

**TRANSITION TEAM POLICY COMMITTEE
HUMAN SERVICES WORK GROUP POLICY RECOMMENDATIONS**

December 29, 2010

To: Linda Kelly, Transition Team Policy Committee Co-chair
Joe McGee, Transition Team Policy Committee Co-chair

From: Ron Cretaro, Executive Director, CT Association of Nonprofits
Terry Edelstein, President/CEO, CT Community Providers Association
Toni M. Fatone, President, TMF Consulting Services

Re: Human Services Work Group – Policy Initiatives – Priority Areas

We have attached the Policy Initiatives from the Transition Team Policy Committee Human Services Work Group. These correspond to the fourteen Policy Recommendations that we sent to you last week.

Please note that the policy initiatives, grouped by priority area of “priority initiatives,” “short-term initiatives” and “long-term initiatives” are not meant to be read in priority order (1,2,3 etc.) Instead, please consider all of the policy initiatives within a priority area as having similar weight.

In developing these priorities we went back to the Policy Recommendations that we had forwarded to the Transition Team on December 20, 2010 and shifted them into this new priority format sequentially.

You will note that most of the attached policy initiatives are grouped in the “priority initiatives” area. We are recommending action on these recommendations during the 2011 session so that the state can garner savings or maximize federal revenue in the years to come.

Please feel free to call upon us with questions or comments.

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3. **Helping Those Who Help:** A Plan for Nonprofit Community Providers
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5. **Persons with Disabilities:** Department of Developmental Services/DDS Services – Waiver Services
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14. **Housing:** Re-Tooling Connecticut’s Homeless Assistance System

Working Group Name: Human Services- Medicaid

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	Immediate Fiscal Impact
1.	Authorize DSS to Est. DRG Reimbursement System for Hospitals	Process will take 2-3 yrs to complete if DSS is authorized in 2011 budget/legislative session to develop system
2.	Revise Current Nursing Home Provider Tax to Utilize 2009/10 revenues to Increase Federal Share	Increase Federal revenues \$5-10 Million. Public Notice Requirements apply to State Plan Amendment changes needed. Proposal is intricately tied to overall State budget expenditure strategies.
3.	Enhance Federal Medicaid Revenues by Expanding Provider Tax to Other Providers**	Almost all the other states include add'l providers to enhance their federal revenues. DSS has revenue estimates. Federal approval required. Proposal is tied to overall State budget expenditure strategies.
4.	Pursue all Federal HC Reform Funds- Community First Choice, CLASS Act, State Balancing Incentives Program	Potential Significant Fed. Funding Available
5.	Residential Substance Abuse Treatment for Women with Children	Savings in Corrections and DCF services per woman and child
6.	Promote CT LTC Insurance Partnership to reduce reliance on Medicaid	Fed funds may be available thru HC Reform "rebalancing" initiatives

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.	Require Nursing Homes to Develop Individualized Business Plans to diversify, downsize, restructure services to stabilize their finances.	Reduction in interim rates and receivership costs
2.	Reorganize DSS Functions- Create Single Point of Entry for Medicaid and other Services	Improves co-ordination thru consolidation and reduction of redundant services.
3.	Expand Group Purchasing concepts to Medicaid providers Expand Group Purchasing concepts to Medicaid providers	Analysis needed but significant cost savings possible
4.	Review increasing Physician fee schedule to Medicare levels in conjunction with development of DRG system	Must be analyzed in conjunction with overall savings realized

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.	Increasing utilization of LTC Insurance to reduce reliance on Medicaid	Significant savings to Medicaid
2.		

On items in which there was not consensus, please append any dissenting opinions.

**** Hospitals and N**

Working Group Name: __Human Services – Purchase of Service Provider Support & Contracting Reform

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	Immediate Fiscal Impact
1.	Create oversight entity for all state agencies to ensure consistent adherence to state contracting processes	None
2.	Execution of all state POS contracts within 15-30 days prior to implementation	None
3.	Utilize prospective payments and encourage electronic payments	None
4.	Utilize multi-year contracts	None
5.	Reduce number of Special Identification Codes	None
6.	Raise threshold requiring budget amendments	None
7.	Fund mandates for Electronic Health Records & data encryption	Cost addition
8.	Review Pos reports & protocols (data reporting) to create more uniformity	None
9.	Collaborative development of a single, web-based reporting system	None
10.	Create online portal or document vault for common forms	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.	Prioritize the adequate and appropriate funding of nonprofit community-based providers	Significant
2.	Consolidate back-office functions of state’s health & human services agencies	Potential Savings

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.	Prioritize adequate and appropriate funding for nonprofit community-based providers	Significant
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: _____ HUMAN SERVICES _____

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Helping Those Who Help – A Plan for Nonprofit Community Providers	Immediate Fiscal Impact
1.	Develop strategies to assure the provision of services provided in community-based settings rather than institutions.	Cost effective spending
2.	Assure that services focus on individuals served in the community, in a wide array of settings and in the least restrictive and most appropriate environment possible.	Cost effective spending
3.	Develop a reliable funding system which recognizes the cost of services and the cost of doing business to be reviewed annually against an external standard.	Cost effective spending to mirror recognized indices
4.	Consolidate “back office” functions in a reorganized state government all the while considering the impact on people being served.	Cost effective spending
5.	Develop enhanced revenues as an alternative to cuts to health and human services.	Revenue generation
6.	Develop revenue maximization strategies as a means to support investment in the nonprofit community-based provider infrastructure such as: <ul style="list-style-type: none"> • The Rehab Option for individuals with behavioral challenges • The 1915(i) waiver for home and community-based services 	Revenue generation/ meeting gaps in services

	<ul style="list-style-type: none"> • An expanded DDS waiver • An expanded Money Follows the Person Waiver for individuals with disabilities, including people who are elderly and other people with disabilities 	
7.	<p>Utilize the proposed Cabinet level head of a Nonprofit Human Services Cabinet to focus on the health and human services arena in conjunction with nonprofit community-based providers in a coordinated fashion including:</p> <ul style="list-style-type: none"> • Creating efficiencies between state agencies. • Removing redundancies, unfunded mandates and outdated requirements on nonprofit community-based providers to reduce costs and improve efficiencies. • Utilizing creative approaches to system reform, service provision and problem-solving 	Cost effective spending

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: HUMAN SERVICES

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Persons with Disabilities - Autism Pilot	Immediate Fiscal Impact
1.	Build upon the work of the proposed Center for Autism and Developmental Disabilities to provide contracts for community-based services at nonprofit community-based provider organizations, much as the “Acquired Brain Injury Waiver” assures an array of services provided through community-based service providers	Cost effective spending
2.	Utilize the services of existing nonprofit community-based provider agencies including residential treatment and other behavioral health providers to provide enhanced services for individuals with autism through rate adjustment and incentives for providing services as an alternative to contracting for out of state services	Cost effective spending/ Cost offset
3.	Seek a federal waiver that will assure the provision of a wide array of community-based, non-institutional services	Revenue generation
4.	Conduct a rate review for Connecticut’s Early Intervention/Birth to Three System which provides the first level of identification and support for children with autism and related disorders.	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Support: The Advisory Council to the Division of Autism of the Department of Developmental Services has offered its support to the Malloy/Wyman administration as the administration assesses and reviews priorities and sets its agenda.

Dissenting opinion: parents of adult child living at Southbury Training School who suggest that the Center for Autism and Developmental Disabilities should be established on the STS grounds.

Working Group Name: HUMAN SERVICES

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Persons with Disabilities - Department of Developmental Services DDS Services – Waiver Services	Immediate Fiscal Impact
1.	Apply for new waiver services	Potential for \$5.5 million in federal reimbursement
2.	Modify DDS payment system to assure compatibility with the federal (CMS) requirements for waiver services <ul style="list-style-type: none"> • Adopt uniform rates through a five year transition plan beginning on July 1, 2011 with DDS funded day services and continuing with DDS funded residential services the following year. 	Risk of federal recoupment of funds and/or loss of future reimbursement

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative: Persons with Disabilities - Department of Developmental Services DDS Services – Waiver Services	Short Term Fiscal Impact
1.	Modify DDS payment system to assure compatibility with the federal (CMS) requirements for waiver services <ul style="list-style-type: none"> • Adopt uniform rates through a five year transition plan beginning on July 1, 2011 with DDS funded day services and continuing with DDS funded residential services the following year. • 	Risk of federal recoupment of funds and/or loss of future reimbursement

2.	Adjust waiver rates: <ul style="list-style-type: none"> • Increase rates for providers below the median. • Reallocate funds realized from attrition in state services to the private sector to increase rates • Ensure that waiver rates are based on a measurable inflation index. 	Cost effective spending/ Cost offset
3.	Convene a public and private workgroup to explore ways to effectively manage data over the next 3-5 years to meet requirements and to maximize federal reimbursement <ul style="list-style-type: none"> • Invest in an IT infrastructure to create a viable, state of the art management information system that would provide comprehensive data management for the public and private sector. 	Revenue maximization

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Supports the work of the legislatively authorized Advisory Committee for Services under Programs Administered by the Department of Developmental Services (section 57 of PA 09-3). Comments are extracted from draft Executive Summary (12/14/10 draft) to be presented to the full Committee 1/11/11.

Dissenting opinion: The Transition Team Human Services Workgroup received recommendations from a parent and several state employees recommending that Southbury Training School remain open. The Human Services Workgroup did not support this position and instead recommends the above focus on strengthening the community-based system.

It is important to note that nonprofit community-based provider organizations are very well equipped to provide the same level of services for the most medically fragile and/or behaviorally challenging individuals as those provided by state-run programs.

Working Group Name: HUMAN SERVICES

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Persons with Disabilities - Department of Developmental Services/DDS Services – Community-Based Services	Immediate Fiscal Impact
1.	Review satisfaction with conversion of group homes utilizing the DDS “Conversion 2004 Survey.”	None
2.	Analyze the comparative costs of public vs private sector service delivery building on the work of the Commission on Nonprofit Health and Human Services established under SA 10-5.	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Dissenting opinions: The Transition Team Human Services Workgroup received recommendations from a parent and several state employees recommending that Southbury Training School remain open. The Human Services Workgroup did not support this position and instead recommends the above focus on strengthening the community-based system.

It is important to note that nonprofit community-based provider organizations are very well equipped to provide the same level of services for the most medically fragile and/or behaviorally challenging individuals as those provided by state-run programs.

Working Group Name: HUMAN SERVICES

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Persons with Disabilities - Community Behavioral Health Services for Children, Youth and Adults	Immediate Fiscal Impact
1.	<p>Generate federal revenue to support community behavioral health services, shifting funds from costly criminal justice, nursing home and crisis services to more cost-effective community-based options.</p> <ul style="list-style-type: none"> • File a State Plan Amendment under 1915(i) to allow the state to bill for Community Support Program (CSP), Assertive Community Treatment (ACT), Peer Support, Supported Employment, Recovery Assistant, Short Term Crisis Stabilization, and Transitional Case Management services. • Bill Medicaid, to the fullest extent allowed, for outpatient services provided by DMHAS state operated providers • Allow for direct billing of Medicaid by nonprofit providers 	Revenue maximization/ Cost offset
2.	Protect access to Medicaid coverage offsetting the need for more costly criminal justice, nursing home and crisis services	Cost offset
3.	Develop a Policy on Health and Human Services for People with Disabilities to encompass the needs of the large and varied number of Connecticut residents in need of supports and services	None

	In conjunction with the work of the Commission on Nonprofit Health and Human Services, develop a reliable funding system that recognizes the cost of services and the cost of doing business to be reviewed annually against an external standard. With this funding system in place, nonprofit community-based providers will be able to hire the direct care staff necessary to implement these system reforms.	Cost effective spending
	Utilize the services of nonprofit community-based providers to maximize cost savings and accountability and benefit a greater number of individuals than would be served in institutional settings	Cost offset

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: Human Services – Persons With Disabilities: Supporting Connecticut’s Residents with Disabilities

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	Immediate Fiscal Impact
1.	Designate individual in Governor’s Office as disability liaison	None
2.	Design state structure for long term care t integrate delivery of services & supports, maximize federal funding and achieves greater efficiency	None
3.	Support Full implementation of Money Follows The Person	Strategic Investment – Long Term Saving
4.	Promote further development of community-based workforce	None
5.	Preserve access to Medications for those on Medicare, Medicaid or ConnPace	None
6.	Maintain toll-free hotlines connecting persons with disabilities with resources	None
7.	Increase availability of accessible and affordable housing for persons with disabilities	Strategic Investment – Cost With Long Term Savings
8.	Maximize opportunities provided by the Affordable Care Act to provide new opportunities to expand community living support through through 1915 (i) State Plan Amendment	Strategic Investment – Cost With Long Term Savings

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.	Increase availability of accessible & affordable transportation	Undetermined Cost
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: _____HUMAN SERVICES_____

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Persons with Disabilities - Cross Disability - Safety Net Support	Immediate Fiscal Impact
1.	Develop a Policy on Health and Human Services for People with Disabilities to encompass the needs of the large and varied number of Connecticut residents in need of supports and services.	None
2.	<p>Ensure provision of community-based services for individuals with disabilities.</p> <ul style="list-style-type: none"> • Convene a conference of disability advocates including primary consumers, family members, service providers and Centers for Independent Living, charged with portraying the scope of disability needs in Connecticut that include affordable housing, accessible transportation, employment, clinical and social services. • Develop a work plan for focusing on these cross-disability needs as well as the specialized needs of such populations such as individuals with acquired brain injury, people with multiple sclerosis, individuals who are blind or who have hearing disorders, people with HIV/AIDS, Alzheimer’s and other disabilities. • Support a “virtual” Center on disabilities supporting research, policy development and service delivery models, avoiding the creation of new institutions in Connecticut to meet the needs of children and adults with disabilities. 	None
3.	Seek federal waivers and expand Money Follows the Person (for eligible individuals of all ages) to assure the provision of a wide array of community-based, non-institutional	Revenue maximization

	services for a large and varied population	
4.	Provide contracts for community-based services at nonprofit community-based provider organizations.	Cost effective spending
5.	Utilize the services of existing nonprofit community-based provider agencies to provide enhanced services for individuals with disabilities.	Cost effective spending
6.	Develop strategies to limit the use of and reduce the cost of institutional care.	Cost offset

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Dissenting opinion: CCM recommends “creating and maintaining a registry of all community residences.” The Transition Team Human Services Work Group does not agree with this recommendation noting that it is a disincentive to community-based supports and services. Such a list, available to the public under FOI, would limit, challenge and serve to restrict the rights of people with disabilities to live in the community.

Working Group Name: HUMAN SERVICES

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Workforce/Jobs - Direct Care Workforce	Immediate Fiscal Impact
1.	Develop forums for current direct care workers and employers of direct care workers to network and share information, resources, strategies, and trainings	Added cost to nonprofit community-based provider contracts
2.	Develop a strategy for recruiting new direct care workers and for improving the image of the workforce	None
3.	Work with aging and disability nonprofit agencies to improve the professionalism of the workforce by developing a career ladder and professional development opportunities	Added cost to nonprofit community-based provider contracts
4.	Identify national and local workforce best practices, systems and funding in order to promote and develop an engaged workforce	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: HUMAN SERVICES

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative: Workforce/Jobs - Internship Program to Support the Workforce for Community-Based Nurses	Immediate Fiscal Impact
1.	Develop an internship program for nursing school graduates that will provide them with community-based experience in order to be hired into community-based nursing jobs.	None
2.		

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.	Implement an internship program for nursing school graduates that will provide them with community-based experience in order to be hired into community-based nursing jobs.	Jobs Program/ Cost offset
2.	Provide incentives for community-based agencies to host the internship programs.	Jobs Program/ Cost offset

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: __Human Services – Philanthropic Giving & Volunteerism

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	Immediate Fiscal Impact
1.	Development of policy statement encouraging private-public partnership	None
2.	Creation of Short term task force to expand philanthropic giving & volunteerism	None
3.	Designation of Governor’s Office staff to oversee state community outreach to philanthropic and other nonprofit organizations	None
4.	Creation of philanthropic calendar and issuance of declarations	None
5.	Exploration of reinstating Annual Governor’s Conference on Volunteerism	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: Human Services – Supportive House

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	Immediate Fiscal Impact
1.	Continue progress of creation of 10,000 units of supportive housing	Strategic Investment – Long term savings
2.	Protect housing in economic development reorganization	None
3.	Protect siting access for affordable & supportive housing	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

Working Group Name: Human Services- Re-tooling Homeless Assistance System

List the priorities of your working group in the appropriate areas below...

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	Immediate Fiscal Impact
1.	Focus homelessness assistance on housing centered solutions – policy direction	None
2.	Align system around common outcomes	None
3.	Use data collection and matching between homeless service system and other state systems to better target services	None
4.	Incentivize community partnerships – create standards of collaboration – policy direction	None
5.	Gain assistance of private philanthropy to provide technical support	None

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	Short Term Fiscal Impact
1.		
2.		

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	Long Term Fiscal Impact
1.		
2.		

On items in which there was not consensus, please append any dissenting opinions.

**TRANSITION TEAM POLICY COMMITTEE
HUMAN SERVICES WORK GROUP POLICY RECOMMENDATIONS**

“What we have before us are some breathtaking opportunities disguised as insoluble problems.” John W. Gardner

December 20, 2010

To: Linda Kelly, Transition Team Policy Committee Co-chair
 Joe McGee, Transition Team Policy Committee Co-chair

From: Ron Cretaro, Executive Director, CT Association of Nonprofits
 Terry Edelstein, President/CEO, CT Community Providers Association
 Toni M. Fatone, President, TMF Consulting Services

Re: Human Services Work Group – Policy Recommendations

We are pleased to provide you with an extensive packet of policy recommendations for consideration by your committee. We would be very glad to present a summary of these recommendations to you or your full committee.

We have attached these recommendations via PDF and a link. We will also provide the Policy Committee with a full set of all materials gathered during our policy development process as requested.

Please feel free to call upon us with questions or comments.

The Transition Team Policy Committee Human Services Work Group polled our member organizations, other trade associations and the human services advocacy community seeking policy recommendations for the Transition Team.

We have attached a database of 156 individuals who were interested in providing information and/or who provided information to our Work Group. This list includes individuals whose comments had been forwarded directly to the Transition Team. In addition, we sent comments that were more germane to other Work Groups to those groups.

Our policy recommendations all highlight the critical role that human service providers play as the safety net for so many of Connecticut’s residents.

The health and well-being of human service providers is critical to the overall policy direction of our state so that we can effectively and efficiently serve Connecticut’s communities as the safety net.

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Transition Team Policy Recommendations On Human Services
"Modernizing Medicaid"

Program Overview: The Medicaid Program was created in the mid-1960's to be America's safety net. Its original premise is as valid today as it was then-perhaps even more so. But the world in which this program now functions, almost half a century later, could not be more different and the demands on the program any greater- with no end in sight. Connecticut's Medicaid program is the State's single largest expenditure at \$3B/YR. Yet Medicaid providers in every facet of the program are being asked to serve an exponentially increasing demand level with dwindling resources. This process tears holes in that safety net -holes that we simply cannot afford to ignore. However, without some structural reform we will not be able to pay for any of the repairs needed. We must begin the process of "modernizing" Medicaid to meet the challenges presented by the world it now functions in. We must ensure every dollar spent is achieving the best outcomes in the most cost effective fashion. We must maximize our federal and philanthropic revenues, cut costs thru innovative and aggressive purchasing models, obtain the requisite data to support our policy decisions, while improving accessibility and reducing Medicaid costs or at a minimum holding the line. Connecticut can be a leader strengthening our relationship with Medicaid providers to create a better more cost effective Medicaid Program for the people of Connecticut-" One Solution at a Time." ¹

II. Proposed Actions : Defined by Provider:

1. Hospitals-

I. Statement of Issue: The hospitals of CT are united and stand ready to be a part of the solution. Our hospitals are major providers of services to the Medicaid and Medicaid Low Income Adult (MLIA) population. They believe if the CT Medicaid program remains unchanged- "it will cripple the hospitals' service capacity for all"²

II. Proposed Action:

- Align the Medicaid program with the Federal Healthcare Reform legislation (PPACA) and use the savings to invest in modernizing Medicaid rates;
- Use those savings to revise Medicaid physician fee schedules at the Medicare rate level and be applicable to all physicians including hospital-based physicians who are currently reimbursed at a lower rate;
- Shift hospital reimbursement system to a DRG format that will reimburse Inpatient services on the average cost to treat in CT and the illness presented.

III. Fiscal Impact: It will take a substantial upfront investment to achieve. Hospitals believe costs can be recouped and state deficit reduced moving forward. CHA did not provide data to workgroup but has it available.

¹ Quote from CANPA Recommendations pg # not listed

² Quote from CHA recommendations pg 12

IV. Jobs Impact and Other Benefits- In 2009 hospitals spent \$8.5B on salaries combined with purchasing products and services and construction projects created a ripple effect of an additional \$9.1B. Hospitals employ 52,300 people.³

V. Connection to Malloy-Wyman Policy Document- Hospitals policy was not addressed. However, Hospitals would like to be included thru a policy statement that reads "CHA supports a series of initiatives that increase access, reduce the state deficit, reduce the government cost shift and shrink hospital losses to preserve access to Medicaid."⁴

2.NURSING HOMES-

I. Statement of Issue: While the two nursing home associations CAHCF and CANPFA did not collaborate on recommendations provided -their recommendations complement each other by providing a broad array of options that can serve to be a part of the solution. The themes center around maximizing federal revenues, strengthening the nursing home system by allowing and encouraging new business planning, and achieving savings thru efforts that lead to reducing the number of nursing homes beds without unneeded displacements caused by financial instability, and implementing aggressive purchasing models for products and services used in our nursing homes to reduce costs. All of the policy recommendations set forth must be reviewed and analyzed within the larger rate policy discussions that will take place.

Proposed Action:

- Allow Development of Individualized Business Plans-allow the professionals in the field to develop individualized business plans to restructure or diversify the services they provide and or downsize their existing facilities and services in order to build a better model of care that will meet market needs in a more cost effective manner stabilizing the finances and reducing reliance on the costly interim rate structure that has in essence become our Medicaid reimbursement system in the State.⁵ Both PA and MN have already adopted restructuring models to decrease the number of nursing home beds, including offering grants or loans to create affordable housing or become home and community based service providers.⁶ But those should not be the only business model options deemed acceptable. This planning program will encourage the diversification of services and the development of continuums of care and state of the art models that meet the demands of a changing consumer and enhance the workplace environment.⁷This recommendation is in keeping with the recommendations on reigning in Medicaid costs outlined in the Commission on Enhancing Agency Outcomes Report released on December 15th 2010.
- Allowing nursing homes to voluntarily give up nursing homes beds as part of their business plan to restructure and increase our efforts towards rebalancing the system and reducing the number of beds in the system. Statewide occupancy rates average about 91% so an easily identifiable number of potential beds is readily available for a giveback program
- Maximizing Federal Revenues. CT is under-realizing the revenues available to us thru our existing provider tax program. Federal law permits the State to operate the provider tax program

³ CHA recommendations pg 8

⁴ CHA Recommendations pg 2

⁵ CANPFA recommendations

⁶ Commission on Enhancing Agency Outcomes pg 75

⁷ CANPFA recommendations

at a maximum rate of 5.5%. Because the tax is currently calculated utilizing 2005 nursing home revenues- increases in Medicare revenues and private pay rates are not being captured and reported so CT is missing out on those matching federal revenues worth between \$5-\$10M/Annually and operating at a slightly lower tax rate.⁸ Again this recommendation must be analyzed within the larger rate policy decisions that will take place as part of the State budgeting process.

- Expand the Provider Tax- CT is passing up additional Federal funds by limiting its Medicaid provider tax program to just nursing homes. Virtually every other State applies the tax to other Medicaid providers and some states include managed care organizations as well.⁹ If CT did expand its program to other providers there would be approximately \$52M/Annually in just existing provider tax funds to be reallocated back from those very providers who currently are being paid for services from the nursing home tax funds that are allocated to them but are not subject to the provider tax. This \$52M does not including the new Federal revenues that would be generated by expanding the tax base to include other providers. DSS will be an important resource in analyzing this budget option.¹⁰ **Dissenting Opinions:** Both the hospitals and non-profit providers the two most commonly taxed providers after nursing homes would be vehemently opposed to expansion of the provider tax program to other providers. They do not want the tax extended to them.¹¹
- State to provide Group Purchasing services to Medicaid providers to reduce costs in the Medicaid program. CT currently has a proposal to aggressively group purchase pharmaceuticals for Medicaid providers with its Prescription Drug Purchasing Plan. This plan estimates \$70M in savings a year.¹² The State could achieve greater savings by maximizing the State's purchasing power alone or in conjunction with a New England Consortium and aggressively purchasing other widely used products and services such as rubber gloves, adult diapers, patient lift machines, medical dispensing machines, electronic medical record programs, replacement elevator motors, creating a Medicaid provider worker's comp pool, cleaning and housekeeping products etc. The potential for reducing costs for providers when the State is unable to provide rate increases to cover costs has significant potential benefit to providers and the State. While this concept is outlined in the nursing home section its theory is applicable throughout the Medicaid continuum of care
- A proposal was also submitted by The Nathaniel Witherall nursing home in Greenwich. The recommendations contained were specific to the facility only and have no statewide policy application. This proposal should be addressed by DSS and OPM respectively as significant state funds are being requested.

III. Fiscal Impact: Increased Federal revenues would be available however exact figures were not provided except for figures noted. More detailed figures are available from DSS. Please note- federal revenues are not exempt from the Constitutional Spending Cap and a thorough analysis by OPM must be conducted. If nursing homes are allowed to diversify and restructure strengthening their own financial well being a significant reduction in interim rate increases will be realized and unexpected receiverships

⁸ DSS should have exact figures readily available

⁹ NCSL Healthcare Provider and Industry Taxes/Fees Oct. 2010 pgs 4-11, Kaiser Commission on Medicaid pg 77

¹⁰ CAHCF proposal #1

¹¹ NCSL Healthcare Provider and Industry Taxes/Fees Oct. 2010 pgs 4-11, Kaiser Commission Report on Medicaid

pg 77

¹² Commission on Enhancing Agency Outcomes

and closures avoided. The reduction in beds creates additional savings as beds are identified and given back. The program would need to be appropriately structured to avoid any issue of a "taking" by the State being raised by providers and avoid compromising any current efforts being utilized by DSS to reduce the number of beds. Additionally DSS could easily calculate any additional revenues that would be available from an expansion of the provider tax program.

IV. Connection to the Malloy-Wyman Policy Document: both organizations support consumer choices. Both agree that nursing homes are not adequately funded and have provided recommendations to achieve better funding. Both agree that current staffing regulations are outdated and need to move towards a state of the art model which would calculate staffing levels over 24 hrs because such a system allows a nursing home flexibility to develop and maintain innovative scheduling models to better meet the individual needs of the residents they are caring for. Air conditioning- DPH has surveyed all nursing homes and found that they all have some level of air conditioning. Nursing homes should plan for extreme heat as they do for all other emergency situations. The rights of Nursing Home residents- both agree that it is a priority to vigilantly guard the basic rights of nursing home residents. There are already many comprehensive federal and state statutes and regulations in place that strictly prohibit abuse and neglect. Nursing homes must report and investigate all alleged or suspected incidents of abuse and neglect. Congress also recently bolstered federal reporting requirements thru the Elder Justice Act a part of the National HC Reform legislation.

3. Assisted Living

I. Statement of Issue- CT has in place several Medicaid programs to assist eligible seniors in assisted living. But Medicaid reimbursement is not available to all Assisted Living centers as Assisted Living services were developed to be a private pay model but for these few programs. However, where available the state subsidy programs are very effectively being combined with federally funded programs in HUD housing settings as well as in congregate and low and moderate income housing. Assisted living can be a very cost-effective community based alternative for seniors who are not able or do not wish to stay in their own homes but who do not require the high acuity level services provided by nursing homes. These assisted living services are an essential part of the community long term care continuum.¹³

II. Proposed Action-

- Continue these cost effective programs to prevent unnecessary institutionalization. Additionally these programs provide essential services such as proper nutrition, medication management and socialization-living at home alone can be very lonely and it is not always cost-effective when there is no caretaker in the house round the clock. For those who participate in the CT Homecare Program for Elders (CHCPE) a co-pay of 15% was enacted in 2009 but was reduced to 6% by the 2010 General Assembly. The Ct Association for Assisted Living is recommending that this co-pay should be eliminated if at all possible as this burden falls on those seniors least able to pay.

III- Fiscal Impact- No data available

IV. Connection to the Malloy-Wyman Policy Document- CALA reports that eliminating the co-pay removes an unnecessary barrier to cost-effective assisted living services consistent with the policy that

¹³ CALA Recommendations to the Malloy-Wyman Human Services Transition Team

supports expansion of community based care. Ultimately these programs should be expanded when possible and maintained now during these challenging fiscal times.¹⁴

4. Homecare/CT LTC Advisory Council

I. Statement of Issue-CT Association of Homecare and Hospice and the State's LTC Advisory Council urge support for establishing a sound Home and Community Based Services (HCBS) infrastructure.¹⁵

II. Proposed Action-There are Federal Funding opportunities provided by the national healthcare reform legislation thru pursuit of the Community First Choice Option for self directed services, pursuit of the State Balancing Incentives Payments program and by broadening the Money Follows the Person (MFP) eligibility standards.¹⁶ CT should encourage people to plan for their future LTC Needs and educate them about options by partnering with the Federal government to strengthen and promote the CLASS Act. A statewide Single Point of Entry for services- would be of tremendous benefit to those in need of services and will save the State money and improve efficiency. This will breakdown the silos that exist with and amongst state agencies and programs improve co-ordination and avoid redundant expense.¹⁷

III. Fiscal Impact: While the CAHCH recommendations did contain cost savings figures please be advised they utilized Medicare figures and should not be used when trying to identify potential savings in Medicaid. While the LTC Advisory Council did not provide numbers per se they clearly spelled out opportunities for CT to secure additional federal revenues thru several new programs to achieve more HCBS programs to assist States in rebalancing efforts as well as increase consumer choice options.

IV. Connection to Malloy-Wyman Policy Document- both organizations support the Assuring Choices in Healthcare policy

5. Substance Abuse Treatment for Women With Children

I. Statement of Purpose-SCADD, The SE CT Center for Alcohol and Drug Dependence reports there are women in need of treatment that avoid seeking the treatment for risk of losing their children to DCF. Without treatment many of these women will end up in jail and without their children costing the state hundreds of thousands of dollars for incarceration and foster care.

II. Proposed Action-

- SCADD recommends a proposal to develop a residential treatment program for women with children that will allow the women to live there in a secure and safe environment with their children as they seek treatment. This program could be replicated across the State and not limited to just SE CT. It is an alternative to incarceration and appears to be a common sense cost effective model that will reduce incidents of incarceration, need for DCF placement and care for the children and concentrate human service resources at the center to ensure successful

¹⁴ CALA Recommendations to the Malloy-Wyman Human Services Transition Team

¹⁵ CT Home & Hospice Recommendations, CT LTC Advisory Council Recommendations

¹⁶ CT LTC Advisory Council Recommendations

¹⁷ LTC Plan 2010

outcome with treatment. The Human Services Workgroup shared this proposal with Housing and Public Safety Workgroups respectively.

III. Fiscal Impact- Potential significant savings in DOC and DCF expenditures.¹⁸

IV. Connection to Malloy-Wyman Policy Document- is consistent with the goal of providing services in the most cost effective format in the community.

6. Alzheimers

- **I. Statement of Issue-** With the aging of the baby boom generation, the number of Americans age 65 and over with Alzheimer's is expected to explode. Today, 5.3 million Americans aged 65 and over are living with Alzheimer's disease and a new individual is diagnosed with the disease every 70 seconds. By mid-century, that number is expected to reach 13.5 million-and could be as high as 16 million. In Connecticut, there are over 70,000 people aged 65 and older with Alzheimer's and other dementias. Alzheimer's is having a large and quickly growing medical and economic impact, and our healthcare system is not delivering adequate care to many of those with Alzheimer's and their caregivers.¹⁹

II. Proposed Action-

- **Creation of a task force** will bring together an array of stakeholder talent and experience from state agencies, legislators, persons with Alzheimer's, family and professional caregivers, community-based groups, health professional community care providers and an Alzheimer's Association representative. The task force will convene to prepare a comprehensive state strategy to address the needs of persons with Alzheimer's, and provides a mechanism to consider all of these pertinent issues-from primary prevention to end-of-life care.

III. Fiscal Impact- According to the *2010 Alzheimer's disease Facts and Figures* report, nearly one-third of Medicare beneficiaries aged 65 and over with Alzheimer's disease or other dementia are also Medicaid beneficiaries. Furthermore, half of all nursing home residents in the United States have a diagnosis of Alzheimer's disease or other dementia in their medical records, and about half of those rely on Medicaid to help pay for their nursing home care. As a result, Medicaid nursing home costs for people with Alzheimer's disease are substantial.²⁰ No other financial data was supplied. Additionally it is important to note that Congress just enacted Federal legislation on Alzheimer's disease. CT should research opportunities to partner with the Federal initiative.

IV. Jobs Impact- the Connecticut Long Term Care Needs Assessment predicts there will be a demand for over 9,000 jobs in the health care industry over the next five years to serve the growing aging population. Given that the long-term care industry employs more than nearly any other industry, and direct-care jobs are the employment core of this industry and are among the nation's fastest-growing occupations, there is opportunity for job creation.²¹

7. CT LTC Insurance Partnership

¹⁸ SCADD Policy Recommendation Document

¹⁹ Alzheimer's Association of CT recommendations

²⁰ Alzheimer's Association of CT Recommendations

²¹ Alzheimer's Association of CT Recommendations

I. Statement of Issue- Ct is well positioned to examine ways to promote the use of our LTC Insurance Partnership program. Citizens can purchase well vetted LTC insurance plans thru the State's Partnership program and protect their assets and have the funds available to them when needed to direct and cover the cost of care needed. LTC Insurance policies vary widely in the benefits they provide and services covered. Consumers are at a disadvantage in comparing policies. The Partnership does the work for them. Consumers thus avoid the need to "spend down their assets" in order to qualify for Medicaid. Long term care insurance in essence allows people to insure over their risk of needing LTC services at some point in the future. This program has never had an aggressive marketing program budget to promote the benefits of having LTC insurance protection but with the efforts in the Federal HC Reform legislation for new balancing policies discussions should be had with the Partnership to see if any Federal funds exist to promote the Partnership, increase enrollment levels and ultimately reduce Medicaid utilization into the future.

II. Proposed Action-

- Create opportunities to increase utilization of LTC Insurance
- Create an education Plan to educate CT consumers on the benefits of LTC insurance in protecting their assets
- Market and Promote the CT Partnership Program as a consumer resource

III. Fiscal Impact- Increased utilization of LTC insurance will reduce Medicaid expenditures both in short term and if successful to an even greater degree into the future. Research is needed to see if federal funds exist in the rebalancing initiatives in the Federal HC Reform legislation to promote these efforts.

In closing, the demand on human service programs has never been greater. Connecticut can and should do better. We spend billions of dollars on human service programs every year and we must ensure that every dollar being spent achieves the best outcomes. It is not simply a moral imperative anymore - it is an economic one as well.²²

²² Malloy-Wyman Policy document- Supporting CT Seniors

TRANSITION TEAM POLICY RECOMMENDATIONS ON HUMAN SERVICES

Policy Priority – POS Provider Support and Contracting Reform

I. Statement of Issue: Currently the state procures health and human services through Purchase of Service (POS) contracts issued by the Departments of Social Services, Public Health, Children & Families, Corrections, Mental Health & Addiction Services, Developmental Services and the Judicial Branch Court Support Services Division. Nonprofit community-based providers are critical partners with the state in providing high quality, efficient, cost-effective health and human services on the state's behalf at a great savings to taxpayers. Unfortunately the state has allowed private providers to become deeply underfunded by not applying consistent cost-of-living adjustments (COLA) to POS contracts. Currently, the average 20 year COLA on state POS contracts stands at less than 1%, which is far below inflation and the increased cost to provide services.

Another major challenge facing the state's nonprofit community-based providers of human services is the state's POS contracting system. This contracting system is fraught with administrative inefficiencies and duplication that create endless and unnecessary challenges for the very nonprofit community-based providers on which the state relies. The practices listed below fail to engender the kind of partnership both state government and private providers espouse.

The POS contracting inefficiencies and duplication among and within state agencies include, but are not limited to: (1) lack of timely contract execution; (2) lack of timely contract payments; (3) restriction on flexibility to properly fund all aspects of a program (e.g.: sometimes caused by the use of multiple "Special Identification Codes" or SIDs within each agency which does not allow for shifting dollars between SIDs if one area of a program is running a surplus and another area is running a deficit); (4) requiring budget amendments to make slight changes due to the above referenced inflexibility; (5) countless unfunded mandates in the area of data collection and reporting (e.g.: electronic health records, data encryption, etc.); (6) duplication in auditing and client document/facility review by multiple state agencies; (7) redundancy in common forms required for various contracts (e.g.: insurance certification, non-discrimination policies, workforce analysis, etc.); (8) and the use of different reporting systems among state agencies to collect similar data.

II. Proposed Action: (Please note that all fiscal impacts below reference the impact on the state. However, many of these actions will result in significant savings to nonprofit community-based providers and are greatly needed at a time when funding increases are rare.)

1. Prioritize the adequate and appropriate funding of nonprofit community-based providers that hold POS contracts with the state. While funding may not be immediately available to accomplish this, it should nevertheless be a significant, long-term priority of the Administration. **Fiscal Impact: Potential significant cost. OFA currently estimates that a 1% COLA on all POS health and human service contracts to be \$13.3 million.**

2. Create an oversight entity for all state agencies to ensure consistent adherence to state contracting processes. The Office of Policy & Management has been reluctant to compel compliance by state agencies for the practices, procedures and policies that it promulgates. There needs to be a vehicle either within OPM or the Governor's Office to hold state agencies accountable to accepted contracting processes. **Fiscal Impact: Dependent upon utilization of current state employee or hiring of new state employee.**

3. Consolidate the back-office functions of the state's health and human services agencies. Doing so would alleviate some of the silos that exist among state agencies and which pose significant challenges to the private providers that contract or receive funding from multiple agencies and also provide greater uniformity. **Fiscal Impact: Potential significant savings. The Commission on Enhancing Agency Outcomes estimates in its December 2010 report that this would yield a potential annual savings of \$1,396,026 to \$3,908,874.**

4. No state POS contract should be executed less than 15-30 days prior to its implementation date.

Given the state budget deficit and limited opportunity for increased funding, at a minimum state government can assure that no POS contract issued and executed by any state agency is delivered to a provider agency in an untimely fashion. Contracts presented to human service contractors months after the implementation date should no longer be an acceptable practice. The failure of some state agencies to render timely contracts creates disruption and chaos within organizations, requires unnecessary utilization of lines of credit and borrowing, and creates anxiety among Board, management and staff of service provider contractors. **Fiscal Impact: None.**

5. Enforce C.G.S. § 4a-71 – 4a-73, utilize prospective payments and encourage electronic payments/fund transfers. Like untimely contract execution, untimely payments create an enormous burden for nonprofit community-based providers. Such practices require the use of lines of credit and borrowing for which private providers do not see reimbursement from the state. As a result many providers incur interest payments to provide services on behalf of the state because they do not receive state payments in a timely fashion. Should the state enforce its statute to pay interest it could deter many instances of late payments. Additionally, prospective payments (implemented after a one year probationary period for new contractors) would eliminate most timely payment problems. Finally, electronic fund transfers would speed up the payment process. **Fiscal Impact: Depending on adherence to timely payment, interest payments could be slight or significant. Prospective payments would not have a fiscal impact. Greater use of electronic fund transfers is a potential savings to the state by going paperless.**

6. Utilize multi-year contracts and a “13th month” contract period. Multi-year contracts drastically reduce the administrative burden on both the state and private providers. By including an additional month on each contract period (e.g.: 13 months for a one year contract, 25 months for a two year contract, etc.) gives both parties more time for contract renewal. Also, in instances where a contract begins on July 1 and a state budget has not yet been adopted, it helps prevent service disruption or situations where a provider continues service without a contract or payment. Another solution would be to grant state agencies the authority for an expedited short-term contracting mechanism similar to a continuing resolution enacted for state and federal budgetary purposes. **Fiscal Impact: None.**

7. Collapse payment for services into as few “Special Identification Codes” (SIDs) as possible and allow for flexibility to appropriately fund all aspects of a program. Most state agencies use multiple SIDs to help track funding for specific programs. While this is helpful to state agencies for tracking purposes, it allows absolutely no flexibility in funding all necessary program areas. For instance, a provider may be running a surplus in personnel due to a vacant position while also running a deficit in a direct service. Because the funding for these two different program areas fall under separate SIDs, the state agency rarely allows for the shifting of dollars to cover the deficit. The Department of Corrections has collapsed all of their funding into one SID which allows greater flexibility for both the state agency and the private provider, so we know the change is possible. **Fiscal Impact: None.**

8. State agencies should not require budget amendments for slight (up to 5%) variances. The budget amendment process is another administrative drain on both state agencies and private providers. The state needs to work in partnership with and trust its POS contractors. Private providers should be able to make slight adjustments to their budgets to meet program needs and the state should trust them to do so without requiring time-consuming paperwork for each small adjustment. **Fiscal Impact: Savings due to lack of time and paper necessary to process budget amendments.**

9. Properly fund and assist private providers with mandates, such as EHR and data encryption. All healthcare providers will be required by federal law to have Electronic Health Record (EHR) systems by 2014. While this is a federal mandate, it is a significant cost and obstacle to Connecticut’s POS contractors of health and human services. Additionally, the state is now requiring that all protected health information be encrypted, another significant technology cost that is not being funded. At a minimum the state should work to identify “preferred providers” of both EHR and data encryption software. Further, the state should provide financial assistance or incentives where possible, such as utilizing the state’s bulk purchasing power to lessen the cost to providers. **Fiscal Impact: None if only identifying preferred providers; Undetermined if providing some level of financial assistance.**

10. The state should conduct a review of all POS reports and protocols (data reporting) to determine that all information requested is applicable, required, being utilized, and uniformly interpreted within and across all POS agencies. State agencies require large amounts of client, program and financial reporting from private providers. Providers have no objection to providing necessary and relevant information to their contracting agency, especially financial reporting; however, providers do question whether all information currently requested is either necessary or utilized. **Fiscal Impact: Potential significant savings from streamlining to ensure that staff resources are only used to gather and review applicable and necessary information.**

11. State agencies, under the oversight of OPM, should collaboratively develop a single, web-based reporting system that would satisfy the requirements for data reporting by private providers. The client and program reporting discussed above is often duplicated among state agencies, all of which have different reporting systems. This should be streamlined to the best of the state's ability. The Judicial Branch Court Support Services Division has a system that they believe can be used for any health and human services program. **Fiscal Impact: Initially moderate cost with potential long-term savings. Creation of a single, web-based reporting system could result in a moderate cost although some state agencies point to possible existing solutions (e.g.: CSSD reporting system). A single system will result in long-term savings as it can be maintained by one state agency (e.g.: DOIT).**

12. The state should create an online portal or "document vault" where common forms required by all state contracting agencies can be loaded and available for review by state agencies when necessary. The common forms associated with most state contracts (e.g.: insurance certification, non-discrimination polices, workforce analysis, etc.) could be loaded into one online portal where all state agencies could access them as necessary instead of requiring that providers send the documents into agencies multiple times for multiple contracts. The responsibility of ensuring that the state has access to the most recent version of the document would be the responsibility of the private provider. **Fiscal Impact: Potential moderate cost. The state would need to set-up an online portal which would need to be maintained by the state, although responsibility for all posting of document would fall on private providers.**

How does it tie-in to the Malloy/Wyman campaign policy: All of the above policy actions are consistent with the Governor and Lt. Governor-Elects' consistent and public support of nonprofit community-based providers. Both Governor-Elect Malloy and Lt. Governor-Elect Wyman recognize the critical partnership that state has with private providers that provide essential, quality health and human services on the state's behalf in an efficient and cost-effective manner. At a time when the economic climate does not allow for state government to immediately begin to appropriately fund nonprofit community-based providers who are drastically underfunded due to years of insufficient or no COLAs, the POS contracting reform discussed above will cost little to no money for the state to implement, but will drastically reduce costs to providers.

III. Long-term Needs/Vision: The state needs to be a good partner with nonprofit community-based providers. Should private providers cease to exist, the cost for the state to directly provide all health and human services would be inconceivable. While increased and appropriate funding for services is an absolute long-term need of nonprofit community-based providers, by streamlining contracting and ensuring consistent practices across all state agencies, the state will be taking a meaningful step in fostering its partnership with private providers. More over, many of the actions discussed above will result in streamlined government and savings to the state.

IV. Jobs Impact & Other Benefits: By streamlining contracting and reducing some of the administrative and financial burdens placed on providers by the existing fragmented and duplicative state contracting system, nonprofit community-based providers may be able to free up some funding to hire additional staff thereby helping to lessen the state's unemployment rate.

Helping Those Who Help – A Plan for Nonprofit Community Providers

I. Overview – Statement of Issue

Governor-Elect Malloy laid out the issues confronting Nonprofit Community Providers in the policy statement he articulated early in 2010. The Transition Team Human Services Work Group would like to reiterate our continued support for the statements the Governor made earlier this year and highlight new developments.

Nonprofit community-based providers have faced funding shortfalls for the last twenty years, not once matching the Medical CPI.

Many state policies and procedures add to the cost of providing services without enhancing the value of those services.

This fall the Boards of Directors of the Connecticut Community Providers Association and the Connecticut Association of Nonprofits, representing nonprofit community-based providers of health and human services, developed a joint statement on consensus points for health and human services for consideration by the Malloy/ Wyman administration, sent December 6, 2010, that summarizes potential future policy direction.

II. Proposed Action

A. Prioritization Schedule

- Develop strategies to assure the provision of services provided in community-based settings rather than institutions.
- Assure that services focus on individuals served in the community, in a wide array of settings and in the least restrictive and most appropriate environment possible.
- Develop a reliable funding system which recognizes the cost of services and the cost of doing business to be reviewed annually against an external standard.
- Consolidate “back office” functions in a reorganized state government all the while considering the impact on people being served.

- Develop enhanced revenues as an alternative to cuts to health and human services. Such cuts to health and human services are a short-term fix to the budget crisis that will create significantly larger fiscal problems for the state and impact the quality of life for our state's most vulnerable residents.
- Develop revenue maximization strategies as a means to support investment in the nonprofit community-based provider infrastructure
- Utilize the proposed Cabinet level head of a Nonprofit Human Services Cabinet to focus on the health and human services arena in conjunction with nonprofit community-based providers in a coordinated fashion including:
 - Ability to create efficiencies between state agencies.
 - Attention to removing redundancies, unfunded mandates and outdated requirements on nonprofit community-based providers to reduce costs and improve efficiencies.
 - Creative approaches to system reform, service provision and problem-solving
 - Ability to consider the impact of change on the individuals and families served
 - Ability to solicit and integrate stakeholder input in policy decisions

B. Fiscal Impacts

Utilizing the services of nonprofit community-based providers will maximize cost savings and accountability and benefit a greater number of individuals than would be served in institutional settings. Positive net economic benefits are consistently documented, with regard to services related to prevention, treatment and supports across various settings and populations.

In conjunction with the work of the Commission on Nonprofit Health and Human Services, develop a reliable funding system that recognizes the cost of services and the cost of doing business to be reviewed annually against an external standard. With this funding system in place, nonprofit community-based providers will be able to hire the direct care staff necessary to implement these system reforms.

In conjunction with the Commission on Enhancing Agency Outcomes, implement more cost-effective strategies for contracting for and providing health and human services.

Utilizing opportunities to expand federal funding in such areas as the Rehab Option for individuals with behavioral challenges, the 1915(i) waiver for home and community-based services, an expanded DDS waiver and an expanded Money Follows the Person Waiver for individuals with disabilities, including people who are elderly and other people with disabilities will enhance and expand service capacity.

C. Correlation with Malloy/Wyman Campaign Policy

This recommendation builds on the Malloy/ Wyman Campaign Policy that speaks to supporting community providers: “Helping Those Who Help: A Plan for Nonprofit Community Providers.”

III. Long-term Needs/Vision

Assures expansion of services and supports in community-based settings for individuals with a varied disabilities

IV. Jobs Impact & Other Benefits

Expands jobs in nonprofit community-based provider organizations to meet the growing need for services and supports

V. Dissenting Opinions & Other Relevant Items

No dissenting opinions received.

Persons with Disabilities

Autism Pilot

I. Overview – Statement of Issue

Ensure provision of community-based services for individuals with autism

Please see related discussion about the needs of individuals with other disabilities in the Human Services Work Group policy statement: Persons with Disabilities – Cross Disability – Safety Net Support

II. Proposed Action

A. Prioritization Schedule

1. Build upon the work of the proposed Center for Autism and Developmental Disabilities to provide contracts for community-based services at nonprofit community-based service provider organizations, much as the “Acquired Brain Injury Waiver” assures an array of services provided through nonprofit community-based service providers.
2. This allows the proposed Center to serve as a “virtual” Center supporting research, policy development and service delivery models, avoiding the creation of a new institution in Connecticut to meet the needs of children and adults with autism.
3. Utilize the services of existing nonprofit community-based provider agencies including residential treatment and other behavioral health providers to provide enhanced services for individuals with autism through rate adjustment and incentives for providing services as an alternative to contracting for out of state services
4. Seek a federal waiver that will assure the provision of a wide array of community-based, non-institutional services
5. Conduct a rate review for Connecticut’s Early Intervention/Birth to Three System which provides the first level of identification and support for children with autism and related disorders.

B. Fiscal Impacts

- State and federal financing are an offset for the costs LEAs bear for services and the future cost if services are not provided to children and adults soon after diagnosis.

- Enhanced funding for existing residential treatment and other nonprofit community-based providers is an offset to the cost of out of state service that separates children from their families

C. Correlation with Malloy/Wyman Campaign Policy

Builds upon Policy relating to Center for Autism and Developmental Disabilities

III. Long-term Needs/Vision

Assures expansion of services in community-based settings for individuals with autism and developmental disabilities

IV. Jobs Impact & Other Benefits

Expands jobs in the community nonprofit provider organizations to meet the growing need for services and supports

V. Dissenting Opinions & Other Relevant Items

Support: The Advisory Council to the Division of Autism of the Department of Developmental Services has offered its support to the Malloy/Wyman administration as the administration assesses and reviews priorities and sets its agenda.

Dissenting opinion: parents of adult child living at Southbury Training School who suggest that the Center for Autism and Developmental Disabilities should be established on the STS grounds.

Persons with Disabilities

Department of Developmental Services / DDS Services – Waiver Services

I. Overview – Statement of Issue

DDS funding for services is driven by the federal Medicaid Home and Community Based Services (HCBS) Waiver. DDS currently operates under two federal waivers and has applied for a third waiver. This federal waiver program matches state funds expended for qualified services. DDS generates 50% federal reimbursement to the General Fund, the highest available to Connecticut based on federal formulas, for these services.

Currently, DDS receives nearly \$400 million in federal reimbursement. With the introduction of new waiver services there is a potential for an additional \$5.5 million in federal reimbursement funds in the near future.

The legislatively established Advisory Committee for Services under Programs Administered by the Department of Developmental Services (section 57 of PA 09-3) is charged with studying the impact of the proposed shift to attendance-based, fee for service reimbursement for DDS funded programs. The Committee has concluded that the DDS payment system is incompatible with the federal Centers for Medicaid and Medicare (CMS) requirements.

The risks of a failure to act to ensure compliance will result in a loss of millions of dollars in federal reimbursement, increase costs to the state, and jeopardize services to people with disabilities, their families, and the provider network that supports them.

II. Proposed Action

A. Prioritization Schedule

- Adopt uniform rates through a five year transition plan beginning on July 1, 2011 with DDS funded day services and continuing with DDS funded residential services the following year.
- Convene a waiver workgroup with members with subject matter expertise to focus on the key variables identified in the Advisory Committee report.
- Continue the responsibilities of the Advisory Committee to oversee and monitor the conversion. The Advisory Committee would be responsible to

and report regularly to the legislative committees of cognizance.

- Include provisions in the transition plan to increase funding to established rates for providers below those rates.
- Ensure waiver rates are tied to and based on a measurable inflation index.
- Ensure funding appropriations recognize the existing rate disparity. Reallocate funds realized from the naturally occurring reduction in state services to the private sector to increase rates and mitigate the impact on nonprofit community-based providers.
- Invest in the IT infrastructure to create a viable, state of the art management information system that would provide comprehensive data management for the public and private sector.
- Ensure that the implementation of future appropriations takes into account the funding disparities and, wherever possible, mitigates them.
- Convene a public and private workgroup to explore ways to effectively manage data over the next 3-5 years to meet requirements and to maximize federal reimbursement.

B. Fiscal Impacts

The existing DDS payment system is incompatible with the federal Centers for Medicaid and Medicare (CMS) requirements for the Home and Community Based Waiver Services. Waiver regulations require that states have:

- a) uniform rate setting methodology for service models;
- b) that states pay only for services actually delivered; and
- c) that states afford service recipients freedom of choice between service providers in order for the state to qualify for federal reimbursement.

Connecticut’s existing payment system does not meet any of these three criteria and places the state at risk of federal recoupment of funds and/or loss of future reimbursement.

C. Correlation with Malloy/Wyman Campaign Policy

The Malloy/ Wyman policy on Health Care makes a commitment to “properly fund privately-operated (non-profit) group homes and day program to maintain and improve care services and job standards. These services have been severely underfunded for years, leading to high staff turnover rates.”

We recommend that the Malloy/ Wyman administration expand on that commitment and create a broader policy that supports financing strategies for community-based services for individuals with developmental and intellectual disabilities.

III. Long-term Needs/Vision

Following through on the recommendations of the Advisory Committee will ensure that services for individuals with developmental and intellectual challenges will remain a cornerstone of safety net services in Connecticut.

IV. Jobs Impact & Other Benefits

These recommendations will require a community-based direct care workforce with reimbursement linked to the cost of providing the services based on the level of need of the individuals served and tied to established indices (such as the CPI).

V. Dissenting Opinions & Other Relevant Items

Supports the work of the legislatively authorized Advisory Committee for Services under Programs Administered by the Department of Developmental Services (section 57 of PA 09-3). Comments are extracted from draft Executive Summary (12/14/10 draft) to be presented to the full Committee 1/11/11.

Dissenting opinion: The Transition Team Human Services Workgroup received recommendations from a parent and several state employees recommending that Southbury Training School remain open. The Human Services Workgroup did not support this position and instead recommends the above focus on strengthening the community-based system.

It is important to note that nonprofit community-based provider organizations are very well equipped to provide the same level of services for the most medically fragile and/or behaviorally challenging individuals as those provided by state-run programs.

Persons with Disabilities

Department of Developmental Services / DDS Services – Community-Based Services

I. Overview – Statement of Issue

Nonprofit community-based providers operate services for over 13,000 individuals within the DDS system providing comprehensive residential, employment and life support services.

We recommend that the Malloy/ Wyman administration ensure that the safety net remains in place for Connecticut’s most vulnerable residents. It is critical for the administration to support an array of programs that provide both vocational and residential and related support services in the least restrictive, most appropriate settings possible.

II. Proposed Action

A. Prioritization Schedule

1. Review satisfaction with conversion of group homes

In 2009, DDS converted 17 publicly operated group homes to private sector operation in response to the Retirement Incentive plan.

This marked the second time in recent years that a conversion plan had been implemented within the DDS. The Department successfully converted 30 group homes to the private sector after the Early Retirement Incentive Plan and layoffs were implemented in 2003.

In November 2010, DDS released the results of the “Conversion 2004 Survey” to summarize the satisfaction of families and consumers relating to the conversion process. The results of this and subsequent surveys should be used to inform future plans to convert services to the private sector.

2. Analyze the comparative costs of public vs private sector service delivery.

B. Fiscal Impacts

Existing data demonstrate that community-based services and supports provided by nonprofit community-based providers cost less than the cost for the state to provide the same services for individuals with comparable needs.

C. Correlation with Malloy/Wyman Campaign Policy

We recommend that the Malloy/ Wyman administration develop a policy that supports expanding community-based services for individuals with developmental and intellectual disabilities using the services of nonprofit community-based providers.

III. Long-term Needs/Vision

Nonprofit community-based providers are partners with the state in serving individuals with disabilities and significant challenges. It is incumbent on the state to develop a long-term plan for addressing the needs of these Connecticut residents.

The Commission on Nonprofit Health and Human Services established under SA 10-5 will be issuing its first report January 1, 2011. This and the final report due April 1, 2011 will provide a detailed analysis of costs to provide services and make recommendations for cost savings.

A key report (12/13/10) from the workgroup on Cost Comparisons – Private and State Services concluded that “For many occupations, both the state and the private sector pay wages determined in the labor market. However, for some positions there is evidence of a disparity between the wages paid by the state sector vs. those paid by the private nonprofit sector. This disparity seems greatest among some positions that provide direct care and services to clients in the DDS, DMHAS, and DCF systems.”

In looking at the entry level direct care positions, the work group determined that “The payscale for the state position Mental Health Assistant 1 (MHA1) is \$21.35 to \$28.75 while for Developmental Services Worker 1 (DSW1) is \$19.44 to \$26.35. These rates are significantly higher than comparable positions in the private non-profit sector.”

The full Commission adopted its preliminary recommendations relating to Contracting and Auditing, Reporting and Data, State Licensing and Quality Assurance and Adoption of Best Practices at its December 14, 2010 meeting. The work group on Achieving Administrative Efficiencies issued a more detailed and expansive report outlining further steps the state could take to decrease state mandated workload requirements and administrative burdens to nonprofit providers on December 10, 2010.

The other two Commission work groups have issued draft reports summarizing progress to date as well.

All reports and backup materials are located on the OPM website:
<http://www.ct.gov/opm/cwp/view.asp?a=3961&q=465440>

IV. Jobs Impact & Other Benefits

Nonprofit community-based providers contract with the state for over \$1.4 B in Purchase of Service contracts for the provision of human services and participate with DSS through fee for service Medicaid billing and managed services for individuals with behavioral health disorders through the Behavioral Health Partnership.

Approximately 80% of Purchase of Service contracts correlate to wages and benefits.

V. Dissenting Opinions & Other Relevant Items

Dissenting opinions: The Transition Team Human Services Workgroup received recommendations from a parent and several state employees recommending that Southbury Training School remain open. The Human Services Workgroup did not support this position and instead recommends the above focus on strengthening the community-based system.

It is important to note that nonprofit community-based provider organizations are very well equipped to provide the same level of services for the most medically fragile and/or behaviorally challenging individuals as those provided by state-run programs.

Persons with Disabilities

Community Behavioral Health Services for Children, Youth and Adults

I. Overview – Statement of Issue

There are thousands of adults and children with mental illnesses, addictions and behavioral health disorders, as well as their families in Connecticut.

A strong advocacy community that includes primary consumers, advocates, family members and service providers has come to consensus on key policies for consideration by the Malloy/ Wyman administration.

II. Proposed Action

A. Prioritization Schedule

Preserve vital community behavioral health services while generating federal revenue, shifting funds from costly criminal justice, nursing home and crisis services to more cost-effective community-based options.

Maintain the integrity of mental health and substance abuse services in subject matter agencies rather than consolidating agencies such as DMHAS or DCF with other state agencies beyond the “back-office” functions identified by the Commission on Enhancing Agency Outcomes. Behavioral health services are specialized; requiring unique expertise and clinical sensitivity.

Protect access to Medicaid coverage. Over 400,000 children, youth, and adults rely on Medicaid coverage in Connecticut. Without this coverage, many people with mental health conditions cannot afford their medications, outpatient treatment, or even regular check-ups. When their health deteriorates, they require more intensive and expensive services.

B. Fiscal Impacts

The state can save money and preserve vital behavioral health services by maximizing federal reimbursement including a state plan amendment under 1915(i) to allow the state to bill for Community Support Program (CSP), Assertive Community Treatment (ACT), Peer Support, Supported Employment, Recovery Assistant, Short Term Crisis Stabilization, and Transitional Case Management, among other potential services.

The state can maximize federal revenue by billing Medicaid, to the fullest extent allowed, for outpatient services provided by DMHAS state operated providers and allow for direct billing of Medicaid by nonprofit community-based providers.

C. Correlation with Malloy/Wyman Campaign Policy

The Malloy/ Wyman policy statement on Health Care provides a detailed proposal for “Mental Health and Health Care,” making recommendations on ways for Connecticut to “invest smartly, save money and save lives.” The report goes on to recommend making mental health a priority.

We recommend that the Malloy/ Wyman administration ensure that the safety net is in place for Connecticut’s most vulnerable residents with a focus on the multiple populations involved and the myriad of services and supports these individuals need.

We recommend the development of a Policy on Health and Human Services for People with Disabilities to encompass the needs of the large and varied number of Connecticut residents in need of supports and services.

III. Long-term Needs/Vision

Assuring the provision of services for individuals with behavioral health challenges will be a continuing obligation of the state. Consumers, advocates, families and providers are all seeking input into current and future service delivery design.

IV. Jobs Impact & Other Benefits

Most supports for individuals with behavioral health challenges are provided by a direct care workforce.

In conjunction with the work of the Commission on Nonprofit Health and Human Services, develop a reliable funding system that recognizes the cost of services and the cost of doing business to be reviewed annually against an external standard. With this funding system in place, nonprofit community-based providers will be able to hire the direct care staff necessary to implement these system reforms.

Utilizing the services of nonprofit community-based providers will maximize cost savings and accountability and benefit a greater number of individuals than would be served in institutional settings.

V. Dissenting Opinions & Other Relevant Items

Information on Fiscal Impact comes in part from recommendations made by Bill Cibes to the Commission on Enhancing Agency Outcomes, “Final Report to the Commission,” dated 11/26/10.

Persons With Disabilities

Supporting Connecticut's Residents with Disabilities

Overview

There is a severe lack of community support services for persons with disabilities, including individuals with autism, mental health disabilities, brain injuries, and physical disabilities all along the continuum of care. Long waiting lists exist for the home and community based services under Medicaid, including the Acquired Brain Injury (ABI) Waiver, Personal Care Assistance (PCA) Waiver, two Developmental Disabilities Services (DDS) Waivers, and the Katie Beckett Waiver. Eligibility requirements based on an individual's label exclude many individuals needing access to home and community based services whose condition doesn't fit into one of the existing waivers; these are the people who fall between the cracks. Accompanying this lack of access is a shortage of a workforce to support people who wish to remain – or return – to community living. Further, there remains a struggle for individuals with disabilities in navigating the government bureaucracy to access what benefits that exist.

Of great importance, many individuals with disabilities, including brain injury, physical disabilities, autism, and mental disabilities, are unnecessarily institutionalized in state's nursing facilities, which are unable to meet their needs, particularly those with behavioral challenges. Indeed, nursing facilities are often not the most appropriate and preferred settings appropriate to their needs. Finally, there is a severe lack of accessible, affordable housing and transportation for persons with disabilities all across the state of Connecticut.

Policy Goals

- Support policies and practices that enable individuals with disabilities and older adults to remain in their own homes, and enable them to return home if they become hospitalized or institutionalized.
- Maximize individual choice and self-direction covering individuals throughout their lifespan.
- Base systems of community support on functional need rather than disability label or age
- Reduce reliance on more costly institutional care
- Ensure adequate service capacity within the community support system

Proposed Action

Specific recommendations (little or no additional costs to the State) include:

1. Designate an individual in the Governor's office to be a disability liaison; this person would be responsible for promoting and monitoring the policies and practices noted in the Policy Goals Statement above, seek inclusion of individuals with disabilities in state affirmative action plans, and be responsible for state compliance with the Americans with Disabilities Act (such a person is required by law).
2. Design a state structure for long-term care that integrates the delivery of services and supports, maximizes federal funding, achieves greater efficiency within state government, and is consistent with national Best Practices. As a part of this recommendation, we ask for the reform of the state Medicaid home and community-based services (HCBS) waiver system and other state-funded and state-administered HCBS programs and pilots by simplifying these waivers and programs/pilots to provide comprehensive supports based on a person's functional need rather than disability label or age.

There are currently layers of bureaucracy operating several different waiver programs, each with different eligibility criteria and a different array of services. In almost all of the existing waivers, a significant waitlist causes individuals to wait years to access services. A single point of entry into the system will streamline the process of accessing home and community based services while lowering administrative costs. In addition, a 1915(i) State Plan Amendment for home and community based services, a new opportunity available to the state under the Affordable Care Act, would eliminate waitlists and save money by preventing costly inpatient stays. There are currently several programs, funded 100% with state dollars, that could be covered under a State Plan Amendment. By including current state-funded services that receive no match the state will have access to previously unavailable federal funds.

3. Support full implementation of MFP (Money Follows the Person) demonstration project, which would result in a rebalancing of the long-term care system (i.e., money spent on home and community based services vs. money spent on institutional settings), the elimination of unnecessary hospital referrals to skilled nursing facilities, and the return to home of individuals currently in institutions, including skilled nursing facilities, DDS institutions, and mental health facilities. *Currently, 48% of individuals receiving long-term care under Medicaid in Connecticut reside in institutions, at a cost of \$1.6 billion (out of \$2.5 billion total Medicaid expenditures) per year. In addition CT is one of 24 states that spends less than 25% of its long term care dollars to support people living in the community (in other words, CT spends over 75% of its long term care dollars on institutional placements).*

Currently more than half of those participating in Money Follows The Person are individuals with disabilities, not exclusively seniors; the existing transitions policy document only refers to seniors. This should be corrected. Also, one drawback with MFP is that individuals must be institutionalized for three months before becoming eligible, thus forcing individuals into institutional care in order to access community care.

4. Maximize the opportunities provided by the Affordable Care Act to provide new options to expand community living support and utilize the legislatively mandated Long-Term Care Advisory Council as advisors in this process. The 1915(i) State Plan Amendment is one such opportunity. *The legislation extends the MFP program until 2016, includes a Community First choice option that provides for an enhanced federal match, creates a Balancing Incentives Payment Program (BIPP) that expands community living options without using a waiver (also with an enhanced federal match), and provides funding to create Aging and Disability Resource Centers that will provide information and assistance to those needing long-term care supports in the home.*

5. Promote the further development of a community-based workforce, including personal care assistants (PCAs), personal managers, and independent living facilitators, and engage the Workforce Investment Boards in the initiative (a work group of the MFP program is already working on this item, and the Governor's support would mean a lot).

6. Increase the availability of readily accessible and affordable transportation, with additional support for Dial-A-Ride services (already in Mr. Malloy's Policy document); support a proposal before the CT Department of Transportation to expand the number of wheelchair accessible taxis in the State (no cost to the State); use federal New Freedom Initiative funds to provide vouchers for individuals who use the new taxis. Transportation options are in need of being increased particularly in rural areas of the State.

7. Increase the availability of accessible and affordable housing for individuals with disabilities and their families, as well as older adults; provide more units of supportive housing for individuals with psychiatric disabilities and other disabilities that combines permanent, affordable and independent rental housing with available support and employment services (already in Policy document); support efforts currently underway to promote the construction of "visitable" housing, in which there is one ground level entrance, wide hallways, and one bathroom that is large enough for a wheelchair user to enter, use the facility, and exit the bathroom (no cost to the State).

8. Preserve access to medications for those who are on Medicare, Medicaid or ConnPACE by eliminating prior authorization, restrictive formularies, and co-payments that have proven to create barriers to treatment. *This need is most urgent need for people with disabilities such as mental illness, epilepsy, multiple sclerosis, and similar conditions for whom the consequences of medication disruptions can be dire.*

9. Maintain toll-free help-lines connecting persons with disabilities with resources and supports as part of Connecticut's safety net. These services are primarily contracted to nonprofit organizations and would require much greater expenditure of state funds to hire specialty trained experts to replicate these services.

Revenue Stream or Source

The adoption of a 1915(i) Medicaid Plan Amendment would provide a federal match for services currently provided with 100% state funds. It would also provide an enhanced match for providing certain community based services. There is also some dividend and cost avoidance to the State by serving persons with disabilities in less restrictive community based settings.

Fiscal Impact

The adoption of a 1915(i) plan amendment, or the expansion of Medicaid Waivers, will require investment of State funds to meet requirements for accessing greater federal funding. If programs that are currently funded 100% by state dollars are included in the Plan Amendment, additional federal revenue will be brought in to help offset increased funding. Accessing of additional federal reimbursement will in the long term save state funds by replacing more restrictive and costly inpatient services with community support services.

Jobs Impact

Greater numbers of individuals receiving funding and services in the community will require the creation of new jobs (e.g., personal care assistants, home health aides, personal managers, independent living facilitators, etc.)

Correlation with Malloy/Wyman Campaign Policy

- The policy framework for the Center on Autism & DD is a starting point, but appears to only target autism, and only children. It should not be limited to any one disability, and should also address the needs of children with other disabilities, such as brain injuries and mental health conditions. All children should be provided appropriate services.
- The policy statement dealing with Money Follows the Person in the Seniors section needs to be modified to include individuals with disabilities, as over half of those it currently serves are younger individuals with disabilities. It should be noted that an unintended consequence of MFP for those eligible for the ABI Waiver and other waivers that are wait-listed is that MFP participants don't have to deal with the

waitlist and so those who are currently being cared for by family at home are penalized by not being currently institutionalized.

- *“As Governor, my guiding principle will be ensuring choice for our seniors regardless of where they fall on the continuum of care. What does that mean? It means investing in services and reforms that allow every senior who needs care more options in terms of where and how that care is administered.”*

We agree with this statement. However, it should ensure choice for seniors **and** individuals with disabilities.

- All applicable comments on services and supports that references elders should be modified to include people with disabilities.

Dissenting Opinions & Other Relevant Items

Members of the disability community and their representatives strongly voiced their concern that the Policy Document section on “Center on Autism and Developmental Disabilities” does not include adults with autism, and fails to address entire sections of the disability population that need similar services and supports.

In addition, they have expressed their desire to have all plans or policy papers - whether discussing children, families, seniors or individuals with autism or other disabilities – address transportation, housing or jobs be expanded and inclusive of all individuals with disabilities.

Persons with Disabilities

Cross Disability - Safety Net Support

I. Overview – Statement of Issue

The community support system should maximize individual choice and self-direction and cover individuals throughout the lifespan. It should be based on functional need rather than disability label or age, should reduce reliance on costly institutional care, and should ensure adequate service capacity within the community support system.

Ensure provision of community-based services for individuals with disabilities. Due to the size of their budgets, much attention in state government is focused on services provided by or contracted with DDS, DMHAS and DCF for individuals with developmental and intellectual challenges, mental illness, addictions and other behavioral health disorders and children and families.

The Malloy/ Wyman Campaign Policy on a Center for Autism and Developmental Disabilities highlights the needs of one of the many constituencies in need of direct attention from the administration, however there are many other groups in need of attention and focus.

II. Proposed Action

A. Prioritization Schedule

- Convene a conference of disability advocates including primary consumers, family members, service providers and Centers for Independent Living, charged with portraying to the Malloy/ Wyman administration the scope of disability needs in Connecticut that include affordable housing, accessible transportation, employment, clinical and social services.
- Develop a work plan for focusing on these cross-disability needs as well as the specialized needs of such populations such as individuals with acquired brain injury, people with multiple sclerosis, individuals who are blind or who have hearing disorders, people with HIV/AIDS, Alzheimer's and other disabilities.
- Support a "virtual" Center on disabilities supporting research, policy development and service delivery models, avoiding the creation of new institutions in Connecticut to meet the needs of children and adults with

disabilities.

- Provide contracts for community-based services at nonprofit community-based provider organizations, much as the “Acquired Brain Injury Waiver” assures an array of services provided through nonprofit community-based service providers.
- Utilize the services of existing nonprofit community-based provider agencies to provide enhanced services for individuals with disabilities.
- Develop strategies to limit the use of and reduce the cost of institutional care.

B. Fiscal Impacts

Explore federal waivers, Money Follows the Person (for eligible individuals of all ages) and other opportunities that will assure the provision of a wide array of community-based, non-institutional services for a large and varied population.

Utilizing the services of nonprofit community-based providers will maximize cost savings and accountability and benefit a greater number of individuals than would be served in institutional settings.

In conjunction with the work of the Commission on Nonprofit Health and Human Services, develop a reliable funding system that recognizes the cost of services and the cost of doing business to be reviewed annually against an external standard. With this funding system in place, nonprofit community-based providers will be able to hire the direct care staff necessary to implement these system reforms.

C. Correlation with Malloy/Wyman Campaign Policy

We recommend that the Malloy/ Wyman administration ensure that the safety net is in place for Connecticut’s most vulnerable residents with a focus on the multiple populations involved and the myriad of services and supports these individuals need.

We recommend the development of a Policy on Health and Human Services for People with Disabilities to encompass the needs of the large and varied number of Connecticut residents in need of supports and services.

III. Long-term Needs/Vision

Assures expansion of services and supports in community-based settings for individuals with disabilities

IV. Jobs Impact & Other Benefits

Expands jobs in the nonprofit community-based provider organizations to meet the growing need for services and supports

V. Dissenting Opinions & Other Relevant Items

Dissenting opinion: CCM recommends “creating and maintaining a registry of all community residences.” The Transition Team Human Services Work Group does not agree with this recommendation noting that it is a disincentive to community-based supports and services. Such a list, available to the public under FOI, would limit, challenge and serve to restrict the rights of people with disabilities to live in the community.

Workforce/Jobs

Direct Care Workforce

I. Overview – Statement of Issue

Connecticut residents, especially older adults and those with disabilities will at some point need the assistance of the direct care workforce. It's projected that by 2030 the elder population will increase nearly 70%, while the pool of direct care workers will decrease by 10%. In order to better support Connecticut residents as they live independently, we need to build and expand a direct care workforce that is respected, skilled and has a career ladder.

The American Network of Community Options and Resources (ANCOR) has made support for Direct Care Professionals a key public policy agenda item and has had legislation introduced at the federal level to assure the viability of the workforce.

II. Proposed Action

A. Prioritization Schedule

- Develop forums for current direct care workers and employers of direct care workers to network and share information, resources, strategies, and trainings
- Develop a strategy for recruiting new direct care workers and for improving the image of the workforce
- Work with aging and disability nonprofit agencies to improve the professionalism of the workforce by developing a career ladder and professional development opportunities
- Identify national and local workforce best practices, systems and funding in order to promote and develop an engaged workforce

B. Fiscal Impacts

No new funds would be needed but coordination among state and federal funding streams is recommended. Currently, there are agencies (CT-State Independent Living Council, CT Community Care, Inc., Money Follows the Person and Senior Resources Agency on Aging) working on parts of the above goals.

This proposal places additional requirements on community-based agencies under contract with the state that may be subject to contract negotiation.

C. Correlation with Malloy/Wyman Campaign Policy

“Dan Malloy on Jobs” discusses the importance of “Focus on Workforce Development and Education” including the importance of developing comprehensive strategies for enhancing education at all levels and “improving links between workforce training and our key competitive industries” and retooling career ladders.

This proposal supports jobs in Connecticut.

III. Long-term Needs/Vision

- increased career options for current direct care workforce
- improved direct care service delivery

IV. Jobs Impact & Other Benefits

- An expanded workforce and better supported workforce

V. Dissenting Opinions & Other Relevant Items

This statement was extracted from information provided by CT State Independent Living Council.

See materials relating to national efforts to support Direct Support Professionals at ANCOR.org or <http://www.youneedtoknowme.org/>

Workforce/Jobs

Internship Program to Support the Workforce for Community-Based Nurses

I. Overview – Statement of Issue

Community-based services rely heavily on well trained nurses. In many settings agencies rely on only one or several nurses, as opposed to a congregate care setting with many nurses on the staff.

New and recent nursing graduates need experience in community-based settings. Their lack of experience limits their ability to find jobs, yet there are jobs available that go unfilled due to the reluctance of nonprofit community-based providers to hire an inexperienced workforce.

II. Proposed Action

A. Prioritization Schedule

- Develop an internship program for nursing school graduates that will provide them with community-based experience in order to be hired into community-based nursing jobs.
- Provide incentives for community-based agencies to host the internship programs.

B. Fiscal Impacts

Community-based agencies would reduce turnover in nursing hires reducing the allover cost of care.

C. Correlation with Malloy/Wyman Campaign Policy

“Dan Malloy on Jobs” discusses the importance of “Focus on Workforce Development and Education” including the importance of developing comprehensive strategies for enhancing education at all levels and “improving links between workforce training and our key competitive industries” and retooling career ladders.

This recommendation would meet the dual goals of assuring that nursing graduates are hired within the nursing field and that these hires would have sufficient experience to work in community-based settings.

III. Long-term Needs/Vision

Community-based agencies would benefit from having access to an experienced, well trained nursing workforce.

Nurses would benefit from having access to employment in varied locations.

IV. Jobs Impact & Other Benefits

Many more graduates would be employed and remain in the state instead of going elsewhere looking for work in their field.

V. Dissenting Opinions & Other Relevant Items

No dissenting opinions.

Philanthropic Giving & Volunteerism

Overview

It is acknowledged that Connecticut State Government cannot provide all the funding resources to support the nonprofit community which performs services and activities that relieves responsibility that might otherwise fall to federal, state, or local government. On the other hand, philanthropic giving from foundations, corporations and individuals cannot alone replace state funding. The government which provides an indirect subsidy to nonprofit organizations through granting tax exemption receives a direct benefit in return. Nonprofit organizations benefit our communities and society as a whole by providing valuable services – a public good.

The Executive Branch can embrace nonprofit organizations as a partner in developing solutions to intractable problems and ensure that its policies, regulations, and practices embody and reflect a genuine partnership approach. Foundations and private philanthropy have a history of partnering with state government to tackle tough challenges. The new administration can help promote philanthropic giving and volunteerism by Connecticut citizens throughout the year.

According to the December 2, 2010 Chronicle of Philanthropy, donations from wealthy Americans dropped by nearly 35% from 2007 to 2009 as recorded in a study by Bank of America Merrill Lynch and the Center on Philanthropy at Indiana University. The study is available at <http://mediaroom.bankofamerica.com> under the press releases section. Overall nationally, philanthropic giving has been hit hard by the weak economy. Donations in the U.S. fell 3.6% to \$303.75 billion last year, down from \$315 billion in 2008, according to Giving USA. In 2008, they were down 2%, Giving USA Foundation.

From the Connecticut Council of Philanthropy, Connecticut citizens while generous can do a lot better:

State ranking

- #1** in average household income (CT \$82,611 – US \$56,996)
- #3** in rate of top wealth holders (number of millionaires per 1,000 people) (2006)
- #2** per capita income (CT \$44,346 – US \$28,838)
- #3** in % of returns with itemized deductions (44.2%)
- #29** in average contribution (CT \$4,089 – US \$4,343) – down from #16
- #29** in average contribution for those with income greater than \$200,000 (CT \$16,538 – US \$17,680) – down from #17
- #35** in amount contributed as a percent of Adjusted Gross Income – down from #33

Policy Goals

- Use government as a catalyst to maximize the partnership between government and the private sector including business and nonprofit sectors
- Help promote greater philanthropic resources and civic engagement
- Infuse the new administration with a spirit of social innovation and the practice of a public-private partnership
- Mobilize citizens, nonprofit organizations, business and government to work more effectively together to solve specific community needs

Proposed Action

- Development of a policy statement encouraging a robust public-private partnership at all levels of state government and require each Commissioner to develop an action plan to effect this partnership.
- Issuance of an Executive Order convening a short term task force to explore how government can assist in helping to promote and expand greater philanthropic giving and volunteerism. The Task Force could consist of philanthropic & other nonprofit, business, and government leaders. One of the recommendations could be the development of a philanthropic calendar where at key times during the course of the year the Governor would promulgate statements or public pronouncements about the value of supporting charitable organizations.
- Designate an individual within the Governor's office to oversee State and community outreach efforts to philanthropy and nonprofit organizations.
- At certain times of the year, the Governor may issue declarations or undertake initiatives to remind Connecticut citizens of the contributions that nonprofit organizations and philanthropy make to the well-being of our citizens and State overall. Connecticut despite maintaining the highest per capita income in the nation still can improve on its 27th ranking in terms of per capita giving.
- Explore reinstating the Annual Governor's Conference on Volunteerism

Fiscal Impact

The designation of an Executive Office staff person who will help marshal private resources to complement public resources and initiatives. Otherwise, minimal fiscal impact.

Potential Benefits

Acquisition of greater civic participation and private resources to assist government in accomplishing its goals.

Jobs Impact

A dynamic partnership between state government and the private business and philanthropic sectors will attract businesses and tourists to Connecticut. Additional private resources directed towards complementing and in partnership with state strategic initiatives will generate jobs. The number projected is hard to measure.

Supportive Housing

Overview

Supportive Housing is permanent, affordable housing with available case management, support services and employment services. It has a proven track record of being an effective means of reintegrating families and individuals with mental illness, chemical dependency, or chronic health challenges into the community by addressing their basic needs for housing and on-going support. Supportive housing is an integral resource to helping people remain self-sufficient and independent thus saving the state and society higher costs resulting from institutional settings and affording people dignity and self-worth.. Supportive housing is a solution to chronic long-term homelessness.

In Connecticut, there are currently 4,400 units of supportive housing located in over 80 towns. The need for such housing far exceeds the supply.

Policy Goals

There exists a plan to create a total of 10,000 new units of supportive housing in Connecticut by 2014 through the Reaching Home Campaign, a coalition of funders, housing developers & experts, and community service providers. The Housing Trust Fund was established to provide funding through bonding funds via the Department of Economic & Community Development. This investment needs to be sustained and enhanced.

- Safe and secure rental housing with support provided by trained staff that specialize in working with people who are homeless and people with disabilities
- Create further alternatives to institutionalization through the development of community based services & housing

Proposed Action

- Continue the implementation and progress towards creation of 10,000 units through strategic investments from bond funds and appropriations for the service component. As well, develop new funding partners.
- Protect existing siting access to local communities and expand where it fits with the state's overall strategic housing and recovery goals.
- Any reorganization of economic development infrastructure within state government needs to make housing an essential component and to exalt its importance to the short and long term growth and prosperity of the state

Fiscal Impact

There is a direct correlation between the access to safe, affordable housing and recidivism to our criminal justice system and to success in recovery from mental illness and chemical dependence. There is a cost avoidance of persons returning to institutional care. The necessary upfront investment will reap long term savings. The service aspect of supportive housing for case management, employment and other support services does require an additional appropriations.

Correlation with Malloy/Wyman Campaign Policy

There has been outspoken support for affordable housing from the outset. Supportive housing was also discussed extensively during the Campaign and in the Housing Policy Paper.

Jobs Impact & Other Benefits

Housing development will create and yield construction jobs. Supportive housing has accompanying services which will create contracted positions.

Dissenting Opinions & Other Relevant Items

There are no dissenting opinions

The Departments of Mental Health & Addiction Services and Children & Families currently sponsor and fund the service portion of Supportive Housing. The Department of Economic & Community Development provides funding for capital aspect.

Both the Transition Team Work Groups on Housing and Public Safety are addressing this issue.

The Partnership For Strong Communities contributed to this document

HOUSING

RE-TOOLING CONNECTICUT'S HOMELESS ASSISTANCE SYSTEM

I. Statement of the Issue

Despite our best efforts, homelessness in Connecticut is not decreasing, and indeed has reached alarming levels in recent months. Last year, Connecticut's emergency shelters alone served over eight thousand (8011) adult individuals, and well over a thousand (1076) families, including 1277 adults and 1535 children. Shelters for families and individuals are operating above capacity, and scores of people are turned away from shelter every day for lack of space.

The State of Connecticut and local governments feel the impacts of homelessness and housing instability directly in their budgets, by paying for increasingly expensive costs that could have been avoided: Medicaid, behavioral health, and uncompensated care funding for inpatient and acute health services; foster care placements; disruptions in education and school transportation for homeless children; recidivism through jails and courts; and subsidies for shelters and specialized homeless services. Unless interrupted, the multi-generational cycle of housing instability continues to take its toll in human and financial terms, as homeless children become homeless adults.

Permanent, affordable housing and supportive housing are essential elements to addressing homelessness. But equally critical is how we respond to housing crisis - increasing the attention and effort we spend on preventing the loss of housing and on moving people quickly out of shelter and into permanent housing.

Currently, the Department of Social Services spends close to \$12 million on emergency shelter and transitional living programs for homeless individuals and families, including victims of domestic violence.²³ Along with funds from HUD and philanthropy, these DSS contracts help support a network of 44 emergency shelter programs and 18 transitional living programs. The Department of Mental Health and Addiction Services spends an additional \$5.6 million on homeless outreach and behavioral health services to persons in shelters. The Department of Education supports liaisons in all of Connecticut's school districts to act as ombudsmen on behalf of homeless children and assure that their education needs are met.

While all of these funds pay for essential crisis services, they can be better aligned, coordinated and prioritized to push the focus of the homelessness assistance system toward greater housing centered solutions. This "retooling" of the homeless assistance system is not expected to require new dollars in the biennium budget - but it will require leadership.

The Governor and the Commissioner of the Department of Social Services, working with other members of the Governor's human services and housing cabinet, should work quickly to develop a common framework and a set of policies and incentives that will spur change at the local level. The five core elements of this framework, described in more detail below, are

1. Focus on housing-centered solutions
2. Align around common outcomes
3. Refine target

²³ A portion of DSS funding for Domestic Violence services also supports crisis hotlines.

4. Incentivize community partnerships
5. Build capacity to retool at the local level

Recent actions at the federal level, including passage of the HEARTH Act²⁴ and the issuance of the Federal Strategic Plan to Prevent and End Homelessness, provide policy guidance and changes in homeless assistance programs that the State can use to its advantage. Under HEARTH, programs and services funded by HUD will re-align to support proven approaches to reducing the incidence of homelessness, shelter usage, and the length of homeless episodes. The Connecticut Coalition to End Homelessness (CCEH) stands ready to assist and support the work of the State with information and data on effective housing-centered practices and systems reforms employed within Connecticut and in other states and advanced by HUD.

The Malloy/Wyman Campaign made clear that creation of affordable housing will be an immediate focus of state government. With the commitment of the Malloy Administration to lead a re-alignment of our homeless assistance system toward greater housing opportunity, Connecticut will make major strides in eliminating homelessness.

II. Proposed Actions

The Governor and the Commissioner of the Department of Social Services, working with other members of the Governor's human services and housing cabinet, should work quickly to develop a common framework and a set of policies and incentives to transform homeless services to a crisis response system focused on the prevention of homelessness and rapidly returning people who experience homelessness to stable housing. This includes the following:

1. **Focus the homelessness assistance system on housing centered solutions.** Re-orient the primary focus of State-funded homeless assistance programs from managing the homelessness problem to solving it. This will require a heightened priority on helping people secure and keep housing, and working across State agencies to link shelter, prevention, rapid re-housing, and outreach programs with each other and with housing resources.
2. **Align the system around common outcomes.** Require all State-funded homeless assistance programs to assess progress toward a set of common outcomes that are aligned with those in the Federal HEARTH Act: reduced incidence of homelessness, reduced length of homeless episodes to under 30 days on average, and reduced recidivism back to homelessness.

Homeless assistance programs that would be affected include:

- emergency shelters
- transitional living programs for homeless people and victims of domestic violence
- homeless outreach programs
- Beyond Shelter CT and Housing First for Families programs (designed to re-house persons entering shelter and provide housing stabilization supports)
- The McKinney Vento funded education of homeless children program administered by State Department of Education
- The Homeless Youth Project administered by the Department of Children and Families

²⁴ The Federal HEARTH Act (Homeless Emergency and Rapid Transition to Housing), passed in 2009, will require organizations and jurisdictions – including the State of Connecticut – who receive funding through the McKinney-Vento Act to reach performance outcomes that require major transformation from the current shelter based system of crisis intervention to a housing based system.

Identify State incentives or rewards to communities that make progress toward these outcome measures, so that they can use these funds to further support the successful implementation of housing-centered emergency response systems.

3. **Hone program targeting.** Develop objective criteria to help target:
 - prevention services to individuals and families at greatest risk of homelessness;
 - appropriate rapid re-housing supports to persons entering shelter; and
 - permanent supportive housing to individuals and families with histories of high use of shelter and other state services or to those who are currently living unsheltered on the streets.

The underlying principle is to target the right resources to the right people at the right time so that the most expensive resources are used to assist those with the greatest needs.

Use data collection and matching between the homeless service system and other state systems to better target services to those most in need. Refined targeting through the DMHAS /DOC supported FUSE program shows great promise in using data from the state funded Homeless Management Information System (HMIS - administered by CCEH) and the Department of Corrections to direct housing services to those who use shelter and incarceration the most. An interest on the part of agency leaders to use data as a tool to refine targeting for new supportive housing slots is a promising development and can support a more direct reduction in ‘street homelessness’ and homelessness among Connecticut’s highest service users. A data match between the Rental Assistance Program waiting list and the homeless services data base (HMIS) could be used to identify currently homeless families to prioritize for available rental subsidies.

4. **Incentivize community partnerships.** Create standards of collaboration between and among local grant recipients and State-operated programs to assure that homeless services are well coordinated and meet community needs. Place a higher priority on using State dollars to fund supportive services via integrated community partnerships rather than exclusively through place-based shelter services. This will set the stage for resource re-direction once shelter use is reduced.
5. **Build capacity at the ground level.** Challenge philanthropy to invest in the technical support that local communities will need to re-align their systems. The shift from managing homelessness through a sole reliance on shelter and transitional living programs to an emphasis on prevention, rapid housing placement, and supporting people *in* housing will be a difficult one for many community-based providers. While the State works from the “top down” to change the system, it can enlist the help of Connecticut’s philanthropic community to support change from the “ground up”. For example, philanthropy can support the work of nonprofit intermediaries that help individual organizations to adapt current program models and that assist local planning bodies to create local system structures to support housing-centered work.

III. Fiscal impacts

The recommendations for re-tooling the homeless assistance system will require maintenance of current state funding levels for homeless/housing services at DSS and homeless shelter and

homeless outreach funds at DMHAS. Other state funded programs that should be preserved, as they only receive modest funding and can be coordinated for reducing homelessness, are:

- DCF Flexible funds utilized for housing (was \$5 million in 2008)
- Transitional Rental Assistance Program administered by DSS as part of its TANF maintenance of effort (approx \$500,000)
- DECD HOME dollars (federal funds administered by DECD), specifically \$500,000 identified in the 2009-2011 plan for homeless families

Success in this proposal will be driven by results in affordable and supportive housing development and the availability of future state and federally subsidized housing and rental assistance vouchers. We support the recommendations of our partner organizations, the Corporation for Supportive Housing, the Partnership for Strong Communities, and the CT Housing Coalition as it relates to state investments in supportive and affordable housing.

IV. Tie-in with Malloy/Wyman Campaign

One of the key platforms of the Malloy/Wyman campaign called for expanding housing affordability and opportunity, a critical component to enhancing Connecticut's quality of life for all. As Governor-elect Malloy has stated, "Connecticut must do more to address homelessness, particularly by enhancing its commitment to successful 'sustainable housing' programs that help those who are at risk of revolving-door homelessness to find stability and to be at home...And it must tackle homelessness by...addressing the root causes of homelessness linked to mental illness and economic opportunity."²⁵

This proposal for re-tooling the homeless assistance system toward housing-centered solutions is a comprehensive strategy that aligns with these principles and pushes the State toward more innovative, effective practices for solving the problem of homelessness. It not only protects essential safety net resources but strengthens them so that families and individuals can more readily move to housing and not be caught within the net for extended periods of time.

V. Long-Term Needs/Vision

Re-tooling the homeless assistance system is one piece of a larger array of systems reforms needed to reach these goals:

- The elimination of chronic homelessness by 2015
- The elimination of homelessness among Veterans by 2015
- The elimination of homelessness among families, children and youth by 2025
- Setting a path for ending all homelessness in the state.

These goals align with those of the Federal Strategic Plan to Prevent and End Homelessness, called "Opening Doors", which was issued in June 2010 by the United States Interagency Council on Homelessness (USICH). Opening Doors calls for accelerating the creation of permanent supportive and affordable housing and improving access to the health care, employment services and economic opportunity that undergird housing stability. To accomplish

²⁵ Dan Malloy Policy Project paper, "Housing Affordability & Opportunity", p.2.

its objectives, the Federal plan calls for an unprecedented level of collaboration among the agencies and departments of the federal government that aligns mainstream housing, health, education and human services to prevent Americans from experiencing homelessness. As the most far-reaching and ambitious plan to end homelessness in our history, the Federal plan is forging new partnerships between agencies like HUD, HHS, and the Department of Labor that will translate into new opportunities for states in addressing homelessness.

Connecticut needs to be prepared to take advantage of these Federal opportunities. The Federal plan offers our state a useful framework for organizing our own collective efforts to prevent and end homelessness, and for aligning our state and local efforts with those of the Federal government. It is also a way to incorporate, under one strategic planning umbrella, the many faceted efforts for addressing homelessness in Connecticut. Creation of a Connecticut Opening Doors 5-year strategy could serve as a roadmap for setting direction and policy at the state and local level.

Leadership from the Malloy Administration in advancing Connecticut's own Opening Doors plan would be critical to its success. CCEH, the Partnership for Strong Communities, CSH and other allies have committed time over the next five months to its development, and we hope the State will be our partner in this effort.

IV. Jobs Impact & Other Benefits

By re-aligning the homeless assistance system to make it more effective at ending homelessness, we can avoid the short and long-term cost impacts of homelessness to those experiencing it, to public systems, and to society at large. Some of these impacts include the following:

Because many homeless children have such poor education experiences, their future productivity and career prospects may suffer. This makes the effects of homelessness much longer lasting than just the time spent in shelters. Homeless children experience frequent moves that make it hard for them to keep up in school. Almost half of homeless children attend two different schools in one year. As a result, **three-quarters of homeless children perform below grade level in reading, and more than half perform below grade level in math.**ⁱ

Last year, there were 460 homeless high school students in Connecticut. The high school graduation rate for homeless children in the state is less than 25%. The National Center on Family Homelessness estimates that the **long-term consequences to Connecticut of homeless students not graduating from high school are a \$70 million loss in lifetime earnings and a \$44 million loss in contributions to society.**

Housing instability can place a family at increased risk of child welfare involvement and placement of children into foster care. Among families involved with child welfare services, the rate of placement in foster care is highest for the children of women with at least one episode of homelessness. Homelessness can also make the reunification of separated families more difficult, particularly if parents lose access to income and housing supports that allow them to create a suitable environment for their children.ⁱⁱ

Teens who have run away or have been thrown out of their homes and families are at high risk for medical problems and other health compromising behaviors. The same is true for youth who become homeless after leaving foster care, incarceration, and other residential

settings. The risks include HIV/AIDS, and other sexually transmitted and infectious diseases; substance abuse; depression and suicide attempts; prostitution and other forms of trauma.ⁱⁱⁱ

As compared with other very low-income people, adults experiencing chronic homelessness disproportionately use shelters, emergency health care, and public mental health services.

They often cycle rapidly through various public institutions – shelters, jails, emergency rooms, and inpatient

hospitals. Extraordinarily high costs for use of public services by homeless adults with mental illness or other disabling health conditions have been documented in studies conducted in a wide range of communities. Because a majority of people who are chronically homeless are unsheltered, they are more visible in many communities, contributing to public perceptions that neighborhoods or downtown districts are unsafe or undesirable.

Housing provides a stable platform for participation in the workforce. Adults who lack a permanent address have difficulty applying for jobs and staying employed.

Sincere appreciation to Carol Walter, Executive Director, Connecticut Coalition to End Homelessness,

For her assistance & efforts related to these recommendations.

ⁱ National Center on Family Homelessness, *Homeless Children: America's New Outcasts*, 1999. Housing America, *There's No Place Like Home: How America's Housing Crisis Threatens Our Children*, 1999; Family Housing Fund, *Homelessness and Its Effects on Children*, 1999.

ⁱⁱ Shinn, M.B., Rog, D., Culhane, D (2005). Family Homelessness: Background Research Findings and Policy Options. University of Pennsylvania.

ⁱⁱⁱ Whitbeck, L.B. & Hoyt, D.R. (1999). *Nowhere to Grow: Homeless and Runaway Adolescents and Their Families*, New York: NY, Aldine De Gruyter.

Transition Team/ Policy Committee/ Human Services Workgroup - Volunteers Respondents

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
Behavioral Health	Cinda	Cash	CT Women's Consortium	(203) 909-6888 (32)	Ccash@womensconsortium.org	1	
Behavioral Health	Sharon	Castelli	Chrysalis Center, Inc.	(860) 263-4400	scastelli@chrysaliscenterct.org	1	
Behavioral Health	Asher	Delerme	Chemical Abuse Services Agency, Inc.	(203) 339-4112	chemicalabuse.agency@snet.net	1	
Behavioral Health	Heather	Gates	Community Health Resources Inc.	(860) 731-5522	hgates@chrhealth.org	1	
Behavioral Health	John	Hamilton	Regional Network of Programs	(203) 929-1954	John.Hamilton@RNPin.org	1	
Behavioral Health	Domenique	Thornton	Mental Health Association of CT	860-529-1970	dthornton@mhact.org	1	
Behavioral Health	Barry	Simon	Gilead Community Services	860-343-5300	bsimon@gileadcs.org	1	
Behavioral Health	Joe	Riker	CT Renaissance	203-336-5225	jriker@ctrenaissance.com	1	
Behavioral Health	Patti	Walker	Continuum of Care, Inc.	(203) 562-2264	pwalker@continuumct.org	1	
Behavioral Health	Lisa	DeMatteis	The Connection, Inc.	(860) 343-5500	ldematteis@theconnectioninc.org	1	
Behavioral Health	Ray	Gorman	Community Mental Health Affiliates, Inc.	(860) 826-1358	rgorman@cmhacc.org	1	
Behavioral Health	Ron	Fleming	Alcohol & Drug Recovery Centers	(860) 714-3701	rfleming@stfranciscare.org	1	
Community Action Agencies	Edith	Karsky	CT Association For Community Action, Inc.	(860) 832-9438	edith@cafca.org	1	
Community Action Agencies	Joe	Mann	NEON, Inc.	(203) 899-2422	jmann@neon-norwalk.org	1	
Community Action Agencies	Lena	Rodriguez	Community Renewal Team, Inc.	(860) 560-5601	lenar@crtct.org	1	
Community Action Agencies	Amos	Smith	Community Action Agency of New Haven	(203) 387-7700	asmith@caanh.net	1	
Community Action Agencies	Rocco	Tricarico	HRA of New Britain	860-225-8601	roccot@hranbct.org	1	
Community Action Agencies	Deborah	Monahan	Thames Valley Council/Community Action	(860) 889-1365	dmonahan@tvcca.org	1	

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
Community Action Agencies	James	Gatling	New Opportunities, Inc.	(203) 575-9799	Jameshgatling@newopportunitiesinc.org	1	
Community Action Agencies	Peter	DeBiasi	The Access Agency	860-450-7452	peter.debiasi@accessagency.org	1	
Community Justice	Sherry	Albert	Community Solutions, Inc.	(860) 683-7100	salbert@csimail.org	1	
Community Justice	Tony	Corso	CT Renaissance, Inc.	(203) 336-5225 (2142)	anthonyc@ctrenaissance.com	1	
Community Justice	Maureen	Price Boreland	Community Partners in Action	(860) 566-2030	MPrice@cpa-ct.org	1	
Developmental Disabilities	Denis	Geary	Jewish Association for Community Living	(860) 522-5225	dgeary@jcl-ct.org	1	
Developmental Disabilities	Patrick	Johnson	Oak Hill	(860) 242-2274	johnsonp@ciboakhill.org	1	
Developmental Disabilities	Terry	Macy	SARAH Tuxis Residential Services	(203) 458-8532	terrym@sarah-tuxis.org	1	
Developmental Disabilities	Lynn	Warner	Arc of Connecticut	(860) 246-6400	lwarner@arcofct.org	1	
Developmental Disabilities	Paul	Rosin	CRI, Inc	860-621-7600	prosin@criinc.org	1	
Developmental Disabilities	Ed	Lamontagne	Allied Rehabilitation Centers, Inc.	(860) 741-3701 (221)	elamontagne@alliedgroup.org	1	
Developmental Disabilities	Ed	Peltier	American School For The Deaf	(860) 570-2300	Ed.Peltier@asd-1817.org	1	
Developmental Disabilities	Janice	Chamberlain	Horizons Programs, Inc.	(860) 456-1032	Janice.chamberlain@camphorizons.org	1	
Developmental Disabilities	Mark	Kovitch	Key Human Services	860-409-7350 ext121	mkovitch@keystonehumanservices.org	1	
Disabilities	Stan	Kosloski	Disability Advocacy Collaborative	860-614-8351	stankosloski@att.net	1	
Disabilities	Julie	Peters	Brain Injury Association of CT, Inc.	(860) 219-0291	jpeters@biact.org	1	
Disabilities	Jan	Van Tassel	CT Legal Rights Project	(860) 262-5030	jvantassel@clrp.org	1	
Disabilities	Alyssa	Woodsby	NAMI - CT	(860) 882-0236	publicpolicy@namict.org	1	

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Disabilities	Eileen	Healy	Independence Northwest	203-729-3299	healy.eileen.m@gmail.com	1	
Domestic Violence	Erika	Tindill	CT Coalition Against Domestic Violence, Inc.	(860) 282-7899	etindill@ctcadv.org	1	
Domestic Violence	Cathy	Zeiner	Women's Center of Southeastern CT	(860) 447-0366	czeiner@womenscenterofsect.org	1	
Domestic Violence	Barbara	Damon	Prudence Crandall Center	860-225-5187	bdamon@prudencecrandall.org	1	
HIV/AIDS	Yvette	Bello	Latino Community Services, Inc.	(860) 296-6400	ybello@lcs-ct.org	1	
HIV/AIDS	Kelly Ann	Day	New Haven Home Recovery	(203) 492-4866	kday@nhhr.org	1	
HIV/AIDS	Shawn	Lang	CT AIDS Resource Coalition	(860) 761-6699	shawn@ctaidcoalition.org	1	
HIV/AIDS	John	Merz	CT AIDS Resource Coalition	(860) 761-6699	john@ctaidcoalition.org	1	
Homeless	Alison	Cunningham	Columbus House, Inc.	(203) 401-4400	acunningham@columbushouse.org	1	
Homeless	Bonita	Grubbs	Christian Community Action	(203) 777-7848	bgrubbs@ccaahelping.org	1	
Homeless	Sr. Patricia	McKeon	Mercy Housing and Shelter Corp.	(860) 808-2028	pmckeon@mercyhousingct.org	1	
Homeless	Rafael	Pagan	Shelter for the Homeless, Inc.	(203) 406-0017	rpagan@shelterforhomeless.org	1	
Homeless	Carol	Walter	CT Coalition to End Homelessness	(860) 721-7876	CWalter@cceh.org	1	
Homeless	Carlal	Miklos	Operation Hope of Fairfield	203-254-2935	Cmiklos@operationhope.org	1	
Homeless	Ellen	Simpson	Friendship Service Center of New Britain	860-225-0211	esimpson@friendshipservicecenter.org	1	
Homeless	Tom	Hyland	Thames River Community Services	860-887-3288	Tomh@trfp.org	1	
Homeless	John	Ferrucci	South Park Inn	(860) 724-0071	jferrucci@southparkinn.org	1	
Senior/Elderly	Neysa	Guerino	Agency on Aging of South Central CT	(203) 785-8533	nsguerino@aoapartnerships.org	1	

Transition Team/ Policy Committee/ Human Services Workgroup - Volunteers Respondents

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
Senior/Elderly	Brenda	Kelly	AARP Connecticut	(860) 240-7279	bkelley@aarp.org	1	
Senior/Elderly	Kate	McEvoy	Agency on Aging of South Central CT	(203) 785-8533	kmcevoy@aoapartnerships.org	1	
Senior/Elderly	Molly	Rees Gavin	CT Community Care, Inc.	(860) 589-6226	mollyg@ctcommunitycare.org	1	
Other	Maggie	Adair	CT Association for Human Services	(860) 951-2212 (239)	madair@cahs.org	1	
Other	Robyn-Jay	Bage	Women & Families Center	(203) 235-9297	rbage@womenfamilies.org	1	
Other	Spencer	Cain		(860) 689-6770	spencer.cain@att.net	1	
Other	Patricia	Clark	Alzheimer's Association of CT	(860) 828-2828	patricia.clark@alz.org	1	
Other	Rudy	Feudo	Greater Bridgeport Adolescent Pregnancy Program	203-384-3629	rfeudo@gbapp.org	1	
Other	Jim	Horan	CT Association for Human Services	(860) 951-2212	jhoran@cahs.org	1	
Other	Nancy	Kushins	CT Sexual Assault Crisis Services, Inc.	(860) 282-9881	nancy@connsacs.org	1	
Other	Jane	McNichol	Legal Assistance Resource Center of Connecticut	(860) 278-5688 ext201	jmcnichol@larcc.org	1	
Other	Lucy	Nolan	End Hunger Connecticut! Inc.	(860) 560-2100	lnolan@endhungerct.org	1	
Other	Dan	O'Connell	CT Council of Family Service Agencies	(860) 571-0093	doconnell@ctfsa.org	1	
Other	Rick	Porth	United Way of Connecticut	(860) 571-7501	richard.porth@ctunitedway.org	1	
Other	Alice	Pritchard	CT Women's Education and Legal Fund (CWEALF)	(860) 247-6090	apritchard@cwealf.org	1	
Other	Deborah	Ullman	YWCA - Hartford Region	(860) 525-1163	deborahu@ywcahartford.org	1	
Other	Pat	Wrice	Operation Fuel	(860) 243-2345	pat@operationfuel.org	1	
Other	Susan	Yolen	Planned Parenthood of Southern New England	(203) 865-5158	susan.yolen@ppsne.org	1	

Transition Team/ Policy Committee/ Human Services Workgroup - Volunteers Respondents

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
Other	Candida	Flores	Family Life Education	860-231-7744	cflores@familylifeedu.org	1	
Other	Bob	Francis	RYSAP	203-579-2727	rfrancis_99@yahoo.com	1	
Other	Susan	Dunn	United Way of Central & Northeastern CT	860-493-6820	Sdunn@unitedwayinc.org	1	
Other	Bill	Hass	FSW, Inc.	203-368-5552	whass@fswinc.org	1	
Other	Jim	Boucher	City of Hartford Council		jimboucher@comcast.net	1	
Other	Brenda	Delgado	Central Area Health Education Center	(860) 920-5149	bdelgado@centralctahc.org	1	
Other	Brian	Anderson	AFSCME Council 4	860-690-2597	banderson@Council4.org	1	
Other	Victoria	Nimirowski	Windham Area Interfaith Ministry	(860) 456-7270	director@waimct.org	1	
Other	Jenny	Carrillo	Planned Parenthood of Southern New England	(203) 865-5158	jenny.carrillo@ppsne.org	1	
Other	Mary Ellen	Hass	Family & Childrens Agency, Inc.	(203) 855-8765 (5321)	mhass@fcagency.org	1	
Other	Judith	Meyers	Child Health & Development Institute of CT	(860) 679-1519	Meyers@adp.uchc.edu	1	
Other	Nancy	Roberts	CT Council For Philanthropy	860-525-5585	Nroberts@ctphilanthropy.org	1	
Other	Jeff	Beadle	Windham Regional Community Council	860-423-4534	jeffrey.beadle@wrcinc.org	1	
Other	Carmen	Sierra	CAUSA	860-424-0077	Csierra2001@snet.net	1	
CCPA volunteer - adult BH	Robert	Cole	CT Mental Health Center/ Yale University		robert.cole@yale.edu	1	
CCPA volunteer - adult BH	Vicki	Furey	Bridge House		Vicki@bridgehousect.org	1	
CCPA volunteer - advocacy	Kim	Harrison	government relations		kahrn@aol.com	1	
CCPA volunteer - child	Luis	Perez	Village for Families and Children		Perez, Luis [lperez@villageforchildren.org]	1	

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
CCPA volunteer - child	Irvin	Jennings	Family and Children's Aid		irvin.jennings@fcaweb.org	1	
CCPA volunteer - child, adult BH	Ray	Gorman	Community Mental Health Affiliates		rgorman@cmhacc.org	1	
CCPA volunteer - child, adult BH	Paul	Acker	InterCommunity Mental Health Group		Paul Acker [paulacker@icmhg.org]	1	
CCPA volunteer - child, adult BH	Andrew	Czerniewski	Rushford Center		aczerni@rushford.org	1	
CCPA volunteer - child, adult BH, community health center	Jamesina	Henderson	Cornell Scott Hill Health Center		jhenderson@hillhealthcenter.com	1	
CCPA volunteer - child, adult BH, developmental disabilities	Nicole	Cadovius	Ability Beyond Disability		nicole.cadovius@abilitybeyonddisability.org	1	
CCPA volunteer - child, adult BH, multiple services	Heather	Gates	Community Health Resources		hgates@chrhealth.org	1	
CCPA volunteer - developmental disabilities	Steve	Becker	HARC		sbecker@harc-ct.org	1	
CCPA volunteer - developmental disabilities	Jay	Halpern	Community Systems, Inc.		Jay Halpern [Jay.Halpern@csi-ct.org]	1	
CCPA volunteer - developmental disabilities	Stan	Soby	Oak Hill		stans@ciboakhill.org	1	
CCPA volunteer - developmental disabilities	Dick	Wilber	Network, Inc.		dickw@network-programs.com	1	
CCPA volunteer - developmental disabilities	Ed	LaMontagne	Allied Rehabilitation Centers		elamontagne@alliedgroup.org	1	
CCPA volunteer - developmental disabilities	Pam	Fields	Arc of Meriden-Wallingford		pfields@mwsinc.org	1	

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
CCPA volunteer - developmental disabilities	Patrick	Johnson	Oak Hill		johnsonp@ciboakhill.org	1	
CCPA volunteer - developmental disabilities	Martin	Schwartz	Kennedy Center		mschwartz@kennedyctr.org	1	
CCPA volunteer - disability advocacy	Daria	Smith	Statewide Independent Living Council		Daria F. Smith [daria.ctsilc@gmail.com]	1	
CCPA volunteer - disability advocacy	Alicia	Woodsby	NAMI CT		publicpolicy@namict.org	1	
CCPA volunteer - home care	Molly	Gavin	Connecticut Community Care		Molly Gavin [molly.rees.gavin@ctcommunitycare.org]	1	
CCPA volunteer - home care	Deborah	Hoyt	CT Association for Health Care and Hospice		hoyt@cahch.org	1	
CCPA volunteer - Medicaid policy expert	Brian	Ellsworth	private consultant		bdellsworth@gmail.com	1	
CCPA volunteer - Substance Abuse	John	Hamilton	Recovery Network of Programs		john.hamilton@rnpinc.org	1	
CCPA volunteer - Substance Abuse	Michele	Bissell	APT Foundation		mbissell@aptfoundation.org	1	
CCPA volunteer - Substance Abuse	Ron	Fleming	Alcohol & Drug Recovery Centers, Inc.		rfleming@stfranciscare.org	1	
CCPA volunteer-child, adult BH	Barry	Simon	Gilead Community Services		Bsimon@gileadcs.org	1	
Hospitals	Jim	Iacobellis	CT Hospital Association	203-265-7611	iacobellis@chime.org	1	
Hospitals	Dan	Lohr	Backus Hospital	860-608-6488	dlohr@wwbh.org	1	
Nursing Homes	Matt	Barrett	Ct Association of Healthcare Facilities	860-290-9424	mbarrett@cahcf.com	1	
Nursing Homes	Mag	Morelli	CANPFA	860-828-2903	Mmorelli@CANPFA.org	1	
District 1199	Deborah	Chernoff	NEHCEU	860-251-6042	deborahchernoff@att.net	1	

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
Home Care	Deborah	Hoyt	CT Assoc for Homecare and Hospice	203-294-7349	Hoyt@cahch.org	1	
Home Care	Ellen	Rothberg	VNA Healthcare	860-493-7165	Erothberg@vnahealthcare.org	1	
Substance Abuse Treatment	Jack	Malone	SCADD	860-886-2495	jackmalone@	1	
Adult Day Care	Mag	Morelli	CANPFA	860-828-2903	mmorelli@CANPFA.org	1	
social work	Steve	Karp	NASW CT	860.257.8066	Steve Karp [skarp@naswct.net]		1
Behavioral Health	Sheila	Amdur	NAMI CT		Sheila Amdur [s.amdur@snet.net]		1
Alzheimers	Win	Heimer	Alzheimer's Association of CT	860-828-2828			1
Alzheimers	Laurie	Julian	Alzheimer's Association of CT	860-828-2828			1
Elderly Services	Christine	Neidermeir	attorney			1	
Behavioral Health	Roberta	Cook	Harbor Health Services		rcook@harborhealthservices.org		1
Behavioral Health	Marilyn	Cormack	Birmingham Group Health Services		mcormack@bghealth.org		1
Behavioral Health	Kim	Beauregard	InterCommunity Mental Health Group		kimbeauregard@icmhg.org		1
Developmental Disabilities	Pat	Bourne	SARAH, Inc.		pbourne@sarah-inc.org		1
Housing	Rafie	Rodolsky	Legal Assistance Resource Center of Connecticut		rrodolsky@larcc.org		1
Workforce	Rita	Brzozowski			ritab103@gmail.com		1
Workforce	Brenda	Buchbinder			brochagila18@gmail.com		1
Cost Savings	Nancy	Matthews			nanandem@yahoo.com		1
Senior Care	Judy	Rolnick			judy_rolnick@yahoo.com		1
Disability	Paul	Ashton			saopa@sbcglobal.net		1
Senior Care	Carol				carolwentbiking@sbcglobal.net		1
Disability	Laurence and Marylyn	Hendricks			larlyn@optonline.net		1

Service Focus	First Name	Last Name	Organization Name	Phone Number	Email Address	Work Group Volunteer	Additional Respondents
Disability	Matt	Salner			policystaff@namict.org		1
Disability	Lori	Conchado	Autism Services Division	860-418-6078	lori.conchado@ct.gov		1
Disability	Alice	Buttwell	NW Medical Home Initiative for Children & Youth with Special Care Needs	203-709-3850	AliceMMBB@aol.com		1
Disability	Jennifer	Carroll	Council on Developmental Disabilities	860-418-6000			1
Disability	Edward	Preneta	Council on Developmental Disabilities	860-418-6157	ed.preneta@ct.gov		1
Behavioral Health	R. Gil	Kerlikowsk e	Office of National Drug Control Policy	202-395-5758			1
Domestic Violence	Cecile	Enrico	Interval House	860-246-9149			1
Elderly Services	Penelope	Young	CT Assn of Area Agencies on Aging				1
Elderly Services	Martha	Roherty	National Association of States United for Aging and Disabilities	202-898-2578	mroherty@nasuad.org		1
Human Services	Lois	Taylor	CT Assn for Human Services	860-951-2212	ltaylor@cahs.org		1
Disability	Stan	Kosloski	CT Disability Advocacy Collaborative	860-614-8351	stankosloski@att.net		1
Disability	John	Carr	CT Disability Advocacy Collaborative	860-614-8351			1
Developmental Disabilities	Marie and Jim	McAllister	parents	860-873-3436	jimmarmc@sbcglobal.net		1
Developmental Disabilities	Lois	Nitch	parent	860-257-4334			1
Human Services			Greater Hartford Faith Based Coalition				1
Human Services	Jeffrey	Archer	CT Health and Educational Facilities Authority	860-761-8414	jasher@cheffa.com		1
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