resident-based, and uses a resident-focused *approach. The approach looks at resident responses and staff performance. The requirements that the facility must meet as an ICF/MR include such areas as, active treatment services, client protection, client behavior and health care services.*

9. The minority report (ARC/MASS/MFOFC) of the Facility Committee provides a different interpretation of data – with different projected outcomes. Will this report be considered?

    The Strategic Planning Steering Committee reviewed and considered the report submitted by ARCMass and MFOFC.

10. Why should there be a <u>choice</u> between facilities and community? I thought there was a <u>mandate</u> to <u>close</u> the facilities?

    There is no mandate to close the facilities. There is, however, a federal requirement that persons eligible for admission to a DMR facility, who are offered Medicaid community services, be given a choice between institutional and community-based services.

11. Is it true that under the consent decree, a person admitted to a facility for 30 consecutive days or 60 days in one calendar year becomes a class client?

    Under the 1993 Final Order in the Ricci case, only individuals admitted to the Monson, Templeton, Wrentham or Fernald Developmental Centers for more than 30 consecutive days or more than 60 days during any 12 month period would become a Ricci class member.

12. Why only adults?

    Admissions to DMR facilities are restricted to adults. In Massachusetts, the special education system and the network of residential schools and pediatric nursing facilities meet the specialized service needs of children with mental retardation.

13. Is a community placement a group home or individualized community support?

    A "community placement" can refer to several different residential support models. Generally, a community placement occurs when arrangements are made for an individual to live in a home, other than the family home, in the community with 15 or more hours per week of support. A more detailed description of various community placement models can be found on our Website.

14. You discussed the "<u>Facilities</u>". What will be available for the people on the "Boulet wait list lawsuit" regarding community placement? You discussed the Ricci class members and the nursing homes.

The Boulet settlement agreement provides for funding and resources to enable DMR to offer community placements to the Boulet class members. Again, a detailed description of the community placement models is available on the DMR Website. In addition, federal law requires that individuals who receive these services paid for through the Medicaid Home and Community Based Waiver are offered a choice between community placement and placement in a large facility.

15. This is a room full of families who wanted Belchertwown State School closed 10 years ago. To W. MA the principle of fairness and equity is this: No services for our family members greater than 1 hour travel from Pittsfield, not beyond 91, from East of Rt. 91, no further than Worcester. How many people on Steering Committee from W. MA? What do we have to do to get you to understand that we in W. MA don't need/want facilities but rather services/supports closer to their families?

The Department of Mental Retardation supports individuals with mental retardation and their families in all parts of the state. These individuals and families have different needs, interests and values. There is a range of opinions held by individuals and families about the need and the future of facilities and the resources they represent. In examining the question about the future role of facilities, DMR, including the Steering Committee, is guided by several principles that include not only fairness and equity, but also balancing competing interests, addressing DMR's legal responsibilities, and using data to inform decision-making.

The Department strives to provide services that are in geographic proximity to a consumer's family. Although it may not always be possible to honor requests that specific services be provided in a specific geographic location, every effort is made to keep services close to an individual's area of meaningful tie. The expansion of community-based residential services in Western Massachusetts through the Boulet funding and the nursing home initiative has been robust and proportional to the population.

16. How much money does DMR pay for one person living in a facility? How much for one person living at home with parents?

In Fiscal Year 2002, the cost of caring for an individual in one of the Department's ICF/MRs was, on average, $182,000 per year. Many of these individuals have intensive and pervasive health and behavioral needs. The cost of supporting an individual to live at home with his or her parents will depend on the severity and intensity of the need that cannot be met by available natural supports. For many individuals living with their families, DMR is paying for service coordination, their day program/supported employment, transportation, and family support. The average annual cost to support individuals living at home with their families through family supports, day supports, transportation, plus the service coordination necessary to arrange these services, is $15,600. In addition, these individuals can access other types of supports and *benefits, not available to individuals living in the facilities, such as supplemental security income payments, personal care attendants, day habilitation, adult day health, and housing subsidies.*

17. What does it mean if you don’t want your child or grandchild in an institution? What would be available to help the family?

    For families caring for their adult son or daughter, or sibling or grandchild, at home, the Department typically will provide a day program or supports, transportation to the day program, service coordination and "family supports," such as respite or other supports. If the Department has determined that the individual needs residential supports, and if resources are available, a family who does not want their son or daughter in an "institution" will have many service options. The DMR community residential service system continues to expand with the increases in the DMR annual appropriations.

18. When will it be determined what facilities will remain open? Will this be done on a regional basis? How are regions defined?

    The report of the facility work group has been submitted for review by the Steering Committee who will make recommendations to the Commissioner about the future of the facilities, including how many facilities will remain open. The decision will be made from a statewide, not regional, perspective.

19. What is the difference between a facility bed and a community bed?

    The word facility is used to refer to our larger institutions. A community bed one located in some community setting – non-institutional.

20. Instead of keeping all facilities open, why not just 2 or 3 and use the savings on improving community residences and staff?

    Any savings achieved through facility closure could, if available, be redirected to improve community residences and staff or to address other needs of the DMR service system.

21. When you reduce the facility beds by moving people out of these facilities, do you have community services ready for them?

    DMR does not place individuals out of a facility without making sure that appropriate supports and arrangements are available and made for the individual in his/her new setting.

22. If you have beds available in "facilities" will you still offer the choice of facility or home (community) or will people be forced to use facilities until they are full?

Departmental policy is not to direct admissions to facilities in order to keep the facilities "full." Only those who meet the specific criteria for admission would be considered for facility admission.

B. HEALTH CARE RELATED QUESTIONS:

1. Define standards of health care?

   The Department of Mental Retardation regulations require that individuals receive an annual physical exam. As part of strategic management group #3 a clear set of health care screening standards has been developed. The standards begin with a set of routine screenings that are recommended for the general public at specific ages and are then expanded to include specific issues that individuals with particular conditions (e.g. down's syndrome) should be screened for at particular ages.

2. What is health status review tool?

   The health status review tool is a checklist for direct support professionals to complete in order to effectively communicate complete health care information to a health care provider. The questions relate to all aspects of a person's health including sleep, nutrition, and various bodily functions and systems. The questions are very specific and rely on direct observation by direct support professionals. The observations so recorded will help the health care provider conduct a more thorough exam and detect and treat health care issues more effectively.

3. Who is implementing all of this? Time lines and costs excepted?

   The tools and processes that have been proposed will be piloted during the Summer of 2002. Revisions will be made based upon feedback and orientation will be conducted with providers and area offices. Timelines will be developed after completion of the pilot. The Department is in the process of evaluating any cost implications.

4. Why do providers have their own peer review committees?

   According to DMR regulations, providers may either have their own Peer Review Committees, or rely upon DMR Regional Committees.

5. How are you obtaining health care providers that will work with MR people?

   For the most part, DMR does not directly arrange for or contract with health care providers for the individuals we serve. When an individual is living with his/her family, the family typically assumes this responsibility. In the DMR provider system, under their contracts with DMR, most providers are responsible for finding and utilizing health care providers for the individuals they support. Regulations require that providers promote optimal health of individuals through arrangements for coordinated *routine, preventive, specialty and emergency health care, professional clinical services and availability of first aid supplies. Support for finding new health care providers can be obtained through the New England Index and the Federation for Children with Special Needs.*

6. Why did O'Meara's group (Health Group) spend so much time on Mental Health services availability and not on MR?

    The primary focus of this work group was on mental health and behavioral support needs of individuals with MR. There is a need for these services because mental health and behavioral support needs appear fairly frequently among individuals served by DMR perhaps 30 % or more.

7. How is the Department preparing for the increasing Alzheimer's issues?

    DMR recognizes that our population is aging and that individuals we support will be more prone to Alzheimer's and other conditions relating to the aging process. Much of the work of the strategic management group has been geared to looking at screening and developing health care support plans for individuals with specific medical conditions. DMR will continue to look at what kinds of supports, both specialized DMR (additional staffing and clinical expertise) and generic (home health aides, VNA, etc.) will be necessary to continue to support individuals as they age.

8. Is DMR doing anything to track the cause of death of deceased individuals served by DMR?

    Yes. In fact, DMR has a well-developed reporting, tracking and clinical mortality review process. All deaths are reported within 24 hours and in-depth clinical reviews are done on those who meet criteria established by the Department. On an annual basis, U/Mass Medical School/Shriver Center, will conduct an independent mortality review of all deaths of DMR individuals over the age of 18. Reports will include detailed information regarding location, age and cause of death.

9. When doctors choose to ignore/not actively pursue symptoms of distress by MR individuals who may not have the verbal ability to describe their pain, what can DMR do to provide <u>medical advocacy</u>?

    If individuals or their families are dissatisfied with medical care, they may avail themselves of the grievance procedures regarding inadequate health care that are available to the general population. These include the Board of Registration in Medicine for physicians, Department of Public Health and Hospital Boards for hospital care. Fortunately, denial of quality health care to individuals with mental retardation is less likely than it may have been in the past, largely due to the efforts of families, providers and DMR area offices. However, the strategic management group did identify this as an issue. That is why several of the recommendations include training *direct care and other staff in how to communicate information to health care providers and how to be a good health care advocate. In addition, the group has developed a tool that will facilitate communication regarding a person's health status so that the health care provider has better information upon which to base a diagnosis. Finally, the group has developed guidelines to assist direct support professionals to recognize early signs and symptoms of illness so that appropriate action can be initiated.*

10. Is there a list of MDs in the community providing excellent care for DMR consumers? Especially in specialty areas?

    The New England Index, that is maintained by the Shriver Center, and the Federation for Children with Special Needs both maintain a database of physicians and other health care professionals.

11. What alternatives to a person's lifestyle have been tried before pulling someone into the mental health system, like a more interesting job and community activities?

    The ISP process provides an opportunity to explore and propose reasonable alternatives for individuals who may appear to need mental health supports. Understanding that mental health/behavioral needs may appear in as many as 30% of the DMR population, we must be careful not to unduly delay or defer necessary treatment and supports. Early recognition, identification and intervention are the primary approaches to be taken and interventions can include alternative program approaches or mental health referral.

12. Peer Review – How many people with MR or they're families have been allowed input, beside staff members, to these groups?

    A behavior plan requires the informed consent of the individual served or their family/guardian. Behavior plans are part of the ISP, so the same type of participation in their development should occur.

13. Why do residents of W.MA have to travel 1-2 hours (one-way) to receive MH or Behavioral Services (outside of Region)?

    Strategic Plan Objective #3 looks at resources in the community to provide mental health and behavioral supports. The distribution of supports is such that sometimes people must travel a distance to have either a specialty MH provider involved, or to decrease the amount of time that they have to wait for an appointment.

14. A majority of the people who have MR/DD that I know do not use Mental or Behavioral Health Services. What percentage of people served need Behavioral or Mental Health services?

Our data indicates that approximately 30 % or more of the individuals served by DMR are receiving some type of specific mental health service or behavioral supports. Some 18 % of the adults in residential or day programs have behavior plans, many individuals receive medicine for a mental health diagnosis, and still others are involved in some type of mental health counseling or supportive therapy.

15. What percentage of funds allocated to community services is used for MH services?

    Because mental health services are generally provided along with medical services through a larger medical service contract, we cannot break out this specific cost at this time. However, the Mental and Behavioral Health Workgroup is examining this data.

16. Have you considered requiring that each residence have one or two appointed staff to be assigned medical visit staff? Allowing direct care staff to be the liaison between physician and clients' healthcare is not very productive. Many direct care staff do not have the capability to be medical interviewers.

    Many providers already do this. Some may even have the RN (if they have one) go on medical visits. This option is not always feasible, however, and therefore it is imperative that direct support professionals have available tools to assure that a health care visit is successful. This includes many of the processes and instruments that have been developed by the strategic management group.

C. WORKFORCE TYPE QUESTIONS RELATED TO HEALTH CARE AND QUALITY:

1. How to ensure quality and qualified staff?

    Recruitment and retention are key elements of our strategic plan workforce goal #2. We know that identifying new potential workers will be a challenge given the changing demographics in our state as well as the nation. We are continually exploring new ways to make our work attractive to new workers. This means connecting with secondary education, community colleges and higher education in more organized ways. Once we have done this we will need to concentrate on what keeps people in the field. Clearly improved wages is an important element, as well as, job satisfaction, benefits, and a supportive work environment.

2. Define training/cultural change preparation.

    Strategic planning is ultimately about positioning DMR to learn to manage strategically. Part of this effort is to change the culture of the organization through a concerted organizational development plan. For example, the Advance Planning Document, the Department's effort to secure a new computer system, is a way of changing the work environment, thereby changing the organizational culture. When the

Department has an effective data reporting system that allows communication across all systems, it will be able to more effectively manage all aspects of its work, including addressing quality issues, critical incidents, etc. We are also working on the development of a management institute that will help managers to understand and communicate the changing practices in a consistent way across the organization. This will insure that the department's policies practices are applied consistently across the Regions. This focus on the change process cuts across all types of agencies, businesses, etc.

3. More and more responsibilities are being put on direct care staff (MRW1s), how can DMR continue to place more and more responsibilities on the lowest paid people in system, many direct care workers are well intentioned, but are not fluent in English, do not have American work ethic and not always able to expressive themselves, don't you think our residents are being victimized by this?

   Our state and our country are becoming increasingly diverse; in fact we have always been proud of our "melting pot" heritage. In the MR community it is highly likely that people from diverse backgrounds will be in direct care positions. This kind of phenomenon has always been true for new populations. We can all learn and be enriched from diversity.

   As part of its recruitment and retention efforts, the Department is focusing upon developing a uniform training curriculum for direct care workers and others in the organization to give them the tools to be successful. The Department works in partnership with our providers to ensure that direct care workers get the training they need. In some cases, English as a second language is being taught to enable direct care workers to communicate more effectively with clients, and to offer them a chance to improve their skills and opportunities.

D. ECONOMICS RELATED QUESTIONS:

1. Costs of meeting needs will vary in different communities. Are these cost variations being considered? Is there an index factor that differentiates cost of living factors for different parts of the state (i.e., costs in Boston are higher than in Pittsfield)?

   We have discussed the impact of geography on costs, particularly on salaries of direct care workers and on real estate. The Committee is currently in the process of reviewing the overall structure for establishing appropriate contract rates based upon needs assessments. We will be returning to an index or cost adjustment factor for geography after the basic approach to contracting is set. We may well look at actual cost variations in the human services field rather than adopting general figures that might not be relevant to the human services industry.

2. Is The Inventory for Client and Agency Planning (ICAP) being rolled out in April 2002? Is this another DMR "releveling" of existing consumer base? When will ICAP and Mass. Assessment be used statewide?

   The ICAP was piloted during the month of June, 2002 with a sample of about 200 to 250 people. During the early part of FY 2003 we will begin to determine the best way to roll out ICAP statewide for all DMR consumers. An exact timetable has not yet been determined. Over time, we do expect that resources will be reallocated according to consumer need as measured through ICAP, and a supplemental tool to determine what other resources may be available to individuals served by DMR.

3. If you were looking at assessment and allocations why did you not consider Wisconsin or Louisiana and were any of these states having a family support bill?

   The Workgroup did review materials from 10 states and had a conference where 4 states presented their models before moving forward with our recommendations Neither Wisconsin nor Louisiana were pursuing such a change.

4. You whipped quickly past a major issue that I'd like to hear explained. Please explain consumer control through the purchase of services.

   In one of the potential options under current consideration, we hope to have a system of allocation of DMR funding based on the ICAP and Mass. Supplemental Assessment that is linked to the consumer. Also under consideration is a plan whereby the consumer could arrange supports directly with providers. Assistance to arrange services would be available from the DMR Service Coordinator and other program staff in the Area Office. There would be information available to consumers about providers including a profile of what services are provided by them and may have related information on experience. Providers would be on an "approved list" based on certification and other "qualifying information". It is likely that some safeguards will be built into this process to provide adequate notice to providers if consumers wish to move their funding to another provider or service, e.g., an open enrollment period.

5. We have a 19 year old son, handicapped, his diagnoses are mental retardation with immobility, speech problems, epilepsy, incontinence, he is not able to feed himself, he needs 24 hour supervision. Can his mother continue to be his care provider and be paid by the system that provides assistance to families with patients with mental retardation?

   We can provide supports to the home as described in the Department's Family Support Guidelines which include many forms of assistance such as in home paid staff, community recreation, respite care etc. However, under current federal and state program requirements, the Department cannot pay parents for the care they provide to their children.

6. What about individuals who have an ISO who need supports so that the provider doesn't take the whole amount of money? In other words "to buy services as needed."

   One of the underlying assumptions in the ISO model is that funding should only be used according to what is really needed by the person. If the person actually didn't need all the funding as originally planned, the excess would be available to someone whose needs may have changed or for someone else in need within the DMR system.

E. ELIGIBILITY RELATED QUESTIONS:

1. Will people who are eligible now continue to be eligible or do they need to reapply?

   The Work Group on Eligibility has completed its work and forwarded a recommendation to the Strategic Plan Steering Committee. Pending internal review of these recommendations, and, following that, public comments on any proposed changes, the Department will continue to use the current eligibility standards and process.

2. What about children services? Nothing has been mentioned re: children's services? This presentation focused on Adults with MR. What about children, birth – 18?

   The Workgroup made some recommendations regarding children's eligibility that are still undergoing internal DMR review. Our children's eligibility will remain the same until there is a public process around proposed changes to our eligibility regulations.

3. How come with a family with four DMR eligible children why only one gets any service? I'm told because it's family support program.

   Family support is designed to support families and clearly if a family has more than one family member with a disability our support for that family will be greater subject to appropriation from the legislature. We suggest that families who find themselves in this situation discuss their individual concerns with the Area Office Director.

4. I recently completed an "intake" with a representative from "ARC" (1/30/02) sent by the DMR. My son is 2 ½ and has ASD. Tonight you spoke of goals to map guidelines for supports and resources, however, I was told there is no "list" of supports available to be presented to families. What will the "intake" accomplish for my family? How will we know how to tap in to DMR for help? No professionals came out for intake – only nice "administrator" – no interaction took place with child as was mentioned during tonight's presentation.

   This question highlights many of the Strategic Plan goals that we hope to accomplish in the future: clear information about what kinds of resources *and supports exist so that families can choose from an array of options and a regional eligibility team process staffed by professionals with the ability to actually observe the person in natural settings. The goal of our plan is to try to achieve these items over the course of the next three years.*

Currently, however, publications exist which describe in some detail the types of services available. For example, for families of children determined to be eligible, the "Family Supports Guidelines" describes the services available.

5. Are the Regional Team members going out to the individuals and family or are they going to have to do the intake at the Regional Office? If so, how are the individuals and families going to get to the Regional Teams?

    We expect members of the Regional Eligibility Teams to go out to individuals and families. Meetings may take place in the family home, the area office, a community program, etc. If individuals and families want to come to the Regional office for intake, that is also an option.

6. How are Regional Teams going to manage cultural/language issues?

    The Regional Team composition must take into account the cultural/linguistic issues of potential applicants. Our staffing pattern will reflect, to the greatest extent possible, the cultural diversity of the community. Additionally, it is our intention to make materials and application forms available in a variety of languages.

7. Do these teams come to your house? Do they include autistic individuals under the Department still?

    A team member can come to your house to gather information, observe your family member and discuss the nature of DMR supports and services with you and your family member.

8. Who are the additional 3 members of the eligibility team?

    Each eligibility team consists of a doctoral level licensed psychologist, a clinical social worker, a number of eligibility specialists, access to a RN for consultation, and an administrative assistant.

9. What assessments would they use for eligibility determination?

    We will use standardized intelligence tests such as the Wechsler and the Binet, the Vineland, Measures of Adaptive Functioning, School and Hospital Reports, Medical Reports and the Inventory Client and Agency Planning Tool (ICAP) coupled with the Mass Supplemental Assessment.

10. When will we know exactly who is eligible?

We will continue to use our current eligibility for the foreseeable future. If we move to change our eligibility there will be a public process for individuals to share their concerns with us.

11. When will the new DMR intake forms be ready?

Our plan is to have the forms available at the beginning of July, 2002.

F. QUALITY RELATED QUESTIONS:

1. We can collect mountains of data/info. But without properly analyzing the data we cannot utilize these data and put them into useful work. How far away is your QMIS to reaching this goal?

That is the purpose of the strategic management group charged with the responsibility of coming up with a quality management and improvement system. The group is looking at what kind of information we want to collect, ways in which data can be transmitted to families, providers, and DMR managers so that it is easily understood, and mechanisms to assure that the data is analyzed by a variety of stakeholders. Most importantly, we will be recommending systems to assure that the information gets used to create service improvements. Many of the data systems are already in place to give us critical information regarding the quality of our supports. Others still need to be developed. The biggest challenge will be integrating our information systems and developing the MIS capability to implement our vision. It is difficult to place an exact timeline on this. We are, however, already reporting on critical quality indicators and will continue to move towards an integrated QMIS system.

2. Do you put the survey data as well as individual profiles into a central location (data storage) but accessible by regional/area offices?

Regional and area offices have access to individual profiles through the Consumer Registry System and the electronic Individual Service Plan (ISP). Data generated by the survey and certification process is maintained in a central database, so that all ratings regarding the services of individuals collected as part of the survey and certification process can be aggregated. In addition, all provider levels of certification and ratings in specific quality of life areas can be compared.

3. Would you further explain what you mean by medication utilization analysis (e.g.)?

Currently, DMR collects information regarding medication usage for anxiety, behavior or mood disorders through the National Core Indicators Project. While this is useful, it does not get at the level of detail that will be helpful over time. We would like to be able to gather information on medication usage for all the individuals we support so that we can track trends and patterns over time.

4. What is the system in place for reporting medication errors?

Under the regulations of the statewide Medication Administration Program (MAP) non-licensed staff (non-RN's and LPN's) are authorized to administer medications after they have successfully completed a training program and passed both a written and skills test. Providers utilizing MAP certified staff are required to report any medication occurrence to DMR. An occurrence is defined as any time an individual misses or receives their medication at the wrong time, wrong dose, wrong route, or gets the wrong medication. Follow up is done and data is maintained on every medication occurrence statewide. This is compared to the total number of dosages given.

G. GENERAL STRATEGIC PLAN QUESTIONS:

1. There were many objectives that were either a) not covered or b) remain to be decided. As these items are finalized is the Department's website updated? If not, how we can know what decisions have been made?

At these public forums we shared the work products of some but not all of our groups. Later in June we intend to publish summaries of the status of all of our work groups. As items are finalized we will update our website.

2. What will the Strategic Plan cost DMR?

To implement the Strategic Plan, the Department will utilize current resources; as in any organization, the Department will regularly reexamine costs and benefits of its activities. Practices adopted through implementation of the Strategic Plan are among the Department's current priorities.

3. If the Strategic Plan started 18 months ago, why is it that advocates were only part of the plan in the last 6 months?

Advocates have been involved since the Plan began, first in our environmental assessment and then in our work groups. Representatives from 5 advocacy groups were invited to join work groups and many did so. All of our work groups have benefited from the diversity of perspectives of the stakeholders.

4. How many workgroups have finished their work? How many presented final reports?

The Eligibility and Regional Team work group has completed its work. The Facility work group has also completed its work. The Rule Book, Recruitment and Retention, and Family Partnership groups will complete their work shortly. The Workgroups' products are presented to the Steering Committee that, in turn, makes a recommendation to the Commissioner to accept, modify, or reject the work group *recommendation. To date only the Regional Team component of the Eligibility Work group has been accepted by the Commissioner for implementation.*

5. When someone goes into a Nursing Home will the Strategic Plan follow the client?

   The Strategic Plan is not a service. It is a plan for how the Department should manage the compelling issues that confront it. It is a tool to assist the Department in managing itself. It is not a thing or service, rather it is a blueprint or guide for future activities.

6. Are the strategic plan services geared to state ops vs. the private providers? Is everyone in the field getting the same message regarding your plan?

   Changes that occur through Strategic Planning will effect all DMR providers, private or state-operated. The reason for the forums, the FAQS, and the summaries is to insure that everyone gets the same message throughout the DMR community: public, private, individuals and families.

7. How much confidentiality is left after all this information is shared?

   No individual client's confidential information has been shared through strategic planning processes and none will be shared. Respecting and protecting confidentiality is critical to the success of our mission.

8. With all these meetings, were any held with families and individuals?

   Yes, many meetings were held with families and individuals.

9. What is the timeframe for the plan to be reviewed by the public? How can you make this plan user friendly?

   We provide frequent opportunities for public review and input of Strategic Plan products through forums like these. We are always interested in how we can make our plan and its work user friendly. Please feel free to offer us suggestions about how to best to do this.

10. What are you going to do about Grandparents raising their Grandchildren?

    This is a new area for us and we are eager to learn from Grandparents about their particular needs and how they are similar or different from other families.

11. What does all this mean to the less knowledgeable consumers?

    As we develop the Plan activities, it means that people will know and understand what we do, how we do it, and what choices they can make about their services and supports.

12. How do you plan to make families educated consumers specifically?

    We believe that information is the most powerful tool that we have and our Family Partnership work group will develop what kind of information and in what format will be most helpful to families. We also know that families learn enormously from each other and we want to encourage opportunities for families to network with each other.

13. How do you expect the cuts in the 2003 budget to affect the strategic plan?

    Budget cuts are always difficult to manage but one of the reasons we began our Strategic Plan was to help us manage in difficult times as well as good times. Strategic Management is learning how to manage differently; the Plan helps us do that.

14. A suggestion: Create a list of service providers that will provide services to people with an ISO as needed, when needed.

    This is an excellent suggestion and we will work on it.

15. Has there been any discussion on changing the name of the Dept. ("Mental Retardation") in any of the groups? We would see more respect that way. Would you ever consider changing the term used for the Department (of) "Mental Retardation"? This would seem to be a first step toward improving community relationships and developing "maturity".

    We have worked with the Statewide Advisory Committee and the Self-Advocates to explore changing the name of the Department. In order to accomplish this we would need to change our statute and only the Legislature can do that. We would also have to agree on what our name should be in the future. Like many issues that confront us there is a wide range of opinions about this.